STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MICHAEL MOBLEY, BY AND THROUGH
HIS FATHER AND NATURAL GUARDIAN,
DAVID MOBLEY,

Petitioners,

vs. Case No. 13-4785MTR

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

On March 17 and 24, 2014, a duly-noticed hearing was held in Pensacola and Tallahassee, Florida, via video teleconference, before F. Scott Boyd, an Administrative Law Judge assigned by the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Floyd B. Faglie, Esquire
Staunton and Faglie, P.L.
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Monticello, Florida 32344

For Respondent: Adam James Stallard, Esquire
Xerox Recovery Services Group
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STATEMENT OF THE ISSUE

The issue to be decided is the amount payable to Respondent in satisfaction of the Agency's Medicaid lien from a settlement,

judgment, or award received by Petitioner from a third-party under section 409.910(17), Florida Statutes.

PRELIMINARY STATEMENT

On December 13, 2013, Petitioner filed a Petition to Determine Amount Payable to the Agency for Health Care Administration in Satisfaction of Medicaid Lien.

A hearing was held on March 17 and 24, 2014. Petitioner presented the testimony of one expert and fact witness, Mr. Matt Schultz. Ten exhibits were admitted into evidence, Exhibits P-9 through P-12, P-15, P-20, P-21, P-23C, P-23D, and P-23F. Respondent offered no witnesses or exhibits. The parties filed a Joint Pre-hearing Stipulation, and facts stipulated there were accepted and made a part of the Findings of Fact below. Official recognition was granted as to numerous Florida Statutes, state and federal judicial cases, and administrative orders, including materials submitted for recognition after the final hearing. A joint motion at hearing for additional time to submit Proposed Final Orders was granted. The Transcript of the final hearing was filed April 29, 2014, and the parties timely filed proposed orders that have been carefully considered.

FINDINGS OF FACT

1. On June 7, 2005, 14-year-old Michael Mobley attended a beach party. The party occurred on, near, or about the beach premises of a hotel. Michael became intoxicated through

consumption of alcohol, and drowned in the Gulf of Mexico. He was revived but suffered brain damage, leaving him unable to communicate, ambulate, eat, toilet, or care for himself in any manner. Michael is now dependent on his father for all aspects of his daily life.

2. As a result of this incident, Michael suffered both economic and noneconomic damages. These damages included, at least, physical and mental pain and suffering, past and future medical expenses, disability, impairment in earning capacity, and loss of quality and enjoyment of life. Michael's parents also suffered damages.

3. Michael's father's employer maintained a self-funded Employee Benefit Plan governed by the Employee Retirement Income Security Act (ERISA Plan).

4. The Florida Statutes provide that Respondent, Agency for Health Care Administration (AHCA), is the Florida state agency authorized to administer Florida's Medicaid program. § 409.902, Fla. Stat.[1/]

5. Michael's past medical care related to his injury was provided through health benefits from the ERISA Plan administered through CIGNA HealthCare and Horizon Blue Cross Blue Shield of New Jersey, and the Florida Medicaid program. The health benefits extended to Michael through his father's employer totaled $515,860.29. The Florida Medicaid program

provided $111,943.89 in benefits. The combined amount of medical benefits Michael received as a result of his injury is $627,804.18.

6. The ERISA Plan provided the employer (through its administrators CIGNA and Horizon Blue Cross Blue Shield), with subrogation and reimbursement rights which provided entitlement to reimbursement from any settlement of 100 percent of what the plan had paid. ACS Recovery Services represented CIGNA and Horizon Blue Cross Blue Shield, the administrators of the Employee Benefit Plan, and on behalf of these clients ACS Recovery Services asserted a $515,860.29 claim against any settlement Michael received.

7. The Florida Statutes provide that Medicaid shall also be reimbursed for medical assistance that it has provided if resources of a liable third party become available. § 409.910(1), Fla. Stat.

8. In 2006, Michael's parents, David Mobley and Brenda Allerheiligen, brought a lawsuit in Okaloosa County Circuit Court to recover all of Michael's damages.

9. By letter dated May 24, 2011, Petitioner's attorney sent AHCA a Letter of Representation requesting the amount of any Medicaid lien and the itemization of charges. The letter also invited AHCA to participate in litigation of the claim or in settlement negotiations.

