STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

JUAN L. VILLA,

Petitioner,

vs. Case No. 15-4423MTR

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

On October 5, 2015, an administrative hearing was held in the above-styled case in Tallahassee, Florida, before Elizabeth W. McArthur, Administrative Law Judge, Division of Administrative Hearings (DOAH).

APPEARANCES

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

For Respondent: David N. Perry, Esquire
Xerox Recovery Services, Inc.
2073 Summit Lake Drive, Suite 300
Tallahassee, Florida 32317

STATEMENT OF THE ISSUE

The issue in this case is the amount that must be paid to Respondent from the proceeds of Petitioner's confidential

settlement with one defendant to satisfy Respondent's Medicaid lien against the proceeds.

PRELIMINARY STATEMENT

On August 7, 2015, Juan L. Villa (Petitioner) filed a petition at DOAH pursuant to section 409.910(17)(b), Florida Statutes (2015),[1/] for a determination of the amount payable to the Agency for Health Care Administration (Respondent or AHCA) in satisfaction of Respondent's Medicaid lien against the proceeds of a confidential settlement.

The case was assigned to the undersigned. Upon consultation with the parties, the hearing was scheduled for October 5, 2015.

Prior to the hearing, the parties filed a Joint Pre-hearing Stipulation in which they stipulated to a number of facts. The parties' stipulations are incorporated below, to the extent relevant.

At hearing, Petitioner presented the testimony of two witnesses, Manuel Reboso and James Gustafson, Jr., both trial attorneys who were accepted as experts in the valuation of damages. Petitioner's Exhibits 1 through 5, 7 through 15, 17, and 18 were admitted in evidence; Petitioner's Exhibits 11 and 12 were acknowledged to be hearsay, and were admitted for the limited purpose of showing material relied on by Petitioner's expert witnesses in formulating their opinions.[2/] Official recognition was taken of Petitioner's Exhibit 19, described as a

compilation of Florida trial court orders regarding Medicaid liens.

Respondent did not present testimony of any of its own witnesses, nor did Respondent offer any additional exhibits.

At the conclusion of the hearing, it was agreed that proposed final orders (PFOs) would be due within ten days after the hearing transcript was prepared and filed. Other post-hearing deadlines established by Order entered before the final hearing or by agreement during the hearing were as follows: (1) Respondent was given ten calendar days after the hearing to submit for official recognition any legal authorities that may not be readily accessible[3/]; (2) Petitioner was given until October 15, 2015, to submit a proposed protective order to protect the confidentiality of the settlement (which would be accomplished by protecting from public disclosure Petitioner's Exhibits 13, 14, and 15, and any designated transcript pages); and (3) Petitioner was given ten days after the filing of the hearing transcript to identify any transcript pages that should be protected from disclosure.

Respondent did not submit any legal authorities for official recognition by the designated deadline. Petitioner did not file a proposed protective order by October 15, 2015.

The final hearing Transcript was filed on October 27, 2015, making the deadline to file PFOs November 6, 2015. However, on

November 4, 2015, counsel for Petitioner filed a Notice of Death, relaying the unfortunate news conveyed to him on November 2, 2015, by Petitioner's trial counsel, Mr. Reboso, that Petitioner had died on October 31, 2015. Counsel for Petitioner asserted in the Notice that Petitioner's death "does not affect the legal analysis of DOAH in relation to the matter presented in this proceeding," offering several citations and attaching one circuit court order as support for that assertion. The Notice also represented that counsel for Petitioner had conferred with Respondent, and that the parties wanted to proceed "under the current DOAH caption," submit PFOs, and have DOAH issue its Final Order. A telephonic status conference was requested "if there is any issue with moving forward as outlined above[.]"

A telephonic status conference was held on the morning of November 6, 2015. Given the nature of this proceeding as one to determine the amount of funds held in an interest-bearing account for AHCA's benefit are payable to AHCA, the parties' agreement that it is unnecessary to require a substitution of parties was accepted. However, it was agreed that Petitioner's death on October 31, 2015, now a matter of record, was a fact that should not be ignored and that would be set forth in the Final Order. Counsel for Petitioner offered to obtain a death certificate to establish that fact; however, Respondent agreed to the facts as represented by counsel for Petitioner, making proof unnecessary.

As to the assertion that the legal analysis would not change by reason of Petitioner's death, the undersigned expressed concern with whether the facts applied to the legal analysis changed by reason of Petitioner's death, even if the legal analysis might not change. In particular, the undersigned pointed to the testimony by Petitioner's damage valuation experts, and questioned whether the predicates for those opinions would be substantially altered by reason of Petitioner's death.

Under the circumstances, the undersigned offered to reopen the record for additional evidence. Counsel for Petitioner declined the offer and chose not to present additional testimony. He contended that Petitioner's death did not change his case, either legally or factually. Counsel offered to submit an affidavit from one of his witnesses, but the undersigned noted that an affidavit could not substitute for additional testimony subject to cross-examination.[4/]

Counsel for Petitioner made an ore tenus motion for a seven-day extension to the deadline for filing PFOs, so that the issue of the impact of Petitioner's death could be addressed. Without objection, the motion was granted.

The parties timely filed their PFOs by the extended deadline. Petitioner also filed a motion for official recognition of trial court orders offered as germane to the question of whether Petitioner's death has any impact on the

issues to be determined here. Petitioner also filed a memorandum setting forth argument on that point. The additional trial court orders filed on November 13, 2015, are officially recognized. The parties' PFOs and legal argument have been considered in the preparation of this Final Order.

On November 24, 2015, counsel for Petitioner filed a proposed protective order. Though six weeks late, the proposed order was considered in the preparation of the Protective Order issued simultaneously with this Final Order.

On December 17, 2015, counsel for Petitioner filed another motion for official recognition, attaching a recent DOAH Final Order. As indicated at hearing, it was helpful for counsel to provide authorities that are not readily accessible through the research tools available to DOAH, as was done with respect to trial court orders. However, it is neither necessary nor appropriate to request official recognition at this point in the proceeding of a DOAH Final Order, which is readily accessible to the undersigned. In general, official recognition is the means to provide material that is the equivalent of evidence in the sense that the material can be used as the basis for findings of fact. See § 120.57(1)(j), Fla. Stat. ("Findings of fact . . . shall be based exclusively on the evidence of record and on matters officially recognized."). Counsel for Petitioner does not contend that the DOAH Final Order for which official

recognition was sought on December 17, 2015, is being offered as the basis for finding facts in this proceeding. If it had been offered for that purpose it would not be timely, as the record on which findings of fact will be based is closed; counsel for Petitioner declined the offer to reopen the record. If, instead, the late motion for official recognition was simply intended to call additional authority to the undersigned's attention, then official recognition is unnecessary. Accordingly, the motion is treated as notice of supplemental authority, and the attached DOAH Final Order has been considered along with the other DOAH Final Orders in Medicaid third-party recovery cases.

