APPENDIX

GIANINNA GALLARDO, AN INCAPACITATED PERSON, BY AND THROUGH HER PARENTS AND CO-GUARDIANS PILAR VASSALLO AND WALTER GALLARDO,

Petitioner,

v.

SIMONE MARSTILLER, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

APPENDIX

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APPENDIX A

[PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 17-13693

D.C. Docket No. 4:16-cv-00116-MW-CAS

[Filed: June 26, 2020]

GIANINNA GALLARDO,
an incapacitated person, by and
through her parents and co-guardians
Pilar Vassallo and Walter Gallardo,

Plaintiff - Appellee,

versus

ELIZABETH DUDEK,
in her official capacity as Secretary
of the Florida Agency for Health Care
Administration,

Defendant,

MARY MAYHEW,)
in her official capacity as Secretary)
of the Florida Agency for Health Care)
Administration,)
)
Defendant - Appellant.)

Appeal from the United States District Court
for the Northern District of Florida

(June 26, 2020)

Before WILSON, BRANCH, and ANDERSON, Circuit Judges.

BRANCH, Circuit Judge:

This appeal requires us to decide the enforceability of Florida's statutory scheme through which it obtains reimbursement from third parties for Medicaid expenses it has paid to injured persons. Specifically at issue in this appeal is whether the Florida Agency for Health Care Administration ("FAHCA"),[1] when it has not consented to the settlement agreement in a personal injury lawsuit between the injured person and a third party, is limited to recovering the expenses it has paid only from amounts of a third-party recovery representing compensation for past medical expenses or whether it can also recover from those amounts that

[1] The Florida Agency for Health Care Administration is the state agency responsible for the administration of Medicaid in Florida.

may be compensation for future medical expenses.[2] That determination turns on whether federal Medicaid law preempts the way Florida pursues reimbursement from Medicaid recipients' personal injury settlements.

The plaintiff in this suit sought declaratory and injunctive relief to prevent FAHCA from recovering beyond that portion of her settlement specifically designated by the settling parties as compensation for her past medical expenses. The district court granted summary judgment for the plaintiff, concluding that federal law preempts Florida's statutory scheme for recovering Medicaid expenses. We conclude that federal law does not preempt these Florida policies, and we reverse the contrary decision of the district court.

I. BACKGROUND

Gianinna Gallardo was grievously injured in 2008 when she was hit by a pickup truck after getting off her school bus. She remains in a persistent vegetative state. Florida's Medicaid program[3] paid $862,688.77 for her medical care. Her parents filed suit in state court on her behalf against the truck's owner, the truck's driver, and the school district. In 2015, the parties

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[2] It is also worth noting what this appeal is *not* about – it is not about whether FAHCA can recover for medical expenses it has not yet paid to Appellee but may have to pay in the future.

[3] The Medicaid program allows states voluntarily to obtain funding from the federal government to provide health care benefits for needy persons. In return, the states must comply with federal laws and regulations in administering their Medicaid programs. *See generally Harris v. McRae*, 448 U.S. 297, 301 (1980).

negotiated, and the state court approved, settlement of that suit for a total of $800,000, which Gallardo's parents view as covering only a small fraction of the total damages she suffered and the future costs she will face for her care.[4] The settlement included an explicit allocation of $35,367.52 for past medical expenses.[5] It further stated that although some of the balance may represent compensation for future medical expenses Gallardo will incur in the future, no portion of the settlement is reimbursement for future medical expenses because Gallardo or others on her behalf have

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[4] Given the lifetime of care Gallardo is likely to require, her parents estimate the true value of her case at $20 million.

[5] As explained by Gallardo in her complaint: "This allocation was based on the calculation of the ratio the settlements bore to the total monetary value of all [Gallardo's] damages. Using the conservative valuation of all [Gallardo's] damages of $20,000,000, it was calculated that [Gallardo] was receiving **4%** of the total monetary value of all her damages in the settlements, and accordingly she was receiving in the settlements **4%** of her $884,188.07 claim for past medical expenses, or $35,367.52."

not yet paid any.[6] Importantly, FAHCA did not participate in or agree to the terms of the settlement.

When Medicaid recipients receive a personal injury judgment or settlement compensating them for medical expenses, federal law requires that the Medicaid program be reimbursed out of those funds. *See* 42 U.S.C. §§ 1396a(a)(25)(H), 1396k. Florida law acknowledges the requirement to seek reimbursement for medical payments it has made in its Medicaid Third-Party Liability Act:

> It is the intent of the Legislature that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients. All other sources of payment for medical care are primary to medical assistance provided by Medicaid. If benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, it is the intent of the Legislature that Medicaid be repaid in full and prior to any other person, program, or entity.

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[6] As further stated by Gallardo in her complaint: "[T]he [settling] parties acknowledge that [Gallardo] may need future medical care related to her injuries, and some portion of this settlement may represent compensation for future medical expenses [Gallardo] will incur in the future. However, the parties acknowledge that [Gallardo], or others on her behalf, have not made payments in the past or in advance for [Gallardo's] future medical care and [Gallardo] has not made a claim for reimbursement, repayment, restitution, indemnification, or to be made whole for payments made in the past or in advance for future medical care. Accordingly, no portion of this settlement represents reimbursement for future medical expenses."

> Medicaid is to be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. . . . It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

Fla. Stat. § 409.910(1). The Act instructs FAHCA to "seek 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*." *Id.* § 409.910(4) (emphasis added).

Florida carries out this policy by granting FAHCA "an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable." *Id.* § 409.910(6)(c). In the event the recipient of the Medicaid funds brings a tort action against a third party that results in a settlement, FAHCA is automatically entitled to half of the recovery (after 25 percent attorney's fees and costs), up to the total amount provided in medical assistance by Medicaid. *Id.* § 409.910(11)(f).

Crucially, and as will be seen below, in line with the Supreme Court in *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013), Florida law allows the Medicaid recipient to challenge this automatic allocation. A Florida Medicaid recipient who receives a personal injury settlement or judgment may challenge the

amount FAHCA is claiming under that formula in the following way. Within 60 days of receiving the settlement proceeds, the Medicaid recipient must place the full amount of FAHCA's entitlement in an interest-bearing trust account. *Id.* § 409.910(17)(a). Then, within 21 days the recipient must file a petition with the state Division of Administrative Hearings. *Id.* § 409.910(17)(b). In that administrative proceeding, "the recipient must prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by the agency." *Id.*

In accordance with these procedures, while Gallardo's personal injury suit was pending, FAHCA attached a lien for $862,688.77 on her cause of action and any future settlement thereof. When the suit settled for $800,000, Gallardo's counsel asked the state how much it would accept in satisfaction of its lien, given that the settlement included only $35,367.52 specifically allocated by the parties for past medical expenses. When there was no response, Gallardo put $300,000 into a trust account[7] and commenced an administrative action to challenge that amount. In the course of that action, FAHCA sought to recover more than the $35,367.52 specifically *allocated by the parties* for past medical expenses, arguing that it was also entitled to recover the amounts it paid from the portion

[7] $300,000 is the amount Florida is presumptively entitled to under the formula of Fla. Stat. § 409.910(11)(f): 25 percent was deducted from the $800,000 settlement for attorney's fees ($200,000), then half of the remaining $600,000 was $300,000.

of the settlement representing compensation for the recipient's future medical expenses.

Gallardo sued the Secretary[8] of FAHCA in the district court under 42 U.S.C. § 1983,[9] seeking a declaration that, under federal law, Florida is not entitled to reimbursement from anything more than the portion of the settlement representing compensation for past medical expenses. She represented that portion as being the parties' unilateral allocation in the settlement to past medical expenses—that is, the cap on Florida's reimbursement would be $35,367.52. The suit also sought a declaration that Florida's administrative procedure for challenging the amount of the state's claim violates federal law. The parties filed cross-motions for summary judgment.

The district court granted Gallardo's motion for summary judgment and denied FAHCA's. *Gallardo ex rel. Vassallo v. Dudek*, 263 F. Supp. 3d 1247, 1249 (N.D. Fla. 2017). It found that Fla. Stat. § 409.910 is preempted by federal Medicaid law, and it enjoined FAHCA from enforcing that law by "seeking reimbursement of past Medicaid payments from

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[8] Elizabeth Dudek was the Secretary when this suit was filed. That office is now held by Mary Mayhew, who has been substituted as a party. Fed. R. App. P. 43(c)(2).

[9] The Supreme Court has accepted (without discussion) that § 1983, which creates a private cause of action for the deprivation of federal rights, allows a Medicaid recipient to sue her state Medicaid agency to enforce the federal Medicaid anti-lien provision, 42 U.S.C. § 1396p(a)(1). *See Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 632 (2013).

portions of a recipient's recovery that represents future medical expenses." The court also declared that

> the federal Medicaid Act prohibits the State of Florida from requiring a Medicaid recipient to affirmatively disprove § 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.

FAHCA now appeals.

While this appeal was pending in our Court, the Florida Supreme Court ruled on an appeal from another Medicaid recipient's administrative action to challenge the amount of the state's claim on his tort settlement. The state court held that federal Medicaid law authorizes the state to obtain reimbursement out of personal injury settlements only from the portion of a settlement that represents past medical expenses. *Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53, 56 (Fla. 2018). When that decision became final, Gallardo moved our Court to dismiss this appeal because the question of future medical expenses was now moot. We will consider and rule upon that motion in this opinion.

II. STANDARD OF REVIEW

"We review the grant of summary judgment *de novo*, drawing all inferences and reviewing all the evidence in the light most favorable to the non-moving party." *Fresenius Med. Care Holdings, Inc. v. Tucker*, 704 F.3d 935, 939 (11th Cir. 2013).

III. DISCUSSION

FAHCA argues that it was entitled to summary judgment because federal law does not preempt its practices of (1) seeking reimbursement for the medical expenses it has paid from the portion of a third-party settlement to which FAHCA did not consent that represents all medical care—both past and future expenses, and (2) allocating tort settlements through a formula and an administrative challenge procedure. Each of these issues is a question of first impression in this Court, and we consider them in turn. But first, we discuss the legal doctrine of conflict preemption, which the district court invoked to invalidate both policies.

A. Conflict Preemption

Because federal laws are "the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding," U.S. Const. art. VI, cl. 2, "state law that conflicts with federal law is 'without effect.'" *Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 516 (1992) (quoting *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)).[10] The Supreme Court has identified two presumptions to assist us in determining whether a state law is preempted by implication in this

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[10] Two other types of federal preemption of state law—express preemption and field preemption—are not at issue here. *See generally Cipollone*, 505 U.S. at 516 (discussing the three types of preemption). The Medicaid statutes contain no statement of express preemption and no evidence that Congress intended to occupy the entire field of single-payer health care. To the contrary, Medicaid is by design a "cooperative" federal–state venture. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006).

way. *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996).[11] First, we presume "that Congress does not cavalierly pre-empt state-law causes of action." *Id.* Therefore, "we start with the assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). Two such police powers at issue here are the states' traditional authority "to protect the health and safety of their citizens" and "to provide tort remedies to [their] citizens"—matters of primarily local concern. *Id.* at 475; *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984). Second, "the purpose of Congress is the ultimate touchstone in every pre-emption case." *Lohr*, 518 U.S. at 485. Therefore, we look primarily to the language of the federal statute and the "statutory framework surrounding it" to determine whether Congress intended to preempt state law. *Id.* at 486.

Together these two principles mean that, in light of the role of the states as "independent sovereigns in our federal system," *id.* at 485, when the text of a statute "is susceptible of more than one plausible reading, courts ordinarily 'accept the reading that disfavors pre-emption.'" *Altria Group, Inc. v. Good*, 555 U.S. 70, 77 (2008) (quoting *Bates v. Dow Agrosciences LLC*, 544 U.S. 431, 449 (2005)). Further counseling caution in this context is the fact that the Medicaid Act is

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[11] Although *Lohr* was an express-preemption case, we have been guided by its two "cornerstones" of preemption jurisprudence in conflict-preemption cases. *See, e.g.*, *Ga. Latino Alliance for Human Rights v. Governor of Ga.*, 691 F.3d 1250, 1263 (11th Cir. 2012).

Spending Clause legislation. *See* U.S. Const. art. I, § 8, cl. 1. Because Congress's power to impose obligations upon the states under that clause "rests on whether the State voluntarily and knowingly accepts the terms" under which federal funding is offered, *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981), "such legislation is binding on States only insofar as it is 'unambiguous.'" *Wos*, 568 U.S. 654 (Roberts, C.J., dissenting) (quoting *Pennhurst*, 451 U.S. at 17). "Where coordinate state and federal efforts exist within a complementary administrative framework, and in the pursuit of common purposes, the case for federal pre-emption becomes a less persuasive one." *N.Y. Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 421 (1973).

For each of the preemption issues raised in this litigation, then, we will examine the text of the federal statutes and determine whether they evince a "clear and manifest purpose" to preempt aspects of Florida's traditional authority over the health of its citizens and its tort law. If they do not, or if Florida law does not "directly conflict" with federal law, *Wos*, 568 U.S. at 636 (quoting *PLIVA, Inc. v. Mensing*, 564 U.S. 604, 617 (2011)), the state law will stand.

B. Reimbursement From Portions of Settlement that Represent All Medical Care – Past and Future

The district court first concluded that, to the extent Florida law authorizes FAHCA to pursue reimbursement from anything other than those amounts of a third-party recovery representing compensation for *past* medical expenses, federal law

preempts it. For the reasons that follow, and in light of the "presumption against preemption," *Wyeth v. Levine*, 555 U.S. 555, 565 n.3 (2009), we disagree.

I. The Parties' Unilateral Allocation Does Not Bind FAHCA

Preliminarily, to the extent Gallardo argues FAHCA's recovery is limited to the amount unilaterally allocated by the parties in the settlement as "past medical expenses"—$35,367.52—her argument has no merit. The parties' unilateral allocation has no bearing on FAHCA's power to seek reimbursement for medical expenses it paid and FAHCA is not bound by the parties' unilateral decision. The Supreme Court worried about just this type of situation: "The [*Ahlborn*] Court nonetheless anticipated the concern that some settlements would not include an itemized allocation. It also recognized the possibility that Medicaid beneficiaries and tortfeasors might collaborate to allocate an artificially low portion of a settlement to medical expenses." *Wos*, 568 U.S. at 634 (citing *Ahlborn*, 547 U.S. at 288). Finding otherwise would lead to incomprehensible results: for example, here, the parties unilaterally allocated $35,367.52 of the settlement amount as "past medical expenses," but what if the parties had decided to unilaterally allocate only $20,000, would FAHCA's reimbursement be limited to only $20,000? Or, put another way, what if Gallardo's parents estimated the true value of her claim at $40,000,000—making the explicit allocation in the settlement for past medical expenses half of what it is now, $17,683.76—would FAHCA's reimbursement be limited to that amount? According to Gallardo, in

both scenarios, FAHCA's reimbursement would be limited by the parties' unilateral allocation and determination. But that cannot be true. Parties' unilateral allocations as to what constitutes "past medical expenses" do not, and should not, bind FAHCA. FAHCA is permitted to seek reimbursement from parts of the settlement money that represent medical care—including those that the parties have designated as "future medical care."

Therefore, when the parties do not seek FAHCA input on the settlement allocation for medical expenses on the front end, FAHCA has its statutory allocation formula on the back end to determine how much of the settlement should be allocated to medical expenses. As set forth below, to the extent that the Florida law permits FAHCA to recover monies it paid from settlement monies ultimately allocated to all medical care, past and future, "but not in excess of medical assistance paid by Medicaid," Fla. Stat. § 409.910(4), it does not conflict with the text of the federal Medicaid statutes and is thus not preempted on this basis.

II. Federal Medicaid Law Does Not Preempt FAHCA's Practice of Seeking Reimbursement from Portions of a Settlement that Represent All Medical Expenses

To address the question of whether FAHCA can seek reimbursement of medical expenses it paid from those portions of the parties' settlement that represent all medical expenses—past and future—we turn to the text of the federal Medicaid statutes to determine if they conflict with (and thus preempt) the Florida statute. Because the text of the federal Medicaid statutes only prohibit a State from asserting a lien

against any part of a settlement not "designated as payments for medical care," *Ahlborn*, 547 U.S. at 284, and Florida's statutes provide it can recover only for "medical assistance paid by Medicaid [to a Medicaid beneficiary]," Fla. Stat. § 409.910(4), as well as a formula for calculating what portion of a settlement represents such medical care, Fla. Stat. § 409.910(11)(f) and (17)(b), the text and structure of the federal Medicaid statutes do not conflict with Florida law and thereby do not preempt it.

As a starting point, federal law prohibits states from imposing liens "against the property of any individual . . . on account of medical assistance paid" to that beneficiary. 42 U.S.C. § 1396p(a)(1) ("anti-lien provision"). An exception to the anti-lien provision is the provision (42 U.S.C. § 1396a(a)(25)) which requires state Medicaid agencies to pursue reimbursement from liable third parties "to the extent of such legal liability"—the entire amount Medicaid paid on behalf of the individual.[12] To aid the States' reimbursement requirement, the Medicaid Act provides an assignment provision (42 U.S.C. § 1396k) which mandates that states require Medicaid recipients to assign their rights

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[12] A State plan for medical assistance must "take all reasonable measures to ascertain the legal liability of third parties" and "that in any case where such legal liability is found to exist after medical assistance has been made available on behalf of the individual . . . the State or local agency will seek reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. §§ 1396a(a)(25)(A, B). The State must have in effect laws providing for such reimbursement rights. 42 U.S.C. § 1396(a)(25)(H).

to payments for medical care from any third party.[13] This assignment for the beneficiary's right to payments for medical care sets a "ceiling" on the State's potential share of a recovery. *Wos*, 568 U.S. at 633. To be sure, the federal statutes are clear that third-party reimbursement is required—indeed, permitted—only for medical expenses, and not for other damages that may be covered by a tort settlement, such as lost wages or pain and suffering. *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 284–85 (2006). To hold otherwise would be, in the words of *Ahlborn*, "absurd and fundamentally unjust." *Id.* at 288 n. 19. And neither party suggests that the Florida statute would permit FAHCA to recover from the settlement anything other than the portion that represents medical expenses.