10. AHCA through ACS Recovery Services by letter of June 9, 2011, asserted a Medicaid lien against any settlement in the amount of $111,943.89.

11. Testimony at hearing established that a conservative "pure value" of Michael's economic damage claims in the case, before consideration of such factors as comparative fault, application of the alcohol statute, a defendant's bankruptcy, and the novel theories of legal liability, was $15 million.

12. A Joint Petition for Approval of Settlement was filed in the Circuit Court in and for Okaloosa County, Florida, on or about June 14, 2012. It stated that although the damages Michael received far exceeded the sum of $500,000, the parties had agreed to fully resolve the action for that amount in light of the parties' respective assessments of the strengths and weaknesses of their cases. The Petition specifically alluded to pending bankruptcy proceedings, summary judgment dismissal of claims premised upon a duty to provide lifeguarding services, Plaintiff's remaining theories of liability, available defenses, specifically including the statutory "alcohol defense" as interpreted by the Florida courts, and anticipated costs of trial and appeal.

13. The Petition also stated: "Plaintiff's claim for past medical expenses related to the incident total $627,804.18.

This claim consists of $515,860.29 paid by a self-funded ERISA plan and $111,943.89 paid by Medicaid."

14. As an attached exhibit, the Petition incorporated a Distribution Sheet/Closing Statement which allocated the $500,000 total recovery among the categories of attorneys' fees, costs, outside attorneys' fees, lien/subrogation/medical expenses, and net proceeds to client. The Distribution Sheet allocated $140,717.54 to "lien/subrogation/medical expenses," subdivided into $120,000.00 to Blue Cross Blue Shield of Florida/CIGNA and $20,717.54 to Medicaid Lien. The proposed settlement did not further describe the $331,365.65 amount identified as "net proceeds to client," or allocate that amount among distinct claims or categories of damages, such as physical or mental pain and suffering, future medical costs discounted to present value, disability, impairment in earning capacity, or loss of quality and enjoyment of life. Under the Joint Petition for Approval of Settlement, most of the total recovery thus remains uncategorized as to the type of damages it represents.

15. The Joint Petition for Approval of Settlement was submitted on behalf of the Defendants and Plaintiffs in the lawsuit, including Michael Mobley, Petitioner here. Respondent did not participate in settlement negotiations or join in the Release, and no one represented its interests in the

negotiations. The Agency has not otherwise executed a release of the lien.

16. A Release was signed by the Plaintiffs contingent upon court approval of the Petition for Approval of Settlement.

17. The court approved the settlement, with the exception of the Medicaid lien, pending an administrative determination of the amount of the lien to be paid.

18. This $500,000 settlement is the only settlement received and is the subject of AHCA's claim lien.

19. In regard to the $500,000 settlement:

A. Michael's parents, Brenda Allerheiligen and David Mobley waived any claim to the settlement funds in compensation for their individual claims associated with their son's injuries;

B. The law firm of Levin, Papantonio, Mitchell, Rafferty & Proctor, P.A., agreed to waive its fees associated with its representation of Michael and his parents;

C. The law firm of Levin, Papantonio, Mitchell, Rafferty & Proctor, P.A., agreed to reduce its reimbursement of the $60,541.22 in costs it advanced in the litigation of the case by 75% and accept $15,135.31 in full payment of its advanced costs; and

D. ACS Recovery Services on behalf of CIGNA and Horizon Blue Cross Blue Shield agreed to reduce its $515,860.29 ERISA reimbursement claim asserted against the settlement and accept $120,000 in satisfaction of its $515,860.29 claim.

20. AHCA is seeking reimbursement of $111,943.89 from the $500,000 settlement in satisfaction of its $111,943.89 Medicaid lien.

21. AHCA correctly computed the lien amount pursuant to statutory formula. Deducting 25 percent for attorney's fees and $60,541.22 taxable costs from the $500,000.00 recovery leaves a sum of $314,458.78, half of which is $157,229.39. In this case, application of the formula therefore results in a statutory lien amount of $111.943.89, the amount actually paid. § 409.910(17), Fla. Stat.

22. The settlement agreement allocated $120,000.00 to be paid to the ERISA plan in partial reimbursement of the $515,860.29 it had paid for medical expenses. This amount must be added to the amount of $20,717.54 allocated for other medical expenses paid by Medicaid, to reflect a total amount of $140,717.54 allocated for past medical expenses in the settlement.