FINDINGS OF FACT

1. On September 12, 2010, Petitioner, then 19 years old, was thrown from his all-terrain vehicle (ATV) when the rubber portion of one tire separated from the rim, and the ATV rolled over.

2. Petitioner was taken by air ambulance to Orlando Regional Medical Center, a trauma center in the area, where it was determined that Petitioner suffered a burst fracture of the eighth and ninth thoracic vertebrae (T-8 and T-9). The nature of this injury was described in layman's terms by Petitioner's trial counsel in the pending personal injury lawsuit as follows: In a burst fracture, the vertebra literally bursts, breaking into small bone fragments; in Petitioner's case, one of the bone

fragments sliced through the spinal cord at the T-8/T-9 level, resulting in complete paraplegia with zero function below that level.

3. Two days later, Petitioner underwent surgery that involved putting in rods and bone grafts, and performing a spinal fusion.

4. Three weeks later, Petitioner was transferred to ORMC Lucerne Rehabilitation Hospital, where he received care in the Brain Injury Rehabilitation Center. He was discharged on November 10, 2010.

5. After his discharge, Petitioner had outpatient physical therapy and occupational therapy for several weeks.

6. Petitioner developed complications that required readmission to the hospital on February 18, 2011. He was admitted initially with a kidney stone and pyelonephritis. He was placed in an induced coma, became septic, developed respiratory distress, and was placed on a ventilator. He remained hospitalized until March 28, 2011.

7. Petitioner then restarted outpatient physical therapy and occupational therapy, which continued for several months.

8. Petitioner was paralyzed from the chest down, and has been determined to be disabled by the Social Security Office.

9. Nearly all of Petitioner's past medical expenses following the ATV incident were paid for by Medicaid. As of

March 2, 2015, the total amount of medical assistance provided by the Medicaid program was $322,222.27, representing over 92 percent of the $347,044.67 paid in total for past medical expenses. The rest of Petitioner's medical expenses were paid for by United HealthCare ($1,457.40) and Medicare ($23,365.00).

10. Petitioner brought a lawsuit to recover his damages against multiple defendants who are allegedly liable for his injuries under tort theories of products liability and negligence (tort lawsuit). The date on which the tort lawsuit was filed was not established in the record; the third amended complaint, in evidence, was filed on March 12, 2015. Petitioner's lead counsel, Manuel Reboso, testified at hearing that the tort lawsuit was pending and set for trial in February 2016. Discovery was ongoing, but no expert witness depositions had been taken yet.

11. AHCA is not a party in Petitioner's tort lawsuit, but was notified of the action at some point after it was filed.

12. By letter dated March 2, 2015, AHCA asserted a $322,222.27 Medicaid lien against Petitioner's cause of action and any future settlement of, or recovery from, that action. Thereafter, AHCA updated the Medicaid lien amount to $324,607.25.

13. On April 8, 2015, Petitioner reached a settlement with one defendant. The terms are reduced to writing in a document called "Confidential Settlement Agreement, General Release, and

Indemnity Agreement" (settlement agreement). The settlement agreement is executed by Petitioner, one defendant, and the defendant's insurer. The settlement did not resolve the tort lawsuit. The other parties to the tort lawsuit were not parties to the settlement. The settlement agreement was not presented to or reviewed by the trial court for approval. Instead, the settlement agreement is confidential, and the tort lawsuit continues. To the extent possible, the confidentiality will be protected, as set forth in a Protective Order that seals and restricts the disclosure of specified exhibits.

14. The settlement agreement is an "undifferentiated settlement"; that is, "[t]here is no section of the release that goes through and itemizes the different elements of damage." (Tr. at 93).

15. Although the settlement agreement does not itemize the different elements of damage, one provision sets forth the agreement between Petitioner and the settling defendant that Petitioner's "alleged damages have a value in excess of $25,000,000" (emphasis added), and that Petitioner and the settling defendant "have agreed to allocate $4,817.56 of this settlement to [Petitioner's] claim for past medical expenses and allocate the remainder of the settlement towards the satisfaction of claims other than past medical expenses."

16. Mr. Reboso testified at hearing that the amount allocated in the settlement agreement to past medical expenses is incorrect. When asked why the parties allocated that amount in the settlement agreement, Mr. Reboso candidly admitted, "Because math is not my forte. I calculated it wrong. . . . Had I done the math correctly, that would be the correct number, $13,881.79." (Tr. at 71-72). He admitted that he drafted this provision, and intended to put in the amount that bears the same proportion to the total past medical expenses as the settlement amount bears to the total value of Petitioner's damages. Accordingly, by his testimony, he offered a "correction" to the settlement agreement's allocation for past medical expenses, from $4,817.56 to $13,881.79. According to Mr. Reboso's own testimony, then, the settlement agreement's "agreed" allocation of $4,817.56 for past medical expenses is unreasonable.

17. By letter dated April 24, 2015, Mr. Reboso notified AHCA of the settlement and provided AHCA with a copy of the executed settlement agreement, along with an itemization of Petitioner's litigation costs in the tort lawsuit. The letter requested AHCA to advise Petitioner of the amount AHCA would accept from the settlement proceeds.

18. AHCA responded by letter dated July 6, 2015, setting forth its calculation of the amount payable pursuant to the statutory formula in section 409.910(11)(f).

19. As set forth in AHCA's letter, the statutory formula first deducts from the settlement proceeds a 25 percent allowance for attorney's fees. Next, the remaining proceeds are further reduced by $106,559.62, as the taxable costs incurred in connection with the tort lawsuit. After deducting the attorney fee allowance and the taxable costs, the remainder is then divided by two. The result of the statutory formula calculation is that the amount of settlement proceeds payable to AHCA is $321,720.16.

