STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GREGORY MIERZWINSKI,

Petitioner,

vs. Case No. 14-3806MTR

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

A formal hearing was conducted in this case on December 19, 2014, in Tallahassee, Florida, before Lawrence P. Stevenson, a duly-designated Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

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

For Respondent: Kevin Andrew Joyce, Esquire
Associate Corporate Counsel
Xerox Recovery Services
2073 Summit Lake Drive, Suite 300
Tallahassee, Florida 32317

STATEMENT OF THE ISSUE

The issue in this proceeding is how much of Petitioner's settlement proceeds should be paid to Respondent, the Agency for

Health Care Administration ("AHCA") to satisfy AHCA's Medicaid lien under section 409.910, Florida Statutes.[1/]

PRELIMINARY STATEMENT

On August 18, 2014, Petitioner Gregory Mierzwinski ("Petitioner") filed with the Division of Administrative Hearings ("DOAH") a Petition to Determine Amount Payable to Agency for Health Care Administration in Satisfaction of Medicaid Lien (the "Petition"). The Petition challenged AHCA's lien for recovery of medical expenses paid by Medicaid in the amount of $135,047.86. Petitioner asserted that section 409.910(17)(b) provided for the reimbursement of a lesser amount of the total third-party settlement proceeds than the amount calculated by AHCA pursuant to the formula established in section 409.910(11)(f).

The case was originally scheduled for hearing on November 17, 2014. One continuance was granted. The hearing was ultimately held on December 19, 2014.

At the hearing, Petitioner testified on his own behalf and offered the testimony of William E. Hahn, the civil trial attorney who handled Petitioner's medical malpractice action. Mr. Hahn testified as a fact witness and was also accepted without objection as an expert in the value of damages suffered by injured parties. Petitioner's Exhibits 1 through 5, 11 and 13 were admitted into evidence. Judicial notice was taken of

Petitioner's Exhibits 10 and 12. AHCA presented no witnesses and offered no exhibits.

At the close of the hearing, the undersigned approved the parties' request that they be given 20 days after the filing of the transcript in which to submit their proposed final orders. The one-volume Transcript of the hearing was filed at DOAH on January 13, 2015. Both parties filed their proposed final orders within 20 days of the filing of the Transcript.

On February 2, 2015, Petitioner filed a Motion for Official Recognition requesting that official recognition be taken of the final orders entered by circuit courts on remand from the Second District Court of Appeal in Agency for Health Care Administration v. Riley, 119 So. 3d 514 (Fla. 2d DCA 2013) and from the First District Court of Appeal in Harrell v. Agency for Health Care Administration, 143 So. 3d 478 (Fla. 1st DCA 2014). AHCA did not object to the motion, which is hereby granted.

FINDINGS OF FACT

1. In mid-October 2012, Petitioner, a trial lawyer, woke up on a Friday morning with a pain in the big toe of his left foot. He called his family practice physician[2/] and was able to obtain an appointment for the following Tuesday. At the appointment, Petitioner saw a nurse practitioner who examined him and pronounced that he had gout. The nurse practitioner prescribed a gout medication.

2. Over the course of the next week, Petitioner's condition worsened, with pain radiating all the way to his hip. On the following Tuesday, he saw the physician. Despite blood testing that showed an elevated white blood cell count, the physician concurred with the nurse practitioner that Petitioner was suffering from an extreme case of gout. The physician prescribed a regimen of steroids for the gout.

3. By the next Saturday, November 3, 2012, Petitioner was so sick that a neighbor drove him to Tampa General Hospital. His blood pressure was extremely low and his kidneys had ceased functioning. Petitioner was on the verge of death. At the hospital, he learned that the physician and his nurse practitioner had misdiagnosed Petitioner's condition. He in fact had a raging staphylococcus aureus infection.

4. Over the course of the next several days, Petitioner underwent several surgeries to save his life. First, the toes on his left foot were amputated. Then, his left foot was amputated. Next, his left leg was amputated below the knee. Finally, the left leg was amputated above the knee.