23. The $500,000 total recovery represents approximately 3.3 percent of the $15 million total economic damages. The

$20,717.54 allocated to "Medicaid Lien" in the distribution sheet of the settlement represents approximately 3.3 percent of the $627,804.18 of total past medical expenses. The sum of $3,694.15 represents approximately 3.3 percent of the $111,943.89 in medical costs paid by Medicaid.

24. The Petitioner has deposited the full Medicaid lien amount in an interest-bearing account for the benefit of AHCA pending an administrative determination of AHCA'S rights. The parties have stipulated that this constitutes "final agency action" for purposes of chapter 120, pursuant to section 409.910(17).

25. Petitioner filed his Petition on December 13, 2013, within 21 days after the Medicaid lien amount was deposited in an interest-bearing account for the benefit of AHCA.

26. While the evidence presented as to the settlement agreement was not sufficient to show the full amount allocated to medical expenses, the evidence does show that the total recovery includes at least $140,717.54 allocated as reimbursement for past medical expenses, which was to be divided unevenly between the ERISA plan and Medicaid.

27. Petitioner failed to prove by clear and convincing evidence that the statutory lien amount of $111,943.89 exceeds the amount actually recovered in the settlement for medical expenses.

CONCLUSIONS OF LAW

28. The Division of Administrative Hearings has jurisdiction over the subject matter and the parties in this case pursuant to sections 120.569, 120.57(1), and 409.910(17), Florida Statutes.

29. The parties stipulated that Petitioner's deposit of the asserted Medicaid lien amount into an interest-bearing account constituted "final agency action" for purposes of chapter 120, pursuant to section 409.910(17). Petitioner filed his Petition on December 13, 2013, within 21 days after that deposit.[2/]

30. As a condition for receipt of federal Medicaid funds, states are required to seek reimbursement for medical expenses incurred on behalf of beneficiaries who later recover from third-party tortfeasors. See Ark. Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268 (2006).

31. Consistent with this federal requirement, the Florida Legislature has enacted section 409.910. This statute authorizes and requires the State to be reimbursed for Medicaid funds paid for a plaintiff's medical care when that plaintiff later receives a personal injury judgment or settlement from a third party. Smith v. Ag. for Health Care Admin., 24 So. 3d 590, 590 (Fla. 5th DCA 2009). The statute creates an automatic lien on any such judgment or settlement for the medical

assistance provided by Medicaid. § 409.910(6)(c), Fla. Stat.

32. A formula is set forth in section 409.910(11)(f) to determine the amount the State is to be reimbursed. The statute sets that amount at half the amount of the total recovery, after deducting taxable costs and 25 percent attorney's fees, not to exceed the amount actually paid by Medicaid on the beneficiary's behalf. Ag. for Health Care Admin. v. Riley, 119 So. 3d 514, 515 n.3 (Fla. 2d DCA 2013). Here, application of the statutory formula yields $111,943.89, the amount actually paid. Petitioner notes that in Wos v. E.M.A., 133 S. Ct. 1391 (2013), the Court invalidated a similar North Carolina statute as being in conflict with federal law. That statute created an irrebuttable presumption that would permit the State to assert its lien against a portion of a Medicaid beneficiary's tort judgment or settlement not allocated as payment for medical care.[3/]

33. Section 409.910(17)(b) provides that a Medicaid recipient has the right to rebut this presumptively valid allocation created under Florida law in an administrative hearing by establishing, through clear and convincing evidence, that either: 1) a lesser portion of the total recovery should be allocated as medical expense reimbursement than has been calculated by the statutory formula; or 2) Medicaid actually

provided a lesser amount of medical assistance than has been asserted by AHCA.

34. Section 409.910(17)(b) thus makes clear that the formula set forth in subsection (11) constitutes a default allocation of the amount of a settlement that is attributable to medical costs, consistent with Ahlborn, and sets forth an administrative procedure for adversarial testing of that allocation, consistent with Wos. Florida courts had similarly interpreted Florida's statutory scheme in light of federal law even prior to the statute's amendment in 2013. See Davis v. Roberts, 130 So. 3d 264, 268 (Fla. 5th DCA 2013); Ag. for Health Care Admin. v. Riley, 119 So. 3d 514, 516 (Fla. 2d DCA 2013); Roberts v. Albertson's Inc., 119 So. 3d 457, 465-466 (Fla. 4th DCA 2012), reh'g and reh'g en banc denied sub nom. Giorgione v. Albertson's, Inc., 2013 Fla. App. LEXIS 10067 (Fla. 4th DCA June 26, 2013).

