STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

LISET MUSEGUEZ, AS THE COURT APPOINTED GUARDIAN OF SERGIO MUSEGUEZ,

Petitioner,

vs. Case No. 16-7379MTR

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

The final hearing in this case was conducted on March 14, 2017, before Administrative Law Judge Lisa Shearer Nelson of the Florida Division of Administrative Hearings (Division or DOAH), by means of video teleconferencing with sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Anthony Dax Bello, Esquire
Stewart, Tilghman, Fox, Bianchi & Cain, P.A.
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Miami, Florida 33131

For Respondent: Alexander R. Boler, Esquire
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Tallahassee, Florida 32317

STATEMENT OF THE ISSUE

The issue to be decided in this proceeding is the amount to be paid to Respondent, the Agency for Health Care Administration (Agency or AHCA), from the proceeds of a personal injury settlement received by Sergio Museguez to reimburse Medicaid for expenditures made on his behalf.

PRELIMINARY STATEMENT

On December 14, 2016, Petitioner, Liset Museguez, as the court-appointed guardian for Sergio Museguez (Museguez), filed a Petition to Contest the Amount Designated as Recovered Medical Expense Damages Payable to the Agency for Health Care Administration. An Amended Petition was filed the following day. On December 28, 2016, the case was scheduled for hearing to take place on March 14, 2017, and the case proceeded as scheduled. On March 3, 2017, the parties filed a Joint Pre-hearing Stipulation that contained a statement of admitted and stipulated facts that have been incorporated into the Findings of Fact below.

At hearing, Petitioner's Exhibits numbered 1 through 16 and 19 were admitted. Petitioner's Exhibits 21, 22, and 23 were depositions of Todd Michaels, Esquire, Lawrence S. Forman, and Frederick A. Raffa, Ph.D., respectively, that the parties agreed would be filed after the conclusion of the hearing and were, in fact, filed with the Division on April 18, 2017. The parties'

stipulated facts were also offered and accepted as Petitioner's Exhibit 20. The Agency presented no witnesses or exhibits.

The Transcript of the hearing was filed with the Division on April 18, 2017. The parties had agreed at hearing that the proposed final orders would be due ten days from the filing of the last transcript. However, on April 21, 2017, the Agency filed a Notice of Federal Court Order and Motion for Stay. The motion provided a copy of an Order dated April 18, 2017, by the Honorable Mark E. Walker in the case of Gallardo v. Dudek, 4:16-cv-116-MW-CAS, 2017 U.S. Dist. LEXIS 59848 (N.D. Fla. Apr. 2017), and advised that Judge Walker had enjoined the Agency from enforcing section 409.910, Florida Statutes. The Agency advised that it was seeking clarification and/or stay of the federal court Order, and requested that the instant case be stayed while that clarification was sought. As a result, on April 24, 2017, an Order was issued placing the case in abeyance and requiring a joint status report no later than May 27, 2017, notifying the Division of the status of the federal court proceedings and the parties' positions with respect to the continued viability of this proceeding.

On May 25, 2017, a Joint Status Report was filed. The Agency contended that the stay should be extended because both the federal proceeding in Gallardo and conflicting state court proceedings in the Supreme Court of Florida on petitions for

review prevented it from going forward. Petitioner, on the other hand, contended that the federal court decision needed no clarification, and that there has been conflict both at DOAH and in the state appellate courts for years. A status conference was held on May 31, 2017, to address the unique procedural posture presented, and on that same day, an Order was issued keeping the case in abeyance and requiring a status report on July 7, 2017. The Joint Status Report, filed on July 10, 2017, updated the procedural posture of both the state and federal proceedings, but provided no change in either party's position regarding moving forward in the instant case.

On July 13, 2017, an Order on Joint Status Report was filed, acknowledging both parties' position. The Order stated, in pertinent part:

> The undersigned is mindful of and sympathetic to the motives underlying each party's position. No doubt counsel for Petitioner seeks to reach a resolution that frees up funds for the care of Petitioner, while the Agency feels constrained by the conflicting directives regarding the lien statute voiced by the state and federal courts. The undersigned's dilemma is that, should the case proceed forward at this point, the injunction entered by Judge Walker removes the structure by which these cases are handled, and the standards by which a decision can be reached. For example, without using the process outlined in section 409.910, who bears the burden of proof and what burden controls? Does the statutory formula remain the standard by which the appropriate lien amount is measured, or is

> some other tool to be used? Given the federal injunction, would any decision made if the case goes forward have any validity? Without some clarity on these issues, it is difficult if not impossible to move forward.
>
> Further complicating the issue is that, while the undersigned is aware that the Agency has sought relief from the decision in Gallardo, she does not know what relief the Agency is seeking and whether, if successful, the Agency's efforts would address the quandaries outlined above.