5. Still, the infection was not controlled. Petitioner was in and out of a coma for a month. He testified that his infectious disease doctor told him that the infection was so bad that the treatment team was at a loss on how to proceed. However, the infection ultimately was brought under control.

Once he was stabilized, Petitioner was transferred to Tampa General's rehabilitation facility and finally released to return to his home.

6. Petitioner was sixty-one years old at the time his leg was amputated. He testified that he practiced as a trial lawyer in Florida from 1977 until his illness. Petitioner stated that he does not find it possible to be a trial lawyer with a prosthetic leg and a walker, but that he does some mediation work. His basic income is $1,653 per month in Social Security benefits. Petitioner testified that this amount is never enough to cover his expenses and that he is required to dip into the proceeds of his settlement with the medical providers in order to make ends meet. He stated that it is "terrifying" to watch the money going out and to wonder what he will do when it is gone.

7. Petitioner lost his Tampa home to foreclosure and was forced to move 40 miles away to find a house that he could afford. Moving away from his longtime home further isolated Petitioner and necessitated paying money for things that he could previously rely on friends and neighbors to help with, such as grocery shopping.

8. Petitioner testified that prior to the amputation he had led an active lifestyle. He ran, rode a bike, and played

golf twice a week. He was an instructor pilot. Petitioner is now incapable of engaging in any of those activities.

9. Petitioner testified that if he falls and is not near a piece of furniture or other object that allows him to use his upper body strength to lift himself, he is helpless until someone comes along to assist him. Merely going to the bathroom involves a complicated transfer from his wheelchair using specially installed bars.

10. Petitioner testified that prior to his settlement he had not, and to his knowledge others had not, made payments in the past or in advance for his future medical care.

11. Civil trial attorney William E. Hahn testified on behalf of Petitioner. Mr. Hahn has practiced since 1972, is a board certified civil trial lawyer, and is a past president of the Florida chapter of the American Board of Trial Advocates, a group that named Mr. Hahn "trial lawyer of the year" in 2012.

12. Mr. Hahn testified that he generally represents plaintiffs in medical malpractice cases and has tried over 100 complex jury trials. He has won verdicts as high as $22.5 million, as low as zero, and "all in between."

13. Mr. Hahn takes cases involving "devastating, catastrophic" injuries such as that suffered by Petitioner. A routine part of his practice is to make a determination of the value of a client's damages. Mr. Hahn was accepted without

objection as an expert in assessing the value of damages suffered by injured parties.

14. Mr. Hahn testified that his evaluation process begins with acquainting himself with the nature of the injury. He then calculates the expenses that have been incurred in the past for the client's treatment and predicts the costs of future treatment. He looks at the medical records and performs his own medical research. He speaks with the treating physicians as well as the client. Mr. Hahn bases his assessments on his experience and training and the experience of other lawyers in handling similar cases throughout Florida and the United States.

15. Mr. Hahn testified that he has known Petitioner since they were both young lawyers practicing in Tampa. When Petitioner called him and explained his situation, Mr. Hahn agreed to represent Petitioner in his medical malpractice action.

16. Mr. Hahn noted that with proper medical treatment Petitioner would have been spared multiple surgeries and the amputation of his leg. He would likely have recovered and returned to law practice. Mr. Hahn opined that the value of Petitioner's case was "well in excess of $2 million," based on Petitioner's background, his training and experience, and the devastating injury and its long term effects. Given Petitioner's status in Tampa and the legal community, and the

outrageousness of what happened, Mr. Hahn believed the verdict would have "exceeded two, four or many more millions of dollars."

17. Mr. Hahn explained that in order to proceed with a medical malpractice claim in Florida, the plaintiff must go through a number of administrative steps called the "notice of intent" process. Mr. Hahn secured the services of a board certified internal medicine physician as his expert. The surgeon confirmed what Mr. Hahn had surmised from the medical records, that this was a case of gross malpractice. Mr. Hahn obtained an affidavit from the surgeon and notified the potential defendants that he was about to make a claim on Petitioner's behalf.