35. Petitioner did not dispute the amount of medical assistance provided by Medicaid, but attempted to show that a lesser portion of the total recovery should be allocated as medical expense reimbursement than that calculated by the statutory formula, principally in the form of evidence as to the terms of the settlement.

36. Petitioner argues that the Medicaid lien should be reduced to the same percentage of the amount paid by Medicaid as

the total recovery bears to the amount of economic damages incurred. Thus, Petitioner maintains that because the $500,000 total recovery represents just 3.3 percent of the $15,000,000 total economic damages, the Medicaid lien should be limited to that same 3.3 percent of the $111,943.89 paid by Medicaid, that is, to the sum of $3,694.15. Putting aside for the moment discussion of the use of pro rata calculations generally, Petitioner's important argument that the appropriate "multiplicand" is the amount of medical expense paid by Medicaid, as opposed to the total amount of medical expense paid, is addressed first.

37. Petitioner's contention is not supported by the terms of the Social Security Act.[4/] Title 42 U.S.C. § 1396a(a)(25)(A) provides that States will ascertain legal liability of third parties to pay for "care and services available under the plan." (Emphasis added.) The statute thus limits state assignment to a category of liability, that is, medical assistance as defined by Medicaid, but does not limit it only to the care and services actually provided by the plan.

38. A second pertinent provision, § 1396a(a)(25)(H), is ambiguous. It requires a State to have "in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have

acquired the rights of such individual to payment by any other party for such health care items or services." 42 U.S.C. § 1396a(a)(25)(H).

39. While an argument can certainly be made that the final "such" in the sentence quoted above refers back to health care items or services for which payment has been made under Medicaid, another reasonable construction is that the sentence's earlier reference to payment made by Medicaid is instead included only for the purpose of establishing a cap or maximum amount that may be recovered ("to the extent that payment has been made under the State plan"), and so the word "such" refers back only to health care items or services furnished to the individual.

40. A third relevant provision specifically requires that, as a condition for eligibility for Medicaid, a recipient must assign to the State "any rights such person has to payment for medical care from any third party." (Emphasis added.) 42 U.S.C. §§ 1396k(a)(1)(A).

41. Yet another provision even expressly allows a state to collect more than the amount paid by Medicaid, stating that "the remainder of such amount collected shall be paid to such individual." 42 U.S.C. § 1396k(b). If initial assignment of rights to the State was limited to recovery amounts allocated to medical expense paid by Medicaid, there could never be such a

"remainder." In fact, Arkansas had argued in Ahlborn that this "remainder" provision was evidence that the lien could extend to recoveries for damages other than medical expenses. The Supreme Court rejected that interpretation, noting: "That view in turn seems to rest on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed the portion of any third-party recovery earmarked for medical expenses. Neither assumption holds up." (Emphasis added.) Ark. Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268, 282, n.11 (2006). In so explaining the existence of the "remainder" provision, the Court concluded that the assignment authorized by federal law could extend to medical expenses not paid by Medicaid.

42. However, there is no need to become mired too deeply in parsing these provisions of the federal Medicaid statute.[5/] As will be discussed, Petitioner has not shown that any federal or Florida court has actually adopted the construction he advocates.[6/]

43. In arguing that federal law preempts the Florida Statute, Petitioner cites to two cases. First, Price v. Wolford, 608 F.3d 698, 706 (10th Cir. 2010), states that "Oklahoma amended its Medicaid-recovery statute in 2007 after the United States Supreme Court held that a state's recovery of Medicaid payments out of a tort settlement is limited to the

portion of the settlement that represents medical costs paid by Medicaid." (Emphasis added.) Wolford's citation to Ahlborn for this proposition is not supported. The Supreme Court in Ahlborn never stated that a recipient's assignment to a State was limited to those portions of settlements representing recovery of medical expenses paid for by Medicaid. Rather, Ahlborn in numerous places does limit such assignments to settlement amounts for medical expenses, and frequently contrasts these with settlement amounts allocated for damages distinct from medical expenses. Ahlborn, 547 U.S. 268, at 272, 280, 281, 282, 284, 285, 287, 290, 291.

