STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

GERARDO QUESADA,

Petitioner,

vs. Case No. 15-3764MTR

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

On September 30, 2015, Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings (DOAH), conducted the final hearing by videoconference in Tallahassee and Miami, Florida.

APPEARANCES

Petitioner: Douglas J. McCarron, Esquire
The Haggard Law Firm, P.A.
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Respondent: David N. Perry, Esquire
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STATEMENT OF THE ISSUE

The issue is whether, pursuant to section 409.910(17)(b), Florida Statutes (2015), Respondent's recovery of medical assistance expenditures from Petitioner's settlement proceeds of $305,000 must be reduced from the amount calculated by the statutory formula contained in section 409.910(11)(f) (Statutory Formula).

PRELIMINARY STATEMENT

On June 30, 2015, Petitioner filed a Petition to Determine Amount Payable to Agency for Health Care Administration in Satisfaction of Medicaid Lien (Petition). The Petition alleges that Respondent has asserted a Medicaid lien for medical assistance expenditures in the amount of $144,651[1] and is seeking, under the Statutory Formula, to recover $114,375 from settlement proceeds of $305,000.

The Petition alleges that Petitioner was the victim of a shooting in his home. The two perpetrators were allegedly sentenced to prison. Petitioner allegedly pursued a personal injury claim against the owner of his apartment building. The Petition alleges that liability issues prompted Petitioner, in settlement, to take a substantial discount on a case worth conservatively $1.5 million, including past medical expenses of $144,651.

The Petition requests the Administrative Law Judge to issue a final order limiting Respondent's recovery from these settlement proceeds to no more than $29,412. This number is derived by determining the ratio of the settlement proceeds ($305,000) to the full value of the case ($1.5 million) and multiplying this ratio by $144,651, which represents the medical assistance that Respondent has expended, as well as the portion of the full value of the case allocable to past medical expenses.

On July 24, 2015, the parties filed a Joint Pre-Hearing Stipulation. At the hearing, Petitioner called two witnesses and offered into evidence four exhibits: Petitioner Exhibits 1-4. Respondent called no witnesses and offered into evidence no exhibits. All exhibits were admitted.

The court reporter filed the transcript on October 28, 2015. The parties filed proposed final orders on December 7, 2015.

FINDINGS OF FACT

1. On the evening of May 22, 2012, Petitioner was angrily confronted in his South Florida apartment by his former girlfriend and another man. Petitioner did not call the police. The couple returned to his apartment later in the evening, and one of them shot Petitioner in the chest.

2. Petitioner was transported to the Ryder Trauma Center at Jackson Memorial Hospital where he underwent an abdominal

washout, colonic anastamosis, and an abdominal wall closure. An exploratory laparotomy revealed lacerations of the spleen, liver, stomach, intestine, diaphragm, and pancreas. A surgeon removed the spleen and a portion of the colon, repaired the diaphragm, liver, stomach and intestine, and inserted a tube in the thorax to allow fluids to drain.

3. After these surgical procedures had been completed, Petitioner was transferred to the intensive care unit, where he remained intubated on a ventilator for several weeks. During this time, Petitioner required a tracheostomy after suffering respiratory failure secondary to a MRSA pneumonia.

4. Fifty days after admission, Petitioner was discharged from the hospital. Following discharge, Petitioner has experienced fatigue, loss of appetite, weight loss, and fever, and he is in constant pain from his original injuries, an abscess, and a large post-surgical ventral hernia that emerged one week after discharge and now protrudes visibly from his chest. The pain from the hernia intensifies after eating because the hernia interferes with digestion. The hernia also requires Petitioner to apply pressure to his chest area when he moves his bowels. Three years post-incident, the quality of Petitioner's life is undermined by anxiety, hyper-vigilance, nightmares, irritability, fear, worry, nervousness, inattentiveness, flashbacks, and bouts of crying with little or no justification.

5. Petitioner has been unable to return to fulltime work. Prior to the incident, five days per week, Petitioner drove a truck, purchasing fruit from farms and wholesalers, loading the fruit in his truck, and selling the fruit at retail. Now, Petitioner is unable to spend as much time behind the wheel and is unable lift as much weight. Able to work only two or three days per week, Petitioner has suffered loss of income.