18. Mr. Hahn was aware that Petitioner had received services from Medicaid and initiated a correspondence with AHCA.[3/] The correspondence indicated that Medicaid had paid $135,047.86 in medical expenses for Petitioner. Mr. Hahn stated that this amount would have been part of Petitioner's claim had the matter been fully litigated.

19. Mr. Hahn testified that, despite the clear liability, the recoverable assets complicated any potential award of damages from the medical providers. The total insurance available was $500,000. The insurance company was acting in good faith in trying to settle the case, which ruled out a bad

faith case against the insurer. The only other potential sources of funds were the personal assets of the nurse practitioner and the physician. The defense attorney informed Mr. Hahn that any assets possessed by these individuals were protected from judgment.

20. The defendants recognized that this was a "terrible" case and wanted to settle. Mr. Hahn stated that it became apparent to him that the best business decision for Petitioner was to get the case resolved within the limits of the insurance coverage. He was able to reduce his fee, keep the litigation costs down, and get the matter resolved quickly. Mr. Hahn secured a settlement of $492,500.

21. Mr. Hahn testified that no amount of money could ever make Petitioner whole, but that the amount of the settlement did not come close to fully compensating him for his damages and would not come close to taking care of him for the rest of his life. Mr. Hahn pointed out that in the document memorializing the settlement agreement, the defendants acknowledged that the settlement would not come close to making Petitioner whole.

22. The portion of the settlement agreement referenced by Mr. Hahn was the "Allocation of Settlement" language, which read as follows:

> Although it is acknowledged that this settlement does not fully compensate the Releasor for the damages he has allegedly

> suffered, this settlement shall operate as a full and complete release as to all claims against the Releasees, without regard to this settlement only compensating the Releasor for a fraction of the total monetary value of his alleged damages. These damages have a value in excess of $2,000,000, of which $135,047.86 represents Releasor's claim for past medical expenses. Given the facts, circumstances, and nature of the Releasor's alleged injuries and this settlement, $33,255.54 of this settlement has been allocated to the Releasor's claim for past medical expenses and the remainder of the settlement has been allocated toward the satisfaction of claims other than past medical expenses. This allocation is a reasonable and proportionate allocation based on the same ratio this settlement bears to the total monetary value of all of the Releasor's alleged damages.
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> Further, the parties acknowledge that the Releasor may need future medical care related to his alleged injuries, and some portion of this settlement may represent compensation for these future medical expenses that the Releasor may incur in the future. However, the parties acknowledge that the Releasor, or others on his behalf, have not made payments in the past or in advance for the Releasor's future medical care and the Releasor 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 payments made to secure future medical care.

23. Mr. Hahn testified that the allocation of settlement paragraphs were the product of a negotiation with the defendants' lawyer. The language was acknowledged and agreed to

by all parties. The defendants agreed with the valuation of damages "in excess of $2 million." The allocation of $33,255.54 to past medical expenses was "simple math," its relation to the $492,500 settlement amount being proportional to the relation of $135,047.86 to the $2 million value of the claim. Petitioner was settling for 24.625% of his claim's value, and therefore the Medicaid lien should be reduced proportionately. Mr. Hahn testified that all the parties believed this settlement to be reasonable.

24. Mr. Hahn stated that in his professional judgment, the allocation of $33,255.54 was not only reasonable, it was overly generous. The real value of the case was well in excess of $2 million. Mr. Hahn believed that it would have been reasonable to value the claim at $4 million, in which case the Medicaid allocation would have been cut in half.

25. Mr. Hahn testified that the parties were trying to recognize that Medicaid did "wonderfully" by Petitioner. They valued the case conservatively at $2 million. Many lawyers would have valued it much higher, and could have supported their valuation with documentation. Mr. Hahn stated that the parties' concern was to be appropriate, conservative, and provide a fair recovery to Medicaid.