44. Further, it is clear from the facts set forth in the Wolford opinion that the trial court's award to the Oklahoma Health Care Authority (OHCA) comprised not only a percentage of the total amount of medical assistance that had been provided by Medicaid, but also that same percentage of medical expenses that had not been paid by Medicaid, but had been paid by the plaintiff's father. Yet the appeal to the 10th Circuit was not to contest the inclusion of these other medical expenses: it was instead filed by OHCA to contest the propriety of using a pro rata analysis. The holding in Wolford was, in fact, that the district court below had recognized the correct legal standard to apply, but had erred because there was no evidence

at trial either as to the total amount of damages or the reasons supporting proportional reduction. Wolford 608 F.3d at 700.

45. The second case cited by Petitioner, E.M.A. v. Cansler, 674 F.3d 290 (4th Cir. 2012), similarly states at page 300 that federal law only permits assignment of settlement proceeds allocated to "past medical bills paid by Medicaid." Again, however, all other discussion in the case refers simply to medical expenses. Cansler, 674 F.3d 290, at 296, 298, 299, 307, 309, 310, and 312. There were no facts before the court in Cansler to suggest that medical expenses had been paid by any entity other than Medicaid. Whether or not a lien could be asserted against only those settlement amounts allocated for expenses "paid by Medicaid" was not an issue before the court. As noted earlier, the Supreme Court's affirmance of the case in Wos v. E.M.A. invalidated the North Carolina statute because it created an irrebuttable presumption allowing a lien against a portion of a settlement not allocated as payment for medical care.

46. Given the facts and legal issues actually addressed in these two cases, it is clear that it was not the holding of either that under the Social Security Act a State is permitted to assert its Medicaid lien against only settlement amounts allocated to that portion of medical expenses paid by Medicaid. In the absence of judicial determination that federal law trumps

a contrary Florida statute, it is the language of the Florida Statutes, not federal law, that must govern.[7/]

47. Section 409.910(11)(f)4. provides that the Agency is entitled to all medical coverage benefits, defined there as "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."

48. Section 409.910(12) goes on to provide in part:

> Only the following benefits are not subject to the rights of the agency: benefits not related in any way to a covered injury or illness; proceeds of life insurance coverage on the recipient; proceeds of insurance coverage, such as coverage for property damage, which by its terms and provisions cannot be construed to cover personal injury, death, or a covered injury or illness; proceeds of disability coverage for lost income; and recovery in excess of the amount of medical benefits provided by Medicaid after repayment in full to the agency.

49. Section 409.910 is therefore quite clear in its intent that Medicaid is to be the "payer of last resort."[8/] Logically, the statute expressly maintains this same priority when funds are recovered from a third-party tortfeasor.

50. Section 409.910(17)(b), as amended after Wos, provides a recipient of Medicaid benefits an opportunity to demonstrate

that a lesser portion of the total recovery should be allocated to reimbursement for past and future[9/] medical expenses than the amount calculated pursuant to the statutory formula. Dillard v. Ag. for Health Care Admin., 127 So. 3d 820, 821 (Fla. 2d DCA 2013). Nothing in this section limits the referenced medical expenses to only those paid by Medicaid.

51. Section 409.910(1) provides:

> 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. 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. Principles of common law and equity as to assignment, lien, and subrogation are abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. 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. (Emphasis added.)

52. Read together, these statutes leave little doubt that under Florida law, all portions of a recovery pertaining to medical expenses, whether provided by Medicare or not, are

subject to the Medicare lien, and that with respect to such settlement amounts, Medicaid is to be reimbursed before any other person, program, or entity.

53. Petitioner's contention that the appropriate "multiplicand" is the amount of medical expense paid by Medicaid is therefore rejected. If a pro rata calculation is to be applied, it should be applied to the full amount of $627,804.18, the total amount of medical expenses paid.