20. The parties stipulated that AHCA's July 6, 2015, letter accurately sets forth the calculation of the statutory formula amount. Petitioner does not dispute AHCA's calculation of the attorney fee allowance, nor does Petitioner dispute the amount of taxable costs determined by AHCA and used in the statutory formula calculation.

21. There is also no dispute that AHCA has spent more than $321,720.16 in payments through the Medicaid program for past medical assistance provided to Petitioner as a result of injuries sustained in the September 2010 ATV incident. As of the March 2, 2015, AHCA letter, the medical assistance provided by Medicaid totaled $322,222.27.

22. The parties stipulated that "[n]o portion of the $322,222.27 paid by AHCA through the Medicaid program on behalf of Mr. Villa represent expenditures for future medical expenses,

and AHCA did not make payments in advance for [future] medical care." By the same token, there was no showing that the Medicaid program would ever pay in advance, or prepay, future medical expenses of current Medicaid beneficiaries.

23. As authorized by section 409.910(17)(b), Petitioner initiated this proceeding to "contest the amount designated as recovered medical expense damages" payable to AHCA pursuant to the statutory formula. Accordingly, Petitioner endeavored to prove "that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses than the amount calculated" pursuant to the statutory formula.

24. Petitioner attempted to prove that the settlement agreement's provision regarding total damages and allocation to past medical expenses should be accepted as reasonable and adopted. However, neither the agreed total value of "alleged" damages nor the agreed allocation of settlement proceeds to compensate for past medical expenses in Petitioner's settlement agreement with one defendant can be credited as reasonable products of arms-length adversarial negotiation. Instead, the partial allocation to just one part of one category of damages (medical expenses) was admittedly prepared by Mr. Reboso shortly after notice of the Medicaid lien, and appears pointedly designed for use in this proceeding to support Petitioner's positions. No other purpose for the limited allocation to only past medical

expenses was suggested. And Mr. Reboso expressly opined that the limited allocation stated in the settlement agreement is not a reasonable allocation; instead, he supports an allocation that is three times the number in the settlement agreement. The one-sided nature of this provision in the settlement agreement could not be more clearly revealed than by Mr. Reboso's concession that the settling parties "agreed" to an incorrect allocation to past medical expenses because Mr. Reboso made a math error in drafting the provision. A more reasonable inference is that the settling defendant, unaffected by this provision, apparently ceded authority to Petitioner to put into the agreement whatever the Petitioner drafted, error and all.

25. As an alternative to relying on the settlement agreement's partial allocation (in an unreasonably low amount) to past medical expenses, Petitioner attempted to prove the total value of Petitioner's damages that would be proven to and awarded by a jury if/when the tort lawsuit goes to trial. Petitioner's position is that the percentage derived from dividing the settlement proceeds by the total damages should be multiplied by the past medical expenses to determine AHCA's share of the settlement proceeds.

26. In preparation for the trial in the pending tort lawsuit, Petitioner retained experts to evaluate and quantify the

economic damages to Petitioner by reason of the injuries from the September 2010 ATV incident.

27. Paul M. Deutsch, Ph.D., a life care planner and vocational rehabilitation specialist with Paul M. Deutsch and Associates, P.A., was retained to prepare a life care plan for Petitioner.[5/] Dr. Deutsch also developed some information about Petitioner's future capacity to work. Dr. Deutsch did not testify in this proceeding. Petitioner also retained F.A. Raffa, Ph.D., an economist with Raffa Consulting Economist, Inc., to develop projections of Petitioner's damages due to lost income and lost future earning capacity, reduced to present value. Dr. Raffa also reduced to present value the life care plan cost projections developed by Dr. Deutsch. Dr. Raffa did not testify in this proceeding. Both the life care plan and economic report, acknowledged to be hearsay, were admitted for the limited purpose of showing material relied on by Petitioner's damage valuation experts in formulating their opinions offered at hearing.

28. Mr. Reboso, lead counsel in Petitioner's tort lawsuit, was accepted as an expert in valuation of damages. He testified that he relied on the Deutsch life care plan and Raffa economic report to gauge Petitioner's economic damages, and that he relied on his own experience and his review of other jury verdicts to gauge Petitioner's likely recovery for noneconomic damages. Considering these factors, he offered his opinion that as of the

October 5, 2015, hearing date, the total value of Petitioner's damages is estimated to be $25,000,000. The economic damage estimate is somewhat dated, however; the life care plan indicates that it was prepared on July 11, 2013, more than two years ago; and the economic report is dated October 17, 2013, nearly two years ago. The life care plan also appears to be incomplete.[6/] Neither report has been sponsored and defended by its author in testimony, either in this proceeding or in depositions in the pending tort lawsuit in which experts have not yet been deposed.

29. One would expect that both the life care plan and the economic report will be updated before the authors are deposed in the tort lawsuit. That assumption was likely true before Petitioner died on October 31, 2015, given the caveats in the reports regarding changing facts. The life care plan is self-described as a "dynamic document," while the cover letter to the economic report states: "Please note that this analysis is based upon the best information currently available and is subject to change should additional information be received."

30. Petitioner's unfortunate death on October 31, 2015, will alter the tort lawsuit and the expert evidence and opinions offered regarding Petitioner's damages. Petitioner's death surely constitutes a change in information that undermines the legitimacy of both the life care plan and the economic report as reasonable predicates for an assessment of Petitioner's damages.

31. Using two-year-old expert reports that have not been updated or defended in an adversarial proceeding as the sole predicate for offering an opinion as to the total value of Petitioner's economic damages would have been questionable without consideration of Petitioner's death. Yet Petitioner's experts offered their opinions as to what Petitioner's total damages were as of the October 5, 2015, hearing, relying solely on the two-year-old reports for the projected future economic damages.

32. At hearing, Petitioner's two experts described the same approach for reaching their identical opinions. As Mr. Reboso explained, he reached his total damage value estimate by taking the mid-point of the range of economic damages identified in the Deutsch and Raffa reports, and adding to that "eight to ten million dollars" for past and future noneconomic damages. He explained that past noneconomic damages would be awarded by a jury for pain and suffering from the date of the incident to the date of the trial, and an additional amount would be awarded by a jury for future pain and suffering from the trial date forward. Mr. Reboso testified that his opinion as to the amount Petitioner is expected to be awarded in a jury trial of his case is supported by comparisons with jury verdicts in other cases. In describing his comparisons, he highlighted such factors as the relative ages and life expectancies of the victims. He offered

his opinion that a large noneconomic damage award is likely for Petitioner because he is young.