The Order directed the Agency to file copies of its post-judgment motions and supplemental briefing in the Gallardo case and deferred a determination as to whether the case should remain in abeyance. On July 20, 2017, the Agency filed the requested documents, as well as copies of an Order Granting in Part and Denying in Part Motion to Alter or Amend Judgment, 2017 U.S. Dist. LEXIS 112448 (Second Order), filed in the Gallardo case on July 18, 2017, and the Agency's Amended Brief on Jurisdiction in Giraldo v. Agency for Health Care Administration, SC17-297.

After review of the documents received, a Scheduling Order was issued, directing the parties to file their proposed final orders no later than August 18, 2017. Proposed Final Orders were timely filed by both parties. On September 5, 2017, AHCA filed a Motion for Leave to File Amended Proposed Final Order, stating that "subsequent to the filing of the proposed final orders, additional consultation between the undersigned and the agency clarified the relief sought by the agency in this proceeding."

The Agency's motion is denied: the time for discussion regarding the relief to be sought is before, not two and a half weeks after, a proposed final order is filed.

All references to the Florida Statutes are to the 2017 codification. All emphasis is in the original unless otherwise indicated.

FINDINGS OF FACT

1. Sergio Museguez was catastrophically injured as a result of being struck by lightning on June 15, 2012.

2. Mr. Museguez has been diagnosed with a traumatic brain injury and suffers from cognitive dysfunction, including, but not limited to, significant problems with memory, orientation, initiating and executive functions. Mr. Museguez is also incontinent as to bowel and bladder. The above-described conditions are permanent and will never resolve.

3. Mr. Museguez's employer, MG3 Developer Group (MG3), failed to carry workers' compensation insurance or any other effective insurance coverage that would cover the injuries he sustained on June 2012, or that would cover his wife Leidi Hernandez's loss of consortium suffered as a result of the accident.

4. An action was filed in Miami-Dade County Circuit Court, Case No. 14-025861 CA 06, against MG3 for damages related to Mr. Museguez's injuries and for Ms. Hernandez's loss of

consortium. MG3's insurance carrier denied coverage and refused to defend the company because its insurance policy excluded coverage for employees.

5. The Museguezes and MG3 entered into a settlement agreement in which they agreed to a judgment against MG3 in the amount of $5,000,000, but which included a payment schedule through which $1,000,000 would actually be paid to Petitioner by MG3. Only that $1,000,000 of the judgment has been or will be recovered by Mr. Museguez against MG3, because of MG3's lack of available insurance coverage, and the lack of anticipated avenues of recovery pursuant to the terms of the settlement, dated June 16, 2016.

6. The settlement agreement provided that the parties "acknowledge and agree that the One Million ($1,000,000) Dollar payment set forth above only represents twenty percent of the total injury/damage value of Museguez's claim, and this fails to fully compensate Museguez for the injuries sustained in the incident at issue. Therefore, Museguez is specifically recovering only twenty percent (20%) of their damages for past medical expenses."

7. Ms. Hernandez waived her right to an apportionment of the recovery for her consortium claim in light of her husband's condition and his need for extensive medical care and treatment for the rest of his life. She opted for any amount that would

have been apportioned to her claim instead be apportioned directly to her husband.

8. Mr. Museguez's condition and need for continuing care is not in dispute. A life care plan identifying the goods and services necessary for Mr. Museguez was prepared by Lawrence S. Forman, an expert in rehabilitation life care planning. Mr. Forman has concluded that Mr. Museguez will require 24-hour attendant medical care for the rest of his life, in addition to a significant amount of future costs associated with his medical condition as a result of his injury. Mr. Forman's opinions are outlined in his report dated April 8, 2016.

9. Frederick A. Raffa, an economist, reviewed the life care plan for Mr. Museguez and determined that the present value of the anticipated medical expenses for Mr. Museguez is $7,943,963. He testified, unrebutted, that Mr. Museguez's total losses were $8,424,028. In short, Mr. Museguez's needs far outweigh the recovery received in this case.

10. According to the United States Life Tables, 2012, Mr. Museguez is expected to live another 24.8 years.

11. Todd Michaels is an attorney who was appointed as guardian ad litem for Mr. Museguez in the personal injury case. Mr. Michaels testified that he was appointed for the purpose of determining whether the settlement of Mr. Museguez's claim was fair to him. Mr. Michaels concluded that the settlement was the

product of an arm's-length transaction and was a fair settlement of the claim.

12. Mr. Michaels also was asked to provide an opinion regarding the value of Mr. Museguez's claim. Mr. Michaels has practiced personal injury law for 15 years, and is generally familiar with the awards related to claims involving catastrophic injuries and, specifically, traumatic brain injuries.