26. AHCA called no witness to contest the valuation of damages made by Mr. Hahn or to offer an alternative methodology

to calculate the allocation to past medical expenses. No evidence was presented indicating the settlement agreement was not reasonable given all the circumstances of the case. It does not appear that the parties colluded to minimize the share of the settlement proceeds attributable to Medicaid's payment of costs for Petitioner's medical care. In fact, the evidence established that the settlement was extremely conservative in its valuation of Petitioner's claim and that the settling parties could have reasonably apportioned far less to Medicaid than they actually did.

27. AHCA was not a party to the settlement of Petitioner's claim. AHCA correctly computed the lien amount pursuant to the statutory formula in section 409.910(11)(f). Deducting the 25 percent attorney's fee, or $123,125, from the $492,500 recovery leaves $371,375, half of which is $185,687.50. That figure exceeds the actual amount expended by Medicaid on Petitioner's medical care. Application of the formula would provide sufficient funds to satisfy the Medicaid lien of $135,047.86.

28. Petitioner proved by clear and convincing evidence that the $2 million total value of the claim was a reasonable, if not unduly conservative, amount. Petitioner proved by clear and convincing evidence, based on the clear strength of his case and on the fact that it was limited only by the inability to collect

the full amount of the likely judgment, that the amount agreed upon in settlement of Petitioner's claims constituted a fair settlement, including the portion attributed to the Medicaid lien for medical expenses.

CONCLUSIONS OF LAW

29. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this proceeding. §§ 120.569, 120.57(1), and 409.910(17), Fla. Stat. (2014).

30. AHCA is the agency authorized to administer Florida's Medicaid program. § 409.902, Fla. Stat.

31. The Medicaid program has been succinctly described as follows:

> The Medicaid program was established in 1965 by Title XIX of the Social Security Act ("the Act"), codified at 42 U.S.C. § 1396-1396v. The primary purpose of the program is to provide federal financial assistance to States that elect to reimburse certain costs of medical treatment for needy individuals. See Harris v. McRae, 448 U.S. 297, 301, 65 L. Ed. 2d 784, 100 S. Ct. 2671 (1980). States voluntarily agree to participate in the program, but must comply with federal requirements once they do so. Id. It is often said that Congress wanted Medicaid to be a "payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 99-146, at 312 (1985), reprinted in 1986 U.S.C.C.A.N. 42, 279.

Ahlborn v. Arkansas Dep't of Human Servs., 397 F.3d 620, 623 (8th Cir. 2005), aff'd Arkansas Dep't of Health and Human Servs. v. Ahlborn, 547 U.S. 268 (2006).

32. As a condition for receipt of federal Medicaid funds, states are required to seek reimbursement for medical expenses incurred on behalf of Medicaid recipients who later recover from liable third parties. 42 U.S.C. § 1396a(a)(25)(H) provides:

> A. A State plan for medical assistance must—
>
> * * *
>
> (25) provide—
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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.

33. 42 U.S.C. § 1396k(a)(1)(A) provides:

> (a) For the purpose of assisting in the collection of medical support payments . . . a State plan for medical assistance shall—
>
> (1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the

> legal capacity to execute an assignment for himself, the individual is required—
>
> (A) to assign the State any rights . . . to payment for medical care from any third party.

34. To implement these federal requirements, the Florida Legislature has enacted section 409.910, the "Medicaid Third-Party Liability Act." In its statement of intent, the statute provides as follows:

> (1) 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.