54. Turning next to the more general question of whether a pro rata calculation should be utilized in this case at all, Petitioner again cites to Ahlborn. However, the United States Supreme Court did not hold there that federal Medicaid law in any way requires States to apply such a calculation, but only affirmed that it could be used in some circumstances. Use of the pro rata calculation in that case was predicated upon the parties' stipulations as to the reasonable value of the total claim, the amount of medical damages in the total claim, the amount of the total recovery, and the amount of the recovery that represented compensation for medical payments made. Ahlborn, 547 U.S. 268, at 274, 281, n.10 (2006).

55. The Agency correctly argues that the portion of the total recovery allocated to medical expense by the settlement is not dispositive of its interests, as it was not a party to the

settlement and did not approve it. §§ 409.910(6)(c)7., (13) Fla. Stat.

56. However, AHCA's lack of participation in a settlement does not necessarily ensure that the statutory formula's default calculation of the medical expense portion of the total recovery will prevail. Florida's new statute authorizes an administrative determination that a lesser portion of a total recovery has been allocated as reimbursement for medical expenses. A settlement agreement does not dictate, but may inform, that administrative determination. A settlement's allocation to medical expenses may be adopted, even when AHCA did not participate in the settlement, provided it is supported by clear and convincing evidence.[10/] § 409.910(17)(b), Fla. Stat.

57. While application of a pro rata calculation is undoubtedly justified in some Medicaid lien cases, it is not appropriate here. This settlement did not actually use a 3.3 percent pro rata calculation to determine the amount allocated for past medical expenses.

58. In this case, there is clear and convincing evidence that the parties to the settlement themselves actually allocated $140,717.54 as reimbursement for past medical expenses. In addition to the "pro rata" amount of $20,717.54 (calculated as described earlier) that was earmarked for Medicaid in the Joint

Petition for Approval of Settlement, the parties also allocated an additional $120,000 for past medical expenses paid by the ERISA plan.[11/]

59. This $120,000 of the settlement agreement was not "meant to compensate the recipient for damages distinct from medical costs — like pain and suffering, lost wages, and loss of future earnings." It clearly is not subject to the anti-lien provisions of federal law. Ahlborn 547 U.S. at 284. Florida law indisputably provides that it is subject to Medicaid lien.

60. Petitioner failed to prove by clear and convincing evidence that less than $111,943.89 of the total recovery should be allocated as reimbursement for medical expenses.

CONCLUSIONS OF LAW

Upon consideration of the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that the Agency for Health Care Administration is entitled to $111,943.89 in satisfaction of its Medicaid lien.

DONE AND ORDERED this 21st day of May, 2014, in Tallahassee, Leon County, Florida.

F. Scott Boyd

F. SCOTT BOYD
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of May, 2014.

ENDNOTES

[1/] All citations are to the 2013 Florida Statutes except as otherwise indicated.

[2/] In light of the stipulation, the curious language of section 409.910(17)(b) is not considered here.

[3/] The federal Medicaid statutes which formed the basis of the Court's opinion have evidently been amended effective October 1, 2014, to allow State Medicaid liens to extend to any payments by a third party that has a legal liability to pay for care and services available under the plan. See P.L. 113-67, Section 202(b).

[4/] Petitioner notes that consideration of federal Medicaid law is required because the United States Supreme Court has determined that a State statute allowing a Medicaid lien to be asserted against any portion of a settlement allocated to other than medical care is contrary to, and preempted by, the "anti-lien" provision of federal law found at 42 U.S.C. 1396p(a)(1). Considered in isolation, that provision appears to prohibit liens of any kind: "No lien may be imposed against the property of an individual on account of medical assistance rendered to him under a State plan." However, the Court interpreted this

provision in conjunction with language in section 1396a(a)(25)(H) requiring a State to acquire the rights of Medicaid recipients to "payment by any other party for such health care items or services" and in conjunction with language in section 1396k(a)(1)(A) requiring Medicaid recipients to assign to the State their rights to "payment for medical care from any third party." The conclusion was that "[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." Ark. Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268, 284-285 (U.S. 2006). The Florida courts have recognized Ahlborn, and Petitioner argues that this law is controlling, but as discussed below, he is actually arguing for an extension of that opinion to an issue not addressed there.

[5/] See Schweiker v. Gray Panthers, 453 U.S. 34, 43 n.14 (1981) (quoting Friedman v. Berger, 409 F. Supp. 1225, 1226 (S.D.N.Y. 1976) in its colorful description of the Medicaid statute as "an aggravated assault on the English language, resistant to attempts to understand it").