13. With respect to Mr. Museguez's claim, Mr. Michaels described it as conservative but necessary given the lack of insurance coverage and significant possibility of insolvency should the case go to verdict. He noted that "without a settlement there was almost zero likelihood of recovery in that the issues of both the fact and law were hotly contested." He acknowledged that the settlement was less than Mr. Museguez's future medical needs, and ignored any claim for pain and suffering, as well as the consortium claim. He stated, "I understand what the situation was and they could have pushed forward and gotten a verdict of 30 million dollars and it would have been worth the paper it was printed on because of the circumstances."

14. Without the very real limitations provided in this case, where there was no insurance coverage, Mr. Michaels believed that the fair settlement value would be about $13 to $15 million. However, his explanation as to how he reached that

range was conclusory at best. Mr. Michaels testified that he did not "physically parse it out." He started with the number $8,424,000 and went from there. He did not consult other attorneys, or do specific jury verdict research, but simply relied on his knowledge from practicing in this area and reviewing jury verdicts on a regular basis.

15. It seems that the "fair value" of a claim must by necessity consider not only the level of a plaintiff's damages, but the likelihood of success and any issues of liability, comparative fault, collectability, and the like. Here, while Petitioner's damages are unfortunately much higher than the settlement amount, Petitioner's witness testified that under the circumstances of this case, the settlement was fair.

16. The undersigned finds that the fair settlement value of this case, given all of the circumstances, is the amount reflected in the settlement, i.e., $5,000,000. The undersigned also finds, consistent with the language in the settlement agreement, that Petitioner recovered only 20 percent of his past medical expenses.

17. The taxable costs associated with the action at law were $27,812.46. While the parties in this proceeding stipulated to the amount of these costs, they did not stipulate to the amount of the attorney's fees related to the claim, and it does

not appear that any evidence to substantiate the amount of attorney's fees actually paid was included in this record.

18. Mr. Museguez received medical services from Medicaid. On December 1, 2016, the Agency notified counsel for Mr. Museguez that Medicaid's lien for medical expenses paid on his behalf was $116,032.84.

19. There was no evidence presented to indicate that the Agency was a party to the settlement negotiations between Petitioner and MG3, or whether the Agency was notified of the litigation prior to the execution of the settlement.

20. Petitioner deposited the amount of the Medicaid lien into an interest-bearing account for the benefit of the Agency in accordance with the requirements of section 409.910, and in compliance with the requirements of bringing an action to contest the amount of the lien before the Division of Administrative Hearings. Petitioner's actions constitute "final agency action" for purposes of chapter 120, Florida Statutes, pursuant to section 409.910(17)(b).

21. Application of the formula contained in section 409.910(11)(f) to Petitioner's $1,000,000 settlement would require payment to the Agency in the amount of $116,032.84, the actual amount of the funds expended by Medicaid.

CONCLUSIONS OF LAW

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

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

24. The Medicaid program provides federal financial assistance to states choosing to reimburse certain costs of medical treatment for needy persons. Harris v. McRae, 448 U.S. 297, 301 (1980). While participation in the Medicaid program is optional, once a state elects to participate, it must comply with the federal requirements of the program. Id.

25. A condition for receipt of federal Medicaid funds is that states will seek reimbursement for medical expenses incurred on behalf of Medicaid recipients who later recover from third parties. Ark. Dep't of Health & Hum. Servs. v. Ahlborn, 547 U.S. 268, 276 (2006).

26. In an effort to comply with this federal requirement, the Florida Legislature enacted section 409.910, which requires the state to be reimbursed for Medicaid funds paid for a recipient's medical care when the recipient receives a personal injury judgment, award, or settlement from a third party. The statute creates an automatic lien against any such judgment,

award, or settlement to reimburse the state for the medical assistance provided. § 409.910(6)(c), Fla. Stat.; Smith v. Ag. for Health Care Admin., 24 So. 3d 590 (Fla. 5th DCA 2009).

27. Section 409.910(11)(f) provides the formula for distribution of any recovery as a result of a judgment, award, or settlement when there is an outstanding Medicaid lien. It provides:

> (f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a judgement, 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 in the Florida Rules of Civil Procedure, one-half of the 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 agreement, or a prepaid health clinic, and the portion of benefits designated for medical payments under

coverage for workers' compensation, personal injury protection, and casualty.

28. In this case, if payment was made under this formula, $250,000 representing attorney's fees and $27,812.46 representing taxable costs would be subtracted from the $1,000,000 settlement, leaving a balance of $722,187.54. Half of that amount, $361,093.77, would be available to satisfy the lien. Because the amount of the lien is substantially less than the amount allowed under the formula, the presumptive recovery by the Agency is the amount the Agency actually expended on Petitioner's behalf. The issue then becomes whether a lesser amount than the amount actually expended, i.e., $116,032.84, should be recovered by the Agency.