35. It was undisputed that Medicaid provided $135,047.86 in medical expenses for Petitioner or that AHCA had a valid Medicaid lien against Petitioner's settlement and the right to

seek reimbursement for its expenses. The mechanism by which AHCA enforces its right is set forth in section 409.910 as follows:

> (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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> (a) If either the recipient, or his or her legal representative, or the agency brings an action against a third party, the recipient, or the recipient's legal representative, or the agency, or their attorneys, shall, within 30 days after filing the action, provide to the other written notice, by personal delivery or registered mail, of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If an action is brought by either the agency, or the recipient or the recipient's legal representative, the other may, at any time before trial on the merits, become a party to, or shall consolidate his or her action with the other if brought independently. Unless waived by the other, the recipient, or his or her legal representative, or the agency shall provide notice to the other of the intent to dismiss at least 21 days prior to voluntary dismissal of an action against a third party. Notice to the agency shall be sent to an address set forth by rule. Notice to the recipient or his or her legal representative, if represented by an attorney, shall be sent to the attorney, and, if not represented, then to the last known address of the recipient or his or her legal representative.

(b) An action by the agency to recover damages in tort under this subsection, which action is derivative of the rights of the recipient or his or her legal representative, shall not constitute a waiver of sovereign immunity pursuant to s. 768.14.

(c) In the event of judgment, award, or settlement in a claim or action against a third party, the court shall order the segregation of an amount sufficient to repay the agency's expenditures for medical assistance, plus any other amounts permitted under this section, and shall order such amounts paid directly to the agency.

(d) No judgment, award, or settlement in any action by a recipient or his or her legal representative to recover damages for injuries or other third-party benefits, when the agency has an interest, shall be satisfied without first giving the agency notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and subrogation rights or proceed with any action as permitted in this section.

(e) Except as otherwise provided in this section, notwithstanding any other provision of law, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the agency's claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto.

(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.
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> 2. The remaining amount of the recovery shall be paid to the recipient.
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> 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.
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> 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.

36. As shown in Finding of Fact 27, supra, AHCA correctly computed the lien amount pursuant to the statutory formula in subsection (11)(f). One-half of the amount remaining, after deduction of the attorney's fee, would be $185,687.50, which exceeds the actual amount expended by Medicaid on Petitioner's medical care. Application of the formula would provide sufficient funds to satisfy the Medicaid lien of $135,047.86.

37. Section 409.910(13) provides that AHCA is not automatically bound by the allocation of damages set forth in Petitioner's settlement agreement:

> (13) No action of the recipient shall prejudice the rights of the agency under this section. No settlement, agreement, consent decree, trust agreement, annuity contract, pledge, security arrangement, or any other device, hereafter collectively referred to in this subsection as a "settlement agreement," entered into or consented to by the recipient or his or her legal representative shall impair the agency's rights. However, in a structured settlement, no settlement agreement by the parties shall be effective or binding against the agency for benefits accrued without the express written consent of the agency or an appropriate order of a court having personal jurisdiction over the agency.

38. Section 409.910(17)(b) provides a mechanism whereby a recipient may challenge AHCA's presumptively correct calculation of medical expenses payable to the agency:

> (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 this 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.

39. In Evans Packing Company v. Department of Agriculture & Consumer Services, 550 So. 2d 112, 116, n.5 (Fla. 1st DCA 1989), the Court defined clear and convincing evidence as follows:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the evidence must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact the firm belief of conviction, without hesitancy, as to the truth of the allegations sought to be established. Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

40. Judge Sharp, in her dissenting opinion in Walker v. Department of Business & Professional Regulation, 705 So. 2d 652, 655 (Fla. 5th DCA 1998) (Sharp, J., dissenting), reviewed recent pronouncements on clear and convincing evidence:

> Clear and convincing evidence requires more proof than preponderance of evidence, but less than beyond a reasonable doubt. In re Inquiry Concerning a Judge re Graziano, 696 So. 2d 744 (Fla. 1997). It is an intermediate level of proof that entails both qualitative and quantative [sic] elements. In re Adoption of Baby E.A.W., 658 So. 2d 961, 967 (Fla. 1995), cert. denied, 516 U.S. 1051, 116 S. Ct. 719, 133 L. Ed. 2d 672 (1996). The sum total of evidence must be sufficient to convince the trier of fact without any hesitancy. Id. It must produce in the mind of the fact finder a firm belief or conviction as to the truth of the allegations sought to be established. Inquiry Concerning Davey, 645 So. 2d 398, 404 (Fla. 1994).