33. Neither expert offered an opinion as to how much of the total damages amount to which they opined is attributable to future medical expenses. No non-hearsay evidence was offered to prove the amount of future medical expenses, with the exception of Mr. Reboso's testimony that Petitioner's future medical expenses would be $9.1 million at the low end. In fairness, however, Mr. Reboso was relying solely on hearsay, and he retreated from that testimony by later admitting uncertainty as to how much of the life care plan cost projections (which are hearsay) were future medical expenses.

CONCLUSIONS OF LAW

34. DOAH has jurisdiction over the subject matter of and parties to this proceeding, and final order authority, pursuant to section 409.910(17), Florida Statutes.

35. As a condition for receipt of federal Medicaid funds, states are required to seek reimbursement for medical expenses incurred on behalf of Medicaid recipients (recipients) who later recover from third-party tortfeasors. See Ark. Dep't of Health and Human Servs. v. Ahlborn, 547 U.S. 268, 126 S. Ct. 1752, 164 L. Ed. 2d 459 (2006).

36. Florida has enacted section 409.910, which is known as the "Medicaid Third-Party Liability Act." Section 409.910(1) expresses the following legislative intent:

> 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.

37. Section 409.910(6)(c) affords Respondent an automatic lien "for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in s. 409.901."

38. Section 409.901(7) defines "collateral" as follows:

> (a) Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services that necessitated that Medicaid provide medical assistance.
>
> (b) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.
>
> (c) Proceeds, as defined in this section.

39. The amount to be recovered for Medicaid expenditures from a judgment, award, or settlement from a third party is determined initially by the formula in section 409.910(11)(f), which provides as follows:

> Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:
>
> 1. After attorney's fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.
>
> 2. The remaining amount of the recovery shall be paid to the recipient.
>
> 3. For purposes of calculating the agency's recovery of medical assistance benefits paid,

> the fee for services of an attorney retained by the recipient or his or her legal representative shall be calculated at 25 percent of the judgment, award, or settlement.
>
> 4. Notwithstanding any provision of this section to the contrary, the agency shall be entitled to all medical coverage benefits up to the total amount of medical assistance provided by Medicaid. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

40. Application of the formula to the proceeds of Petitioner's settlement with one defendant is not in dispute. Pursuant to the formula, the amount payable to Respondent is $321,720.16, as the parties stipulated.

41. As provided by section 409.910(11)(f), since the amount calculated pursuant to the formula is less than the total amount of medical assistance provided to Petitioner by Medicaid, it is the amount that "shall be paid" to Respondent, unless Petitioner proves, pursuant to section 409.910(17)(b), that a lesser amount of the recovery should be allocated for the payment of medical expenses.

42. Section 409.910(17)(b) sets forth the procedure by which a Medicaid recipient may challenge the statutory formula

results, and establishes the evidentiary burden that must be met by the challenger:

> 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.

43. Section 409.910(17)(b) was enacted in 2013 to address Wos v. E.M.A. ex rel. Johnson, ___ U.S. ___, 133 S. Ct. 1391, 185 L. Ed. 2d 471 (2013). In Wos, the U.S. Supreme Court held that a North Carolina statute prescribing a formula for recovery

of Medicaid expenditures from third-party proceeds (similar to Florida's in section 409.910(11)(f)) was preempted by federal law prohibiting states from imposing Medicaid liens and recovering Medicaid expenditures from property of the recipient.

44. In Wos, the Court explained that states are not only permitted, but are required by federal Medicaid law to recover Medicaid expenditures from third-party proceeds to the extent those proceeds are compensation for medical damages. However, to the extent the proceeds are compensation for nonmedical damages, such as pain and suffering, lost wages, or lost earning capacity, they are property of the recipient and not available for recovery by states to recoup their Medicaid expenditures for medical assistance provided to the recipient. The Court held that North Carolina's statutory formula ran afoul of the federal anti-lien law by creating an irrebuttable presumption that the calculated amount was the amount of the third-party recovery attributable to medical expense damages.

45. Florida courts applied the holding in Wos, prior to the 2013 amendment to section 409.910(17), by ruling that the statutory formula in section 409.910(11)(f) had to be treated as a default allocation of the amount of the third-party proceeds that should be treated as compensation for medical expenses, but that recipients must first be given the opportunity to seek a reduction in the statutory formula amount by proving that a lower

amount of the recovery was compensation for medical expenses. As the First District Court of Appeal held in Harrell v. State, 143 So. 3d 478, 480 (Fla. 1st DCA 2014):

> [W]e now hold that a plaintiff must be given the opportunity to seek a reduction of the amount of a Medicaid lien established by the statutory formula outlined in section 409.910(11)(f), by demonstrating, with evidence, that the lien amount exceeds the amount recovered for medical expenses. When such evidence is introduced, a trial court must consider it in making a determination on whether AHCA's lien amount should be adjusted to be consistent with federal law. (emphasis added).

46. In a footnote, the court in Harrell added:

> Because section 409.910 was substantially amended, effective July 1, 2013, to provide a mechanism for the hearings envisioned by Wos to challenge the presumptive lien amount, see § 409.910(17)(b)-(e), Fla. Stat. (2013), much of the debate regarding the continued viability of the prior case law is now largely academic.

Id. at 480 n.1.

47. As noted in Harrell, section 409.910(17)(b)-(e) was created in 2013 to provide for the hearing envisioned by Wos to challenge the presumptive lien amount calculated by the statutory formula.[7/] Section 409.910(17)(b) begins with the recognition that the statutory formula results in an "amount designated as recovered medical expense damages," but that amount is subject to challenge by the recipient in an administrative hearing, as Petitioner has sought to do here. This way, the statutory

formula does not create an irrebuttable presumption as to the amount of recovered medical expense damages.

48. As the party challenging the statutory formula results, Petitioner bears the burden of proof by clear and convincing evidence.