But what restrictions, if any, do the federal statutes impose on a state agency seeking reimbursement for amounts it has paid from settlement monies allocated to medical expenses? After all, as noted above, the assignment provision in section 1396k(a)(1)(A) broadly requires States to provide that Medicaid recipients must assign to the state "any" of their rights to "payment for medical care from any third party" as a condition of their acceptance of benefits. And that provision applies before a recipient receives a single dollar's worth of medical care through Medicaid. In contrast to the broad assignment provision set forth in

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[13] A State plan for medical assistance must provide that "as a condition of eligibility for medical assistance" from Medicaid, an individual "is required . . . . to assign any rights . . . . to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A).

section 1396k, the language of 42 U.S.C. § 1396a(a)(25)(H) requires states to enact third-party liability laws under which "the State is considered to have acquired the rights . . . to payment by any other party," "to the extent that payment *has been made* under the State plan for medical assistance for health care items or services furnished." 42 U.S.C. § 1396a(a)(25)(H) (emphasis added).[14] This past-tense language, Gallardo and the district court say, clearly shows that only reimbursement from portions of a settlement allocated to past expenses is permitted. The dissent also embraces this argument. But the plain language of this provision (or any other provision of the Medicaid statutes, for that matter) clearly contains no such limitation. While section 1396a(a)(25)(H) is narrower than the assignment provision in describing the subrogation rights a state acquires when "payment has been made," it simply provides *for what* the state can get reimbursed now that it has a general

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[14] The dissent dubs 42 U.S.C. § 1396a(a)(25)(H) as the "specific assignment provision." But, unlike the assignment provision (42 U.S.C. § 1396k(a)(1)(A))—a subsection in section 1396k titled "*Assignment*, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State," *id*. which mandates a State require assignment from a liable third party for the medical expenses paid by the state—42 U.S.C. § 1396a(a)(25)(H) is a subsection in section 1396a which focuses on what "[a] State plan for medical assistance must--provide," 42 U.S.C. § 1396a(a)(25)(H), not what a State must require an individual to assign. And while the dissent does accurately quote the language of 42 U.S.C. § 1396a(a)(25)(H) initially, it later says "the state gets the right to only third party payments made for past medical care." However, this language is what the dissent concludes the statute means, not what the statute actually provides.

assignment on all medical expenses—it can recover medical expenses it has already paid.[15] Gallardo, the district court, and the dissent, however, all make the same leap-in-logic mistake here and assert that because the agency is limited to recovering monies it paid in the past, it necessarily is limited to recovering these monies *from* what represents compensation in the settlement for "past medical expenses." But while the language of the federal Medicaid statutes clearly prohibits FAHCA from seeking reimbursement *for* future expenses it has not yet paid (which it is not seeking to do in this case), the language does not in any way prohibit the agency from seeking reimbursement *from* settlement monies for medical care allocated to future care.[16] To take an example offered by the

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[15] Congress, in enacting § 1396a(a)(25)(H) sixteen years after it enacted § 1396k(a)(1)(A), did not contradict or restrict § 1396k(a)(1)(A); rather it added to the exceptions to the anti-lien provision by adding a specific assignment permission for when payment has been made. Accordingly, the dissent's citation to the general/specific canon is inapposite here because the statutes can be harmonized *in pari materia*. *See* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 183-85, 252 (2012), noting that the general/specific canon is in effect only when a specific provision contradicts a general provision—i.e., a general prohibition that is contradicted by a specific permission; but when they can exist in harmony as laws dealing with the same subject they should be read as such—a general permission followed by a more specific permission.

[16] The very existence of this dispute about the federal statutory text answers the preemption question. Federal law must evince a "clear and manifest purpose" to supersede the states' traditional powers over health care and tort law. What is evident here is at most ambiguity, and when it comes to preemption, mere ambiguity is not enough. We conclude, therefore, that in the absence of a

dissent, the fruit stand analogy, one step further: (1) imagine you sold $10 worth of apples, $10 worth of oranges and $10 worth of cucumbers for a total of $30; (2) you owed your town $15 for a license it granted you to pick apples in the town's orchards; and (3) your town passed a law stating that, until the license fee is paid in full, it gets the rights "to payment by any other party" for fruits. The text of the law, permitting reimbursement for the apple license from payments by any other party for "fruits" would allow the town to take $15 from payments made for "fruits"—apples *and* oranges—and is not limited to the $10 of apples sold. If, however, you sold only $5 worth of apples, $5 worth of

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clearly expressed intent to preempt state law in this area, Florida's policy must be allowed to stand.

The dissent argues that the question is not, in fact, close, because "most of the country" believes this question is not a close one and "most courts have held that the Medicaid Act clearly preempts state law" in cases like this one. That charge, on its face, seems persuasive. But what does the dissent mean by "most courts"? Not what one might think—just one circuit court, two district courts, and a handful of state courts of appeal and state supreme courts. These cases hardly suggest that this issue is settled. And looking at the one decision rendered by our sister circuit, we find that it is not. In *E.M.A. ex rel. Plyer v. Cansler*, 674 F.3d 290, 312 (4th Circuit. 2012), *aff'd sub nom. on other grounds Wos v E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013)—notably, this is the case underlying the Supreme Court case we have discussed extensively herein—the dissent points to language in the opinion where the Fourth Circuit was simply summarizing (perhaps a little loosely) the holding in *Ahlborn*. The Fourth Circuit did not actually render a decision on the issue involved in this case. And while the dissent acknowledges that two district courts and one state supreme court have agreed with the majority, it dismisses them, characterizing them as "[a] fleeting few." In any event, this issue is hardly a settled one.

oranges, and $20 worth of cucumbers, the town would be limited to the $10 paid for fruits and could not take the remaining $5 from the payments made for cucumbers. Similarly, here, according to the plain text of the Medicaid statutes, the State is allowed to seek reimbursement for payments it made for medical care under section 1396a(a)(25)(H) (apple picking license) from settlement monies allocated to all medical care per section 1396k(a)(1)(A) (fruits) and the only limitation on its recovery is that it cannot seek reimbursement from settlement amounts allocated to categories other than medical care under section 1396p(a)(1) and (b)(1) (cucumbers).

Nor has the Supreme Court held otherwise, despite the dissent's suggestion to the contrary. In *Ahlborn*, the Supreme Court examined some of the Medicaid provisions we cite today. In that case, the Court differentiated between reimbursement from the portion of a settlement that represents medical expenses and all other parts of a settlement which the State cannot reach under the anti-lien provision. In interpreting § 1396k(a)(1)(A)'s text—requiring recipients to assign "any rights . . . . to payment for *medical care* from any third party"— the Supreme Court stated that a State may obtain only an assignment of right to third-party payments for "medical expenses—not lost wages, not pain and suffering, not an inheritance." *Ahlborn*, 547 U.S. at 281. And although *Ahlborn* did not resolve how to determine what portion of a settlement represents medical care, *see Wos,* 568 U.S. at 634, the Supreme Court repeatedly made clear that the State's assignment and reimbursement was from the portion of a settlement that represented "medical expenses"

and "medical care" and did not limit it solely to "*past*" medical expenses.[17] The dissent ignores that nuance, arguing that "[a]lthough the Supreme Court didn't feel the need to spell it out, the logical and necessary extension of this rule is that the state can recover only from payments marked for past medical care."[18] Putting aside the dissent's willingness to read into a Supreme Court case a holding (and add an extra word—"past") the Court did not reach, the statute itself supports no such reading, as noted above.

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[17] *See Ahlborn*, 547 U.S. at 275 ("The Eighth Circuit reversed. It held that ADHS was entitled only to that portion of the judgment that represented payments for medical care. For the reasons that follow, we affirm."); *id*. at 280 ("We must decide whether ADHS can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses. The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care." (footnote omitted)); *id*. at 281 ("Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance."); *id*. at 282 ("[U]nder the federal statute the State's assigned rights extend only to recovery of payments for medical care. Accordingly, what § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care."); *id*. at 284 ("There is no question that the State can require an assignment of the right . . . to receive payments for medical care. . . . [T]he exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.").

[18] The dissent also says "[b]ut even if the actual letter of Ahlborn doesn't command preemption . . . Ahlborn's logic necessarily compels it" and "the Court never used the term "past medical care" (even though that's clearly what it meant…)."

And the dissent ignores a crucial premise underlying *Ahlborn*. In settling the case, the parties did not allocate categories of damages and the State did not participate in the settlement; however, to facilitate the district court's decision, the State at trial stipulated to an amount in the settlement agreement attributable to "medical payments made." *Ahlborn*, 547 U.S. at 274. This amount was much less than the past medical expenses, so the district court never had to reach the issue of the state's entitlement to amounts in the settlement agreement attributable to future medical expenses. The stipulation there put a cap on the amount recoverable by the State even if the amount in the settlement allocated for *past* medical expenses exceeded the stipulation. *See Ahlborn*, 547 U.S. at 284 n. 13. Here, however, FAHCA never agreed to the amount attributable in the settlement agreement to past or future medical expenses. Accordingly, as described herein, Florida's Medicaid Third-Party Liability Act would allow FAHCA to recover the monies it paid up to (but not in excess of) $300,000 unless Gallardo is able to show that the amounts she recovered from a third party for her medical expenses, past and future, are less than that amount. *See* § 409.910(17)(b).[19] Thus, as "discerned from the language of the . . . statute," *Lohr*, 518 U.S. at 485, and

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[19] In effect, then, FAHCA has two ceilings on its recovery: one, it can get reimbursed up to "but not in excess of medical assistance paid by Medicaid," Fla. Stat. § 409.910(4); the second, a lower ceiling, is the amount designated by the formula. Even if a higher amount than $300,000 in the settlement represents compensation for medical care, FAHCA is limited to reimbursement only from the $300,000 allocated by the formula.

heeding the Supreme Court's findings that the anti-lien provisions only "prohibits a State from making a claim to any part of a Medicaid beneficiary's tort recovery not 'designated as payments for medical care.'" *Wos*, 568 U.S. at 636 (quoting *Ahlborn*, 547 U.S. at 284), we conclude that § 409.910(17)(b) of Florida's Medicaid Third-Party Liability Act does not conflict with federal law and is not preempted.

Gallardo has argued, however, that the question before us is moot because FAHCA is now bound by the recent decision of the Florida Supreme Court in *Giraldo* and thus can seek reimbursement only for amounts allocated by the settlement to past medical expenses. *See Giraldo*, 248 So. 3d at 56 (interpreting only 42 U.S.C. § 1396a(a)(25)(H)). But first, as both parties acknowledge, this issue is a question of federal law, and this federal Court is not bound by a state court's interpretations of federal law. *Venn v. St. Paul Fire & Marine Ins. Co.*, 99 F.3d 1058, 1064 (11th Cir. 1996). And second, the court in *Giraldo* while citing Ahlborn, makes the same mistake in logic about section 1396a(a)(25)(H) that the district court and the dissent make here. Thus, whatever effect *Giraldo* may have upon any other case, *Giraldo* does not bar us from granting the relief that Florida seeks in the present case, as Gallardo has conceded. Oral Arg. at 36:52. "A case is moot when it no longer presents a live controversy with respect to which the court can give meaningful relief." *Ethredge v. Hail*, 996 F.2d 1173, 1175 (11th Cir. 1993). Because we can give meaningful relief, this case is not moot. Accordingly, Gallardo's motion to dismiss this appeal must be denied.

C. Statutory Formula and Challenge Procedure

The district court also concluded that federal law preempts Florida's method of allocating the share of a personal injury settlement from which it is entitled to seek reimbursement: its formula of half the settlement after 25 percent attorney's fees, combined with the procedure in which a recipient may challenge that allocation in an administrative hearing by clear and convincing evidence. *See* Fla. Stat. § 409.910(11)(f), (b). For the reasons that follow, and again in light of the presumption against preemption, we disagree.

The district court relied on the Supreme Court's 2013 decision in *Wos*, in which the Court held that the federal Medicaid anti-lien provision, 42 U.S.C. § 1396p(a)(1), preempted North Carolina's third-party reimbursement scheme, which automatically allocated one-third of any recipient's tort settlement as reimbursement for medical expenses. *Wos*, 568 U.S. at 636. In *Wos*, the Supreme Court explained that North Carolina's statutory scheme conflicted with federal law by "set[ting] forth no process" for determining what portion was actually for medical expenses, where the state did not show that the one-third allocation was "reasonable in the mine run of cases." *Id.* at 636, 637. The district court in this case found that Florida's scheme also suffered from these flaws. It concluded that, although Florida provides a process for challenging Florida's claim, the formula's allocation "is nearly impossible to rebut" and that "requiring a Medicaid recipient to overcome a hodgepodge of hurdles amounts to a quasi-irrebuttable presumption."

Our preemption analysis on this issue begins with the "ultimate touchstone," "the purpose of Congress" which "primarily is discerned from the language of the . . . statute." *Lohr*, 518 U.S. at 485. On this point we are bound by the Supreme Court's statement in *Wos*: "The Medicaid anti-lien provision prohibits a State from making a claim to any part of a Medicaid beneficiary's tort recovery not 'designated as payments for medical care.'" *Wos*, 568 U.S. at 636 (quoting *Ahlborn*, 547 U.S. at 284). Thus, "[a]n irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate" because "[i]n some circumstances . . . the statute would permit the State to take a portion of a Medicaid beneficiary's tort judgment or settlement not 'designated as payments for medical care.'" *Id.* at 639, 644.

In light of the clear mandate against an "irrebuttable, one-size-fits-all" presumption, we next ask whether Florida's scheme directly conflicts with it. "State law is pre-empted 'to the extent of any conflict with a federal statute,'" *Hillman v. Maretta*, 569 U.S. 483, 490 (2013) (quoting *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000)), but no further. We find that the Florida scheme differs significantly from the North Carolina scheme that the *Wos* Court found was preempted, and we conclude that it does not directly conflict with federal law.

Unlike North Carolina, which imposed an irrebuttable formulaic allocation, Florida "provide[s] a mechanism for determining whether" its formulaic allocation is a reasonable approximation of a recipient's

medical expenses. *See Wos*, 568 U.S. at 637. Under the Florida Medicaid Third-Party Liability Act,

> a recipient . . . may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition . . . with the Division of Administrative Hearings. . . . In order to successfully challenge the amount designated as recovered medical expenses, the recipient must prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f).

Fla. Stat. § 409.910(17)(b).

We reject the district court's assertions that Florida's allocation is "nearly impossible to rebut" and "quasi-irrebuttable." Nothing in the statute or the record supports those assertions. "Clear and convincing evidence" is not an "impossible" evidentiary standard. It is a familiar and widely used standard of proof in Florida civil proceedings, requiring evidence "of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established." *S. Fla. Water Mgmt. Dist. v. RLI Live Oak, LLC*, 139 So. 3d 869, 872–73 (Fla. 2014) (listing types of cases where this standard applies). Most importantly for purposes of our preemption analysis, nothing about this standard of proof stands in clear conflict with federal law under *Wos*.

Our conclusion that Florida's statutory formula is not preempted by federal law finds support in the Supreme Court's extensive dicta in *Wos* about what North Carolina could have done differently to avoid a conflict with federal law. *See Wos*, 568 U.S. at 641–43. The Court opined that "a judicial or administrative proceeding" could be an appropriate way to allocate a settlement. *Id.* at 638–39. Noting that "States have considerable latitude to design administrative and judicial procedures to ensure a prompt and fair allocation of damages," the Court favorably pointed out several states' specific procedures, all involving "rebuttable presumptions and adjusted burdens of proof." *Id.* at 641. Oklahoma's procedure, which it labeled "more accurate" than North Carolina's, is similar to Florida's: it uses a formula that allocates 100 percent of a settlement after attorney's fees, and then allows the recipient to rebut that allocation by clear and convincing evidence. *See id.* (citing Okla. Stat. tit. 63 § 5051.1(D)(1)(d)).

Because we find that Florida's approach to threading the needle of federal third-party reimbursement requirements does not directly conflict with them, we conclude that it is not preempted.

IV. CONCLUSION

Gallardo's motion to dismiss this appeal as moot is **DENIED**. The judgment of the district court is **REVERSED** and **REMANDED**.

WILSON, Circuit Judge, concurring in part and dissenting in part:

Today this court tells Florida that it can pocket funds marked for things it never paid for.[1] The court does so even though the Medicaid Act says differently, the United States Supreme Court says differently, and most other courts say differently. Although I agree with the majority that federal law does not preempt Florida's allocation process (though I use a slightly different analysis, as I explain in Part II), I disagree with its view that federal law does not preempt Florida's self-proclaimed right to third-party payments for future medical care. On this larger issue, I must dissent.

I.

There's no need to repeat the majority's rundown of the dizzying Medicaid Act. But as the Act is a labyrinth, a quick glossary might help. There are five provisions to remember. Two are general rules; three are exceptions.

First is the anti-lien provision. This section says that no lien "may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the [s]tate plan [with exceptions not relevant here]." 42 U.S.C. § 1396p(a)(1).

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[1] The majority calls the defendant "FAHCA" throughout its opinion. Since FAHCA is conducting business for the state, and since the Medicaid Act speaks in terms of what a state must do to comply with the Act, I will refer to FAHCA as "Florida" or "the state" for simplicity.

Second, the anti-recovery provision. It says that no "adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the [s]tate plan may be made [also with exceptions not relevant here]." *Id.* § 1396p(b)(1). These provisions are the general rules. Read "literally and in isolation," they stop states from picking at a Medicaid recipient's tort recovery. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 284 & n.13 (2006).

That brings us to the exceptions, and the third provision to remember: the third-party-liability provision. This section tells the state to first "take all reasonable measures 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). If the state finds "after medical assistance has been made available on behalf of the [recipient]" that a third party is liable for the recipient's injuries, the state must "seek reimbursement for such assistance to the extent of such legal liability." *Id.* § 1396a(a)(25)(B).

Fourth up is the general assignment provision. *Id.* § 1396k(a)–(b). This provision generally entitles the state to the recipient's right to "payment for medical care from any third party." *Id.* § 1396k(a)(1)(A). It then notes that the state can keep those payments "as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed . . . and the remainder of such amount collected shall be paid to such individual." *Id.* § 1396k(b).

The last exception—the crux of this appeal—is the specific assignment provision. It applies "to the extent

that payment has been made under the [s]tate plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance." *Id.* § 1396a(a)(25)(H). In that event, the state must have in effect laws that, "to the extent that payment has been made under the [s]tate plan for medical assistance for health care items or services furnished to an individual," give the state the right to recover third-party payments "for such health care items or services." *Id.*[2]

These provisions, taken together, set up the state recovery scheme. The general rules protect a Medicaid recipient's recovery from the state; the exceptions list the few times when the state can claw into a recipient's coffers. But this point bears repeating: Without an exception, the general rules barring state recovery apply. *See Ahlborn*, 547 U.S. at 284–85. The state can recover only what the exceptions say it can recover. *See id.*

In *Ahlborn*, the Supreme Court clarified the narrow reach of the exceptions. It held that the exceptions

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[2] The majority uses different names for the last two provisions. It calls the general assignment provision the "assignment provision" and references the specific assignment provision only by its statutory code. Given how important these provisions are here, I respectfully diverge from the majority's framing and will use distinct labels for clarity. And despite the majority's suggestion in footnote 14 (and as we will discuss more below), the specific assignment provision *does* focus on "what a State must require an individual to assign"—it tells the state that it must have laws assigning to it the recipient's right to payment for past medical care. So this label is accurate and will help us make sense of the Medicaid Act.

entitle the state to only the part of a Medicaid recipient's recovery that represents payment for "medical care." *Id.* at 282. That makes sense—under the Medicaid program, the state pays for only a recipient's medical care, and so the state can recover from only the part of a recipient's recovery that represents payment for medical care. The question here is whether the state can reach the part of a recipient's recovery that represents payment not for past medical care, but for *future* medical care—care that the state has never paid for.

The answer is no. Under the Medicaid Act, the state can reimburse itself only from the amount of the recovery that represents payment for past medical care. Federal law preempts state law to the contrary. *See PLIVA, Inc. v. Mensing*, 564 U.S. 604, 617 (2011) ("Where state and federal law directly conflict, state law must give way.").

Despite the majority's efforts, the question is not close. The statute's plain text demands this result. As the United States Supreme Court and most other courts have recognized.[3]

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[3] Before we go on, let's briefly discuss what this dissent is not about. The majority starts its analysis by rejecting a bad argument—that the state is limited to the part of the settlement that the recipient and the tortfeasor unilaterally allocated as payment for past medical care. *See* Majority Op. at 12–13. The majority and I agree on this point. As I explain in Part II, the Supreme Court has made clear that the recipient cannot unilaterally allocate away the state's interest in the part of her recovery that represents payment for past medical care. *See infra* at 53–61. To protect against abusive unilateral allocations, the Court has armed the state with powerful tools to determine what

A.

The gist of the majority's holding is that its hands are tied: Because the exceptions do not clearly limit the state to the part of the recovery that represents payment for past medical care, respect for state law precludes conflict preemption. The problem for the majority is that the exceptions *do* clearly limit the state to the part of the recovery that represents payment for past medical care. In fact, they're riddled with references to the past.