41. The evidence is clear and convincing that the allocation for Petitioner's past medical expenses in the amount of $33,255.54 as set forth in the settlement agreement constitutes a fair, reasonable, and accurate share of the total recovery for those past medical expenses actually paid by Medicaid. The evidence is clear and convincing that the parties to the settlement engaged in no manipulation of the apportionment to minimize or prejudice AHCA's right to reimbursement for medical expenditures. If anything, the parties to the settlement were overly generous in the apportionment for medical expenses. They based the apportionment on a very conservative estimate of the value of Petitioner's claim. They also based the apportionment on the full value of the $492,500 settlement, without deducting an attorney's fee for Mr. Hahn.

42. There was no evidence that Medicaid funds were either committed to or paid for future medical expenses.

43. The full amount of the Medicaid lien was accounted for, and made subject to "an allocation between medical and nonmedical damages--in the form of either a jury verdict, court decree, or stipulation binding on all parties," a process approved in Wos v. E.M.A., 528 U.S. ___; 133 S. Ct. 1391, 1399; 185 L. Ed. 2d 471, 483; 2013 U.S. LEXIS 2372, *18-19 (2013).

44. Petitioner has proven, by clear and convincing evidence, that $33,255.54 of the total third-party recovery represents that share of the settlement proceeds fairly attributable to expenditures that were actually paid by Respondent for Petitioner's medical expenses.

45. In addition to being able to satisfy its lien from the portion of the settlement proceeds representing payment for past medical expenses, AHCA also contends that settlement funds received by Petitioner for payment of future medical expenses are subject to AHCA's lien. It bases this contention on the language from section 409.910(17)(b) that a challenger such as Petitioner 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)." (emphasis added.)

46. 42 U.S.C. § 1396p(a)(1), the "anti-lien provision" of the Medicaid statute, prohibits the state from attaching a lien on the property of a Medicaid beneficiary to recover benefits paid by the state. "The anti-lien provision pre-empts a State's effort to take any portion of a Medicaid beneficiary's tort judgment or settlement not 'designated as payments for medical care.'" Wos at 133 S. Ct. 1395; 185 L. Ed. 2d 478; 2013 U.S. LEXIS 2372, *6.

47. In Ahlborn v. Arkansas Department of Human Services, 397 F.3d 620 (8th Cir. 2004), the United States Court of Appeals for the Eighth Circuit reviewed a district court's grant of summary judgment in favor of the Arkansas Department of Human Services ("ADHS") in a dispute concerning the extent to which a recovery from a tortfeasor could be taken by the State as reimbursement for the cost of medical care provided to Ms. Ahlborn by the Medicaid program. Id. at 621.

48. ADHS had provided Medicaid benefits in the amount of $215,645.30 to Ms. Ahlborn. The parties agreed that Ms. Ahlborn's injuries gave rise to a damages claim estimated at $3,040,708.12, which claim was settled for a lump sum of $550,000. Pursuant to Arkansas' third party liability statute, ADHS asserted a lien against Ms. Ahlborn's settlement for the full amount of the benefits ADHS had provided. Id. at 622.

49. Ms. Ahlborn brought suit seeking a declaratory judgment "arguing that ADHS can only recover that portion of her settlement representing payment for past medical expenses." Id. Thus, the issue presented by the case was "whether federal Medicaid statutes, which provide for the assignment of rights to third-party payments, but prohibit placing a lien on a Medicaid recipient's property, limit the State's recovery to only those portions of the payments made for medical expenses." Id. The parties stipulated that if the state prevailed, it would recover $215,645.30, the total amount of the Medicaid payments made for the care of Ms. Ahlborn. If Ms. Ahlborn prevailed, the state would recover $35,581.47, which represented 16.5% of the total amount as "a fair representation of the percentage of the settlement constituting payment by the tortfeasor for past medical care." Id. (emphasis added).