49. Clear and convincing evidence is an "intermediate standard," "requir[ing] more proof than a 'preponderance of the evidence' but less than 'beyond and to the exclusion of a reasonable doubt.'" In re Graziano, 696 So. 2d 744, 753 (Fla. 1997). As described by the Florida Supreme Court:

> Clear 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 testimony 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 a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005) (quoting Slomowitz v. Walker, 492 So. 2d 797, 800 (Fla. 4th DCA 1983)). See also In re Adoption of Baby E.A.W., 658 So. 2d 961, 967 (Fla. 1995) ("The evidence [in order to be clear and convincing] must be sufficient to convince the trier of fact without hesitancy."); Westinghouse Electric Corp., Inc. v. Shuler Bros., Inc., 590 So. 2d 986, 988 (Fla. 1st DCA 1991) ("Although this standard of proof may be met

where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous.").

50. Since section 409.910(17) was amended to comport with the requirements announced by the U.S. Supreme Court in Wos, that opinion is instructive with regard to the parameters of an administrative hearing to determine the amount payable to AHCA. First, the Court described the type of case (not present here) in which there would be little left for determination:

> In some instances, no estimate [of a reasonable allocation of a third-party recovery to medical expense damages] will be necessary or appropriate. When there has been a judicial finding or approval of an allocation between medical and nonmedical damages--in the form of either a jury verdict, court decree, or stipulation binding on all parties--that is the end of the matter. Ahlborn was a case of this sort. All parties (including the State of Arkansas) stipulated that approximately 6 percent of the plaintiff's settlement represented payment for medical costs. 547 U.S., at 274, 126 S. Ct. 1752, 164 L. Ed. 2d 459. In other cases a settlement may not be reached and the judge or jury, in its findings, may make an allocation. With a stipulation or judgment under this procedure, the anti-lien provision protects from state demand the portion of a beneficiary's tort recovery that the stipulation or judgment does not attribute to medical expenses. (emphasis added).

133 S. Ct. at 1399.

51. Thus, where a third-party recovery is allocated between medical damages and nonmedical damages, and that allocation is judicially approved or adopted in a settlement or stipulation

binding on all parties (including the state), or where there is a recovery following a trial, with findings by a judge or jury verdict allocating the total damages awarded between medical damages and nonmedical damages, then those allocation numbers, established in an adversarial proceeding, might be considered "locked in" and binding in this proceeding. Then it would be a relatively simple matter of comparing the amount of the recovery allocated to medical damages and the amount established by the statutory formula. The amount payable to AHCA would be the lesser of the two.

52. In this case, however, there has not been a "binding" allocation of the settlement proceeds between medical damages and nonmedical damages. There has not been a judicial finding or approval of a settlement with such an allocation; there has not been a settlement or stipulation binding on all of the parties, including AHCA, with such an allocation; nor has there been an outcome from the tort lawsuit in the form of a judgment or jury verdict that allocates damages between medical and nonmedical damages. Instead, there has been only a confidential partial settlement between Petitioner and one of multiple defendants. The tort lawsuit remains pending against the other defendants. The remaining defendants were not parties to the settlement agreement. AHCA was not a party to the settlement agreement. As of the October 5, 2015, hearing in this proceeding, none of the

expert witnesses retained for the tort lawsuit had been deposed, and the case was still months away from the scheduled trial date.

53. The settlement agreement does not purport to allocate either total damages or the settlement proceeds between medical and nonmedical damages, nor does it fully allocate total damages or the settlement proceeds by damage categories that would enable grouping into medical damages versus nonmedical damages. The settlement agreement fails to establish the requisite allocation necessary to be considered binding in this proceeding.

54. Moreover, it must be concluded that to the extent there are recitations in the settlement agreement of Petitioner's "alleged damages" and the portion of the settlement proceeds that the settling parties agreed to allocate to "past medical expenses," those recitations were not the bargained-for results of an adversarial process. To the contrary, Petitioner's trial counsel candidly admitted that this settlement language was his work product, including his math error understating the allocation he intended by threefold. It is quite obvious that the language and numbers recited in the settlement agreement were the product of one party only, for the purpose of attempting a binding allocation in this proceeding. The other party was so disinterested in this language that it allowed Petitioner to inject erroneous numbers.

55. As determined in Ahlborn and Wos, where, as here, there was no allocation of settlement proceeds by judicial decree or binding stipulation of all parties, and the state and the recipient are unable to agree on an allocation, the parties may submit the matter to a court or an administrative tribunal for decision. As the Court explained in Wos, in such a proceeding, a fair allocation of the settlement should be made based on "projections of the damages the plaintiff likely could have proved had the case gone to trial" and "how much [the plaintiff] reasonably could have expected to receive on each claim[.]" Wos, supra, 133 S. Ct. at 1400.

56. Where, as here, the settlement proceeds are only a partial settlement of a pending tort lawsuit with an upcoming trial date scheduled, as framed by the Court in Wos, the issue presented for determination is how much is expected to be received as compensation for Petitioner's medical damages and nonmedical damages in the trial of Petitioner's tort lawsuit.

57. Respondent argues that the amount of total expected damages is irrelevant, and that allocating the proceeds proportionally may be equitable, but is not provided for by statute. However, section 409.910(17)(b) does call for a determination of whether a lesser amount of the recovery than calculated under the statutory formula should be allocated as reimbursement for past and future medical expenses, to rebut the

statutory formula, which presumptively determines the amount designated as recovered medical expense damages. In keeping with Wos, then, the undersigned must consider a reasonable allocation between medical and nonmedical damages, recognizing that the full value of damages being claimed in the pending tort lawsuit have only been recovered in part with the partial settlement with one defendant. Certainly one way to do that, where, as here, there is a partial settlement of a still-pending tort lawsuit, would be to determine what damages are expected in the upcoming trial, and what percentage of the total damages has been recovered by the partial settlement. That percentage could then be multiplied by the total expected damages allocable to medical damages, to define the amount of the recovery that should be allocated to medical damages. The lesser of this amount and the statutory formula amount would be the amount payable to AHCA.

58. However, Petitioner failed to prove the amount of compensation reasonably expected for medical damages as distinct from nonmedical damages in the trial of Petitioner's pending tort lawsuit. That is true whether or not one considers the proper time to evaluate the amount of damages as the time of the partial settlement of the tort lawsuit, or as the time when the trial would be held.