29. Petitioner contends that a pro rata share of attorney's fees should be subtracted from the lien amount, based upon 40 percent of the settlement, as opposed to subtracting 25 percent at the beginning as contemplated in the statutory formula in section 409.910(11)(f). There are two problems with this approach. First, as noted in the findings of fact, no evidence was presented and no stipulation reached regarding the amount of attorney's fees actually paid in this case. Without any evidence as to the amount of attorney's fees actually paid, no deduction for that amount, or any percentage of it, can be established. Second, Petitioner presented no authority related to section

409.910 that would authorize a deduction related to the Agency's "pro rata share" of the attorney's fees instead of using the deduction identified in section 409.910.[1/] Where, as here, no evidence or stipulation was presented regarding the actual payment of attorney's fees, Petitioner is well served by the 25 percent statutory allocation.

30. Section 409.910(1) also establishes that repayment to Medicaid is paramount, providing in pertinent part:

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

31. As a condition for providing Medicaid funds, AHCA also is placed in a priority position for recovery of all funds expended, as mandated by section 409.910(6) ("Equities of a recipient, his or her legal creditors, or health care providers

shall not defeat, reduce, or prorate recovery by the agency as to its subrogation rights under this paragraph.").

32. The Agency also is not bound by any allocation of damages included in a settlement between a Medicaid recipient and a third party where AHCA did not participate in the settlement. § 409.910(13), Fla. Stat. See also § 409.910(6)(c)7., Fla. Stat. ("No release or satisfaction of any . . . settlement agreement shall be valid or effectual as against a lien created under this paragraph, unless the agency joins in the release or satisfaction or executes a release of the lien."). While perhaps not binding, the Agency has not contested the percentage named in the settlement agreement for past medical expenses, and it is accepted as reasonable.

33. There are restrictions on the Agency's ability to recoup its expenditures on Petitioner's behalf. The Agency cannot receive settlement proceeds which are not designated as payments for medical care, because those proceeds qualify as a recipient's property. Ahlborn, 547 U.S. at 283-86; Goheagan v. Perkins, 197 So. 3d 112, 116 (Fla. 4th DCA 2016). In Davis v. Roberts, 130 So. 3d 264, 268 (Fla. 5th DCA 2013), the Fifth District reasoned, consistent with its decision in Smith, that absent proof of an allocation in a settlement agreement, the formula in section 409.910(11)(f) must be used to calculate the amount owed to the Agency. The purpose of a hearing is to establish, with evidence,

that the lien amount exceeds the amount recovered for medical expenses. The court stated:

> Ahlborn and Wos [v. E.M.A. ex rel. Johnson, 133 S.Ct. 1391, 185 L.Ed. 2d 471 (2013)] make clear that section 409.910(11)(f) is preempted by the federal Medicaid statute's anti-lien provision to the extent it creates an irrebuttable presumption and permits recovery beyond that portion of the Medicaid recipient's third-party recovery representing compensation for past medical expenses. Accordingly, we agree with the fourth district in Roberts [v. Albertson's, Inc., 119 So. 3d 457 (Fla. 4th DCA 2012)] that section 409.910(11)(f) is a "default allocation" . . . [and] we reiterate our prior directive and hold that a Medicaid recipient "should be afforded the opportunity to seek the reduction of a Medicaid lien amount by demonstrating, with evidence, that the lien amount [established by section 409.910(11)(f)] exceeds the amount recovered for medical expenses. Smith, 24 So. 3d at 592; see also Agency for Health Care Admin. v. Riley, 119 So. 3d 514, 516 (Fla. 2d DCA 2013)(expressly adopting the fourth district's holding in Roberts that a plaintiff should be afforded an opportunity to seek the reduction of a Medicaid lien amount established by the statutory default allocation by demonstrating, with evidence, that the lien amount exceeds the amount recovered for medical expenses).

(Emphasis supplied); see also Harrell v. State, 143 So. 478, 480 (Fla. 1st DCA 2014) ("we now hold that a plaintiff must be given the opportunity to seek reduction of the amount of a Medicaid lien established by the statutory formula . . . 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."); Mobley v. State, 181 So. 3d 1233 (Fla. 1st DCA 2015). The need for a hearing to rebut the statutory formula was recognized in the Florida Supreme Court's decision in Garcon v. Agency for Health Care Administration, 150 So. 3d 1101 (Fla. 2014). The Florida Supreme Court noted that it had accepted jurisdiction in Garcon on the issue of whether a plaintiff should be afforded the opportunity to demonstrate that a Medicaid lien exceeds the amount recovered by the plaintiff for medical expenses, but agreed that the United States Supreme Court's decision in Wos was determinative of the issue.

34. As noted by the First District in Harrell, section 409.910 was amended in 2013 to provide a mechanism for the hearings envisioned in Wos to challenge the presumptive amount. In those cases where the Agency has not participated in or approved the settlement, the Legislature created a procedure in section 409.910(17)(b) as a means for determining whether a lesser portion of a total recovery should be allocated as reimbursement for medical expenses, instead of the amount of expended by Medicaid, or the amount calculated pursuant to the formula in section 409.910(11)(f).