6. Petitioner desires the hernia repair, but is unable to pay for cost of the surgery, which is unlikely to exceed $25,000. Respondent expended medical assistance for all of Petitioner's medical expenses while he was hospitalized, but declined to expend medical assistance to repair the hernia and Petitioner is no longer covered by Medicaid. Facing the prospect of nonpayment, physicians have declined to repair the hernia, in its current condition, but have advised Respondent to return to the hospital if the hernia becomes strangulated. In the meantime, pursuant to the recommendation of a physician, Petitioner wears a hernia belt, which provides only limited relief.

7. In 2013, Petitioner commenced a legal action for economic and noneconomic damages on the basis of negligent security against the owner of his apartment complex. Due to liability problems with the case, on August 22, 2014, Petitioner accepted $305,000 in settlement of his claim. The settlement agreement does not allocate the settlement proceeds among items

of damages. However, at the time of the settlement, Respondent's medical assistance expenditures totaled $144,651.

8. At the time of the settlement, Respondent was liable for attorney's fees of 40% of the settlement ($122,000) and taxable costs of about $8088. As set forth in the Conclusions of Law, under the Statutory Formula, Respondent's recovery is calculated by reducing the settlement by the statutory allowance of 25% for attorney's fees. The net settlement of $228,750 is then reduced by the taxable costs of $8088, for a final figure of $220,662. Respondent's recovery would be half of this amount, or $110,331.

9. Without regard to liability issues, the full value of Petitioner's damages was $2 million. Past medical expenses totaled the medical assistance expenditures, or $144,651. The remaining $1.856 million of full value was for other economic damages, such as lost wages and the loss of future earning capacity, and noneconomic damages in the form of pain and suffering.

10. The sole potential item of future medical expenses at the time of the settlement was a procedure to repair the post-surgical hernia. As noted above, the cost of the procedure is relatively modest, and, unless the hernia strangulates, it is possible that the procedure will never be performed. For these reasons, as well, perhaps, as the large difference between the settlement amount and the full value of the claim, the parties to

the settlement do not appear to have considered future medical expenses in arriving at the settlement amount. Further, on the basis of the present record, Respondent will not expend medical assistance for any future hernia-repair procedure.

11. The ratio of the settlement to the full value of the case is $305,000 to $2 million, or 0.1525 (Full Value Ratio). Pursuant to the authority discussed in the Conclusions of Law, Respondent's recovery may not exceed the product of multiplying the Full Value Ratio by $144,651, or $22,059, and is also subject to its prorata share of actual attorney's fees and taxable costs. Respondent's prorata share of the settlement is 7.2% ($22,059/$305,000), so Respondent must bear 7.2% of the actual attorney's fees of $122,000 and taxable costs of $8088, which reduces Respondent's recovery by about $9366, leaving a net recovery of $12,693.

CONCLUSIONS OF LAW

12. DOAH has jurisdiction over a Medicaid recipient's request to reduce Respondent's recovery amount for medical assistance expenditures from settlement or judgment proceeds from the amount determined under the Statutory Formula. §§ 120.569, 120.57(1), and 409.910(17)(b), Fla. Stat. (2013); Suarez v. Port Charlotte HMA, LLC, 171 So. 3d 740 (Fla. 2d DCA 2015) (per curiam).[2] In general, circuit courts have jurisdiction to approve a settlement and distribute settlement or judgment proceeds among

various claimants. See, e.g., Auerbach v. McKinney, 549 So. 2d 1022 (Fla. 3d DCA 1989). The administrative proceeding under section 409.910(17)(b) (17b proceeding) is subordinate to this jurisdiction of the circuit courts.

13. As set forth in section 409.910(11)(f), the Statutory Formula is calculated as follows:

> Notwithstanding any provision in this section to the contrary,[3] 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.