59. In the filings submitted after Petitioner's death, counsel for Petitioner contends that the proper time for

determining the total value of damages reasonably expected in a trial of the tort lawsuit is as of the time of the settlement, asserting that the numbers were "locked in" as of that time. It must be noted that at hearing, that was not the tenor of his questions or the witnesses' opinions. Instead, counsel asked his damage valuation experts what the total value of Petitioner's damages "is," "today," and what trial counsel will be presenting to the jury and expecting by way of damages when the tort lawsuit is tried. Perhaps counsel's argument that the numbers were "locked in" as of the settlement agreement would be well-founded if the settlement was a complete resolution of the tort lawsuit and the recovery was fully allocated, or at least allocated between medical damages and nonmedical damages, as described in Wos. However, those are not the circumstances here.

60. Even if the proper time at which to judge the anticipated compensation for medical damages and nonmedical damages is as of the partial settlement of the tort lawsuit with one defendant, Petitioner chose only to offer evidence that at the time of the settlement agreement and as of the October 5, 2015, hearing, the total value of Petitioner's damages was estimated to be $25,000,000, and the amount that should be allocated as compensation for past medical expenses is $13,881.79. The opinions offered by Petitioner's experts were not compelling, as they were predicated in large part on two-

year-old incomplete reports prepared by other experts who did not testify.

61. Significantly, Petitioner did not attempt to prove how much of the estimated total damages would be allocable as compensation for medical damages, as distinct from nonmedical damages. Neither of Petitioner's damage valuation experts testified to a reasonable allocation of the total expected compensation between medical damages and nonmedical damages. While Petitioner's experts acknowledged that the medical damages that will be sought in the tort lawsuit include both past medical expenses and future projected medical expenses, they did not offer any opinions as to the value of the claim for future medical expenses. Likewise, they offered no opinions as to the amount of the recovery from the settlement agreement that should be allocated for future medical expenses.

62. Petitioner's position is that it has met its burden of proof by virtue of the settlement agreement provision agreeing that Petitioner's alleged damages are $25,000,000, and that the amount allocated to past medical expenses is $4,817.56. These numbers, Petitioner contends, are locked in (although Petitioner also wants to correct the erroneous allocation to past medical expenses). Petitioner contends that it need not prove the amount allocated to future medical expenses.

63. Petitioner's argument cannot be squared with the 2013 legislation amending section 409.910 to specifically address the preemption concerns following the U.S. Supreme Court's decision in Wos. As noted in Harrell, these amendments render much of the debate reflected in decisions predating the statutory changes largely academic.

64. None of the appellate decisions and none of the trial court orders presented by Petitioner in this proceeding analyze or apply section 409.910 as amended in 2013.

65. Petitioner also refers to several DOAH Final Orders issued under the amended law. Petitioner does not refer to several other DOAH Final Orders that reject the position advocated by Petitioner here.

66. No prior DOAH Final Order addresses the combination of circumstances presented here, where a recipient enters into a partial settlement with one defendant; where the settlement agreement provision regarding "alleged" total damages and an allocation to past medical expenses was shown to be the product of one party only, including an unreasonable erroneous allocation; where the tort lawsuit was still pending and set for trial soon; where no evidence was offered as to expected total medical expense damages, including both past and future medical expenses; and where the Medicaid recipient died before entry of the Final Order.

67. One issue examined in several other DOAH Final Orders is the interpretation of the following emphasized language in section 409.910(17)(b):

> 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. (emphasis added).

68. Petitioner offers a strained interpretation of the emphasized language. Petitioner contends that the "amount that should be allocated as reimbursement for . . . future medical expenses" means the amount that is allocated to pay back the Medicaid program for past expenditures that were advance payments or prepayments for future medical expenses.

69. Petitioner's argument places singular emphasis on the word "reimbursement," to the exclusion of the surrounding words. Indeed, when the focus has been on that singular word, the result of several DOAH Final Orders has been to agree with Petitioner's statutory interpretation argument. This argument is premised on one common dictionary definition of the word "reimburse" as meaning "to pay someone an amount of money equal to an amount that person has spent." See Merriam Webster Online Dictionary, at http://www.merriam-webster.com/dictionary/reimburse.

70. However, there is another common dictionary definition of the word "reimburse" as meaning "to repay or compensate (a person) for expenses, damages, losses, etc." (emphasis added). See Collins American English Dictionary, at http://www.collinsdictionary.com/dictionary/american/reimburse. Similar alternative definitions of the word "reimburse" and "reimbursement" are found in the following commonly used online dictionary resources: One Look Dictionary online search for "reimbursement" at http://www.onelook.com/?w=reimbursement&ls=a, offering the following quick definition by WordNet: "reimbursement" means "compensation paid (to someone) for damages or losses or money already spent etc."; American Heritage Dictionary, at https://ahdictionary.com/word/search.html?q=reimburse&submit.x=55&submit.y=23, defining "reimburse" to mean "pay back or compensate (another party) for money spent or losses incurred;" and Webster's New Word Collegiate Dictionary, at http://www.yourdictionary.com/reimburse#websters, defining "reimburse" to mean "to repay or compensate (a person) for expenses, damages, losses, etc."

71. Thus, common dictionary definitions of "reimbursement" support the statutory interpretation offered by AHCA, as meaning the amount of the recovery allocated to compensate the recipient for past and future medical expense damages.

72. Petitioner's statutory interpretation argument falters when an attempt is made to reconcile the proffered meaning of "reimbursement" with the phrase it modifies: "for past and future medical expenses." Not surprisingly, those DOAH Final Orders that focus on the latter phrase have concluded that the portion of a recovery payable to AHCA towards its Medicaid lien is the portion allocated for both past and future medical expenses. In other words, the task is to separate the portion of the proceeds allocated as compensation for medical damages (past and future), from which AHCA's Medicaid lien may be satisfied, from the portion of the proceeds allocated as compensation for nonmedical damages (including past and future lost wages and lost earning capacity, and past and future pain and suffering).

73. The undersigned is persuaded by the logic of those DOAH Final Orders that have interpreted section 409.910(17)(b) to require proof of the amount of the third-party recovery that should be allocated to medical damages (past and future), from which AHCA may satisfy its Medicaid lien consistent with Florida law, Ahlborn, and Wos. See, e.g., Savasuk v. Ag. for Health Care Admin., Case No. 13-4130MTR (Fla. DOAH Jan. 29, 2014); Holland v. Ag. for Health Care Admin., 13-4951MTR (Fla. DOAH May 2, 2014); Silnicki v. Ag. for Health Care Admin., Case No. 13-3852MTR (Fla. DOAH July 15, 2014); Goddard v. Ag. for Health Care Admin., Case No. 14-4140MTR (Fla. DOAH March 23, 2015).