35. Section 409.910(17)(b) provides:

> (b) If federal law limits the agency to reimbursement from the recovered medical expense damages, a recipient, or his or her legal representative, 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 designated as recovered medical expenses, the recipient must prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f). Alternatively, the recipient must prove by clear and convincing evidence that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

36. While section 409.910(17)(b) provides a burden of proof and the ultimate conclusion to be reached when challenging the amount of the Agency's lien, it does not provide the method by

which a Petitioner may establish that a lesser amount is more reasonable. Case law predating the hearing process in section 409.910(17)(b) provides the best guidance of what is required. The focus is not on a comparison of the percentage allocated for past medical expenses with a hypothetical "fair value" of the case, but rather on whether the lien amount exceeds the amount actually recovered for past medical expenses.[2/]

37. In recent years, there has been a lively debate in both state and federal courts, as well as at DOAH, regarding whether the federal anti-lien provisions allow for a Medicaid agency to recover funds designated for future medical expenses. In Florida, for example, Giraldo v. Agency for Health Care Administration, 208 So. 3d 244, 252 (Fla. 1st DCA 2016), held that a Medicaid lien could reach those sums contained in a settlement that were recovered for future medical expenses, as well as past medical expenses. The Second District disagreed in Willoughby v. Agency for Health Care Administration, 212 So. 3d 516, 523 (Fla. 2d DCA 2017), and held that Ahlborn and its progeny "are best read as limiting the recovery of the Medicaid lien to that portion of a settlement allocable to past medical expenses," and certified conflict with Giraldo. The Willoughby court noted that there was a split on this issue, but aligned itself with what it believed to be the better view. On September 6, 2017, the Florida Supreme Court accepted jurisdiction of Giraldo and dispensed with oral

argument. Giraldo v. Ag. for Health Care Admin., Case No. SC17-297.

38. Of more concern is the decision in Gallardo v. Dudek, Case No. 4:16-cv-116-MW-CAS, 2017 U.S. Dist. LEXIS 59848, *31 (N.D. Fla. Apr. 18, 2017).[3/] In that case, Judge Walker of the Northern District of Florida issued a Judgment that states, in part:

> It is declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses.
>
> It is also declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from requiring a Medicaid recipient to affirmatively disprove Florida Statutes § 409.190(17)(b)'s formula-based allocation with clear and convincing evidence to successfully challenge it where, as here, that allocation is arbitrary and there is no evidence that it is likely to yield reasonable results in the mine run of cases.

39. The reasoning for Judge Walker's decision can be found in his Order on Summary Judgment Motions, also issued April 18, 2017. After discussion of the anti-lien provisions in the federal law, as well as the decisions in Ahlborn and Wos, Judge Walker concluded that "federal law prohibits state agencies from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses.

Florida's statute is therefore preempted if and to the extent that it operates that way." Gallardo, at 17-18. The court also addressed Gallardo's argument that Florida's entire reimbursement statute conflicts with and is preempted by federal law, and stated, "[t]o the extent that Medicaid recipients must affirmatively disprove the arbitrary formula-based allocation with clear and convincing evidence to successfully overcome it, this Court agrees." Id. at 21. The court noted that in Wos, the United States Supreme Court determined that North Carolina's reimbursement statute created an irrebuttable, "one-size-fits-all statutory presumption" that a predetermined percentage of the recipient's recovery constitutes payment for medical care, particularly where the state has not provided evidence that such an allocation was reasonable in the mine run of cases and has no process for "determining whether [such an allocation] is a reasonable approximation in any case." 133 S.Ct. at 1398-99 (emphasis supplied).[4/]

40. Judge Walker found Florida's statutory scheme to be "quasi-irrebuttable," in part because of what he viewed as the arbitrary nature of the formula, but also because the burden of proof placed on the recipient is that of clear and convincing evidence. He stated in part:

> In so ruling, this Court wants to make itself absolutely clear. This Court is not saying that Florida may not enact a rebuttable,

> formula-based allocation to determine what portion of a judgment represents past medical expenses; in fact, the Supreme Court has suggested, without holding, just the opposite. . . . Nor is it saying that Florida may not shift the burden to Medicaid recipients to disprove that allocation; that issue is not before this Court, but it probably can. . . .
>
> And although this Court doesn't get to rewrite Florida's statute – and it doesn't endeavor to do so – it can say when a Florida statute runs afoul of federal law. . . . It does here. The reimbursement statute's clear and convincing burden – when coupled with a formula-based baseline wholly divorced from reality and a requirement that the recipient affirmatively disprove that baseline to successfully rebut it – is in direct conflict with the Medicaid statute's anti-lien and anti-recovery provisions. Thus, in this specific scenario, Florida's clear and convincing burden is preempted by federal law.