Consider the specific assignment provision. It declares that when a state acquires a recipient's right to third-party payment, the state acquires only the right to payment for the recipient's past medical care—the only care for which the state has paid:

> [T]o the extent that *payment has been made* under the [s]tate plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the [s]tate has in effect laws under which, *to the extent that payment has been made* under the [s]tate plan for medical assistance *for health care items or services furnished* to an individual, the [s]tate is considered to have acquired the rights of such

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part of a recovery represents payment for past medical care: judicial determinations, presumptive allocations, and administrative hearings. *See id.* at 53–57. The majority and I diverge on a different point: Whether, after the state figures out what part of the recovery represents payment for past medical care, it can then take from the part of the recovery that represents payment for future medical care. That is what this dissent is about.

> individual to payment by any other party *for such health care items or services* . . . .

42 U.S.C. § 1396a(a)(25)(H) (emphasis added).

The paragraph starts with the headline "to the extent that *payment has been made*." *Id.* (emphasis added). Then, to eliminate any doubt, it repeats itself: "[T]o the extent *that payment has been made* under the [s]tate plan for medical assistance *for health care items or services furnished* to an individual," the state gets the right to third-party payments for "*such* health care items or services." *Id.* (emphasis added). This latter phrase naturally refers to the only health care items or services that have been "furnished" to the recipient—past medical care. *See, e.g.*, *Latham v. Office of Recovery Servs.*, 2019 UT 51, ¶ 32 (Utah 2019), *cert. denied*, *Office of Recovery Servs. v. Latham*, 140 S. Ct. 852 (2020).

So this exception, in no uncertain terms, says that the state gets only the right to third-party payments made for the recipient's past medical care—the only care for which the state has paid. In the settlement context, the "payments made for the recipient's past medical care" are, as all agree, the parts of the settlement that represent payment for past medical care. The specific assignment provision thus limits the state to that part of the recovery. And the legislative history confirms that this is the right reading. *See* H.R. Rep. No. 103-111, 210 (1993) ("The Committee bill provides that, in any case where a third party has a legal liability *to make payment for services provided to a Medicaid beneficiary*, a State is subrogated to the right of any other party to *payment for such services* to

the extent that payment has been made by the Medicaid program." (emphasis added)).

B.

Rather than tackle this seemingly clear directive, the majority claims that the very existence of a contrary interpretation creates ambiguity, barring conflict preemption. But that's true only if the contrary reading is reasonable. *See Houghton v. Payne*, 194 U.S. 88, 99 (1904) (holding that a statute is ambiguous when it is "susceptible of two reasonable interpretations"); *Freemanville Water Sys., Inc. v. Poarch Band of Creek Indians*, 563 F.3d 1205, 1210 (11th Cir. 2009) (noting that the "very definition of ambiguity" is the existence of "two *reasonable*, competing interpretations" (emphasis added)). The majority's reading is not.

Aside from a claim that the specific assignment provision does not textually distinguish between past and future medical care (which, as explained before, it does), the majority hangs its hat on the general assignment provision. This provision, unlike the specific assignment provision, does not refer to the past. It mentions only that a recipient assigns to the state the recipient's right to "payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). Put another way, the general assignment provision says that the state gets the recipient's right to third-party payments for all medical care, past *and* future.

Yet a simple rule settles these inconsistencies: The more specific provision controls. *See* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of*

Legal Texts 183 (2012) (noting that when "there is a conflict between a general provision and a specific provision, the specific provision prevails"). To be sure, the general assignment provision describes the state's right to third-party payments for medical care generally. But the specific assignment provision describes what happens when the state seeks to recover third-party payments for medical care that the state fronted for the recipient—exactly the issue presented here. *See Latham*, 2019 UT 51, ¶ 35.

And specificity isn't the only problem for the majority; another is time. As Florida highlights in its briefs, Congress passed the specific assignment provision 16 years *after* the general assignment provision. *Compare* Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, 91 Stat. 1175 (1977) (enacting the general assignment provision), *with* Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993) (enacting the specific assignment provision). It is thus the most recent word on the subject. And when interpreting statutes, "we rely on the long-standing principle that, if two statutes conflict, the more recent or more specific statute controls." *Tug Allie-B, Inc. v. United States*, 273 F.3d 936, 948 (11th Cir. 2001). The specific assignment provision wins on both counts. So it is the more on-point authority.

The majority has a different take, though. It says that the specific assignment provision simply "provides *for what* the state" can recover, not *from where* the state can recover. *See* Majority Op. at 16–19. In the majority's eyes, the specific assignment provision

merely explains that the state can recover only up to the amount that it paid for past medical care. It does not, per the majority, say that the state can recoup that amount from only the part of the recovery that represents payment for past medical care.

And yet that can't be right. For starters, both the general assignment provision and the third-party-liability provision already explain "*what*" the state can recover—each makes clear that the state can reimburse itself only up to the amount that it spent on past medical care. The general assignment provision says that the state can take a recipient's third-party payments only as "necessary to reimburse [the state] for medical assistance payments made [for the recipient] . . . the remainder of such amount collected shall be paid to [the recipient]." 42 U.S.C. § 1396k(b). And the third-party-liability provision—which comes before the specific assignment provision in 42 U.S.C. § 1396a(a)(25)—tells us that when the state has paid for "medical assistance," the state gets reimbursement "for such assistance." *See id.* § 1396a(a)(25)(B). Layman's terms: When the state has paid for the recipient's past medical care, it is entitled to reimbursement only for the cost of the recipient's past medical care. Why, then, would Congress reiterate (for a third time) this bedrock principle in the specific assignment provision? The answer is that it wouldn't. And we should avoid any reading that relies on this redundancy. *See United States v. Fuentes-Rivera*, 323 F.3d 869, 872 (11th Cir. 2003) (per curiam) (explaining that we interpret statutory provisions "so that no words shall be discarded as being meaningless, redundant, or mere surplusage").

At any rate, we need not turn to tools of statutory interpretation to knock down the majority's construction; the statute's plain language is enough. The specific assignment provision says that the state gets only the recipient's right "to payment by any other party" for past medical care. 42 U.S.C. § 1396a(a)(25)(H) (emphasis added). This means that the state acquires only the recipient's right to whatever payment the third party paid for past medical care. Put differently, the state can recover from only the part of the settlement (i.e., the payment) that was paid for past medical care. Florida doesn't somehow get the right to pick at other third-party payments, like the part of the settlement paid for future medical care.

An example confirms that this reading is right. Imagine that you own a fruit stand. One day, you sell your friend $5 worth of apples and $5 worth of oranges for a total of $10. Now let's also say that you owe your town $10. To recoup the debt, your town passes a law entitling the town to your rights "to payment by any other party" for apples. Putting aside that you might vote your city council out of office in the next election, you would naturally read this law to give your town the right to $5—the amount of the "payment" that your friend gave you for the apples. You wouldn't think that the town could take the full $10 dollars that your friend paid you, because part of that payment was paid for oranges. And it doesn't matter that you owe the town $10—the town limited itself to third-party payments paid for apples, and so that is all it can recover.

The specific assignment provision is no different. It entitles the state to recover from only third-party

payments for past medical care. So the state gets the right to recover from whatever amount the third party paid for past medical care, no matter if the recipient's past medical bills exceed the part of the settlement paid for past medical care. *See id.*

So despite the majority's effort to make this a dispute over *what* the state may recover, that's not what we're debating—everyone agrees that the state can recover only up to the amount that it paid for the recipient's past medical care. We are debating *where* the state can recover those expenses from, or said differently, whether the state is limited to reimbursing itself from the part of the recipient's settlement that represents payment for past medical care. The plain language of the specific assignment provision answers that question: The state can take from only the part of the settlement paid for past medical care. Nothing more.[4]

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[4] For what it's worth, this rule makes good sense. Yes, this provision may prevent the state from reimbursing itself fully for the amount that it spent on the recipient's past medical care. This is because the part of a recipient's tort recovery paid for past medical care could be less than the actual amount of those costs. Yet the Medicaid Act makes clear that the state has a right to recover only for what it has paid—the recipient's past medical costs. So the Act necessarily fractionalizes the state's recovery to encompass only the fraction of the settlement that represents those costs. Otherwise, the state could swallow parts of the settlement that have nothing to do with the benefits that the state has fronted for the recipient (here, the part of the settlement representing payment for the recipient's future medical care). As I explain more below, the Supreme Court has rejected that outcome—the outcome that the majority condones here—calling it "absurd and fundamentally unjust." *See Ahlborn*, 547 U.S. at 288

And so contrary to the majority's footnote 15, the general assignment provision and the specific assignment provision are *not* in harmony. The general assignment provision says that the state gets the right to all third-party payments made for medical care. *See id.* § 1396k(a)(1)(A). The specific assignment provision says that the state gets the right to only third-party payments made for past medical care. *See id.* § 1396a(a)(25)(H). These provisions cannot be reconciled. Since the specific assignment provision is more recent and more on point, *see supra* at 34–36, it applies over the general assignment provision. And with the general assignment provision vanished, the majority's reading has no leg to stand on.

C.

Still, the majority might say, the text of the Medicaid Act is just not clear enough to warrant conflict preemption. It is, after all, a Byzantine enterprise. *Ga., Dep't of Med. Assistance ex rel. Toal v. Shalala*, 8 F.3d 1565, 1568 (11th Cir. 1993). Luckily though, if there were ever a riddle about what this text means, *Ahlborn* unraveled it.

1.

In *Ahlborn*, the Supreme Court analyzed the interplay between the general rules and the exceptions. Faced with a claim that a state can recoup its debt from any part of a recipient's recovery, the Court said

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n.19. And as I also explain more below, the state has several Court-sanctioned tools to protect against the recipient allocating away the state's limited recovery interest. *See infra* at 53–57.

no. It held, in a nine-to-nothing opinion, that the Act's plain text "makes clear" that when the state has paid for "health care items or services furnished" to a recipient, "the [s]tate must be assigned" only "the rights of the recipient to payment by any other party for such health care items or services." *See Ahlborn*, 547 U.S. at 281–82 (alterations accepted) (emphasis omitted). Put another way, the state can claim only third-party payments for medical care that the state paid for first. *See id.*; *accord supra* at 28–39.

Although the Supreme Court didn't feel the need to spell it out, the logical and necessary extension of this rule is that the state can recover only from third-party payments marked for past medical care. Indeed, *Ahlborn* held that the exceptions allow the state to take only from a recipient's recovery for medical care because medical care was the only thing that the state had paid for. *See id.* By extension, the exceptions allow the state to take only from a recipient's recovery for past medical care because past medical care is the only thing that the state has paid for.

The Court made this point clear through an example. It analogized to a state-court case in which the state paid workers'-compensation benefits to the spouse of an employee whose injuries were caused by a third-party tortfeasor. *See id.* at 288 n.19 (citing *Flanigan v. Dep't of Labor & Indus.*, 869 P.2d 14, 17 (Wash. 1994)). After the spouse recovered loss-of-consortium damages from the tortfeasor, the state sought the rights to the spouse's loss-of-consortium damages to pay itself back for the workers'-compensation benefits. *See Flanigan*, 869 P.2d

at 15. The Washington Supreme Court rejected this bid, explaining that the state could not reach the spouse's loss-of-consortium damages, because the state did not "cover" the spouse's "damages for loss of consortium." *Id.* at 17. *Ahlborn* approved of this result, recognizing that the state agency there could not "share" in the part of the recovery representing loss-of-consortium damages, because the state had "provided no compensation" for those damages. *See* 547 U.S. at 288 n.19. Such a result would be "absurd and fundamentally unjust." *See id.*

So too with settlement proceeds marked for a recipient's future medical care. Florida has never paid for the recipient's future medical care. And thus Florida cannot "share" in the recipient's right to settlement proceeds paid for future medical care. *See id.* Such a result would be "absurd and fundamentally unjust." *See id.*

Another *Ahlborn* example underscores this rule. After explaining that the state can recover only from settlement proceeds representing payment for "health care items or services" that the state paid for first, the Court emphasized that "the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance." *Id.* at 281. Although "the Court did not include 'future medical expenses' in that list, it would have fit." *Latham*, 2019 UT 51, ¶ 36. Because just as the state has fronted no part of a recipient's wages, pain and suffering, or missing inheritance, the state has fronted no part of a recipient's future medical bills. The state has paid for

only the recipient's past medical bills. And so the state can lay claim to only that part of the recipient's recovery. *See Ahlborn*, 547 U.S. at 281.

The bottom line then is this. *Ahlborn* teaches that the Act's past-tense references aren't just references: They're restrictions. *See id.* The Act's nods to the past limit the state's recovery to proceeds earmarked for past medical expenses—the only expenses that the state has ever paid. *See* 42 U.S.C. § 1396a(a)(25)(A)–(B), (H).

2.

Against this backdrop, the majority's semantics stretch too thin. It says that since *Ahlborn* held that the state could recover from third-party payments made for "medical care," but never used the magic words "past medical care," federal law does not clearly forbid recovery from third-party payments made for future medical care. But even if the actual letter of *Ahlborn* doesn't command preemption (though it does—more on that later), *Ahlborn*'s logic necessarily compels it. *Ahlborn*'s basic premise is that the state can recover only from third-party payments made for debts that the state paid for the recipient. This generally means medical care. But it *specifically* means past medical care—the only health care items or services that the state has "furnished." *See id.* § 1396a(a)(25)(H).

And let's take a step back here. Why would the Supreme Court go through all this trouble to explain that the state can't take money marked for things that it never paid for, only to then let the state take money

marked for things that it never paid for? Yet that's the rule the majority mints today. Simply because the Court never used the term "past medical care" (even though that's clearly what it meant), the majority says the state can pluck payments paid for a recipient's future medical burdens—burdens for which the state has never paid and may never pay.

That rule flouts *Ahlborn*. And despite the majority's gloss, the most logical construction is what Congress in fact did: limit the state to the part of the recovery that encompasses what the state actually "furnished"—past medical care.

D.

In any event, this isn't an open question: *Ahlborn* held that federal law limits the state to the part of the settlement that represents payment for past medical care.

Here's why. The plaintiff's argument throughout *Ahlborn* was that the state "is limited to that portion of the settlement proceeds which fairly represents the *past medical expense* component of her recovery." *Ahlborn v. Ark. Dep't of Human Servs.*, 280 F. Supp. 2d 881, 883 (E.D. Ark. 2003) (emphasis added); *see also Ahlborn v. Ark. Dep't of Human Servs.*, 397 F.3d 620, 622 (8th Cir. 2005) ("Ahlborn brought suit seeking a declaratory judgment, arguing that [the state] can only recover that portion of her settlement representing payment for *past medical expenses*." (emphasis added)). To move the case along, the state and the recipient stipulated that the part of the settlement representing payment for past medical care was $35,581.47. *See*

Ahlborn, 547 U.S. at 274 ("To facilitate the District Court's resolution of the legal questions presented, the parties stipulated that . . . if Ahlborn's construction of federal law was correct, [the state] would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for *medical payments made*." (emphasis added)).[5]

The Supreme Court later held that the exceptions limit the state's recovery to the part of the settlement representing payment for medical care. *See id.* at 291– But in doing so, it also held that "Federal Medicaid law does not authorize [the state] to assert a lien on Ahlborn's settlement *in an amount exceeding $35,581.47*"—the amount of the settlement representing payment for past medical care. *Id.* at 292 (emphasis added).

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[5] The lower court opinions also confirm that when the Supreme Court said that the parties stipulated to how much of the settlement represented "medical payments made," it was referring to the parties' agreement about how much of the settlement represented payment for past medical care. The Eighth Circuit, for instance, explained that the "parties stipulated" that $35,581.47 was "a fair representation of the [part] of the settlement constituting payment by the tortfeasor for past medical care." *Ahlborn*, 397 F.3d at 622. And the district court made clear that if the recipient there were to prevail on her claim that the state's recovery "is limited to that portion of the settlement proceeds which fairly represents the past medical expense component of her recovery," then the recipient would recover $35,581.47—the amount of the settlement that the parties agreed as representing payment for past medical care. *Ahlborn*, 280 F. Supp. 2d at 883.

That decides the issue. Although the Court didn't draw out that its use of the term "medical care" meant "past medical care," that's what the plaintiff argued throughout the case, and that must be what the Court held. Otherwise, it could not have ruled that the state could take only $35,581.47—the amount of the settlement representing payment for past medical care. It wouldn't have held that the state can't assert a lien "in an amount exceeding $35,581.47"; it would have held that the state can't assert a lien "in an amount exceeding $35,581.47 [plus any amount representing payment for future medical care]."

That's not what the Court wrote. And since the Courts of Appeals are not in the business of assuming that the Supreme Court made a typo, there's only one reasonable conclusion: This query is closed. "Medical care" means "past medical care."

The majority puts up two arguments in response; neither is persuasive. It first notes the obvious—*Ahlborn* did not textually distinguish between past and future medical care. But as explained above, *Ahlborn*'s reasoning and its holding—which limited the state to only the amount that the parties stipulated as representing payment for past medical care—makes clear that *Ahlborn* was talking about past medical care, not all medical care.

Second, the majority tries to limit *Ahlborn* to its facts. *See* Majority Op. at 20–21. It notes that, in *Ahlborn*, the state and the recipient stipulated to how much of the settlement represented payment for past medical care. Here, in contrast, Florida did not consent

to the allocation proffered by Gallardo and the tortfeasor and has not agreed to a stipulated allocation.

To start, it is unclear why this distinction makes a difference. If anything, the spotlight the majority shines on the stipulation in *Ahlborn* only proves my point: The state there agreed that about $35,000 of the settlement represented payment for past medical care. For all intents and purposes, then, the amount of the settlement allocated for past medical care equaled about $35,000. After this, the Supreme Court ruled generally that the Medicaid Act allowed the state to recover from only the part of the settlement allocated for medical care. And then the Court held specifically that the state could recover only about $35,000 of the settlement—the amount of the settlement allocated for past medical care. As I explained before, the only way the Court could have reached that result is if it concluded that the state may recover from only the amount of the settlement that represents payment for past medical care. *See supra* at 43–45.

But in any event, if the majority is claiming that *Ahlborn* doesn't apply here because Florida has not consented or stipulated to an allocation, the majority is mistaken. It cites nothing from *Ahlborn* to support such a claim. And in fact, the Fourth Circuit rejected this exact argument. *See E.M.A. ex rel. Plyler v. Cansler*, 674 F.3d 290, 307 (4th Cir. 2012), *aff'd sub nom. on other grounds Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013). There the district court endorsed a "narrow interpretation of *Ahlborn*," limiting it to cases where the parties (i.e., the recipient and the state) agreed on an allocation or where there was a

prior judicial determination about the correct allocation. *See id.* The Fourth Circuit reversed, rejecting this "crabbed application" of *Ahlborn*. *Id.* It noted that the Court's ruling "in no way" turned on "whether there has been a prior determination or stipulation as to the medical expenses portion of a Medicaid recipient's settlement." *Id.* Rather, "*Ahlborn* is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care already received." *Id.* That rule applies no matter if Florida has stipulated to an allocation. *See id.*; *see also Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53, 56 (Fla. 2018) (holding that a plain reading of the Medicaid Act preempts Florida's practice of garnishing more than the part of a settlement representing payment for past medical care, even when Florida has not stipulated to the recipient's proffered allocation); *see id.* at 57–59 (Polston, J., concurring in part and dissenting in part) (reaching the same conclusion solely due to the Court's holding in *Ahlborn*, and concluding that *Ahlborn* applies even when Florida has not stipulated to the recipient's proffered allocation).

E.