14. The 17b proceeding and the Statutory Formula are parts of the Medicaid Third-Party Liability Act, which is section 409.910. § 409.910(2). Numerous provisions[4] of the Medicaid Third-Party Liability Act reveal the legislature's intent to

maximize Respondent's recoveries and reimbursements of medical assistance expenditures to reduce the net cost of Medicaid to the state of Florida. See generally Ag. for Health Care Admin. v. Associated Indus. of Fla., Inc., 678 So. 2d 1239 (Fla. 1996), cert. denied, 520 U.S. 1115 (1997) (courts must defer to these legislative efforts to control Medicaid costs).

15. However, federal law limits the amount of a state Medicaid agency's reimbursement. In Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006), a 19-year-old in a car accident suffered severe and permanent injuries, including brain damage. The recipient filed a personal injury action, claiming damages for past and future medical expenses, lost earnings, the loss of earning capacity, and pain and suffering. The parties settled for $550,000 and did not allocate the settlement among the various items of damages. The state Medicaid agency asserted a lien against the settlement in the amount of its medical assistance expenditures of $216,000. An Arkansas statute provided that the state Medicaid agency was entitled to a portion of any settlement or judgment proceeds equal to its medical assistance expenditures.

16. The recipient filed an action in federal court for a declaration that the agency's statutory right to her settlement proceeds violated the federal Anti-Lien Statute, which is set forth below. In the Court's phrasing, the issue was whether the

agency's recovery amount could extend to "proceeds meant to compensate the recipient for damages distinct from medical costs--like pain and suffering, lost wages, and loss of future earnings." 547 U.S. at 272. The Court framed the issue as: "whether [the state Medicaid agency] can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." Id. at 281.

17. The parties stipulated that the full value of the recipient's case was about $3 million, the settlement approximated one-sixth of the damages, and, if the recipient's interpretation of the law were correct, the state Medicaid agency "would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made"--i.e., the same one-sixth of the agency's medical assistance expenditures.[5] Id. at 274. This stipulation, which multiplies the Full Value Ratio by already-expended medical assistance, limits the scope of the Ahlborn holding, which neither endorses the formula nor attempts to identify another acceptable means of identifying the portion of proceeds that may be used to calculate an agency's recovery amount.

18. The district court ruled that the state Medicaid agency was entitled to the full $215,000 because the Arkansas recovery and reimbursement statute did not conflict with federal law. The Eighth Circuit reversed, ruling that the state Medicaid agency

was entitled only to the portion of the settlement proceeds allocable to "medical care," and the Supreme Court affirmed.

19. The Ahlborn decision turns on several federal statutory provisions that address medical assistance expenditures, not medical expenses. As required by 42 U.S.C. § 1396a(a)(25)(B), a state plan must contain a provision that:

> . . . in any case where such a legal liability[6] is found to exist after medical assistance has been made available on behalf of the individual . . ., the State . . . will seek reimbursement for such assistance to the extent of such legal liability[.]

Also, 42 U.S.C. § 1396a(a)(25)(H) requires that a state plan contain a provision that:

> to the extent that payment has been made . . . for medical assistance where a third party has 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[.]

Lastly, 42 U.S.C. section 1396k(a)(1)(A) is for "the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance" and requires that a state plan direct a recipient to assign to the state Medicaid agency "any rights to support . . . and to payments for medical care from any third party." Section

1396k(b) adds that any amounts collected by the agency pursuant to the assignment "shall be retained by the [agency] as is necessary to reimburse it for medical assistance payments made on behalf of" the recipient.

20. The Court discussed in detail these three statutory provisions (Medicaid Recovery and Reimbursement Statutes). It noted that Section 1396a(a)(25)(B) provides for reimbursement for medical assistance to the extent of the "legal liability of third parties . . . to pay for care and services available under the [state Medicaid] plan." 547 U.S. at 280. Also, the language of section 1396a(a)(25)(H) limits the right of the state Medicaid agency to third-party obligations to the recipient to the extent of medical assistance expended for the recipient and to the portion of the obligation pertaining to "such health care items or services." This language limits the right of the state Medicaid agency, not merely to the portion of the liability pertaining to medical expenses, but specifically to the portion of the liability pertaining to those medical expenses for which the state Medicaid agency expended medical assistance. Id. at 281. Lastly, section 1396k(b) provides that proceeds first reimburse the state Medicaid agency for its medical assistance expenditures before they are applied to pay for the recipient's costs of medical care. Id. at 282. The Court appeared to be responding to a party's arguments, so it omitted section 1396k(a), but the introductory language of

section 1396k states that its purpose is to facilitate the recovery of medical assistance expenditures.