2017 U.S. Dist. LEXIS 59848, at *29-30.

41. AHCA filed a Motion to Alter or Amend the Judgment, which resulted in a lengthy Order Granting in Part and Denying in Part Motion to Alter or Amend Judgment, along with a Second Amended Judgment. Gallardo v. Senior, 2017 U.S. Dist. LEXIS 112448 (N.D. Fla. July 18, 2017) (the Second Order). The Second Order rejects the majority of AHCA's arguments because they should have been raised earlier. AHCA raised a standing argument which Judge Walker acknowledged was properly before him, but found it unconvincing.

42. AHCA challenged Gallardo's standing because AHCA does not enforce the challenged portions of section 409.910, as that task is reserved for DOAH. Judge Walker agreed that AHCA does not apply the clear and convincing burden, but determined that this fact was not determinative of Gallardo's standing. He stated:

> By no means did [the court] intend to enjoin AHCA from requiring a recipient to overcome the formula-based allocation with clear and [convincing] evidence for that recipient to be successful – that would be an exercise in futility. Rather, it simply meant to enjoin AHCA from seeking reimbursement for past medical expenses through portions of a recipient's recovery that represents future medical expenses either directly from the recipient or through DOAH. By extension, that also means AHCA cannot seek reimbursement based on the formula-based allocation when doing so would allow it to obtain more than that which it is entitled to. Those are both tasks that AHCA – which is responsible for administering Medicaid and asserting Medicaid liens – "ha[s] some connection with . . . ." Socialist Workers Party [v. Leahy, 145 F.3d 1240, 1248 (11 Cir. 1998)]. Therefore, AHCA is properly enjoined from "seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses." Gallardo, 2017 WL 1405166, at *11. (footnotes omitted)

2017 U.S. Dist. LEXIS 112448* at *16-17.

43. The court acknowledged that, with regards to the injunction's scope, the prior judgment was "not a model of clarity" and amended it to clarify that the injunction does not extend to the portion referencing the reimbursement statute's

clear and convincing burden. However, the next paragraph states that it was nonetheless proper to declare that section 409.910's clear and convincing burden is preempted by the federal Medicaid statute even though DOAH – not AHCA – applies that standard.[5/] The court determined that standing is appropriate where the redress is effectuated by an unnamed third party and the steps necessary to effectuate that redress are "purely mechanical," and it is substantially likely that the third party would abide by an authoritative interpretation, citing Utah v. Evans, 536 U.S. 452, 463-64 (2002). Judge Walker further stated:

> Similar to Evans, a declaration that the reimbursement statute's clear and convincing burden is preempted by federal law would also significantly increase the likelihood that Gallardo would obtain the redress she seeks. Of course, unlike the reimbursement portion of the prior judgment, this Court's declaration that the clear and convincing burden is preempted in this type of scenario would require additional steps to redress Gallardo's injury; namely, DOAH not requiring Gallardo to disprove the reimbursement statute's formula-based allocation with clear and convincing evidence in Gallardo's administrative proceeding. But that step is "purely mechanical." Id. at 463. What is more, though, is that DOAH – which is, in effect, a quasi-judicial body – is substantially likely to "abide by an authoritative interpretation[,] id., at 464, from this Court (and through AHCA) that it cannot apply such a burden. (footnote omitted).[6/]

Id. at 20.

44. The court stated that, even where the additional steps were not "purely mechanical," it would assume that DOAH will give full credence to its ruling. It then entered a Second Amended Judgment, which states in pertinent part:

> It is declared that the federal Medicaid Act prohibits the State of Florida Agency for Health Care Administration from seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses. The State of Florida Agency for Health Care Administration is therefore enjoined from doing just that: seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses.
>
> It is also declared that the federal Medicaid Act prohibits the State of Florida from requiring a Medicaid recipient to affirmatively disprove § 409.910(17)(b)'s formula-based allocation with clear and convincing evidence to successfully challenge it where, as here, that allocation is arbitrary and there is no evidence that it is likely to yield reasonable results in the mine run of cases.

Id. at 24.

45. Turning to the present case, the question becomes, where do we go from here? While the process and DOAH's role in light of the injunction is described as "purely mechanical" in the Second Order, the perspective of how the injunction affects the fact-finding function in these cases is a little different here on the garage floor. Indeed, one administrative law judge has determined that the injunction in Gallardo so eviscerates the formula in

section 409.910(11)(f) that it deprives DOAH of jurisdiction to go forward. See Smathers v. Ag. for Health Care Admin., Case No. 16-3590 (Fla. DOAH Sept. 13, 2017), a view the undersigned respects, but does not share.