That our court breaks with most of the country today only solidifies that this question is not close. Because though the majority claims that a lack of clarity bars conflict preemption, most other courts have had no trouble reading this supposed crystal ball. Far and away, most courts have held that the Medicaid Act clearly preempts state law allowing state recovery from settlement proceeds paid for future medical care. *See,*

e.g., *Plyler*, 674 F.3d at 307, 312; *McKinney ex rel. Gage v. Philadelphia Hous. Auth.*, 2010 WL 3364400, at *9 (E.D. Pa. Aug. 24, 2010); *Price v. Wolford*, 2008 WL 4722977, at *2 (W.D. Okla. Oct. 23, 2008); *Sw. Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1108–10 (Ariz. Ct. App. 2011); *In re Estate of Martin*, 574 S.W.3d 693, 696 (Ark. App. 2019), *reh'g denied* (Ark. App. Apr. 24, 2019); *Bolanos v. Superior Court*, 87 Cal. Rptr. 3d 174, 179–81 (Cal. App. 4th 2008); *Giraldo*, 248 So. 3d at 56; *Lugo ex rel. Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892, 895–96 (N.Y. Sup. Ct. 2006); *In re E.B.*, 729 S.E.2d 270, 453 (W. Va. 2012) ("After a thorough examination of the *Ahlborn* decision and the language contained in [the West Virginia statute] . . . we find that [the statute] directly conflicts with *Ahlborn*, insofar as it permits [the state] to assert a claim to more than the portion of a recipient's settlement that represents past medical expenses."); *Latham*, 2019 UT 51, ¶ 20. So though the majority suggests that this is a close call—and thus one that inherently precludes conflict preemption—a countrywide consensus says exactly the opposite.[6]

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[6] A fleeting few have accepted the majority's view. *See I.P. ex rel. Cardenas v. Henneberry*, 795 F. Supp. 2d 1189, 1197 (D. Colo. 2011); *Special Needs Tr. for K.C.S. v. Folkemer*, 2011 WL 1231319, at *1 (D. Md. Mar. 28, 2011); *In re Matey*, 147 Idaho 604, 608 (2009). Yet their analysis is sparse, and they ignore the points made above. In fact, one court seemed to hold that a recipient's likelihood of staying on Medicaid somehow influences the construction of the Medicaid Act—a plainly incorrect view. *See Henneberry*, 795 F. Supp. 2d at 1197 ("Because Plaintiff intends on staying on Medicaid, any funds allocated for future medical expenses should rightfully be exposed to the state's lien so that

The majority contends that, despite this federal- and state-court consensus, this "issue is hardly a settled one." Majority Op. at 17–18 n.16. It disregards most the cases I cite above, altogether ignoring the district-court and state-court cases. *Id.* Instead, it zeroes in on just the Fourth Circuit case, dismissing that court as interpreting *Ahlborn* "a little loosely." *Id.* At the gate, I'm puzzled by the ease in which the majority rejects well-reasoned opinions from federal district courts and state appellate courts—three of which come from state supreme courts. But at any rate, the majority is wrong to dismiss the Fourth Circuit case. *Plyler*'s interpretation of *Ahlborn* was unequivocal: "[F]ederal Medicaid law limits a state's recovery to settlement proceeds that are shown to be *properly allocable to past medical expenses*." 674 F.3d at 312 (emphasis added). Although that holding wasn't the only issue in the case, it was essential to the Fourth Circuit's analysis (and ultimate rejection) of the district court's interpretation of the Medicaid Act. *See id.* at 307. So we cannot dismiss the Fourth Circuit's interpretation of *Ahlborn* as mere dicta. *See United States v. Gillis*, 938 F.3d 1181, 1198 (11th Cir. 2019) (per curiam) (explaining that dicta is "a statement that neither constitutes the holding of a case, nor arises from a part of the opinion that is necessary to the holding of the case"). It is persuasive authority from a sister circuit—apparently the only other circuit to have addressed this issue.

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the state can be reimbursed for its past medical payments."). At any rate, these cases are in the minority and pale against the majority trend.

The majority also forgets to add an important piece of persuasive authority to the mix: the Supreme Court's recent denial of certiorari in *Office of Recovery Services v. Latham*, 140 S. Ct. 852 (2020). In *Latham*, the Supreme Court of Utah issued a detailed opinion that unanimously rejected the majority's minority-trend interpretation of the Medicaid Act, adopting instead the majority-trend position that I have taken here. *See* 2019 UT 51. The Court's denial of certiorari there is by no means a binding holding. But given the widespread consensus described above, one would think that the Court would have tackled this issue had it thought that most courts were wrong and that, instead, the minority view was right. The Court's pass on the issue thus suggests that the majority view, not the majority's view, is the right one.

Finally, you may have noticed near the end of the string cite above that even Florida has rejected the majority's application of the Medicaid Act to Florida law. *See Giraldo*, 248 So. 3d at 56. In short order, all seven of Florida's Supreme Court Justices held that the Medicaid Act trumps Florida's recovery plan; six because the text clearly preempts, one because *Ahlborn* expressly decided this issue. *Id.* at 56– 59. Although Florida's take on federal law doesn't bind us, its invalidation of its own law should give us pause. Indeed, for an opinion that claims to rest on respect for Florida's rights, overruling a unanimous panel of Florida's Supreme Court seems inconsistent.

F.

To close, I'll note that the majority's ruling has laid the foundation for federal-state forum shopping.

Florida Medicaid recipients will now head to state administrative court to benefit from the Florida Supreme Court's holding in *Giraldo* (in fact, Florida law compels recipients to challenge the state's lien in state administrative court, *see* Fla. Stat. § 409.910(17)(b)). Meanwhile, Florida may seek declaratory relief in federal court to bypass *Giraldo* and benefit from our holding in *Gallardo*. That holding will bind our district courts to declare that the Medicaid Act does not preempt Florida's attempt to recover from the part of the recipient's recovery that represents payment for future medical care. And then Florida will take the federal-court judgment to state court and argue that it has a preclusive effect on the recipient.

This situation is far from hypothetical—it's exactly what's happening here. The parties agree that the reason *Giraldo* has not mooted this case is that Florida intends to use the preclusive effect of our judgment in state administrative court. Although the administrative court will decide in the first instance whether preclusion applies, it will apply federal preclusion law. *See Philadelphia Fin. Mgmt. of San Francisco, LLC v. DJSP Enters., Inc.*, 227 So. 3d 612, 616 (Fla. 4th DCA 2017). And under federal law, it seems likely that res judicata will apply. *See In re Piper Aircraft Corp.*, 244 F.3d 1289, 1296 (11th Cir. 2001) (noting that res judicata generally bars relitigation when (1) there is a final judgment on the merits; (2) the decision was rendered by a court of competent jurisdiction; (3) the parties, or those in privity with them, are identical in both suits; and (4) the same cause of action is involved in both cases). So, perversely, the state administrative court will likely

apply the Eleventh Circuit's decision in *Gallardo*, rather than the Florida Supreme Court's decision in *Giraldo*.

I see nothing to stop Florida from taking this tact again. And thus the majority, by cutting a chasm between federal and Florida law, has sown the seeds for forum shopping. Recipients will rush to state court. Florida will rush to federal court. And whoever gets the ruling first will win. That is a stereotypical forum-shopping scenario. And it is an arbitrary outcome that warrants either en banc or Supreme Court review.

* * *

In the end, the majority says that it can't make heads or tails of the Medicaid Act, so the tie goes to Florida. That is wrong. Conflict preemption must be clear, no doubt, but Congress doesn't need to etch its intent in statutory stone. Said differently, you don't need a weatherman to know which way the wind blows. Given the text's plain preference for the past, the logic and letter of *Ahlborn*, and the sound reasoning of most courts across the country (including Florida's Supreme Court), it's clear that federal law preempts Florida's practice of garnishing the part of a recipient's recovery paid for future medical care. And so I dissent.

II.

That all said, I agree with the majority that Florida's allocation scheme (i.e., the way that it decides how much of the settlement represents payment for past medical care) complies with federal law. Still, Florida's plan is not perfect. On this record, federal law would preempt Florida's allocation formula if it stood

alone. But because Florida allows the recipient to rebut the presumptive allocation in an administrative proceeding, and because Gallardo has not shown that the presumptive allocation is in fact irrebuttable, Florida's process complies with the Medicaid Act.

A.

In *Wos*, the Supreme Court reaffirmed that the Medicaid Act preempts state laws that allow the state to claim part of a recipient's tort recovery not designated as payments for past medical care. *See* 568 U.S. at 636. But the Court recognized a problem: It's not always clear what part of a tort recovery represents payment for past medical care. *See id.* at 640. So how does the state divvy up an ambiguous recovery in a way that complies with the Act? Although the Court did not provide a surefire path around preemption, it hinted at two ways through which the state might winnow out past medical costs: an easy way and a hard way. *See id.* at 636– 43.[7]

The easy way to avoid preemption is for the state to have a proceeding to decide the correct allocation. *See id.* at 638–39 (expressing repeatedly the Court's preference for individual adjudication over a one-size-fits-all formula). The tribunal there can decide

[7] Of course, *Wos* did not limit the ways that a state might comply with the Medicaid Act. To the contrary, the Court left open the possibility that other administrative methods could comply with federal law, so long as those methods do not let the state claim any part of a recipient's recovery allocated for anything besides past medical care and do not violate other Medicaid objectives. *See Wos*, 568 U.S. at 636.

the right way to divide the tort recovery, with an eye toward how much the recipient might have received for past medical care had the case gone to trial. *See id.* at 640 (stating that although a "fair allocation" of an ambiguous recovery "may be difficult to determine," trial judges and lawyers "can find objective benchmarks to make projections of the damages the plaintiff likely could have proved had the case gone to trial").

To simplify this process, the state can also establish a presumptive allocation for how much of the recovery represents past medical costs, so long as the challenger can rebut that presumption in a proceeding. *See id.* at 641–42 (describing several state presumption-based allocation methods as "more accurate" than North Carolina's law and noting that North Carolina "might also consider a different [allocation method] along the lines of what other [s]tates have done in Medicaid reimbursement cases"). But this is key: If the state uses a presumptive allocation, the presumption must in fact be rebuttable. *See id.* at 639. "An irrebuttable, one-size-fits-all statutory presumption" violates the Medicaid Act. *See id.*

Now, the hard way. Should the state decide that "case-by-case judicial allocations will prove unwieldy," the state can "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." *See id.* at 643. If the state does so, it need not hold an allocation proceeding; the evidence-backed allocation method decides what part

of the settlement represents payment for past medical care. *See id.* (distinguishing state recovery through *ex ante* criteria from state recovery through "case-by-case judicial allocations").

The reason this is the hard way is that the state, if it wants to rely solely on an *ex ante* allocation method, must provide evidence that the method will reach a fair allocation "in the mine run of cases." *See id.* In other words, the state bears the burden of showing that its method usually works. *See id.* at 655–56 (Roberts, C.J., dissenting) (pointing out that *Wos* requires that the state provide "some sort of study substantiating the idea that [the *ex ante* allocation method works] in most cases," which is "quite odd" given that the Supreme Court has "never before, in a preemption case, put the burden on the [s]tate to compile an evidentiary record supporting its legislative determination").

Though this is a unique standard, it makes sense. Even a skim through *Wos* reveals that the Court favors individualized determinations over broad-brush algorithms. *See id.* at 638–43 (making repeated reference to individual adjudications, but spending just two sentences on *ex ante* procedures). And for good reason: Without a proceeding to check its work, a formulaic allocation may let the state reach parts of a recipient's tort recovery not marked for past medical costs. *See id.* at 636. The Court thus held that if a state wants to rely on an *ex ante* allocation method alone (like an allocation formula), it needs to prove that the method typically leads to a reasonable allocation for past medical costs. *See id.* at 643.

B.

Given these rules, Florida's formula—standing alone as an *ex ante* allocation method—does not comply with *Wos*. This is because the state has not shown that its formula works "in the mine run of cases." *See id.* at 643. Nowhere in the record does Florida put forth studies, expert analysis, or even anecdotal evidence to prove that its formula typically reaches a fair result. In fact, Florida conceded in response to a public-records request that it has "no responsive documents" containing any "analysis" on whether the formula-based allocation "is a reasonable approximation of the amount recovered for past medical expenses." As North Carolina did in *Wos*, Florida has adopted a "one-size-fits-all allocation for all cases," with no proof that the formula usually works. *See id.* at 643. This process, on its own, does not comply with federal law. And if that were the end of it, federal law would preempt Florida's allocation scheme.

C.

Fortunately for Florida, that's not the end of it, because Florida's allocation scheme does not hinge solely on the formula. Instead, Florida takes the easy route: It allows the recipient to challenge the formula's presumptive allocation in an administrative proceeding. *See* Fla. Stat. § 409.910(17)(b). This presumption-based process balances the state's interest in recouping Medicaid payments—and the administrative realities of doing so—with the recipient's property interest in tort recovery. *See Wos*, 568 U.S. at 641 (noting that states have "considerable latitude to design administrative and judicial

procedures to ensure a prompt and fair allocation of damages"). And since a recipient can challenge the presumption in an administrative proceeding, the process follows *Wos*'s strong preference for individual review. *See id.* at 638–43.

The recipient calls this process bunk because it requires that the recipient prove that the presumptive allocation is wrong by clear and convincing evidence. But the Court has suggested—almost a wink and a nudge—that federal law does not forbid this level of burden-shifting. *See id.* at 641 (describing several burden-shifting schemes as "more accurate" than North Carolina's process, including one in which the recipient must rebut the presumption by clear and convincing evidence). And Gallardo has not proven that the clear and convincing evidence standard makes the presumption effectively irrebuttable. To the contrary, Florida has shown that recipients can and often do rebut the presumption by clear and convincing evidence. *See, e.g.*, *Herrera v. Agency for Health Care Admin.*, No. 16-1270, 2016 WL 6068013 (Fla. DOAH Oct. 11, 2016); *Cardenas v. Agency for Health Care Admin.*, No. 15-6594, 2016 WL 5784135 (Fla. DOAH Sept. 29, 2016); *Weedo v. Agency for Health Care Admin.*, No. 16-1932, 2016 WL 5643668 (Fla. DOAH Sept. 27, 2016). The procedure thus complies with the level of burden-shifting considered in *Wos*. *See* 568 U.S. at 641.[8]

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[8] It is not lost on me that by showing that challengers often rebut the presumption, the state proves that the formula often gets it wrong. But again, Florida's formula isn't the end—it's the beginning. For administrative convenience, Florida sets a

Gallardo also claims that Florida's presumptive-allocation formula poisons its allocation process because the formula might spit out the wrong number to start. But that is inherently true of all presumptive allocations: They don't always get the correct allocation right off the bat. That is why the Supreme Court held that the state must have a way to ensure that the presumptive allocation is reasonable in each particular case—a feat that the state can accomplish through a proceeding in which the recipient can rebut the presumptive amount. *See id.* at 639–40. On top of this, the Supreme Court seems open to rebuttable presumptions, some even more onerous than Florida's. *See id.* at 641 (describing several rebuttable presumptions as "more accurate" than North Carolina's process, including one in which the state presumes that the *entire tort recovery* represents past medical costs and requires that the recipient rebut the presumption by clear and convincing evidence). So the presumption can be off at the start, as long as the recipient can meaningfully rebut that result in the end.

Gallardo also levies another attack on Florida's presumptive allocation. She seems to say that the state, if it wants to use a presumption, must first prove that its presumptive allocation is reasonable "in the mine run of cases." In other words, Gallardo slaps onto

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presumptive number using a standard formula and then allows the challenger to rebut that number. Since the presumptive number is in fact rebuttable, the procedure properly balances the state's interest in administrative feasibility with the individual's right to tort recovery. *See Wos*, 568 U.S. at 639.

the presumptive-allocation method the same burden that *Wos* attached to the *ex-ante*-criteria method.

This argument misses the mark for a few reasons. For one, *Wos* discusses presumptive allocations and *ex ante* criteria at different parts of the opinion, and there is no indication that it meant to tie them together. *Compare id.* (discussing presumptive allocations), *with id.* at 643 (discussing *ex ante* criteria). In fact, the Court said that presumptive allocations are simply proceeding modifications—they ensure that individual proceedings do not become too burdensome in the aggregate. *See id.* at 641. Because they are part and parcel of individual proceedings, these presumptions seem to receive the same deference that the Court gives to individual review, not the heightened standard that the Court applies to *ex ante* formulas not backed by individual review. *See id.* at 641. And again, *Wos* considered presumptive allocations just as arbitrary as (and far more onerous than) Florida's presumption, and it did so without suggesting that those states would need to prove that their presumptions are correct in the mine run of cases. *See id.*

Above all, the reasons for imposing a heightened standard to stand-alone formulas do not apply to rebuttable presumptions. When a state relies solely on an *ex ante* formula without proof that the formula works in the "mine run of cases," the state provides no assurance that the allocation will be fair for each particular case. *See id.* at 637. But when the state uses a rebuttable presumption, there remains a way to ensure that the allocation is reasonable in each case: an individual proceeding in which the recipient can

rebut the presumptive amount. *See id.* at 641. So when a state uses an administrative proceeding as a failsafe for its presumptive allocation, it need not bear the heavy burden of proving that its presumptive allocation is reasonable in the mine run of cases. *See id.*

* * *

If Florida relied on only its formula to administer its allocation scheme, Gallardo would be right that the scheme conflicts with *Wos*. But because Florida uses its formula to create a presumptive allocation, and because Gallardo has not shown that the presumptive allocation is in fact irrebuttable, Florida's process complies with federal law. For these reasons, I concur with the majority.

APPENDIX B

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

Case No. 4:16cv116-MW/CAS

[Filed: July 18, 2017]

GIANINNA GALLARDO, AN INCAPACITATED PERSON, BY AND THROUGH HER PARENTS AND CO-GUARDIANS PILAR VASSALLO AND WALTER GALLARDO,	)
Plaintiff,	)
v.	)
JUSTIN M. SENIOR, IN HIS OFFICIAL CAPACITY AS SECRETARY OF FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,	)
Defendant.	)

ORDER GRANTING IN PART AND DENYING IN PART MOTION TO ALTER OR AMEND JUDGMENT

In a cult-classic film, an eccentric inventor transforms a DeLorean sports car into a sleek time

machine. *Cf. Back to the Future* (Universal Pictures 1985). Enthralled, the protagonist travels back in time, where (Great Scott!) he soon realizes that his actions in the past can nonetheless affect the future.

The Florida Agency for Health Care Administration ("AHCA")[1] has also tried to go back in time but, unlike the protagonist mentioned above, it *hopes to change* the future (more specifically, this Court's prior judgment). AHCA's vehicle of choice, though, isn't a time-traveling DeLorean; it is a Motion to Alter or Amend the Judgment. In that motion, AHCA makes a number of arguments—most of which were previously available to it. But this is not a movie; AHCA has not pointed to a sufficient reason for this Court to go back in time to allow it to raise those arguments in the first instance. AHCA also presents a separate standing argument, which is properly before this Court. But because AHCA is the agency that administers Medicaid and the only additional steps necessary to redress Gallardo's injuries are purely mechanical, its standing argument is unconvincing on the merits.

AHCA's motion is therefore **GRANTED** in part and **DENIED** in part.[2]

I

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[1] For simplicity sake, This Court will refer to AHCA rather than Justin M. Senior (or Elizabeth Dudek, the original Defendant who has since stepped down from her position), who has been sued in his official capacity as Secretary of AHCA.

[2] Court reaches this conclusion with the benefit of a June 15, 2017, hearing.

The facts were addressed at length in this Court's original order granting summary judgment. *Gallardo v. Dudek*, No. 4:16-cv-116, 2017 WL 1405166 (N.D. Fla. Apr. 18, 2017). They are summarized briefly below and supplemented with the more recent events in this case.

Medicaid is a joint federal–state program whereby the federal government pays a significant portion of a recipient's medical costs and, in return, participating states must comply with the applicable federal statutes and regulations. *Id.* at *2. One of those provisions—the so-called anti-lien provision—states 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, [with exceptions not relevant here]." 42 U.S.C. § 1396p(a)(1) (2012). But two other provisions—the third-party liability and assignment provisions—are narrow exceptions that allow the state to assert liens on payments for medical care. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 285 (2006) ("[T]he exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.").