21. The fourth federal statute that the Court analyzed was the Anti-Lien Statute, 42 U.S.C. § 1396p(a)(1), which is a self-executing prohibition against states placing liens against the property of recipients, during their lives, to recover medical assistance expenditures. The Anti-Lien Statute provides:

> 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 [subject to exceptions for benefits incorrectly paid and for real property owned by the recipient].[7]

22. The Court noted that, in isolation, the Anti-Lien Statute would appear to ban a lien on the portion of settlement proceeds representing payments for medical care. But, in another important limitation on the scope of Ahlborn, the recipient conceded that the portion of her settlement proceeds for past medical expenses was subject to the recovery claim of the state Medicaid agency. The recipient argued only that the other portions of her settlement proceeds were not subject to the agency's recovery claim. Id. at 284. The Court agreed and limited the agency's recovery to payments for "medical care." Id. at 284-85. Although the recipient's concession explains the Supreme Court's application of the Full Value Ratio to past medical expenses, rather than already-expended medical assistance,

there would seem to be no other method of determining the portion of the settlement proceeds for past medical expenses than by multiplying the Full Value Ratio by the medical assistance expenditures or the portion of the settlement or judgment proceeds representing medical expenses (Full Value Formula).

23. The Ahlborn Court offered a simple hypothetical to illustrate the broader nature of its concerns with the Arkansas recovery and reimbursement statute. If a state Medicaid agency had expended $20,000 in medical assistance, the recipient had obtained only $20,000 in settlement of her personal injury action that included damages for lost wages, and the state Medicaid agency recovered all of its medical assistance expenditures, thus exhausting the settlement proceeds, the state recovery and reimbursement statute "squarely conflicts" with the Anti-Lien Statute because the state statute authorizes the state Medicaid agency to "lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." Id. at 280. On these facts, in the language of the three Medicaid Recovery and Reimbursement Statutes, the agency could lay claim to a greater portion of the settlement proceeds than corresponds to the agency's medical assistance expenditures, which are necessarily related to medical expenses.

24. Two major issues remained to be resolved after Ahlborn. The first issue was whether a recipient was entitled to an

evidentiary hearing on whether a state Medicaid agency's reimbursement should be less than the amount provided in a state recovery and reimbursement statute. The Supreme Court answered this question in the affirmative in Wos v. E. M. A., 133 S. Ct. 1391 (2013), when it invalidated the North Carolina statutory formula for dividing settlement or judgment proceeds between the state Medicaid agency and a recipient.

25. The second issue, which has not been resolved, is the proper means of determining the portion of a recipient's settlement or judgment proceeds that is subject to a state Medicaid agency's reimbursement claim. The best approach is found in two opinions that calculate the state Medicaid agency's recovery based on its medical assistance expenditures corresponding to past and future medical expenses in relation to the medical assistance expenditures.

26. In Doe v. Vermont Office of Health Access, 54 A.3d 474, 480-82 (Vt. 2012), the court limited the calculation of the state Medicaid agency's recovery to its already-expended medical assistance when the medical assistance did not extend to all of the past medical expenses. The Doe recipient argued that the agency's recovery could be based on the portion of past medical expenses for which the agency had expended medical assistance. Id. at 480-81. By way of example, the recipient argued that, if he paid for two nursing shifts daily and the agency expended

medical assistance for one nursing shift daily, the agency's recovery claim could not be calculated based on the past medical expenses for the two shifts for which the recipient was paying. To resolve this issue, the Doe court examined the Medicaid Recovery and Reimbursement Statutes. Noting that Ahlborn did not involve a case in which the past medical expenses exceeded the medical assistance expenditures for the same period, the Doe court agreed with the recipient, but did not endorse a formula to calculate the agency's recovery amount.[8]

27. In Aguilera v. Loma Linda University Medical Center, 185 Cal. Rptr. 3d 699, 705-08 (Ct. App. 2015), the court extended the calculation of the state Medicaid agency's recovery to medical assistance not yet expended. In Aguilera, the recipient settled her medical malpractice claims for $950,000, out of which she was liable for attorney's fees and costs of about $253,000. The state Medicaid agency had expended about $211,000 in medical assistance.