46. First, Judge Walker's Second Order does not contemplate that it is depriving DOAH of jurisdiction. As noted above, the Second Order states in part, "this Court's declaration that the clear and convincing burden is preempted in this type of scenario would require additional steps to redress Gallardo's injury; namely, DOAH not requiring Gallardo to disprove the reimbursement statute's formula-based allocation with clear and convincing evidence in Gallardo's administrative proceeding. But that step is 'purely mechanical.'" Moreover, in the court's discussion of AHCA's standing argument, the court noted that declaratory relief, which it granted, was appropriate when a favorable ruling may result in a change in a party's legal status, and the practical consequence of that change would significantly increase the likelihood that the plaintiff would obtain relief from the injury suffered. To hold that there is no longer jurisdiction at DOAH does the opposite, and deprives a petitioner of any remedy at all.

47. Section 409.910(17)(b) provides that the hearing afforded to petitioners at DOAH is the "exclusive method for challenging the amount of third-party benefits payable to the agency." Until the Legislature revisits this issue, unless a

petitioner can proceed at DOAH, he or she would have no opportunity to protest the amount of the lien. To nullify the hearing opportunity afforded under section 409.910(17)(b) would run afoul of the holding in Wos, as well as the Florida decisions in Garcon, Smith, and Harrell. So while what remains of the process in light of Gallardo may be problematic, it is a puzzle that must be addressed.

48. First, the clear and convincing burden of proof can no longer be applied in this proceeding. Fortunately, section 120.57(1)(j) has a default provision regarding the burden of proof, and provides that "findings of fact shall be based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings or except as otherwise provided by statute." The Agency acknowledges the appropriateness of the preponderance of the evidence standard in its Proposed Final Order. A preponderance of the evidence is defined as "the greater weight of the evidence," or evidence that "more likely than not tends to prove a certain proposition." S. Fla. Water Mgmt. v. RLI Live Oak, LLC, 139 So. 3d 869, 871 (Fla. 2014).

49. Second, the impact of the injunction on this case depends on how closely aligned the facts of this case are to those presented in Gallardo. A comparison of the two cases shows some marked differences. First, in Gallardo, AHCA was clearly seeking to satisfy the lien amount from funds designated for both past and

future medical expenses. In this case, AHCA acknowledges in its Proposed Final Order that only the amount of proceeds allocable to past medical expenses is at issue here, and the settlement agreement only segregates the portion allocated for past medical expenses.

50. Third, in Gallardo, the funds expended by Medicaid exceeded the actual settlement amount, and the amount sought by AHCA to satisfy the lien was based on the percentage in the statutory formula. Here, the lien amount sought to be recovered is based upon the actual expenditure by Medicaid, not an artificial number created by section 409.910. While the percentage calculated under the formula may be considered arbitrary, the actual funds expended cannot be viewed in the same light. Moreover, while the Gallardo Order on Summary Judgment indicates that the settlement was approved by the court, it does not indicate that the settlement specifically identified what portion of the recovery represented past or future medical expenses. In this case, the settlement expressly states "Museguez is specifically recovering only twenty percent (20%) of their damages for past medical expenses." As noted in Smith, the formula need only come into play where there is no allocation in the settlement agreement.

51. Fourth, and perhaps most important, the court in Gallardo appears to take at face value Gallardo's estimation of

the value of Gallardo's claim, while in this case, the parties did not stipulate to the value of the underlying lawsuit, and Mr. Michaels' testimony that the fair value of the claim is more than the amount reflected in the settlement itself is rejected as not supported by competent, substantial evidence.

52. The settlement indicates that the parties to the original litigation agreed that "the One Million ($1,000,000) Dollar payment set forth above only represents twenty percent (20%) of the total injury/damage value of Museguez's claim." Mr. Michaels' testimony regarding the value of the claim, setting it at $13-15 million, was general in nature and by his own admission, he did not "parse out" the damages assumed to reach that amount. He did no jury research, but instead relied solely on his own past experience. He also recognized that in this case, there were significant questions regarding not only insurance coverage, but liability, and had informed the trial court that the settlement was fair to Mr. Museguez.[7/] The undersigned notes that, given that Mr. Museguez's injuries resulted from a lightning strike, bringing the case to completion may have been risky at best. Mr. Michaels' testimony regarding the value of the claim does not carry the same weight as the agreement of the parties reached in what he described as an arm's-length negotiation.

53. To be clear, while some administrative law judges have accepted the premise that the amount to be paid should be measured

by a percentage of the "fair value" of the claim, this one does not. In Willoughby, the court acknowledged the "total value" methodology method and stated:

> We do not condemn this approach; we recognize that ALJ's frequently resort to this methodology in calculating amounts available to satisfy Medicaid liens. But we also acknowledge that the U.S. Supreme Court has not explicitly endorsed this method. The Supreme Court "in no way adopted the formula as a required or sanctioned method to determine the medical expense portion of an overall settlement amount." Smith v. Agency for Health Care Admin., 24 So. 3d 590 So. 590, 591 (Fla. 5th DCA 2009).