Florida, which participates in the Medicaid program, applies a one-size fits all statutory formula to determine how much of a recipient's recovery constitutes medical expenses and is therefore available for Medicaid reimbursement. *See* 409.910(11)(f), Fla. Stat. (2016). The ultimate result is that AHCA is awarded the lesser of(1) the amount it actually paid on the Medicaid recipient's behalf, or (2) 37.5% of the Medicaid recipient's total recovery. *Gallardo*, 2017 WL

1405166, at *3. The Medicaid recipient, however, may challenge that formula-based allocation and thus reduce the amount payable to AHCA by filing a petition with the Division of Administrative Hearings ("DOAH") and "'prov[ing], 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' required by the statutory formula." *Id.* (quoting § 409.910(17)(b), Fla. Stat. (2016)).

Gallardo is currently in the midst of that administrative process. She was struck by a vehicle and suffered severe and permanent injuries. Gallardo's medical expenses were covered by Medicaid and WellCare of Florida, which paid $862,688.77 and $21,499.30, respectively. *Id.* Gallardo's parents filed suit against those allegedly responsible for her injuries, and AHCA asserted a lien against that cause of action for the $862,688.77 it expended on her behalf. *Id.* Gallardo's case settled for $800,000. *Id.* Under Florida's formula-based allocation, AHCA was therefore due to be reimbursed $323,508.29 in medical expenses. *Id.*

Rather than pay that lien in its entirety, Gallardo contested it through the state administrative procedure outlined in § 409.910(17)(b). *Id.* at *4. In those proceedings, Gallardo has argued that, contrary to federal law, AHCA is attempting to recover its past Medicaid payments from settlement funds that do not represent compensation for pa st medical expenses. *Id.* AHCA, however, has argued that it may satisfy its lien from the portion of Gallardo's settlement representing compensation for past and *future* medical expenses. *Id.* It has further argued that Gallardo may successfully

challenge that formula-based allocation only if she can prove by clear and convincing evidence that the amount of her settlement representing past and future medical expenses is less than $323,508.29. *Id.*

Gallardo then sought declaratory and injunctive relief from this Court, ECF No. 1, and summary judgment was granted in its favor. More specifically, this Court declared that the federal Medicaid Act preempted certain portions of § 409.910(17)(b) and that AHCA therefore could not (1) "seek[] reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses" or (2) "requir[e] a Medicaid recipient to affirmatively disprove . . . § 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." *Gallardo*, 2017 WL 1405166,at *11. AHCA was therefore enjoined from enforcing § 409.910(17)(b) in its current form. *Id.*

Apparently frustrated with this Court's ruling, AHCA hired new counsel, *see* ECF Nos. 42–43 (filing notices of appearance) and moved to vacate or amend the prior judgment, *see* ECF No. 44 (filing motion to alter judgment). According to AHCA, this Court erred in refusing to consider the reimbursement statute's practical effect and improperly shifted the burden to AHCA, thus requiring it—the non-moving party—to present evidence establishing that the reimbursement statute is not in conflict with (and therefore preempted by) federal law. *Id.* at 2–3. AHCA also asserts that this Court's prior judgment should be vacated because

amendments to the federal Medicaid Act —which will apparently allow states "to obtain reimbursement from all or any part of a" Medicaid recipient's recovery—are scheduled to take effect on October 1, 2017. *Id.* at 17. Finally, AHCA submits that it does not enforce certain preempted portions of the reimbursement statute; thus, the judgment must be vacated or amended. *Id.* at 3.

II

Rules 59 and 60 of the Federal Rules of Civil Procedure are tools of limited utility. They are not intended to provide disgruntled litigants with a second bite at the apple. *See O'Neal v. Kennamer*, 958 F.2d 1044, 1047 (11th Cir. 1992) (explaining that attempts under Rule 59 "to obtain a second bite at the apple" are generally inappropriate); *Seamon v. Vaughan*, 921 F.2d 1217, 1220 n.6 (11th Cir. 1991) (asserting that "raising . . . new arguments on a motion to amend . . . affords a litigant two bites at the apple" (citation omitted)). That is because the extraordinary remedy of reconsideration is only appropriate in rare circumstances. *See Pensacola Firefighters' Relief Pension Fund Bd. of Trs. v. Merrill Lynch Pierce Fenner & Smith, Inc.*, 265 F.R.D. 589, 591 (N.D. Fla. 2010) ("Reconsideration of a court's previous order is an extraordinary remedy and, thus, is a power which should be used sparingly." (citations omitted)).

AHCA moves for reconsideration on three separate grounds, one of which is Rule 59(e). Reconsideration under Rule 59(e) is available in the limited scenarios "where there is newly-discovered evidence, an intervening change in the law, or manifest errors of law

or fact." *Fisher v. Carnival Corp.*, No. 11-22316-CIV, 2013 WL 12061861, at *1 (S.D. Fla. July 29, 2013) (citing *Arthur v. King*, 500 F.3d 1335, 1343 (11th Cir. 2007))). It is thus improper to use that vehicle "to relitigate old matters, raise forgotten arguments, or present evidence that could have been, but was not, raised prior to the entry of judgment." *Id.* (citing *Michael Linet, Inc. v. Village of Wellington, Fla.*, 408 F.3d 757, 763 (11th Cir. 2005)). Relief under Rule 59(e) is particularly inappropriate when the moving "party has failed to articulate any reason for the failure to raise an issue at an earlier stage in the litigation." *Lussier v. Dugger*, 904 F.2d 661, 667 (11th Cir. 1990) (citing *Van Ryn v. Korean Air Lines*, 640 F. Supp. 284, 286 (C.D. Ca. 1985)).

AHCA also moves for reconsideration under Rule 60(b)(4) and (5). Rule 60(b)(4) offers relief only when the judgment was void—that is, rendered without jurisdiction or "in a manner inconsistent with due process of law." *Burke v. Smith*, 252 F.3d 1260, 1263 (11th Cir. 2001) (quoting *In re Edwards*, 962 F.2d 641, 644 (7th Cir. 1992)). Relief is warranted under Rule 60(b)(5) only if the moving party can establish "a significant change either in factual conditions or in law." *Fla. Wildlife Fed'n Inc. v. Admin, U.S. Envtl. Protective Agency*, 620 F. App'x 705, 707 (11th Cir. 2015) (quoting *Sierra Club v. Meiburg*, 296 F.3d 1021 (11th Cir. 2002)). Such relief is rarely granted. *See Enax v. Goldsmith*, 322 F. App'x 833, 835 (11th Cir. 2009) ("Relief under Rule 60(b) is an 'extraordinary remedy which may be invoked upon only a showing of exceptional circumstances.'" (quoting *Crapp v. City of Miami Beach*, 242 F.3d 1017, 1020 (11th Cir. 2001)));

see also *United Student Aid Funds, Inc. v. Espinosa*, 559 U.S. 260, 271 (2010) (expressing that Rule 60(b)(4) applies in "rare" circumstances).

III

AHCA raises three arguments on the meritsin support of its motion: (1) the formula-based allocation is not quasi-irrebuttable; this (2) Court ignored the presumption against preemption and improperly shifted the burden to AHCA; and (3) that a possible future amendment to federal law will require vacatur of the injunction at some later date. ECF No. 44, at 4–23.

Those should-have, could-have, and (to round out the trilogy) would-have arguments are too little, too late. Quite simply, a motion to alter or amend a judgment is not like a time-traveling DeLorean; namely, it does not allow an unhappy litigant to repackage and relitigate previously decided issues or make new arguments that it wished it made in the first place. Yet that is precisely what AHCA seeks to do here. Unfortunately for AHCA, "I want a re-do" is not a valid reason to grant its motion. Nor has it "articulate[d] any reason" for this Court to allow it to make those arguments here. *Lussier*, 904 F.2d at 667. AHCA made a free, counseled, deliberate choice in deciding what arguments to make in its original motion and how to make them. It is irrelevant that the results of that motion are not to AHCA's liking. AHCA made its bed the first time around. Now it must lie in it.

AHCA's motion is especially pernicious in that this litigation strategy—retaining new counsel to file some

species of reconsideration motion after receiving an unfavorable ruling—is all too common for Florida and its agencies. Despite numerous opportunities to adequately defend cases brought against it, Florida consistently drags its feet. Then, after receiving an unfavorable ruling, it complains about the original ruling and hires outside counsel (and spends, quite literally, hundreds of millions of taxpayer dollars)[3] to essentially relitigate the case.

Putting that aside, AHCA's arguments are unavailing. First, it is, in AHCA's words, "simply wrong" that this Court committed manifest error in concluding that the reimbursement statute's formula-based allocation amounts to a quasi-irrebuttable presumption based on the fact that, as AHCA points out, a handful of Medicaid recipients

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[3] Since 2011, Florida has shelled out an astounding $237 million – or close to $40 million a year – on outside counsel. Gary Fineout, *State Spends $237 million on private lawyers, records show*, Orlando Sentinel (Mar. 13, 2017), http://www.orlandosentinel.com/news/politics/political-pulse/os-floridalegal-fees-20170313-story.html. For context, New York— which has a *larger* population than Florida—spent less than half that amount. *Id.* And many of those dollars aren't even being funneled back into the state; instead, Florida often sends its taxpayer dollars to other states or jurisdictions. In one case alone, Florida racked up $97.8 million in attorneys' fees. Mary Ellen Klas, *Secretary resigned after $98 million in legal fees in Florida water wars*, Tampa Bay Times (Jan. 23, 2017), http://www.tampabay.com/news/secretaryresigned-after-98-million-in-legal-fees-in-florida-water-wars/2310572. Of that $97.8 million, Latham & Watkins LLP (which does not have a Florida office) was paid $35.9 million. *Id.* The two firms involved in that case with Florida offices—Foley & Lardner LLP and Carlton Fields Jorden Burt, P.A.—were paid a mere $2.6 million and $966,000, respectively. *Id.*

have rebutted the reimbursement statute's formula-based allocation. ECF No. 44, at 4, 6. AHCA plainly conceded that it was "not relying upon the practice" of "how individual [DOAH hearing officer]s may or may not apply the" formula-based allocation. ECF No. 44-1, at 13, 15. It cannot now reasonably expect this Court to ignore that concession.

Yet the result would be the same even if it did. That is because the formula-based allocation is still preempted if, "[i]n some circumstances, . . . [it] permit[s] the State to take a portion of a Medicaid beneficiary's tort judgment or settlement not 'designated as payments for medical care.'" *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 644 (2013) (quoting *Ahlborn*, 547 U.S. at 284). And, after reasoning that the formula -based allocation ignores allocations made by a judge or jury and has no rational relationship to the Florida Bar's attorneys' fees rules,[4]

[4] AHCA denounces this Court for considering these factors. ECF No. 44, at 10–12. That denunciation is misplaced. The former was relevant to this Court's analysis in that *Wos* considered whether the statute at issue "operate[d] to allow the State to take one-third of the total recovery, even if aproper stipulation or judgment attributes a smaller percentage to medical expenses." 568 U.S. at 638. AHCA admitted that the formula-based allocation at issue here does just that. *See* ECF No. 44-1, at 11 (acknowledging that nothing "in the Florida statute . . . says the jury verdict will control the agency's lien amount"). Similarly, it was appropriate for this Court to consider the attorneys' fees provision. "[A] preemption analysis must contemplate the practical result of the state law . . . ." *United States v. Alabama*, 691 F.3d 1269, 1296 (11th Cir. 2012); *see also Blue Cross and Blue Shield of Fla., Inc. v. Dep't of Banking and Fin.*, 613 F. Supp. 188, 191 (M.D. Fla. 1985) (explaining that a preemption analysis requires courts "to consider the relationship between state and federal laws as they are

Gallardo, 2017 WL 1405166, at *9, this Court concluded that it does.

Second, AHCA argues that this Court ignored the presumption against preemption and improperly shifted "the burden to AHCA to show whether the default allocation will yield reasonable results in the mine run of cases . . . ." ECF No. 44, at 13–14. Nonsense. Contrary to AHCA's assertion, the presumption against preemption is an interpretative presumption—not an evidentiary one. *See Fla. State Conference of N.A.A.C.P. v. Browning*, 522 F.3d 1153, 1167–68 (11th Cir. 2008) (explaining that the presumption against preemption applies to "statutory interpretation" and, further, that "it is difficult to understand what a presumption in conflict preemption cases amounts to"); *see also CSX Transp., Inc. v. Healey*, Nos. 16-2171, 16-2172, 2017 WL 2703431, at *8 (1st Cir. June 23, 2017) (stating that the presumption against preemption is an "interpretative presumption[]" (citing *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996))). That presumption "dissipates when the intention of Congress is 'clear and manifest.'" *Smith v. CSX Transp., Inc.*, 381 F. App'x 885, 886 (11th Cir. 2010) (quoting *Riegel v. Medtronic, Inc.*, 552 U.S. 312, 334 (2008)). And that is precisely the case here; this Court thoroughly analyzed the anti-lien and anti-recovery provisions and concluded that they

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interpreted and applied, not merely as they are written" (quoting *Jones v. Rath Packing Co.*, 430 U.S. 519, 526 (1977))). Considering the attorneys' fees provision here simply revealed that, as applied, the formula-based allocation allows AHCA to take more than that which it is entitled to.

preempted portions of Florida's Medicaid statute. Such an analysis was eminently appropriate. *See Medtronic, Inc.*, 518 U.S. at 486 ("Congress' intent, of course, is primarily discerned from the language of the pre-emption statute and the 'statutory framework' surrounding it." (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 111 (1992) (Kennedy, J., concurring in part and concurring in judgment))).

Moreover, this Court did not improperly shift the burden to AHCA on summary judgment. *See* ECF No. 44, at 15 (arguing that this Court "deviated from the accepted standard on summary judgment"). Rather, it simply adhered to *Wos*'s teaching that Florida could "adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses, *provided that th[o]se criteria are backed by evidence* suggesting that they are likely to yield reasonable results in the mine run of cases." 568 U.S. at 643 (emphasis added). Because AHCA presented zero evidence suggesting that Florida's reimbursement statute follows (let alone considered[5]) that teaching, this Court correctly concluded that portions of it were preempted.

Third, it is immaterial that a potential amendment to the federal Medicaid Act may (or may not) allow states to "obtain reimbursement from all or any part of

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[5] Although certainly not dispositive, Gallardo's counsel filed a Public Records Request seeking records containing "[a]ny analysis by AHCA that the [formula-based allocation] is a reasonable approximation of the amount recovered for past medical expenses incurred by AHCA . . . ." ECF No. 51-1, at 1. In response, AHCA stated that it possessed "no responsive documents." ECF No. 51-2, at 1.

a" Medicaid recipient's recovery at some later time. ECF No. 44, at 17.That amendment's effective date has been, at best, mercurial.[6] And even assuming the amendment *does* go into effect as planned and *actually* grants the states a more expansive right of recovery, other critical questions would remain unanswered —most relevant here, whether the amendment applies retroactively or prospectively. In any event, AHCA can seek relief under Rule 60(b)(5) if and when the Medicaid amendment goes into effect.

IV

Finally, AHCA contends that this Court's prior judgment must be vacated (or at least amended) for lack of subject matter jurisdiction. More specifically, AHCA argues that Gallardo did not have standing to sue it because it does not enforce the challenged portions of Florida's reimbursement statute. Unlike AHCA's other arguments, its jurisdictional one is properly raised at this juncture. *See Fla. Ass'n of Med. Equip. Dealers v. Apfel*, 194 F.3d 1227, 1230 (11th Cir. 1999) ("[E]very court has an independent duty to review standing as a basis for jurisdiction at any time, for every case it adjudicates." (citing *FW/PBS, Inc. v. Dallas*, 493 U.S. 215, 230–31 (1990))); *see also* Fed. R.

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[6] *See* Bipartisan Budget Act of 2013, Pub. L. 113-67, § 202(c), 127 Stat. 1165, 1177 (2013) (setting effective date of October 1, 2014); Protecting Access to Medicare Act of 2014, Pub. L. 113-93, § 211, 128 Stat. 1040, 1047 (2014) (moving effective date October 1, 2016); Medicare Access and Chip Reauthorization Act of 2015), Pub. L. 114-10, § 220, 129 Stat. 87, 154 (2015) (moving effective date to October 1, 2017).

Civ. P. 12(h)(3) (allowing subject-matter jurisdiction arguments "at any time").

A

Federal courts are not courts of general jurisdiction; instead, they are limited to hearing actual cases and controversies. U.S. Const. art. III, § 2. Necessarily baked into this "bedrock requirement," *Raines v. Byrd*, 521 U.S. 811, 818 (1997) (quoting *Valley Force Christian College v. Ams. United for Separation of Church and State, Inc.*, 454 U.S. 464, 471 (1982)), is that a plaintiff have standing, *see Via Mat Int'l S. Am. Ltd. v. United States*, 446 F.3d 1258, 1262 (11th Cir. 2006) (noting that standing is a "threshold matter required for a claim to be considered by the federal courts"). For a plaintiff to have standing, he or she must establish, among other things,[7] that his or her injury is likely to be "redressed by a favorable decision."*Nat'l Parks Conservation Ass'n v. Norton*, 324 F.3d 1229, 1241 (11th Cir. 2003) (quoting *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992)). This is commonly referred to as the "redressability"

[7] A plaintiff must also establish "that he [or she] has suffered an injury-in-fact—that is, an injury that is concrete and particularized, and actual or imminent" and "a causal connection between the injury and the defendant's conduct[.]" *Navellier v. Florida*, 672 F. App'x 925, 928 (11th Cir. 2016) (citing *DiMaio v. Democratic Nat'l Comm.*, 520 F.3d 1299, 1302 (11th Cir. 2008)). Those requirements, however, are not at issue here.

prong.[8] *I.L. v. Alabama*, 739 F.3d 1273, 1278 (11th Cir. 2014).

Reduced to its most basic form, the redressability prong ensures that the court's judgment has teeth and can effectively rectify a cognizable injury. "Relief that does not remedy the injury suffered" is no relief at all and certainly "cannot bootstrap a plaintiff into federal court . . . ." *Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83, 107 (1998). Thus, in suits such as this one, where "the plaintiff seeks a declaration of the unconstitutionality of a state statute and an injunction against its enforcement, a state officer, in order to be an appropriate defendant, must, at a minimum, have *some connection* with enforcement of the provision at issue." *Socialist Workers Party v.*

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[8] One minor point of clarification. At the June 15, 2017, hearing, this Court did *not* ask "the parties to consider whether a less rigorous standard of redressability applies to claims for declaratory relief than to claims for injunctive relief." ECF No. 54, at 2. Nor did it imply (much less state) that some different redressability standard applied to claims for declaratory relief. Indeed, it is without question that "[t]he requirements for a justiciable case or controversy are no less strict in a declaratory judgment proceeding than in any other type of suit." *Ala. State Fed'n of Labor, Local Union No. 103 v. McAdory*, 325 U.S. 450, 561 (1945) (citations omitted). Rather, it simply asked whether those identical redressability principles apply differently to cases of declaratory relief such that it is possible to have standing for declaratory relief, but not injunctive relief. It is. *See Doe v. Stincer*, 175 F.3d 879, 887 n.6 (11th Cir. 1999) (concluding that the plaintiff had standing to sue the state Attorney General even assuming that he "lack[ed] the necessary enforcement authority to support the grant of injunctive relief enjoining the statute's enforcement" because "a favorable ruling could result in a declaratory judgment against the Attorney General holding the Florida statute invalid").