28. The recipient commenced a proceeding to determine the amount of the agency's recovery from the proceeds. The recipient presented evidence, including as to her life expectancy and the cost of future care, to support a full value of $14.8 million, including $13.2 million of future medical expenses in future medical care and, mostly, future attendant care. The state Medicaid agency countered with an agency program analyst who

opined that the agency would cover all future medical expenses under the conditions of the Medicaid program in California.

29. The parties could not agree on a formula to determine the agency's recovery amount. Using the Full Value Formula, evidently by applying the Full Value Ratio to the already-expended medical assistance, the recipient determined that the agency's recovery amount was about $10,000 after deducting the recipient's attorney's fees and costs in the tort case from the settlement.[9] The agency demanded a much higher recovery amount, but offered no method to support its demand. Accused by the recipient of having "plucked" a number "from the air," the state Medicaid agency lowered its demand by a small amount by using the recipient's Full Value Formula--with a significant modification. Arguing that it would be expending additional medical assistance for future attendant care expenses, the agency reduced the denominator by $11.5 million, which represented the additional medical assistance expenditures for future medical expenses, including future attendant care.

30. The Aguilera court agreed to this modification of the Full Value Formula that reduces the denominator in the Full Value Ratio by any future medical expenses that the agency will pay through additional medical assistance expenditures. This adjustment produces a much larger recovery amount than is typically produced by the Full Value Formula when it is applied

in a high-dollar case only to past medical expenses or already-expended medical assistance. But this part of Aguilera is unpersuasive. The court did not explain why it did not also remove from the denominator the past medical expenses that the agency had effectively paid through already expended medical assistance, or whether the court would apply the ratio if the settlement proceeds exceed what is left of the full value after netting out the medical assistance expenditures, in which case the numerator would exceed the denominator. Adjustments to the denominator are simple and powerful, but problematic.

31. The Aguilera opinion's discussion of the proof of additional medical assistance is much more useful. The trial court found that the agency would expend medical assistance for future medical care, but not future attendant care. The Aguilera court noted that, under California common law,[10] the recipient bears the burden of proving that the agency's recovery amount is excessive. The court held, though, that once the recipient satisfies her burden by applying the Ahlborn formula to the already-expended medical assistance, the agency has the burden of proving as an affirmative defense that it will expend additional medical assistance, so as to achieve the above-described reduction of the denominator. Id. at 829-30.

32. The Aguilera court was dissatisfied with the trial court's crediting of the testimony of the agency's program

analyst that the agency would expend medical assistance for the costs of future medical care, but rejecting of the testimony of the same program analyst that the agency would expend medical assistance for the much-larger costs of future attendant care. Id. at 831. In ruling that the agency would not cover future attendant care, the trial court relied on a concession by the agency's lawyer, who relied on a representation to this effect by the recipient's lawyer. Id. at 829.

33. On the other hand, the recipient acknowledged that she was receiving medical assistance, at present, for both components of these future medical expenses, and there was no other foreseeable source to pay these expenses, presumably after the exhaustion of the net settlement proceeds, which were much less than the future medical expenses. The court rejected the recipient's argument that assurances of Medicaid eligibility criteria 40 years out were inherently unreliable, noting that it could not justly impose on the agency the requirement of showing with "absolute certainty" eligibility criteria and funding 40 years into the future, especially when the only evidence in the record, however slight, showed that the agency would pay these expenses. Id. at 832.

34. The Aguilera court remanded the case to the trial court, so each party could present additional evidence on past and current program coverage for the above-described services.

After receiving the evidence, the trial court could redetermine if it was "reasonably probable" that the agency would expend medical assistance for these expenses in the future, and, to the extent that the trial court found coverage, it was to exclude these additional medical assistance expenditures from the denominator and rerun the Full Value Formula to determine the agency's recovery amount. Id. at 832-33.