74. Those DOAH Final Orders reaching a different conclusion do not consider the alternative meaning of "reimburse" and "reimbursement" evident from common dictionary definitions. This alternative meaning (sometimes offered as the first definition, sometimes as the second definition) is the only definition that allows for the phrase that follows to be given meaning.

75. If the word "reimbursement" was intended to mean paying AHCA back for Medicaid expenditures previously made, then the phrase "reimbursement for . . . future medical expenses" would take on the strained meaning offered by Petitioner in this case: to pay AHCA back for past payments made by Medicaid in advance, or as a prepayment, for future medical expenses. Not only is the proffered meaning strained, requiring that one read additional words into the statute that are not there, it is nonsensical. Petitioner failed to show that it is even possible, under state and federal laws or regulations, for the Medicaid program to ever prepay or pay in advance for future medical expenses of current Medicaid beneficiaries. The very notion seems inconceivable.

76. The opening line of section 409.910(17)(b), describing the nature of this proceeding, is also illuminating. In providing for the proceeding that would transform an impermissible irrebuttable presumption into a permissible rebuttable presumption, the Legislature described the proceeding as follows: "A recipient may contest the amount designated as

recovered medical expense damages payable to the agency pursuant to the formula . . . .” (emphasis added). Thus, while the formula is presumptively correct as an allocation of “recovered medical expense damages,” the recipient may contest the formula results by proving with evidence that a lesser amount of the recovery should be allocated for medical expense damages (including both past and future medical expenses).

77. Thousands of pages of analysis have been devoted in many jurisdictions and many tribunals to interpreting the reach of Ahlborn and Wos with regard to whether states may satisfy their liens from the portion of a third-party recovery representing future medical expense damages, without running afoul of preemptive federal law. The undersigned agrees with one recent observation that neither Ahlborn nor Wos definitively address this issue, and that “the better reading of the case law supports the conclusion that Respondent’s share may extend to the portion of the proceeds allocated or allocable to past and future medical expenses. . . . Neither of these items of damages can be thought of as the [recipient’s] property, so the anti-lien statute does not protect either of these items of damages from the reach of state Medicaid third-party recovery and reimbursement laws.” Goddard, supra, Case No. 14-4140MTR, at 76-77.

78. As repeatedly described by the Court in both Ahlborn and Wos, the separation required by the anti-lien law is between medical damages (available to satisfy Medicaid liens) and nonmedical damages (which are property of the recipient). The Florida Legislature has provided for the proceeding envisioned by these U.S. Supreme Court opinions. The language chosen to describe the proceeding is consistent with those opinions.

79. While Petitioner presents a good case for pro rata allocation of a third-party recovery such that each category of damages is reduced ratably when there is only a partial recovery, Petitioner has failed to present an equally compelling case for making an additional temporal allocation within the medical-expense damages category between past medical expenses and future medical expenses. Instead, it is more logical and fair, consistent with the language of section 409.910(17)(b), to use recovered medical expense damages to pay for past medical expenses first, up to the extent of those expenditures, rather than holding in reserve a portion of the recovered medical expense damages for those who will be, in the future, owed money for anticipated future medical goods and services. That is what a non-Medicaid recipient would do--it logically follows that if an injured person recovers damages from a third-party tortfeasor for medical expenses (past and future), the injured person would pay the medical bills already incurred for past goods and

services first, rather than ratably allocate the recovered medical expense damages to past, present, and future expected medical expenses.

80. The undersigned is unwilling to assume that the U.S. Supreme Court was not choosing its words advisedly in stating repeatedly that a state's Medicaid lien can be imposed against proceeds recovered for medical damages, but not against proceeds recovered for nonmedical damages. Moreover, the undersigned is unwilling to ignore the Florida Legislature's chosen words that set forth its belief that the term "medical damages," as used by the Wos Court and distinguished from "nonmedical damages," means both past and future medical expense damages.

81. As counsel acknowledged at the October 5, 2015, hearing, there is no definitive appellate decisional law interpreting the 2013 amendment to section 409.910(17).[8/] As such, that law should be applied in accordance with a reasonable interpretation that gives meaning to all of the language chosen. As to the suggestion that this interpretation might not withstand constitutional preemption scrutiny, the undersigned does not agree, but also notes that that determination is more properly made by a different tribunal.

82. Petitioner's choice not to prove the amount of Petitioner's future medical expense damages requires the conclusion that Petitioner failed to meet its burden to rebut the

statutory formula's amount designated as recovered medical expense damages.

83. Regardless of how one interprets section 409.910(17)(b), the undersigned must conclude that the fact that Petitioner died on October 31, 2015, makes it impossible on this record to determine the amount that a jury would award in total damages in a trial of Petitioner's tort lawsuit. Whether the number multiplied against the fractional recovery amount is past medical expense damages only (as Petitioner contends), or past and future medical expense damages (as Respondent contends and the undersigned concludes), the fraction has as the numerator the settlement recovery amount, and the denominator is the total compensation expected in the trial of Petitioner's tort lawsuit against the remaining defendants.

84. The opinion testimony offered by Petitioner's damage valuation experts is substantially undermined by the changed circumstances wrought by Petitioner's early death. While on the one hand, future medical expenses are presumably substantially curtailed, so too, future pain and suffering presumably are eliminated. Petitioner's long expected life was a predicate for the opinions offered at hearing as to the total damages. There is no evidentiary support in the record that would allow the undersigned to determine the amount reasonably expected as compensation for Petitioner's damages in a trial of his pending

tort case, nor how those damages should be allocated between medical damages and nonmedical damages. That is why the undersigned offered to reopen the record.

85. Petitioner's contention that the date of the settlement agreement is the relevant time for establishing the total value of damages and the appropriate allocation of the settlement proceeds is rejected for the reasons previously given for the conclusion of law regarding the insufficiency of this particular partial settlement with one defendant to establish any allocation that would be "locked in" so as to be binding in this proceeding.

86. Petitioner presented several trial court orders, which Petitioner contends should be persuasive on the point of whether Petitioner's death has any impact on the determinations to be made here. None of those trial court orders address the combination of issues presented here. None of the cases appear to involve a settlement agreement with an unreliable partial allocation provision, and none of the cases appear to involve a partial settlement with a single defendant, with the remainder of the tort lawsuit set for trial in the future. Those factors combine to create the framework described by Wos, whereby the determinations to be made by this Final Order include the total expected compensation in a trial of Petitioner's tort lawsuit, and how that compensation should be allocated between medical damages and nonmedical damages.