Leahy, 145 F.3d 1240, 1248 (11th Cir. 1998) (emphasis added) (citations omitted). If relief is sought against an official who cannot remedy the plaintiff's alleged injury, there is no "'case or controversy' *between himself and the defendant[s]* within the meaning of Art[icle] III." *Scott v. Taylor*, 405 F.3d 1251, 1259 (11th Cir. 2005) (Jordan, J., concurring) (emphasis added) (quoting *Warth v. Seldin*, 422 U.S. 490, 498 (1975)).

B

Injunctive relief will be addressed first. The amended judgment enjoined AHCA "from enforcing [§ 409.910(17)(b)] in its current form." *Gallardo*, 2017 WL 1405166, at *11 . Yet AHCA states that it cannot enforce that injunction because it does not "decide what burden of proof applies or whether the recipient has satisfied that burden"; that task is reserved for DOAH. ECF No. 44, at 24. While this Court recognizes and agrees that AHCA does not apply the clear and convincing burden, that fact is not determinative of the standing question.

Common sense dictates that courts cannot force a defendant "to act in any way that is beyond [the defendant's] authority to act in the first place." *Okpalobi v. Foster*, 244 F.3d 405, 427 (5th Cir. 2001); *see also Swan v. Bd. of Educ. Of City of Chicago*, 956 F. Supp. 2d 913, 918 (N.D. Ill. 2013) ("[W]here . . . a plaintiff seeks an injunction against a defendant, he or she must demonstrate that the defendant to be enjoined has the authority to effectuate the injunction." (citations omitted)). That is because, absent such authority, the defendant would be "powerless to remedy the alleged injury." *Scott*, 405 F.3d at 1259

(citations omitted). In other words, enjoining such a defendant "would be a meaningless gesture." *Bronson v. Swensen*, 500 F.3d 1099, 1112 (10th Cir. 2007).

And this Court was well aware of that fact when it enjoined AHCA from enforcing the current iteration of the reimbursement statute. By no means did it intend to enjoin AHCA from requiring a recipient to overcome the formula-based allocation with clear and evidence for that recipient to be successful—that would be an exercise in futility. Rather, it simply meant to enjoin AHCA from seeking reimbursement for past medical expenses through portions of a recipient's recovery that represents future medical expenses either directly from the recipient[9] or through DOAH.[10] By extension, that also means AHCA cannot seek reimbursement based on the formula-based allocation when doing so would allow it to obtain more than that which it is entitled to. Those are both tasks that AHCA—which is responsible for administering Medicaid and asserting Medicaid liens—""ha[s] *some connection* with . . . ." *Socialist Workers Party*, 145 F.3d at 1248 (emphasis added) (citations omitted)[11] Therefore, AHCA is properly

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[9] A lien only makes it to AHCA if the recipient contests it. § 409.910(17)(b), Fla. Stat. (2016). Thus, for the vast majority of liens that go uncontested, AHCA is the only entity involved in the reimbursement process.

[10] For simplicity sake, this Court will refer to this as the "reimbursement portion of the judgment."

[11] On this point, the cases cited by AHCA are distinguishable. Take *Socialist Workers Party v. Leahy*, 145 F.3d 1240 (11th Cir. 1998). There, the plaintiff lacked standing to bring suit against

enjoined from "seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses." *Gallardo*, 2017 WL 1405166, at *11.[12] With that said, this Court is not so prideful that it will not acknowledge its mistakes. It freely admits that, at least with regards to the injunction's scope, the prior judgment is not a model of clarity. It will therefore be amended to clarify that it does *not* extend to the portion referencing the reimbursement statute's clear and convincing burden.

C

One issue therefore remains: whether it was nonetheless proper for this Court to declare that the reimbursement statute's clear and convincing burden is preempted by the federal Medicaid Act even though DOAH—not AHCA —applies that standard. It was.

Declaratory relief is appropriate when a favorable ruling for one party may result in "a change in a legal status . . . and the practical consequence of that change

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certain defendants because they lacked the authority to enforce the challenged statutes. *See id.* at 1248 (denying standing for injunctive relief because the relevant defendants "ha[d] no authority to enforce" the challenged statute). But AHCA wields such authority. For example, it "is the Medicaid agency for the state, as provided under federal law[,]" § 409.901(2), Fla. Stat. (2016), and is permitted "as a matter of right, in order to enforce its rights" to "institute, intervene in, or join any legal or administrative proceeding in its own name . . . ." § 409.910(11), Fla. Stat. (2016).

[12] For that same reason, declaratory relief is proper as well.

would amount to a significant increase in the likelihood that the plaintiff would obtain relief that directly redresses the injury suffered." *Utah v. Evans*, 536 U.S. 452, 464 (2002) (citations omitted). Generally, the availability of such relief hinges on the declaration's capacity to secure redress "*through* the court, but *from* the defendant." *Canup v. Chimpan–Union, Inc.*, 123 F.3d 1440, 1443 (11th Cir. 1997) (emphasis in original) (quoting *Hewitt v. Helms*, 482 U.S. 755, 761 (1987)). But it isn't always so cut and dried; rather, standing is also appropriate if the redress is effectuated by an unnamed third party or parties, the steps necessary to effectuate that redress are "purely mechanical," and it is "substantially likely that the [third party or parties] would abide by an authoritative interpretation" of the court's ruling. *Evans*, 536 U.S. at 463–64 (quoting *Franklin v. Massachusetts*, 505 U.S. 788, 803 (1992)).

An example is helpful. In *Evans*, Utah brought suit against the Census Bureau and the Secretary of Commerce seeking, among other things, a declaration that a certain method of "imputing" census information—specifically, the number of people living in a certain household—violated federal law. *Id.* at 459.[13] At bottom, Utah argued that "imputing" the size of those households that the Census Bureau lacked

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[13] The process at issue in *Evans* is, to put it lightly, dizzying. Suffice it to say that Census Bureau employees would attempt to obtain household information through a variety of different channels. If those attempts were unsuccessful, the Bureau would "impute" the relevant information—including the number of people living in the unknown household—by inferring the unknown household's characteristics from those of a nearby one. *Evans*, 536 U.S. at 457–58.

information about caused it to receive a less favorable apportionment of congressional representatives than if the number of individuals living in those households was simply counted as "zero." *Id.* at 458. North Carolina, which benefited from such "imputing," argued that a favorable ruling would not redress Utah's asserted injury. *Id.* at 459. That was because such redress would require a perfectly executed domino effect, yet some of those other dominoes were not named parties: the Secretary of Commerce would have to create a new report and submit it to the President, who would then transmit that report to Congress, and finally (after some time) the Clerk of the House of Representatives would notify each individual state how many congressional seats it was entitled to. *Id.* at 461. Thus, according to North Carolina, Utah's asserted redress was *through* the Court, but not *from* the defendants. *See id.* (restating North Carolina's argument that the ultimate relief "cannot help bring about th[e] ultimate 'redress'").

But the Supreme Court disagreed. It reasoned that a ruling in Utah's favor would force the Secretary of Commerce to create a new report. *Id.* at 463. If that report "contain[ed] a different conclusion about the relative populations of North Carolina and Utah," then it would eventually go into effect. *Id.* It was immaterial that other dominoes needed to fall with absolute precision for that to occur; those subsequent "apportionment-related steps would be purely mechanical . . . ." *Id.* And, under those circumstances, it was "substantially likely that the President and other executive and congressional officials would abide by an authoritative interpretation of the census statute

and constitutional provision . . . ."[14] *Id.* at 464 (quoting *Franklin*, 505 U.S. at 803). In other words, a favorable ruling "would amount to a significant increase in the likelihood that the plaintiff would obtain relief that directly addresses the injury suffered." *Id.* at 564.

Similar to *Evans*, a declaration that the reimbursement statute's clear and convincing burden is preempted by federal law would also significantly increase the likelihood that Gallardo would obtain the redress she seeks. Of course, unlike the reimbursement portion of the prior judgment, this Court's declaration that the clear and convincing burden is preempted in this type of scenario would require additional steps to redress Gallardo's injury; namely, DOAH not requiring Gallardo to disprove the reimbursement statute's formula-based allocation with clear and convincing evidence in Gallardo's administrative proceeding. But that step is "purely mechanical." *Id.* at 463. What is more, though, is that DOAH—which is, in effect, a quasi-judicial body[15]—is substantially likely to "abide by an authoritative interpretation[,]" *id.*, at 464, from this Court (and through AHCA) that it cannot apply such a burden.

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[14] That was so even though the President was "not expressly required to adhere to the policy decisions reflected in the Secretary [of Commerce]'s report." *Franklin v. Massachusetts*, 505 U.S. 788, 799 (1992).

[15] *See Fla. State Univ. v. Hatton*, 672 So.2d 576, 579 (1st DCA 1996) (stating that DOAH hearing officers are "quasi-judicial officer[s] of a quasi-judicial forum").

There is more. Even if the additional steps were not "purely mechanical" such that *Evans* applied, *id.*, this Court could nonetheless assume that DOAH "will give full credence" to this Court's ruling. *Roe v. Wade*, 410 U.S. 113, 166 (1973); *see also Phelps v. Powers*, 63 F. Supp. 3d 943, 958 (S.D. Iowa 2014) (suggesting that declaratory relief was sufficient "based on the assumption that the Iowa prosecutorial authorities will give full credence to th[e] Court's holding").That would also make declaratory relief appropriate. *SeeRoe*, 410 U.S. at 166; *Phelps*, 63 F. Supp. 3d at 958.

AHCA's pleas to the contrary are unpersuasive. It cites cases like *Nova Health Systems v. Gandy*, 416 F.3d 1149 (10th Cir. 2005), to argue that Gallardo lacks standing for declaratory relief as to the reimbursement statute's clear and convincing burden. In that case, an Oklahoma statute provided that those who performed an abortion on a minor without parental consent or knowledge were liable "for the cost of any subsequent medical treatment such minor might require because of the abortion." *Id.* at 1153 (citation omitted). The plaintiff filed suit against four "Oklahoma public officials whose functions include overseeing certain state medical institutions" seeking, among other things, a declaration that the statute was unconstitutional. *Id.* at 1153–54. Those four defendants, however, did not represent the *only* institutions where subsequent medical treatment for those minors took place; they were just four big-name players. *Id.* at 1157, 1159. That made it "entirely speculative" that a declaration in the plaintiff's favor would redress its injury. *Id.* at 1159. Such relief was therefore inappropriate. *See id.* (rejecting the argument

"that a favorable declaratory judgment against the[] defendants would redress its injury by deterring other potential litigants from relying on [the statute at issue], even in state court").

But that case, like the other similar cases that AHCA relies on, is distinguishable on two fronts. First, it ignores *Evans* (and, for that matter, *Roe* as well). Instead, it—and AHCA —cites Scalia's concurrence in *Franklin* for the proposition that "[r]edressability requires that the court be able to afford relief through the exercise of its power, not through the persuasive or even awe-inspiring effect of the opinion explaining the exercise of its power." *Id.* (quoting *Franklin*, 505 U.S. at 825 (Scalia, J., concurring in the judgment)). But that concurrence persuaded neither the *Franklin* plurality nor the *Evans* Court. This Court is at a loss as to why it should apply such logic here. Second, unlike *Gandy*, there aren't a myriad of other parties who can assert liens against a Florida Medicaid recipient's recovery, thus kick starting the process to possibly bring the recipient before DOAH to challenge that lien. Who else could be expected to assert such a lien, and then allow the subsequent "purely mechanical" steps to take place such that the recipient could receive the type of redress sought here? The answer is simple: AHCA, and only AHCA. *See* ECF No. 5, at 1 (admitting that AHCA is responsible for enforcing Medicaid liens).

D

In short, AHCA is absolutely correct that it cannot be enjoined from requiring a recipient to overcome the formula-based allocation with clear and convincing

evidence for that recipient to be successful. DOAH applies that standard, not AHCA. The prior judgment will therefore be amended to clarify the injunction's scope. But that doesn't divest this Court of standing to address the reimbursement statute's clear and convincing burden. Rather, it properly declared that applying such a burden—at least in certain circumstances—runs afoul of and is therefore preempted by federal law. AHCA's motion is therefore **GRANTED** in part and **DENIED** in part.

Accordingly,

IT IS ORDERED:

1. AHCA's Motion to Alter or Amend the Judgment and for Relief from Judgment, ECF No. 44, is **GRANTED** in part and **DENIED** in part.

2. AHCA's motion is **GRANTED** to the extent that it seeks an amendment clarifying the injunction's scope.

3. The balance of AHCA's motion is **DENIED**.

4. The Clerk shall enter a second amended judgment stating:

Gianinna Gallardo, an incapacitated person, by and through her parents and co-guardians, Pilar Vassallo and Walter Gallardo, successfully proved that portions of § 409.910(11)(f), Fla. Stat. (2016) and § 409.910(17)(b), Fla. Stat. are preempted by federal law.

It is declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses. The State of Florida Agency for Health Care Administration is therefore enjoined from doing just that: seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses.

It is also declared that the federal Medicaid Act prohibits the State of Florida from requiring a Medicaid recipient to affirmatively disprove § 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.

SO ORDERED on July 18, 2017.

s/Mark E. Walker
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

CASE NO. 4:16-cv-116-MW-CAS

[Filed: July 18, 2017]

GIANINNA GALLARDO	)
	)
VS	)
	)
ELIZABETH DUDEK and	)
JUSTIN M SENIOR	)
	)

SECOND AMENDED JUDGMENT

Gianinna Gallardo, an incapacitated person, by and through her parents and co- guardians, Pilar Vassallo and Walter Gallardo, successfully proved that portions of § 409.910(11)(f), Fla. Stat. (2016) and § 409.910(17)(b), Fla. Stat. (2016) are preempted by federal law. It is declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses. The State of Florida Agency for Health Care Administration is therefore enjoined from doing just that: seeking reimbursement of past Medicaid

payments from portions of a recipient's recovery that represents future medical expenses. It is also declared that the federal Medicaid Act prohibits the State of Florida from requiring a Medicaid recipient to affirmatively disprove § 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.

JESSICA J. LYUBLANOVITS
CLERK OF COURT

July 18, 2017
DATE

s/ Chip Epperson
Deputy Clerk: Chip Epperson

APPENDIX D

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE DIVISION

Case No. 4:16cv116-MW/CAS

[Filed: April 18, 2017]

GIANINNA GALLARDO,	)
AN INCAPACITATED PERSON,	)
BY AND THROUGH HER PARENTS	)
AND CO-GUARDIANS, PILAR	)
VASSALLO AND WALTER GALLARDO,	)
	)
***Plaintiff*,**	)
	)
v.	)
	)
ELIZABETH DUDEK,	)
IN HER OFFICIAL CAPACITY AS	)
SECRETARY OF FLORIDA	)
AGENCY FOR	)
HEALTH CARE ADMINISTRATION,	)
	)
Defendant.	)
	)

ORDER ON SUMMARY JUDGMENT MOTIONS

Imagine this scenario. You're the parent of a thirteen-year-old girl, whom you love dearly. She is

your world. Tragically, one day you receive the phone call that every parent fears more than anything; the daughter that you adore was struck by a vehicle, medevacked to a nearby hospital, and is now in critical condition. Medicaid covers around $800,000 for her treatment. Although the hospital staff tries their best, they aren't miracle workers. As a result of the accident, your beloved daughter is now in a persistent vegetative state and can no longer ambulate, communicate, eat, or care for herself in any manner. You try to wake up from this nightmare. But you're not asleep—the nightmare is real.

And it only gets worse. Knowing that your daughter will need continuous medical care for the rest of her life (and hoping to recover past expenses and emotional damages), you file suit against the responsible parties. Even though your suit is worth somewhere around $20,000,000, you eventually settle for $800,000; a 4% recovery. You then notify the applicable state agency, which will for purposes of this hypothetical be called "the agency" for short, of the settlement and explain that around $35,000 of that settlement is for past medical expenses—4% of the approximately $800,000. Nonetheless, as allowed by the state's statute, the agency imposes an approximately $300,000 lien—an amount representing, as prescribed by the state's statute, 37.5% of your settlement. Moreover, the agency seeks to satisfy that lien from the settlement funds representing both past *and* future medical expenses. And the only way you can successfully reduce that lien is to prove by clear and convincing evidence that the actual amount allocable to past and future medical expenses is, in fact, less than that $300,000.

Gianinna Gallardo's parents are currently living that nightmare. After initiating administrative proceedings to challenge that lien, Gallardo's parents and guardians filed this case on her behalf seeking a declaratory judgment that Florida's reimbursement statute—which that hypothetical was based on—violates federal law. Particularly relevant to that issue is the federal Medicaid statute's anti-lien provision, which generally prohibits participating states from placing a lien on any portion of a Medicaid beneficiary's recovery not designated as payments for medical care.

Is Florida's reimbursement statute preempted by federal Medicaid law? The short answer is "yes." By allowing the State Agency for Health Care Administration ("AHCA")—Florida's agency that is charged with administering Medicaid—to satisfy its lien from settlement funds allocable to both past and future medical expenses, Florida has run afoul of the Medicaid statute. The same is true for Florida's arbitrary, one-size-fits-all statutory formula. Specifically, Florida's reimbursement statute—which, coupled with a host of other obstacles, only allows the Medicaid recipient to rebut that formula-based allocation by presenting clear and convincing evidence that it is inaccurate—amounts to a quasi-irrebuttable presumption and thus conflicts with and is preempted by federal law.

Gallardo's Motion for Summary Judgment, ECF No. 11, is therefore **GRANTED**, and AHCA's Motion for

Summary Judgment, ECF No. 13, is therefore **DENIED**.[1]

I

This case involves a few relatively straightforward provisions of the otherwise dizzying Medicaid Act[2] and Florida's attempt to legislate against those provisions. To simplify this Court's analysis, it will outline the following in turn: (1) the relevant portions of the federal Medicaid statute; (2) Florida's reimbursement statute; and (3) the underlying facts of this case.

A. Federal Law

Medicaid is a joint federal–state program designed to help participating states provide medical treatment for their residents that cannot afford to pay. *Moore ex rel. Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011). Although states are not required to participate in Medicaid, all of them do. *Id.* The federal government pays a significant portion of the costs for patient care and, in return, the states pay the remainder and must comply with the federal statutory and regulatory requirements. *See Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985) (stating that the federal government "subsidizes a significant portion of the financial obligations the State has agreed to assume" and that

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[1] This Court reaches these conclusions with the benefit of an April 11, 2017, hearing.

[2] The Supreme Court has previously stated that Medicaid's "Byzantine construction . . . makes [it] 'almost unintelligible to the uninitiated.'" *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (quoting *Friedman v. Berger*, 547 F.2d 724, 727 n.7 (2d Cir. 1976)).

"[o]nce a State voluntarily chooses to participate in Medicaid, the State must comply with the requirements of Title XIX and applicable regulations" (citing *Harris v. McRae*, 448 U.S. 297, 301 (1980))).

Two of those requirements are the so-called anti-lien and anti-recovery provisions. These requirements are broad and "express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf." *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S 268, 283 (2006). Specifically, the antilien provision states 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, [with exceptions not relevant here]." 42 U.S.C. § 1396p(a)(1) (2012). Similarly, the anti-recovery provision states that "[n]o adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, [with exceptions not relevant here]." *Id.* § 1396p(b). Thus, considered "literally and in isolation," the anti-lien and anti-recovery provisions prohibit states from reaching the proceeds from a Medicaid recipient's recovery. *Ahlborn*, 547 U.S. at 284.