35. For the present, relatively simple case, the teaching of Ahlborn, Doe, and Aguilera is that the Anti-Lien Statute limits Respondent's recovery to the portion of Petitioner's $305,000 settlement that is allocable to past medical expenses--to the extent that Respondent has expended medical assistance and--to future medical assistance--to the extent that Respondent will expend additional medical assistance. As is often the case, Respondent has already expended medical assistance equal to the past medical expenses, so the Anti-Lien Statute does not bar Respondent's recovery based on the portion of the settlement allocable to past medical expenses. But Respondent will not be expending additional medical assistance, so the Anti-Lien Statute bars Respondent's recovery based on the portion of the settlement allocable to future medical expenses--or, of course, lost wages, the loss of future earning capacity, or pain and suffering.

36. The purpose of the 17b proceeding is to determine whether, under the above-discussed authority, Respondent's

recovery must be reduced from the amount calculated under the Statutory Formula. With the emphasis supplied, section 409.910(17)(b) states:

> 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 . . .. The petition shall be filed with the Division of Administrative Hearings. . . . 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.

37. Petitioner does not contest the amount of medical assistance expended, so the issue in this 17b proceeding is whether Petitioner has proved, 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 using the Statutory Formula.

38. A "lesser portion of the total recovery" refers to the portion of the proceeds obtained from the tortfeasors that is

determined under the Statutory Formula to constitute Respondent's recovery amount. This language refers to the recipient's claim that Respondent's recovery from the settlement or judgment proceeds must be reduced from the amount calculated under the Statutory Formula.

39. "Reimbursement for past and future medical expenses" refers to the sums obtained by Respondent. "Reimbursement" clearly signifies that the payee at this point is Respondent, not the recipient.[11] The reference to "past and future medical expenses" refers to Respondent's expenditures of medical assistance. Reinforcing this interpretation, the first sentence of section 409.910(17)(b) refers to "recovered medical expense damages" payable to Respondent.

40. In this manner, section 409.910(17)(b) provides a recipient an administrative hearing on the recipient's claim that the recovery amount in the Statutory Formula is too high. Obviously missing from section 409.910(17)(b) is an explicit standard, formula, or method for determining if the recovery amount in the Statutory Formula is too high. However, the Medicaid Third-Party Liability Act supplies adequate standards for the 17b proceeding. The act clearly provides that Respondent's recovery is to be the maximum allowable under the law, subject to the limit imposed by the Statutory Formula. The 17b proceeding shields the Statutory Formula from judicial

invalidation, as occurred with a similar recovery and reimbursement statutory formula in Wos,[12] by establishing the 17b proceeding as the means for determining whether Respondent's recovery must be reduced and, if so, by how much.

41. The Full Value Formula is the means by which to determine Respondent's maximum allowable recovery. The Full Value Formula requires the multiplication of the Full Value Ratio--as noted above, 0.1525--by the total of the medical assistance expenditures, not in excess of the portion of the settlement proceeds allocable to medical expenses. As noted above, in this case, Respondent is limited to its already-expended medical assistance--i.e., $144,651. As explained above, Respondent's recovery may thus not exceed $22,059.

42. However, a final reduction to Respondent's recovery is necessary. Respondent's recovery in a 17b proceeding must bear its prorata share of the attorney's fees and taxable costs incurred by the recipient in collecting the settlement or judgment proceeds. This requirement finds support in the case law,[13] as well as the Statutory Formula, which nets out taxable costs and a fixed percentage representing attorney's fees before determining Respondent's recovery amount. These litigation expenses have an above-the-line quality because they produce the settlement or judgment proceeds, so it is necessary to reduce

Respondent's recovery by its prorata share of these litigation expenses.

ORDER

It is

ORDERED that Respondent's recovery under section 409.910(17)(b) is limited to $12,693.

DONE AND ORDERED this 28th day of January, 2016, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of January, 2016.

ENDNOTES

[1] Many dollar amounts in this final order are rounded off.