87. Petitioner has failed to prove by clear and convincing evidence that a lesser amount of the total recovery from the settlement with one defendant should be allocated as reimbursement for past and future medical expenses than the amount established by the statutory formula, or that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

DISPOSITION

Based on the foregoing Findings of Fact and Conclusions of Law, it is DETERMINED that the amount of AHCA's Medicaid lien payable from the proceeds of Petitioner's confidential settlement with one defendant is fixed at $321,720.16, as claimed by AHCA.

DONE AND ORDERED this 30th day of December, 2015, in Tallahassee, Leon County, Florida.

ELIZABETH W. MCARTHUR
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of December, 2015.

ENDNOTES

[1/] For ease of reference, citations to Florida Statutes are to the 2015 codification, unless otherwise indicated. It is noted that the Medicaid statutes relevant to this proceeding were not materially amended in 2015 after the settlement giving rise to this proceeding. See Suarez v. Port Charlotte HMA, LLC, 171 So. 3d 740, 742 (Fla. 2d DCA 2015) (holding that the 2013 amendment to section 409.910, which amended paragraph (17) to establish the administrative hearing process that was invoked by Petitioner herein, applied to a Medicaid lien against a settlement entered into after the new law's effective date).

[2/] Under the Administrative Procedure Act (chapter 120, Florida Statutes) and uniform rules of procedure applicable to DOAH proceedings, hearsay that would not be admissible over objection in civil actions cannot be used as the sole basis for findings of fact. § 120.57(1)(c), Fla. Stat.; Fla. Admin. Code R. 28-106.213(3). Further, while opinions of expert witnesses are not rendered improper by reason of reliance on hearsay (whether admitted or not), an expert's opinion relying on hearsay cannot serve as a conduit for the hearsay evidence itself such that the hearsay relied on could be considered competent evidence on which findings of fact might be predicated.

[3/] Counsel for Respondent was permitted to submit authorities for official recognition post-hearing as a means to address his stated concern that the trial court orders in Petitioner's Exhibit 19 were "cherry-picked." Accordingly, he was offered the chance to submit for official recognition additional authorities that are not readily accessible. Counsel stated he would likely rely on DOAH final orders, which could be just cited in his PFO.

[4/] Despite those comments, counsel for Petitioner filed an affidavit by Mr. Reboso along with his PFO. The affidavit is rejected as contrary to Mr. Reboso's testimony at hearing, and as presenting more argument than factual statements. Mr. Reboso's affidavit states that Petitioner's death would not change his opinions offered at hearing because the relevant time period to assess the total value of damages was as of the settlement agreement. At hearing, however, Mr. Reboso was repeatedly asked for, and gave, his opinion regarding what the total value of Petitioner's damages "is," "today," and what will be the amount of Petitioner's damages that will be sought from the jury at trial. See, e.g., Tr. at 42-43, 50-51, 64.

[5/] The first page of the life care plan prepared for Petitioner states that a "life care plan is a dynamic document . . . [by which] a clear, concise, and sensible presentation of the complex requirements of the patient are identified as a means of documenting current and future medical needs for individuals who have experienced catastrophic injury or have chronic health care needs." Consistent with this general characterization of the scope of a life care plan, Mr. Reboso described the cost projections in Petitioner's life care plan as future medical expenses: "If one looks at the projected future medical expense in Mr. Villa's case, even using the low end [of the life care plan's cost projections], you're at $9.1 million at the low end." (Tr. at 56). That amount is the low end of the cost projections for Petitioner's life care needs in the life care plan, reduced to present value in Dr. Raffa's economic report. Mr. Reboso backtracked from this testimony later, suggesting that while the life care plan costs certainly include a large amount of future medical expenses, Mr. Reboso expressed uncertainty as to which items in the life care plan are considered medical expenses, noting that the Deutsch life care plan does not delineate which expense projection is considered "medical expenses."

[6/] The life care plan, Petitioner's Exhibit 11 in evidence for a limited purpose, appears to be incomplete. The body of the document includes pages 1 through 29, followed by three unnumbered pages that appear to be part of the life care plan, identifying potential complications "for informational purposes only." The next page is a copy of a blank page tabbed "Appendix B," apparently a divider. Appendix B is a seven-page "Vocational Worksheet" that provides information about Petitioner's work expectancies in light of injuries. It appears that the assessment in Appendix B was used by Dr. Raffa to quantify damages for loss of income and future earning capacity. No explanation was offered for the apparent incompleteness of Petitioner's Exhibit 11, or what may be contained in the apparently missing Appendix A. While the apparent incompleteness of the document is less significant given the limited purpose for its admission (to show the material relied on by Petitioner's experts), it does cast some doubt on the reasonableness of Mr. Reboso's reliance on an apparently incomplete document, and whether the omitted material may have affected Mr. Reboso's opinion.

[7/] This statement in Harrell is confirmed by the Staff Analysis on CS/CS/HB 939 prepared by the Health and Human Services Committee of the Florida House of Representatives on April 12, 2013. The Staff Analysis, at page 4, makes clear that the

intended effect of the statutory changes was to address the U.S. Supreme Court decision in Wos:

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

[8/] Pursuant to section 409.910(17)(d), venue for appeals from DOAH Final Orders is assigned to the First District Court of Appeal, at the agency's discretion. In the first hint of how section 409.910(17)(b) might be interpreted, the First District Court of Appeal recently issued an opinion (which is not yet final) in Mobley v. Agency for Health Care Administration, Case No. 1D14-2770 (Fla. 1st DCA Slip Op., Dec. 18, 2015). In Mobley, the court addressed a dispute regarding evidence of the allocation for past medical expenses. The court agreed with the appellant that certain evidence was insufficient to prove an allocation for past medical expenses. However, the court did not, as urged by the appellant's briefs, reverse with instructions to determine the amount payable to AHCA as the pro rata allocation for past medical expenses paid by AHCA for medical assistance under the Medicaid program. Instead, the court reversed and remanded for consideration of whether appellant met his burden of 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 formula." Mobley, Slip Op. at 7.

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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.