But the third-party liability and assignment provisions temper that sweeping prohibition by providing narrow exceptions. The third-party liability provision, for example, requires states "to ascertain the legal liability of third parties . . . to pay for care and services under the plan[.]" § 1396a(a)(25)(A). If third-party liability is found to exist, states must seek reimbursement for medical expenses incurred on behalf

of recipients who later recover from those third parties. *See id.* § 1396a(a)(25)(B) ("[I]n any case where such a legal liability is found to exist *after medical assistance* has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for *such assistance* to the extent of such legal liability[.]" (emphasis added)). Likewise, under the assignment provision, states must have in effect laws that, "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," give the state the right to recover payment "for such [furnished] health care items or services" from liable third parties. *Id.* § 1396a(a)(25)(H) (emphasis added). To help effectuate that requirement, states must require a recipient "to assign the State any rights . . . to *payment for medical care* from any third party." *Id.* § 1396k(a)(1)(A) (emphasis added).

To summarize, the third-party liability and assignment provisions outlined in §§ 1396(a)(25) and 1396k(a) are narrow exceptions to the broad anti-lien and anti-recovery provisions, and those exceptions only apply to payments for medical care. *See Ahlborn*, 547 U.S. at 284–85 ("As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care."). "Beyond that, the anti-lien provision" shields a recipient's recovery from the state's clutches. *Id.* at 285–86.

B. State Law

Florida applies a one-size-fits-all statutory formula to determine how much of a recipient's recovery constitutes medical expenses and is therefore available for Medicaid reimbursement. First, the formula reduces the gross recovery by 25% to account for the recipient's attorney's fees. *See* § 409.910(11)(f)(1), Fla. Stat. (2016) (deducting "attorney's fees and taxable costs" from the "judgment, award, or settlement"); *id.* § 409.910(11)(f)(3) (deciding for purposes of the statutory formula that attorney's fees "shall be calculated at 25 percent of the judgment, award, or settlement"). The already-reduced total is then cut in half, and AHCA is awarded the lesser of the amount it actually paid or the resulting number. *See id.* § 409.910(11)(f)(1) (awarding AHCA "one-half of the remaining recovery" after accounting for attorney's fees, "up to the total amount of medical assistance provided by Medicaid"). The remaining amount is paid to the Medicaid recipient. *Id.* §409.910(11)(f)(2).

The Medicaid recipient, however, may challenge that formula-based allocation through an administrative proceeding. To do so, the recipient must either pay AHCA the formula-based reimbursement or place those reimbursement funds in an interest-bearing trust account and then file a petition with the Division of Administrative Hearings in Tallahassee. *See id.* § 409.910(17)(b) (outlining the administrative procedure); *id.* § 409.910(17)(d) ("Venue for all administrative proceedings pursuant to this subsection lies in Leon County, at the discretion of the agency." (footnote omitted)). To successfully challenge the

formula-based allocation and thus reduce the amount payable to AHCA, "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 the amount" required by the statutory formula. *Id.* § 409.910(17)(b). That administrative process "is the exclusive method for challenging" the formula-based allocation. *Id.*

C. Present Litigation

On November 19, 2008, Gianinna Gallardo ("Gallardo"), then a thirteen-year-old student, suffered severe and permanent injuries as a result of being struck by a vehicle after she was dropped off by her school bus. ECF No. 1, at 11. She is in a persistent vegetative state and is no longer able to care for herself. *Id.* Gallardo's medical expenses were paid by Medicaid and WellCare of Florida, which paid $862,688.77 and $21,499.30, respectively. *Id.* at 12.

Gallardo's parents filed suit in state court against those allegedly responsible for her injuries—the truck's owner, the truck's driver, and the Lee County School Board. ECF No. 10-1. Gallardo sought past medical expenses, future medical expenses, lost earnings, and other damages, while her parents sought loss-of-consortium damages. *Id.* As required by Florida law, *see* § 409.910 (11)(a), AHCA was notified of that lawsuit and, in turn, it asserted a lien against that cause of action for the amount it expended for Gallardo's past medical expenses: $862,688.77. ECF No. 1, at 17. Gallardo's case eventually settled for $800,000, and the court approved that settlement. *Id.* at 13; *see also* ECF No. 10- 2 (approving the

settlements). Thus, pursuant to Florida's formula-based allocation, AHCA was due to be reimbursed $323,508.29 in medical expenses.

Shortly after the settlement was finalized, Gallardo's counsel notified AHCA of the settlement by letter. ECF No. 1, at 17–18. In that letter, counsel explained that Gallardo's damages were valued at over $20,000,000, and that the settlement amounted to a mere 4% recovery. *Id.* at 18. Thus, according to Gallardo, only $35,367.52 of her $800,000 settlement represented past medical expenses. *Id.* AHCA never responded to Gallardo's letter. *Id.*

Gallardo chose to contest AHCA's lien through the state administrative procedure outlined in § 409.910(17)(b). *Id.* She therefore followed the necessary requirements; namely, depositing the formula-based reimbursement of $323,508.29 into an interest-bearing account and filing a petition with the Division of Administrative Hearings in Tallahassee. *Id.* In those proceedings, Gallardo has argued that contrary to federal law, AHCA is endeavoring to recover its past Medicaid payments from settlement funds that do not represent compensation for past medical expenses. *Id.* at 18–19. AHCA, however, has argued that it is entitled to satisfy its lien from the portion of Gallardo's settlement representing compensation for past *and future* medical expenses. *Id* at 19. AHCA has further argued that Gallardo may successfully challenge the formula-based allocation only if she can prove by clear and convincing evidence that the amount of her settlement representing past

and future medical expenses is less than $323,508.29. *Id.*

Gallardo brought this case seeking an injunction and declaratory judgment that Florida's reimbursement statute violates federal law to the extent it (1) allows ACHA to satisfy its lien beyond the portion of her settlement representing compensation for past medical expenses and (2) only allows her to successfully challenge the formula-based allocation by presenting clear and convincing evidence that that amount is more than the portion of her settlement that represents compensation for past medical expenses. ECF No. 11, at 2. After this case was filed, the parties moved the Administrative Law Judge to hold those proceedings in abeyance, and that motion was granted pending resolution of the instant case. ECF No. 10-3. In this case, the parties have filed cross motions for summary judgment. ECF Nos. 11–12 (Gallardo); ECF Nos. 13–14 (AHCA).

II

Summary judgment is appropriate when "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The parties agree to all material facts; thus, the only disputes relate to questions of law. "'Where the unresolved issues are primarily legal rather than factual, summary judgment is particularly appropriate.'" *Bruley v. Village Green Mgmt. Co.*, 592 F. Supp. 2d 1381, 1388 (M.D. Fla. 2008) (quoting *Uhl v. Swanstrom*, 79 F.3d 751, 754 (8th Cir. 1996)).

III

Gallardo contends that § 409.910 conflicts with federal law and is therefore preempted to the extent that it allows AHCA to satisfy its lien from a Medicaid recipient's recovery for future medical expenses. This Court agrees.

When a statute's text is unambiguous, as is the case here, the court's analysis begins and ends with the text. *Reeves v. Astrue*, 526 F.3d 732, 734 (11th Cir. 2008) (citing *CBS Inc. v. PrimeTime 24 Joint Venture*, 245 F.3d 1217, 1222–25 (11th Cir. 2001)). That is because "'[i]f the statute speaks clearly to the precise question at issue, [courts] must give effect to the unambiguously expressed intent of Congress.'" *Jackson v. Comm'r of Soc. Sec.*, 601 F.3d 1268, 1271 (11th Cir. 2010) (quoting *Barnhart v. Walton*, 535 U.S. 212, 217–18 (2002)).

AHCA suggests that, given the Gordian knot that is the Medicaid Act, the issue before this Court is "not an easy" one to decide. ECF No. 14, at 3 & n.1. But as to the issue presented to this Court, the Medicaid Act could not be any clearer. By its plain language, it prohibits AHCA from satisfying its lien from anything but a Medicaid recipient's recovery for past medical expenses.

As a general matter, the anti-lien provision prohibits AHCA from imposing a lien against the property of a Medicaid recipient. § 1396p(a)(1). That includes liens against "medical assistance *paid* or *to be paid*." *Id* (emphasis added). And although the third-party liability and assignment provisions are

exceptions that grant AHCA a restricted right of recovery, they are exceedingly narrow ones. *See Ahlborn*, 547 U.S. at 284–85 (noting these are narrow "exception[s] to the anti-lien provision" (citing *Wash. State Dep't of Soc. and Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 383–85 & n.7 (2003))).

A plain reading of the statutory text shows that AHCA's right of recovery is even narrower than it suggests; namely, it only applies to payments made for *past* medical expenses. To simplify this Court's analysis, the critical statutory language is italicized. The anti-lien provision prohibits ACHA from seeking reimbursement from a recipient's recovery for "medical assistance paid *or to be paid*." § 1396p(a) (emphasis added). But "to the extent *that payment has been made* under the State plan for medical assistance," AHCA 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 AHCA may only seek reimbursement from funds representing payments for medical expenses that it previously made on the beneficiary's behalf. *See McKinney ex rel. Gage v. Phila. Housing Auth.*, No. 07-4432, 2010 WL 3364400, at *9 (E.D. Pa. Aug. 24, 2010) ("It is clear from a reading of the statutory language that the italicized 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." (emphasis in original)).

Other provisions bolster that conclusion. For example, §§ 1396a(a)(25)(A)–(B) direct AHCA 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 AHCA 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; AHCA cannot reimburse itself for its *past* medical expenses from portions of the recipient's recovery allocated to compensate for *future* medical expenses.[3]

Although the Supreme Court has not addressed this precise issue, related cases suggest it would reach the same conclusion. Take *Ahlborn*, for example. There, the Court held that a state may satisfy its Medicaid lien only through the portion of a recovery allocated for medical expenses. *See Ahlborn*, 547 U.S. at 281 (limiting reimbursement to "medical expenses—not lost wages, not pain and suffering, not an inheritance"). In reaching that conclusion, it reasoned that "the federal

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[3] *See, e.g.*, *In re E.B.*, 729 S.E.2d 270, 299 n.35 (W. Va. 2012) (agreeing that "*Ahlborn* is more consistent with limiting a state's recovery to settlement proceeds that are allocated to past medical expenses, rather than to proceeds allocated to both past and future medical expenses generally"); *McKinney*, 2010 WL 3364400, at *9 ("Therefore, it would appear 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." (emphasis in original)).

third-party liability provisions *require* an assignment of no more than the right to recover that portion of a [recovery] that represents *payments for medical care*." *Id.* at 282 (emphasis added and in original). Likewise, the Supreme Court later emphasized that states may "seek reimbursement for *medical expenses paid* on the beneficiary's behalf, but the anti-lien provision protects the beneficiary's interest in the remainder of the settlement." *Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1397 (2013) (emphasis added) (citing *Ahlborn*, 547 U.S. at 284). The Supreme Court's references to "past medical expenses" and "medical expenses paid" support the conclusion that state agencies may not seek reimbursement of their past Medicaid payments from portions of a recipient's recovery representing future medical expenses.

Of course, this Court acknowledges that other courts have disagreed. *See Special Needs Trust for K.C.S. v. Folkemer*, No. 8:10-cv-1077, 2011 WL 1231319, at *12 (D. Md. Mar. 28, 2011) ("The fact that the settlement in this case contained unstipulated amounts that might represent payments for future medical expenses, and the fact that the Department is seeking to recover from this unstipulated amount does not violate the anti-lien provision . . . ."); *IP ex rel. Cardenas v. Henneberry*, 795 F. Supp. 2d 1189, 1197 (D. Colo. 2011) (concluding that the state agency "may seek reimbursement for its past medical expenses from funds allocated to 'medical expenses,' regardless of whether those funds are allocated for past or future medical expenses"); *In re Matey*, 213 P.3d 389, 394 (Idaho 2009) ("Nothing in 42 U.S.C § 1396p indicates that the State may not seek recovery of its payments

from a Medicaid recipient's total award of damages for medical care whether for past, present, or future care."). Those cases are non-binding. That aside, those cases are not persuasive because the courts 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.

AHCA cites to other provisions in § 1396k to argue that it may seek reimbursement for past medical expenses through portions of a recipient's recovery allocated to compensate for future medical expenses. ECF No. 14, at 16–18. Specifically, it references language in § 1396k(a)(1)(A) that requires the recipient "to assign the State any rights . . . to support . . . and to payment for medical care from any third party." According to AHCA, "payment for medical care" contemplates *all* medical care—including future medical care. ECF No. 14, at 17.

That argument is clever, yet ultimately unconvincing. "[C]ourts cannot use tunnel vision when construing statutes; rather, statutes must be considered as a whole." *Fla. Democratic Party v. Scott*, No. 4:16-cv-626, 2016 WL 6080990, at *2 (N.D. Fla. Oct. 10, 2016) (Walker, J.) (citing *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 94 (1993)). Moreover, "specific statutes prevail over general ones." *Id.* (citing *D. Ginsberg & Sons v. Popkin*, 285 U.S. 204, 208 (1932)). The Supreme Court thus construes the assignment provision in § 1396k(a) identically as the one in § 1396a(a)(25); indeed, it has 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)[.]" *Ahlborn*, 547 U.S. at 281. Because § 1396k(a) is not interpreted as narrowly as AHCA suggests, its blinders-on approach is unavailing.

This Court concludes that federal law prohibits state agencies from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses. Florida's statute is therefore preempted if and to the extent that it operates that way. *See Irving v. Mazda Motor Corp.*, 136 F.3d 764, 768 (11th Cir. 1998) ("Conflict preemption exists where state law actually conflicts with federal law, making it impossible to comply with both, or where the state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" (quoting *Lewis v. Brunswick Corp.*, 107 F.3d 1494, 1500 (11th Cir. 1997))). And for that reason it is preempted. Florida law does not prohibit AHCA from asserting a lien on portions of a recipient's recovery representing future medical expenses; in fact, it explicitly allows it to do just that. § 409.910(17)(b) (allowing AHCA to recover from the "portion of the total recovery . . . for past *and future* medical expenses" (emphasis added)). Accordingly, that portion of the statute is preempted.

IV

Gallardo also asserts that § 409.910 and its one-size-fits-all statutory formula—which the Medicaid recipient may only rebut by presenting clear and

convincing evidence to the contrary—violates due process and is preempted by federal law.

A

At first glance, Gallardo's due-process argument is both circular and conclusory. According to her, the reimbursement statute violates due process because it takes the recipient's property without affording it adequate process. Reading between the blurred lines of her gaunt argument, however, this Court can conceive of two possible due-process challenges.

Gallardo could first argue, and it appears she does, that Florida's reimbursement statute effectively turns due process on its head. The argument goes as follows. Florida's statutory formula violates the Due Process Clause by allowing AHCA to take Gallardo's property—namely, the settlement funds not allocated for past medical expenses—and only allowing her to recover those funds if she can affirmatively disprove the formula-based allocation with clear and convincing evidence. In support, Gallardo cites cases holding that "the State's power to regulate procedural burdens [is] subject to proscription under the Due Process Clause if it 'offends some principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental[.]'" *Cooper v. Oklahoma*, 517 U.S. 348, 367 (1996) (citing *Patterson v. New York*, 432 U.S. 197, 201–02 (1977)); *see also Del Valle v. State*, 80 So.3d 999, 1013 (Fla. 2011) (holding that the necessity of certain criminal procedures "is rooted in the fundamental fairness notion required by due process"). But this case just doesn't involve such a rule. Those cases highlight rare circumstances where a person is

deprived of something so fundamental that imposing a heightened burden to challenge that deprivation violates the Due Process Clause. And in fact, those cases make explicit that the mere deprivation of money is not one of those rare circumstances. *See Cooper*, 517 U.S. at 363 (distinguishing the "'mere loss of money'" from other civil proceedings where due process allows a heightened burden of proof (citing *Santosky v. Kramer*, 455 U.S. 745, 756 (1982))). Those cases are therefore readily distinguishable.

Alternatively, Gallardo could have asserted that Florida's reimbursement statute violates the Due Process Clause because it does not provide notice and a meaningful opportunity to be heard. *See Mathews v. Eldridge*, 424 U.S. 319, 349 (1976) (stating that "the essence of due process is the requirement that" a person be provided notice and a "meaningful opportunity to present their case"). It is undisputed that Medicaid recipients are provided notice. Thus, the only issue is whether Florida's reimbursement statute grants recipients a meaningful opportunity to be heard. Gallardo could have argued that it doesn't; that is, by placing such an onerous burden on Medicaid recipients to regain their property, Florida has so drastically undermined § 409.910's post-deprivation remedy that it is essentially nonexistent and thus inadequate under federal law. *See Hamlin v. Vaudenberg*, 95 F.3d 580, 585 (7th Cir. 1996) (holding that a "meaningless or nonexistent" post-deprivation remedy is inadequate). But that argument was not made, and this Court will not go out of its way to decide an issue that is not before it. This is particularly true where, as here, this Court explicitly asked Gallardo's counsel to define the

contours of her due process claim at the hearing and whether he was making this specific argument, and counsel redirected this Court to *Cooper* and its progeny.

B

Secondly, and more broadly, Gallardo argues that Florida's entire reimbursement statute conflicts with and is preempted by federal law. To the extent that Medicaid recipients must affirmatively disprove the arbitrary formula-based allocation with clear and convincing evidence to successfully overcome it, this Court agrees.

One particular issue relevant to this case remained undecided after *Ahlborn*. Because states may not seek reimbursement from "any part of a Medicaid beneficiary's tort recovery 'not designated as payments for medical care,'" how can states "determine what portion of a settlement represents payment for medical care[?]" *Wos*, 133 S. Ct. at 1397–98 (quoting *Ahlborn*, 547 U.S. at 284). In *Wos*, the Supreme Court considered a North Carolina statute that "establishe[d] a conclusive presumption that one-third of the [Medicaid recipient's] recovery represents compensation for medical expenses." *Id.* at 1398. The Court recognized that while some "rebuttable presumptions and adjusted burdens of proof" may comply with the Medicaid statute, "[a]n irrebuttable, one-size-fits-all statutory presumption" that a pre-determined percentage of the recipient's recovery constitutes "payment for medical care" does not. *Id.* at 1398–99, 1401 (citations omitted). That is particularly so if the state has not provided evidence that such an

allocation was "reasonable in the mine run of cases" and has no process "for determining whether [such an allocation] is a reasonable approximation in any particular case." *Id.* at 1398–99. Because North Carolina's irrebuttable, one-size-fits-all statutory presumption allowed "the State to take a portion of a Medicaid beneficiary's tort judgment or settlement not 'designated as payments for medical care[,]'" *id.* at 1402 (quoting *Ahlborn*, 547 U.S. at 284), it was preempted by federal law.

Florida's statute suffers from that same defect, yet for more nuanced reasons. And this Court is not reaching that conclusion just because Florida's reimbursement statute doesn't pass the "smell test." Rather, the Supreme Court has provided an effective framework to analyze this kind of scenario—a rebuttable presumption that is nearly impossible to rebut. Specifically, *Wos* teaches that states cannot accomplish through creative legislative draftsmanship that which is prohibited under federal law. *See Wos*, 133 S. Ct. at 1398 ("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." (citing *Nat'l Meat Assn. v. Harris*, 565 U.S. 452 (2012))). That is because "[i]n a pre-emption case . . . a proper analysis requires consideration of what the state law in fact does, not how the litigant might choose to describe it." *Id*. In other words, preemption "is not a matter of semantics." *Id.*

But that is precisely what Florida has tried to do here; namely, evade federal law by enacting a

"rebuttable" one-size-fits-all statutory formula that almost by definition allows AHCA to obtain more than that which it is entitled to. And by setting a baseline wholly detached from any rational standard—for instance, the federal Medicaid statute, Supreme Court case law, or AHCA's past medical expenditures in that specific case—it does so in a wildly arbitrary fashion.