50. The Eighth Circuit concluded, after review of the relevant statutes, that Ms. Ahlborn "has the better of the argument." Id. at 621-22. ADHS's main assertion was that because other federal statutes require the state to impose a statutory lien for Medicaid reimbursement, the Arkansas third-party liability statute could not be in conflict with the federal anti-lien statute. Id. at 624.

51. The Eighth Circuit examined the text of 42 U.S.C. § 1396a(a)(25)(H) and 42 U.S.C. § 1396k(a)(1)(A), the relevant

portions of which are set forth at Conclusions of Law 32 and 33, supra. The court concluded that "a straightforward interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary for medical care and services incurred by the beneficiary." Id. at 625. Both of the cited statutes are "limited to rights to third-party payments made to compensate for medical care." Id.

52. The Eighth Circuit reversed the district court's summary judgment in favor of ADHS and remanded the case "with directions to enter judgment for the State in the amount of $35,581.47." Id. at 628. It should be noted that this amount was expressly noted by the court as constituting payment for past medical care.

53. The case was appealed to the United States Supreme Court, which unanimously affirmed the decision of the Eighth Circuit. Arkansas Dep't of Health and Human Servs. v. Ahlborn, 547 U.S. 268 (2006). The Supreme Court concluded, as had the Eighth Circuit, that "the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf" and that "Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision

affirmatively prohibits it from doing so." 547 U.S. at 283, 292. The Medicaid law's third-party liability provisions are an exception to the anti-lien provision and therefore are strictly limited to payments for medical care. Id. at 284-85.

54. In E.M.A. v. Cansler, 674 F.3d 290 (4th Cir. 2012), the issue before the Fourth Circuit was whether North Carolina's third-party liability statute comported with federal Medicaid law and Ahlborn "merely because the subrogation statute . . . 'caps' the state's recovery at the lesser of the actual medical expenses paid or one-third of the total settlement." Id. at 307. The Fourth Circuit concluded that the North Carolina statute violated federal law because its presumption that the state is entitled to the actual medical expenses or one-third of the total settlement was unrebuttable. The court held that to comport with federal law as interpreted in Ahlborn, the statutory presumption "must be subject to adversarial testing." Id. at 311.

55. The Fourth Circuit succinctly and correctly described Ahlborn as follows:

> In Ahlborn, the Supreme Court reconciled seemingly conflicting legal standards when it considered whether an Arkansas third-party liability statute permitting the state to claim a right to the entirety of the costs it paid on a Medicaid recipient's behalf, regardless of whether that amount exceeded the portion of the recipient's judgment or settlement representing past medical expenses, violated federal Medicaid law. 547 U.S. at 278. In an opinion by Justice

> Stevens for a unanimous Court, Ahlborn held that Arkansas' assertion of a lien on a Medicaid recipient's tort settlement in an amount exceeding the stipulated medical-expenses portion was not authorized by federal Medicaid law; to the contrary, the state's attempt to do so was affirmatively prohibited by the general anti-lien provision in 42 U.S.C. § 1396p. Id. at 292.

E.M.A. v. Cansler, 674 F.3d at 299.

56. The lower court had seized upon the fact that E.M.A.'s settlement was an unallocated lump sum to hold that Ahlborn was inapplicable and that the North Carolina statute's mandatory allocation of one-third of the settlement was reasonable. The Fourth Circuit rejected "such a crabbed interpretation" of Ahlborn. 674 F.3d at 307. The Fourth Circuit noted that the Ahlborn court's analysis "in no way rested" "on whether there has been a prior determination or stipulation as to the medical expenses portion of a Medicaid recipient's settlement." The court found that "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.

57. The Fourth Circuit concluded as follows:

> As the unanimous Ahlborn Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses. In the event of an unallocated lump-sum settlement exceeding the amount of the state's Medicaid

> expenditures, as in this case, the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption in favor of the state that allocation of one-third of a lump sum settlement is consistent with the anti-lien provision in federal law.