[2] This case is pending in the Florida Supreme Court under Case No. SC15-1848.

[3] This clause does not apply to the 17b proceeding.

[4] Providing the backbone of the Medicaid Third-Party Liability Act, section 409.910(6)(a), (b), and (c) describes the extent of Respondent's subrogation rights to third-party benefits, assignment of third-party benefits, and lien. The subrogation

rights and lien are "for the full amount of medical assistance provided by Medicaid." Id. at 409.910(6)(a) and (c).

For subrogation rights, the section 409.910(6)(a) states: "Recovery pursuant to the[se] subrogation rights . . . shall not be reduced, prorated, or applied to only a portion of a judgment . . . or settlement, but is to provide a full recovery by the agency from any and all third-party benefits." "Third-party benefits" are defined broadly enough to include the settlement or judgment proceeds in connection with a personal injury action against a tortfeasor. § 409.901(28), Fla. Stat. Section 409.910(6)(a) concludes: "Equities of a recipient . . . shall not defeat, reduce, or prorate recovery [i.e., reimbursement] by [Respondent] . . .."

For liens, section 409.910(6)(c)6. provides that one claim of lien shall provide sufficient notice of "an additional or after-paid amount of medical assistance provided by Medicaid."

For assignments, section 409.910(6)(b) provides that it is for "any right . . . [a recipient] has to any third-party benefit." § 409.910(6)(b). However, section 409.910(6)(b)1. limits the assignment to "the amount of medical assistance provided by the agency." Section 409.910(6)(b)2. provides: "Equities of a recipient . . . shall not defeat or reduce recovery [i.e., reimbursement] by [Respondent] . . .."

Section 409.910(7) requires Respondent to recover the full amount of "all medical assistance . . . to the full extent of third-party benefits." In connection with a settlement or judgment of a claim against a third party, section 409.910(11)(c) directs a court to segregate an amount sufficient to repay the medical assistance expenditures.

Section 409.910(11)(e) provides that, except as otherwise provided in section 409.910, "the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to [Respondent's] claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto." As noted below, section 409.910(11)(f) is carved out of section 409.910(11)(e), as section 409.910(11)(f) applies only to settlement or judgment proceeds obtained after the recipient has commenced a tort action.

Section 409.910(12) limits Respondent's share of settlement or judgment proceeds only to the extent that the proceeds are unrelated to the covered injury or represent benefits for life insurance, property insurance, or disability insurance, as well as proceeds "in excess of the amount of medical benefits provided by Medicaid after repayment in full to the agency."

Lastly, all provisions of the Medicaid Third-Party Liability Act must be construed in light of section 409.910(1), which provides that Medicaid is "the payor of last resort." Section 409.910(1) continues: "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." And section 409.910(1) concludes: "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."

[5] The stipulation ignored the attorney's fees and costs incurred by the recipient in prosecuting the tort action, so the Court was not presented with the question of whether the agency must bear its prorata share of these litigation expenses.

[6] "Such a legal liability" refers to the legal liability identified in 42 U.S.C. § 1396a(a)(25)(A), which requires each state Medicaid plan to provide that the state "will take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan."

[7] Congress has amended these federal statutes. Originally, the amendments were to take effect October 1, 2014, according to Public Law No. 113-67, section 202(b), 127 Stat. 1165 (2013). However, the effective date of these amendments was postponed to October 1, 2016, in Public Law No. 113-93, section 211, 128 Stat. 1040 (2014) and to October 1, 2017, in Public Law No. 114-10, section 220, 129 Stat. 87 (2015).

As applicable to the cited statutes, the deletion from section 1396a(a)(25)(B) is indicated by the stricken-through language:

> that in any case where such a legal liability [of third parties] is found to exist after medical assistance has been made available on behalf of an individual . . ., the State . . . will seek reimbursement for

such assistance ~~to the extent of such legal liability~~;

The addition to the Anti-Lien Statute is indicated by the underlined language, and the deletion is indicated by the stricken-through language:

> (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--
>
> (A) pursuant to: . . .
>
> (ii) rights acquired by or assigned to the State in accordance with § 1396(a)(25)[.]