Like in *Wos*, nothing in the record helps explain why Florida chose the precise formula that it did. It is therefore impossible to judge whether it is "likely to yield reasonable results in the mine run of cases." *Id.* at 1402. If this case is any example, it is not likely to do so. When the Florida legislature amended the reimbursement statute, it had the benefit of *Wos* and knew what changes were required to comply with federal law. *See* ECF No. 10-5, at 5. But rather than trying to adequately address *Wos* through thoughtful amendments, the Florida legislature simply slapped a band-aid on the reimbursement statute by calling the formula-based allocation rebuttable and requiring the recipient to meet a heightened burden to successfully challenge it. That superficial response is simply not enough.

Similarly, although not before this Court, Florida's reimbursement statute ignores that "[w]hen there has been a judicial finding or approval of an allocation between medical and nonmedical damages—in the form of either a jury verdict, court decree, or stipulation binding on all parties—that is the end of the matter." *Wos*, 133 S. Ct. at 1399. In Florida, not even a jury's allocation is immune from the reimbursement statute. *See* § 409.910(11)(f) (applying

Florida's statutory formula to any case "in which the recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party"). That is further evidence that Florida did not adequately tailor its reimbursement statute to federal law.

Moreover, Florida's arbitrary statutory formula—which plucks a 25% figure for attorney's fees out of mid-air—allows AHCA to take even more money than it is entitled to. The Rules Regulating the Florida Bar allow attorneys to set their fee on a sliding scale up to 40% of the plaintiff's recovery.[4] *See* R. Regulating Fla. Bar 4–1.5(f)(4)(B)(I) (2017) (allowing an attorney to charge a contingent fee up to 33.3% of any recovery up to $1 million before the filing of an answer and up to 40% after the filing of an answer). Florida's statutory formula, however, only reserves 25% of the judgment for attorney's fees. That necessarily strips even more money from the recipient.

An example is helpful. Imagine that AHCA asserts a $300,000 lien against a recipient's cause of action as reimbursement for expenditures it made on the

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[4] That figure is conditioned on whether an answer has been filed or whether a demand for appointment of arbitrators has been made. Before either of those conditions occurs, Plaintiff's attorneys may charge "33 1/3% of any recovery up to $1 million," plus "30% of any portion of the recovery between $1 million and $2 million," plus "20% of any portion of the recovery exceeding $2 million." R. Regulating Fla. Bar 4–1.5(f)(4)(B)(i)(a) (2017). After one of those conditions occur, Plaintiff's attorneys may charge "40% of any recovery up to $1 million," plus "30% of any portion of the recovery between $1 million and $2 million," plus "20% of any portion of the recovery exceeding $2 million." *Id.* 4– 1.5(f)(4)(B)(i)(b).

recipient's behalf. Because of liability issues, the recipient settles the case for $100,000—$10,000 of which represents past medical expenses. Since the recovery is less than AHCA's lien, the formula-based allocation applies. Given the Florida Bar's rules for attorney's fees, the recipient's attorney in either scenario could receive up to $40,000, and let's say he does. Assuming a hypothetical formula tied to the Florida Bar's attorney's fees rules—meaning that 40% of the recipient's recovery is reserved for attorney's fees—and further assuming that the recipient is not able to rebut the formula-based allocation, AHCA and the recipient would both receive $30,000. Yet under Florida's actual statutory formula, AHCA would receive $37,500, which would leave only $22,500 for the recipient—$7,500 less than the recipient would have received under the hypothetical formula.

	Hypothetical Formula-Based Allocation tied to the Florida Bar's Attorney's Fees Rules	**§ 409.910(17)'s Formula-Based Allocation**
Attorney's Fees	$40,000	$40,000
AHCA's Reimbursement	$30,000	$37,500
Recipient Recovery	$30,000	$22,500

Consequently, Florida's statutory formula allows AHCA to pocket even more money it would have been entitled to under a formula tailored to the Florida Bar's attorney's fees rules.

That result is not an accident. Florida did not hide the ball here; rather, it made explicit its intent to tilt the scales in AHCA's favor. *See* ECF No. 10-4, at 4 (opining that § 409.910's current iteration "increase[es] the likelihood the State will prevail in defending Medicaid liens," "result[s] in an increase in [third-party liability] collections[,]" and "reduc[es] the expense and staff time" required to defend Medicaid liens). That is consistent with the Florida legislature's intent "that Medicaid be the payor of last resort for medically necessary goods and services furnished to Medicaid recipients." § 409.910(1).

The arbitrary nature of Florida's reimbursement statute alone is likely enough to rule that it is preempted. *See Wos*, 133 S. Ct. at 1398 ("If a State arbitrarily may designate one-third of any recovery as payment for medical expenses, there is no logical reason why it could not designate half, three-quarters, or all of a tort recovery in the same way."). Yet it gets worse. On top of that arbitrary baseline, Florida has shifted the burden to the Medicaid recipient to prove that she is entitled to that which is already hers. And that burden is a particularly onerous one. *Cf. Mfg. Research Corp. v. Graybar Elec. Co., Inc.*, 679 F.2d 1355, 1360 (11th Cir. 1982) (suggesting that a clear and convincing burden "is an onerous one"); *Gordon v. Dennis Burlin Sales, Inc.*, 174 B.R. 257, 259 (Bankr. N.D. Ohio 1994) (stating that "a clear and convincing

evidence standard . . . is a more onerous burden of proof" (citing *In re Smith*, 170 B.R. 111 (Bankr. N.D. Ohio 1994))).

What makes Florida's reimbursement statute and AHCA's application of that statute even more pernicious is that AHCA has both the authority and the capability to seek its reimbursement directly from the responsible third party (or, as here, parties). *See* § 409.910(11) ("The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of [a variety of] capacities[.]"). Yet in this case and many others, it simply chooses not to. And the effect of that choice should not be overlooked. Rather than paying its own attorneys to recover these funds, AHCA shifts a disproportionate share of the costs to the recipient—costs which come directly out of the recipient's recovery. Then AHCA seeks its reimbursement directly from the recipient's already-reduced recovery.

At a certain point, requiring a Medicaid recipient to overcome a hodgepodge of hurdles amounts to a quasi-irrebuttable presumption. That is the case here; although Florida's reimbursement statute—which requires Medicaid recipients to overcome obstacle after obstacle just to keep a portion of the judgment that the recipient is already entitled to—may be "rebuttable," in practice, it is a quasi-irrebuttable one.[5] Yet that flouts

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[5] AHCA's reference to other administrative proceedings where Medicaid recipients successfully rebutted the formula-based

federal law. Because Florida cannot save its reimbursement statute through wily draftsmanship, *see Wos*, 133 S. Ct. at 1398 ("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."), it is therefore preempted.

In so ruling, this Court wants to make itself absolutely clear. This Court is not saying that Florida may not enact a rebuttable, formula-based allocation to determine what portion of a judgment represents past medical expenses; in fact, the Supreme Court has suggested, without holding, just the opposite. *See id.* at 1402 (mentioning that states "may even be able to adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses"); *see also Ahlborn*, 547 U.S. at 288 n.18 (suggesting that states can enact "special rules and procedures for allocating tort settlements"). Nor is it saying that Florida may not shift the burden to Medicaid recipients to disprove that allocation; that issue is not before this Court, but it probably can. *See Wos*, 133 S. Ct. at 1401 (implying that certain "rebuttable presumptions and adjusted burdens of proof" may be "compliant with the federal statute").

And although this Court doesn't get to rewrite Florida's statute—and it doesn't endeavor to do so—it

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allocation does not undermine this conclusion. It is of no matter how certain Administrative Law Judges apply Florida's reimbursement statute; their application of that statute isn't before this Court. The statute itself is.

can say when a Florida statute runs afoul of federal law. *See Fresenius Med. Care Holdings, Inc. v. Francois*, 832 F. Supp. 2d 1364, 1367 (N.D. Fla. 2011) (Mickle, J.) ("Other times, preemption is implied, such as when . . . the state and federal law are in such conflict that their objectives are at odds or when it would be impossible to comply with both (known as conflict preemption)." (citing *Fla. State Conference of the NAACP v. Browning*, 522 F.3d 1153, 1167 (11th Cir. 2008))). It does here. The reimbursement statute's clear and convincing burden—when coupled with a formula-based baseline wholly divorced from reality and a requirement that the recipient affirmatively disprove that baseline to successfully rebut it—is in direct conflict with the Medicaid statute's anti-lien and antirecovery provisions. Thus, in this specific scenario, Florida's clear and convincing burden is preempted by federal law.

Accordingly,

IT IS ORDERED:

1. Gallardo's Motion for Summary Judgment, ECF No. 11, is **GRANTED**.

2. AHCA's Motion for Summary Judgment, ECF No. 13, is **DENIED**.

3. In its current form, § 409.910, Fla. Stat. (2016), is preempted by federal law; namely, 42 U.S.C. § 1396a, 42 U.S.C. § 1396k, and 42 U.S.C. § 1396p.

4. The Clerk shall enter judgment stating:

Gianinna Gallardo, an incapacitated person, by and through her parents and co-guardians, Pilar Vassallo and Walter Gallardo, successfully proved that portions of § 409.910(17)(b), Fla. Stat. (2016) are preempted by federal law. The State of Florida Agency for Health Care Administration is therefore enjoined from enforcing that statute in its current form.

It is declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses.

It is also declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from requiring a Medicaid recipient to affirmatively disprove Florida Statutes § 409.190(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.

5. The Clerk shall close the file.

SO ORDERED on April 18, 2017.

s/ MARK E. WALKER
United States District Judge

APPENDIX E

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

Case No. 15-6960MTR

[Filed: June 14, 2016]

GIANNINNA GALLARDO, BY AND THROUGH HER PARENTS AND CO-GUARDIANS PILAR VASSALLO AND WALTER GALLARDO,	)
Petitioner,	)
vs.	)
AGENCY FOR HEALTH CARE ADMINISTRATION,	)
Respondent.	)

ORDER CANCELING HEARING AND PLACING CASE IN ABEYANCE

On June 13, 2016, the parties filed the Joint Motion to Abate Proceedings. It is

ORDERED that:

1. The final hearing scheduled for July 11, 2016, is canceled.

2. The case is placed in abeyance.

3. The parties shall confer and advise the undersigned in writing when judgement is entered in the Federal 1983 Action or within six months, whichever occurs sooner, as to the status of this matter and as to the length of time required for the final hearing and several mutually-agreeable dates for scheduling the final hearing should one be necessary. Failure to timely advise will result in the conclusion that this cause has been amicably resolved, and the file of the Division of Administrative Hearings will be closed.

DONE AND ORDERED this 14th day of June, 2016, in Tallahassee, Leon County, Florida.

/s/ Robert E. Meale
S ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
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Filed with the Clerk of the
Division of Administrative Hearings
this 14th day of June, 2016.

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APPENDIX F

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 17-13693

D.C. Docket No. 4:16-cv-00116-MW-CAS

[Filed: October 20, 2020]

GIANINNA GALLARDO, an incapacitated person, by and through her parents and co-guardians Pilar Vassallo and Walter Gallardo,	)
Plaintiff - Appellee,	)
versus	)
ELIZABETH DUDEK, in her official capacity as Secretary of the Florida Agency for Health Care Administration,	)
Defendant,	)

MARY MAYHEW,)
in her official capacity as Secretary)
of the Florida Agency for Health Care)
Administration,)
)
Defendant - Appellant.)

Appeal from the United States District Court
for the Northern District of Florida

Before WILSON, BRANCH, and ANDERSON, Circuit Judges.

BRANCH, Circuit Judge:

No judge in regular active service on the Court having requested that the Court be polled on rehearing en banc, the Petition for Rehearing En Banc is DENIED. The Petition for Rehearing En Banc is also treated as a Petition for Rehearing before the panel and is DENIED.[1]

Although it is unfortunate that our interpretation of federal law conflicts with the Florida Supreme Court's interpretation of federal law and presents a forum shopping possibility, we cannot for that reason endorse an incorrect interpretation of federal law. Our system of federalism allows for parallel state and federal interpretations of federal law. *See Casale v. Tillman*, 558 F.3d 1258, 1260 (11th Cir. 2009) (per curiam). Moreover, we are not bound by a state court's interpretation of federal law. *See Venn v. St. Paul Fire & Marine Ins. Co.*, 99 F.3d 1058, 1064 (11th Cir. 1996);

[1] Judge Wilson would grant the petition for panel rehearing.

See also, e.g., RAR, Inc. v. Turner Diesel, Ltd., 107 F.3d 1272, 1276 (7th Cir. 1997) ("Although state court precedent is binding upon us regarding issues of state law, it is only persuasive authority on matters of federal law."). Accordingly, we *deny* Gallardo's petition for panel rehearing.

WILSON, Circuit Judge, dissenting from denial of rehearing by the panel:

Medicaid recipients in Florida have a forum-shopping problem. In 2018, a unanimous Florida Supreme Court held that the Medicaid Act partially preempts Florida Statutes § 409.910(17)(b). *See Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53 (Fla. 2018). That statute lets Florida siphon money from the part of a recipient's tort recovery that represents payment for the recipient's past and future medical care. But six justices of the Florida Supreme Court held that the plain text of the Medicaid Act limits Florida to just the part of the recovery that represents payment for past medical care. *Id.* at 56. One justice held that the Supreme Court of the United States specifically decided this issue in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006). *Id.* at 57–58 (Polston, J., concurring specially in part and dissenting in part).

Two years later, this court held just the opposite. *See Gallardo by & through Vassallo v. Dudek*, 963 F.3d 1167, 1171 (11th Cir. 2020). A fractured panel dismissed the Florida Supreme Court's construction of the Medicaid Act as a "mistake in logic." *Id.* at 1178. It ruled that the Medicaid Act lets Florida recover from the part of the recipient's recovery that represents

payment for both past and future medical care. *Id.* at 1180.

I dissented for three reasons. For one, the plain text of the Medicaid Act limits Florida to just the part of the recovery representing payment for the care that Florida fronted first—the recipient's past medical care. *Id.* at 1184–87 (Wilson, J., concurring in part and dissenting in part). For another, the Supreme Court decided this issue in *Ahlborn*, holding that the state there could recover from only the part of the recovery representing payment for past medical care. *Id.* at 1188–91. And for a third, almost every court to consider this issue has rejected the majority's view, adopting instead the Florida Supreme Court's position that the state can recover from only the past-medical-care part of the recipient's tort recovery. *Id.* at 1191–92 (citing *E.M.A. ex rel. Plyler v. Cansler*, 674 F.3d 290, 307, 312 (4th Cir. 2012), *aff'd sub nom. on other grounds Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013); *McKinney ex rel. Gage v. Phila. Hous. Auth.*, 2010 WL 3364400, at *9 (E.D. Pa. Aug. 24, 2010); *Price v. Wolford*, 2008 WL 4722977, at *2 (W.D. Okla. Oct. 23, 2008); *Sw. Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1108–10 (Ariz. Ct. App. 2011); *In re Estate of Martin*, 574 S.W.3d 693, 696 (Ark. App. 2019), *reh'g denied* (Ark. App. Apr. 24, 2019); *Bolanos v. Superior Court*, 87 Cal. Rptr. 3d 174, 179–81 (Cal. App. 4th 2008); *Lugo ex rel. Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892, 895–96 (N.Y. Sup. Ct. 2006); *In re E.B.*, 729 S.E.2d 270, 453 (W. Va. 2012); *Latham v. Office of Recovery Servs.*, 2019 UT 51, ¶ 20 (Utah 2019), *cert. denied*, *Office of Recovery Servs. v. Latham*, 140 S. Ct. 852 (2020)).

These points underscore "that the majority view, not the majority's view, is the right one." *Id.* at 1192.

I also previewed what would flow from the majority's mistake: forum shopping in its purest form. *See id.* at 1192–93. "Florida Medicaid recipients will now head to state administrative court to benefit from the Florida Supreme Court's holding in *Giraldo*." *Id.* "Meanwhile, Florida may seek declaratory relief in federal court to bypass *Giraldo* and benefit from our holding in *Gallardo*." *Id.* at 1193. "That holding will bind our district courts to declare that the Medicaid Act does not preempt Florida's attempt to recover from the part of the recipient's recovery that represents payment for future medical care." *Id.* "And then Florida will take the federal-court judgment to state court and argue that it has a preclusive effect on the recipient." *Id.*

Even then, it was clear that this consequence was "far from hypothetical": Florida has admitted that it will use "the preclusive effect of our judgment in state administrative court." *Id.* Yet that stance sets the stage for a bizarre outcome. In the weeks since the majority's ruling, at least two Florida courts have held that *Giraldo* controls in Florida's state courts, while *Gallardo* controls in the Eleventh Circuit's federal courts. *See Jones v. Agency for Health Care Admin.*, 2020 WL 4259195, at *8 (Fla. DOAH July 17, 2020); *Bonnett v. Agency for Health Care Admin.*, 2020 WL 4378897, at *4 n.3 (Fla. DOAH July 22, 2020). But when Florida wins a federal judgment first and brings the judgment back to state court, res judicata principles will "perversely" compel "the state

administrative court [to] apply the Eleventh Circuit's decision in *Gallardo*, rather than the Florida Supreme Court's decision in *Giraldo*." *Gallardo*, 963 F.3d at 1193 (Wilson, J., concurring in part and dissenting in part).

That's a problem. The risk that "the same event may be judged by two different laws, depending upon whether a state court or a federal forum within that state is available" is precisely the "type of evil" that the Supreme Court sought to curb in *Erie Railroad Co. v. Tompkins*, 304 U.S. 64 (1938). *See Wells v. Simonds Abrasive Co.*, 345 U.S. 514, 521 (1953) (Jackson, J., dissenting). Within these cracks in the law's forum-shopping armor, randomness and inequity abound. Pick-your- law scenarios "can empower strong, well-off, and sophisticated parties"—like a state—to the detriment of "paradigmatically worse-off part[ies]"—like a Medicaid recipient. *See* Ori Aronson, *Forum by Coin Flip: A Random Allocation Model for Jurisdictional Overlap*, 45 SETON HALL L. REV. 63, 75–76 (2015). They sanction "inequitable administration of the laws" in a system that strives for equal justice. *See Hanna v. Plumer*, 380 U.S. 460, 468 (1965). And they "encourage gamesmanship"—like a state wielding a federal-court judgment to bypass its own state supreme court's ruling. *See Atl. Marine Const. Co. v. U.S. Dist. Court for W. Dist. of Tex.*, 571 U.S. 49, 65 (2013).

Unfortunately, there is nothing left to do in the Eleventh Circuit or the Florida Supreme Court. The dust in those courts have settled, leaving each on different sides of the chasm. Until their differences are

reconciled, though, Florida Medicaid recipients must straddle two worlds: one where they win, and one where they lose. It is an arrangement as arbitrary as it is wrong; a system that awards first place not to the winner of the case, but to the winner of the race to the courthouse. At some point, someone must decide whether *Giraldo* or *Gallardo* got it right.

I remain steadfast in my view that *Gallardo* got it wrong. As most courts have long held, the Medicaid Act prevents Florida from robbing its recipients of tort payments paid for their future medical burdens. I dissent from the denial of rehearing by the panel.

APPENDIX G

STATUTORY PROVISIONS INVOLVED

42 U.S. Code § 1396a - State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(25) provide –

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or

redetermination of eligibility for medical assistance, and

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

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

* * *

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* * *

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an

individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

* * *

42 U.S. Code § 1396k - Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

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

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

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

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the

> enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S. Code § 1396p - Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

> (1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—
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(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

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

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(11) The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

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(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the 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 as defined by the Florida Rules of Civil Procedure, 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's 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. Notwithstanding any provision of this section to the contrary, the agency shall be entitled to all medical coverage benefits up to the total amount of medical assistance provided by Medicaid. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

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(b) A recipient may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of 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. Final order authority for the proceedings specified in 1this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. 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 the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f) or that Medicaid provided a lesser

amount of medical assistance than that asserted by the agency. [footnote omitted]

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