E.M.A. v. Cansler, 674 F.3d at 312 (emphasis added).

58. On review, the United States Supreme Court affirmed the Fourth Circuit's decision. Wos v. E.M.A., 528 U.S. ___; 133 S. Ct. 1391; 185 L. Ed. 2d 471; 2013 U.S. LEXIS 2372 (2013). At the outset of its opinion, the Supreme Court reaffirmed its Ahlborn holding that "The anti-lien provision pre-empts a State's effort to take any portion of a Medicaid beneficiary's tort judgment or settlement not 'designated as payments for medical care.'" Wos, 2013 U.S. LEXIS 2372 at *6, quoting Ahlborn, 547 U.S. at 284.

59. Nothing in Wos contradicts the Fourth Circuit's statement that Ahlborn "makes clear" that federal Medicaid law limits a state's recovery to settlement proceeds that are allocable to past medical expenses. The Fourth Circuit's statement was based on Ahlborn's unanimous affirmance of the Eighth Circuit's express determination that the state was entitled only to "the percentage of the settlement constituting payment by the tortfeasor for past medical care." Ahlborn v.

Arkansas Dep't of Human Servs., 397 F.3d 620, 622 (emphasis added).

60. The conclusion is inescapable that reimbursement of Medicaid expenditures from a settlement is limited by the federal Medicaid anti-lien statute to that portion of a settlement allocable to past medical expenses. Reimbursement from a portion of a settlement reserved for future care, including medical expenses, is prohibited by the Medicaid anti-lien statute.

61. This conclusion is supported by Florida case law. In Davis v. Roberts, 130 So. 3d 264 (Fla. 5th DCA 2013), the Court reversed a lower court ruling that AHCA was entitled to recover the full amount of its Medicaid lien, calculated pursuant to the formula established in section 409.910(11)(f), from a Medicaid recipient's third-party recovery. The Court held that:

> Ahlborn and Wos make clear that section 409.910(11)(f) is preempted by the federal Medicaid statute's anti-lien provision to the extent it creates an irrebuttable presumption and permits recovery beyond that portion of the Medicaid recipient's third-party recovery representing compensation for past medical expenses.

Davis v. Roberts, 130 So. 3d at 270 (footnote omitted). Accord, Harrell v. Ag. for Health Care Admin., 143 So. 3d 478 (Fla. 1st DCA 2014).

62. The decision in Davis v. Roberts was reached prior to the 2013 amendments establishing the procedure in section 409.910(17)(b) that allows a Medicaid recipient to contest the amount designated as recovered medical expense damages payable to AHCA by proving 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)." (emphasis added). However, there has been no change to the federal Medicaid anti-lien statute on which Davis v. Roberts is based and therefore no reason to believe that the Court's analysis would be any different in light of the change to section 409.910. The Medicaid anti-lien statute, as interpreted by Ahlborn and Wos, limits AHCA's recovery to that portion of Petitioner's settlement representing compensation for past medical expenses.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is hereby:

ORDERED that the Agency for Health Care Administration is entitled to $33,255.54 in satisfaction of its Medicaid lien.

DONE AND ORDERED this 6th day of March, 2015, in Tallahassee, Leon County, Florida.

LAWRENCE P. STEVENSON
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 6th day of March, 2015.

ENDNOTES

[1/] Citations will be to Florida Statutes (2013) unless otherwise indicated.

[2/] Out of courtesy to the settling medical providers, Petitioner has requested that their names not be used in this Final Order. Seeing no pressing need to identify the providers in the context of this order, the undersigned is respecting Petitioner's request.

[3/] AHCA's authorized contract representative for the Medicaid Third Party Liability Program is Xerox Recovery Services. The referenced correspondence was with an employee of Xerox. However, because Xerox was effectively standing in the agency's shoes, the main body of the text refers to AHCA.

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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 the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk of the District Court of Appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.