The meaning of these changes is clear. According to Director Cindy Mann of the Centers for Medicare & Medicaid Services, the effect of these changes is to "give states the ability to recover costs from the full amount of a beneficiary's liability settlement, instead of only the portion of the settlement designated for medical expenses . . .." CMS Informational Bulletin dated December 27, 2013, found on January 16, 2015, at http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-27-13.pdf.

[8] But see In re Matey, 213 P.3d 389, 394 (Idaho 2009), where the past medical expenses exceeded the medical assistance expenditures due to payments by other parties. The court held that the state Medicaid agency's recovery extended to the entire portion of proceeds allocable to past medical expenses.

[9] The net settlement, after fees and costs, divided by the full value multiplied by the already-expended medical assistance is $9937, which is within $100 of the amount calculated by the recipient.

[10] 185 Cal. Rptr. 3d at 706. The Aguilera opinion cites McMillian v. Stroud, 83 Cal. Rptr. 3d 261, 269-70 (Cal. App. 2008), which states that, under California common law, a party has the burden of proof "as to each fact the existence or nonexistence of which is essential to the claim for relief or to the defense that he is asserting" (citation omitted), and the burden of proof is imposed on the party that has "sole or primary control over the dispositive evidence." Absent statutory

authority to the contrary, Florida generally imposes the burden of proof on the party with the affirmative of the issue. Young v. Dep't of Comm. Affairs, 625 So. 2d 831, 833-34 (Fla. 1993); Golfcrest Nursing Home v. Agency for Health Care Admin., 662 So. 2d 1330, 1334 (Fla. 1st DCA 1995); Dep't of Transp. v. J. W. C. Co., 396 So. 2d 778, 787-88 (Fla. 1st DCA 1981); Balino v. Dep't of Health & Rehab. Servs. 348 So. 2d 349, (Fla. 1st DCA 1977). Florida likewise imposes the burden on the party better able to produce the necessary evidence. Golfcrest, supra at 1334.

[11] "Reimbursement" refers to the process by which Respondent is repaid from responsible parties for medical assistance that it has expended. The definition of "reimburse" in the online Merriam Webster dictionary is "to pay someone an amount of money equal to an amount that person has spent." http://www.merriam-webster.com/dictionary/reimburse.

"Reimbursement" is a term of art in Medicaid. Consistent with its dictionary meaning, "reimburse" and "reimbursement" are reserved for a payment to offset a party's paying or incurring of a specific cost. Thus, Respondent reimburses providers for covered goods and services that they have supplied to recipients. §§ 409.908 and 409.913(1)(a)1. and (d), (8), (15)(k), (21), (27)(a) and (b), (31), and (34). Likewise, an over-reimbursed provider must reimburse Respondent the amount of the overpayment. § 409.913(30).

The Medicaid Third-Party Liability Act consistently uses "reimburse" or "reimbursement" in this manner. In section 409.910, "reimburse" or "reimbursement" occurs nine other times, and each time it means a payment to offset a party's paying or incurring of a specific cost. Seven times, the party is Respondent, and the cost is its medical assistance expenditures--precisely the meaning assigned by the adopted interpretation of the phrase within section 409.910(17)(f). Never does "reimburse" or "reimbursement" refer to the amount recovered by a recipient from a tortfeasor. As indicated in the first sentence of section 409.910(17)(b), the statute uses "recovery," not "reimbursement," to describe what a recipient obtains from a tortfeasor.

[12] See Florida House of Representatives Final Bill Analysis, CS/CS/HB 939, June 10, 2013, pp. 6-8, http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=h0939z1.HIS.DOCX&DocumentType=Analysis&BillNumber=0939&Session=2013.

[13] See, e.g., Arex Indemnity Co. v. Radin, 72 So. 2d 393, 396 (Fla. 1954); Lewis v. W. Va. Dep't of Health & Human Res., 729 S.E. 2d 270, 304 (2012) (as required by state statute); McKinney v. Phil. Hous. Auth., 2010 U.S. Dist. LEXIS 86773, p. 34 (E.D. Pa. 2010).

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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.