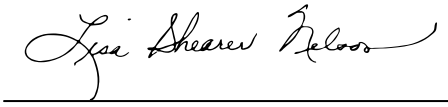
212 So. 3d at 522-23. To the contrary, Smith, Riley, and Harrell all hold that the purpose of a hearing is to establish, with evidence, that the lien amount exceeds the amount recovered for past medical expenses.

54. Here, Petitioner has demonstrated by a preponderance of the evidence that he recovered $1,000,000 pursuant to a settlement with his employer, well below what it will cost to care for him. The settlement expressly states that it represented only 20 percent of his total past medical expenses. Twenty percent of the Medicaid lien is $23,206.57. This amount equals, consistent with the holdings in Smith, Riley, and Harrell, the amount actually recovered for past medical expenses.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is ORDERED that the Agency is entitled to payment of $23,206.57 in satisfaction of its Medicaid lien.

DONE AND ORDERED this 19th day of September, 2017, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of September, 2017.

ENDNOTES

[1/] Petitioner cited the following cases in support of the claim that a pro rata share of the attorney's fees award should be borne by the Agency: Arex Indemnity Co. v. Radin, 72 So. 2d 393, 396 (Fla. 1954); Lewis v. W. Va. Dep't of Health & Hum. Res., 729 S.E. 2d 270, 304 (2012); and McKinney v. Phil. Hous. Auth., 2010 U.S. Dis. LEXIS 86773, p. 34 (E.D. Pa. 2010). Radin clearly predates section 409.910 and deals with the allocation of a workers' compensation award, and interprets a provision in section 440.39(3), Florida Statutes (1951). The provision in section 409.910 clearly contemplates a different resolution regarding attorney's fees than that contemplated in section 440.39(3). Lewis and McKinney are also tied to statutory provisions in their respective jurisdictions. Florida's statutory scheme addresses attorney's fees differently. Even if the full 40 percent were deducted instead of 25 percent, the

formula would still result in an amount higher than the actual amount paid by Medicaid as available to satisfy the lien. Either way, the formula essentially falls away, and the issue remains what part of the settlement was allocated for past medical expenses.

[2/] In McKinney v. Philadelphia Housing Authority, 2010 U.S. Dist. LEXIS 86773 (E.D. Pa. 2010), the court noted that the parties had stipulated to a method of calculating the percentage of the settlement constituting payment by the tortfeasor for past medical expenses. There is no such stipulation here, and as stated by the court in McKinney, "it does not follow that all other parties are bound to apply this calculation merely because the parties in one case agreed to use it. The Ahlborn court did not entrench the parties' method of calculation." The court went on to state:

> The second problem with Plaintiff's ratio theory is that it requires a judicial ascertainment of the platonic "true value" of Plaintiff's claims. At best, this would convert Ahlborn hearings into mini-trials, replete with competing damages experts and witnesses testifying as to issues like humiliation, pain and suffering, and loss of enjoyment of life. This would seriously undermine the economy of settlement. At worst, this would send judges on a quixotic intellectual journey in search of an illusory number.
>
> Aside from the logistical difficulties that Plaintiff's theory would produce, it also suffers from a logical failing. Why should one assume that simply because Plaintiff settled for a fraction of the supposed "true value" of their claim, that this fractional reduction applies uniformly across the various heads of damage? For example, a plaintiff's past medical expenses can more easily be proven to a jury than can a plaintiff's non-economic damages. Therefore, plaintiffs face less uncertainty regarding recovery of medical expenses and thus will be less willing during settlement talks to reduce their request for past

medical expenses than for other, more uncertain heads of damage.

[3/] During the pendency of the federal court litigation, Ms. Dudek stepped down as agency head for AHCA, and the current agency head was substituted in her place, changing the style of the case to Gallardo v. Senior. Curiously, despite the fact that the decisions in Giraldo, Willoughby, and Gallardo all resulted in a delay in the resolution of this case, and all three interpret section 409.910, Petitioner never mentions any of them in his Proposed Final Order. However, they cannot in good conscience be ignored.

[4/] Florida has the process that North Carolina did not. However, Judge Walker found the process outlined in section 409.910 to create "a rebuttable presumption that is nearly impossible to rebut."

[5/] DOAH was not a party to the Gallardo litigation.

[6/] The court cites in its footnote to Florida State University v. Hattan, 672 So. 2d 576, 579 (Fla. 1st DCA 1996), for the premise that DOAH hearing officers are quasi-judicial officers of a quasi-judicial forum. While the Second Order consistently refers to DOAH hearing officers, the designation was changed to administrative law judges over 20 years ago. § 31, Ch. 96-150, Laws of Fla.

[7/] Curiously, while Mr. Michaels testified that he had reviewed the settlement agreement as guardian ad litem to determine whether it was fair to Mr. Museguez, he was not asked and the Petitioner did not present any other evidence to demonstrate that the settlement was approved by the court. However, AHCA has not raised this issue, so it is inferred from Mr. Michaels' testimony that the settlement was, in fact, approved.

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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.