[6/] In fact, at least one Florida appellate court has evidently concluded otherwise in two cases. In Smith v. Agency for Health Care Administration, 24 So. 3d 590, 591 (Fla. 5th DCA 2009), the court stated, "Moreover, the formula used by the Ahlborn parties is problematic in that it assumes the Medicaid lien amount to be the *only* medical expense included by the plaintiff as part of his or her overall damage claim, which is not a reasonable assumption. Stated another way, without knowing how much of a plaintiff's total damage claim is comprised of medical expenses, there is no way to calculate the medical expense portion of a settlement by simply comparing the damage claim to the ultimate settlement amount." Then, in Davis v. Roberts, 130 So. 3d 264 (Fla. 5th DCA 2013), a more recent case arising under former section 409.910, the court, in recognition of federal limitations, affirmed that trial courts had discretion to lower the lien calculated by the statutory formula. The court there added together the medical benefits provided by Medicaid with other medical benefits provided by the Department of Health to determine the entire amount of past medical expenses before remanding the case for reconsideration of possible proportional reduction.

[7/] In light of the Florida Statute's provisions that a Medicaid lien takes precedence over all third-party claims, Petitioner's argument that the Medicaid lien can only be asserted against settlement funds allocated to that portion of medical expenses

paid by Medicaid could prevail only if the Florida Statute is unconstitutional because federal law limits liens to expenses paid by Medicaid. As noted above, that construction of federal Medicaid law is not persuasive, and even if it were, it is well established that only a court could make such a finding. Gulf Pines Mem. Park, Inc. v. Oaklawn Mem. Park, Inc., 361 So. 2d 695, 699 (Fla. 1978).

[8/] This priority is, in fact, dictated to a large extent by federal law. Ahlborn, 547 U.S. 268, at 282, ("what § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care"); United States ex rel. Digital Healthcare, Inc. v. Affiliated Computer Services, 778 F. Supp. 2d 37, 41 (D.D.C. 2011)("if a Medicaid beneficiary also has another source of payment for health services, that source is to pay instead of Medicaid").

[9/] Petitioner also argues that both federal and Florida cases have determined that federal law limits State assignments to those portions of recoveries allocated to past medical expenses as opposed to future medical expenses. Given the finding that the settlement agreement here allocated an amount for past medical expenses greater than the amount paid by Medicaid, it is unnecessary to consider that issue.

[10/] The Supreme Court acknowledged a risk that parties to a tort suit might allocate away the State's interest. Ark. Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268, 272 (2006).

[11/] Inclusion of the settlement amount allocated to the ERISA plan for past medical expenses in order to calculate the amount of the settlement subject to the Medicaid lien does not call into question the ERISA settlement itself. Petitioner understandably would prefer to consider that the $140,717.54 allocated to medical expenses by the settlement represents the entire amount available to Medicaid and the ERISA plan. If so, then the provisions of the Florida Statutes assigning priority to the Medicaid lien and the conflict preemption provisions of the federal ERISA law might need to be considered together. See Caremark, Inc. v. Goetz, 480 F.3d 779, 790 (6th Cir. 2007)(ERISA provides that its preemption provision does not apply to recoupment of Medicaid payments by the states) (superseded in part by statute on other grounds as stated in United States ex rel Ramadoss v. Caremark, Inc., 586 F. Supp. 2d 668, 674 (W.D. Tex. 2008). On the other hand, accepting Petitioner's representation at hearing that the ERISA plan's subrogation rights extend to the entire settlement, the Medicaid exclusion

at 29 U.S.C. § 1144(b)(8)(B) might not even be implicated. See Schwade v. Total Plastics, Inc., 837 F. Supp. 2d 1255, 1267 (M.D. Fla. 2011), aff'd, Fla. Health Sci. Ctr. v. Total Plastics, Inc., 496 F. App'x 6, 12 (11th Cir. 2012). In any event, such issues lie beyond the jurisdiction and expertise of this administrative tribunal.

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NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing one copy of a Notice of Appeal with the agency clerk of the Division of Administrative Hearings and a second copy, accompanied by filing fees prescribed by law, with the District Court of Appeal, First District, or with the District Court of Appeal in the appellate district where the party resides. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.