STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ANGELA MOJICA, A MINOR, BY AND
THROUGH HER MOTHER AND NATURAL
GUARDIAN, GLEXYS MOJICA,

Petitioner,

vs. Case No. 17-1966MTR

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Respondent.
_______________________________/

# FINAL ORDER

Pursuant to notice, a final hearing was held in this case via video teleconference with locations in Tallahassee and Orlando, Florida, on December 7, 2017, before Suzanne Van Wyk, a designated Administrative Law Judge of the Division of Administrative Hearings (DOAH).

## APPEARANCES

For Petitioner: Floyd B. Faglie, Esquire
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Monticello, Florida 32344

For Respondent: Elizabeth A. Teegen, Esquire
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## STATEMENT OF THE ISSUE

The amount of Petitioner's medical malpractice settlement payable to Respondent, Agency for Health Care Administration (AHCA), to satisfy AHCA's $322,048.83 Medicaid lien.

## PRELIMINARY STATEMENT

On March 29, 2017, Petitioner filed a Petition to Determine Amount Payable to Agency for Health Care Administration in Satisfaction of Medicaid Lien (Petition), pursuant to section 409.910(17)(b), Florida Statutes. On March 30, 2018, the matter was assigned to the undersigned. The matter was set for hearing to commence on June 8, 2017.

On April 18, 2017, the U.S. District Court for the Northern District of Florida entered a Judgment granting a Medicaid recipient declaratory and injunctive relief relative to AHCA's enforcement of section 409.910(17)(b) in Gallardo v. Dudek, 263 F. Supp. 3d 1247 (N.D. Fla. Apr. 18, 2017). The Gallardo court held that portions of section 409.910(17)(b) were preempted by federal law, enjoined Respondent from enforcing the statute in its current form, and declared invalid that statutory requirement that a petitioner disprove Respondent's formula-based allocation by clear and convincing evidence.

Respondent in the Gallardo case filed a Motion to Alter or Amend Judgment, and on May 15, 2017, Respondent in the instant case, filed a Motion to Stay Proceeding requesting this matter be

stayed pending final resolution of Gallardo. On May 23, 2017, the undersigned entered an Order Cancelling Hearing and Placing Case in Abeyance.

On July 18, 2017, the Gallardo court resolved all pending post-judgment motions and ordered entry of a Second Amended Judgment. See Gallardo v. Senior, 2017 U.S. Dist. LEXIS 112448 (N.D. Fla. July 18, 2017).

Following the issuance of the Second Amended Judgment, Petitioner filed a Motion to Lift Abeyance, which was granted and the final hearing in this matter was set for December 7, 2017.

The hearing proceeded as scheduled. Petitioner presented the testimony of Hector More and R. Vinson Barrett, both of whom are personal injury trial lawyers and who were accepted as experts in the valuation of damages of personal injury medical malpractice claims. Petitioner's Exhibits 1 through 12 were admitted in evidence.

Respondent presented the testimony of Jesse Suber, who is also a personal injury trial lawyer, and who was accepted as an expert in evaluating a personal injury case from a defense perspective, particularly the value of the settlement. Respondent did not introduce any exhibits.

The one-volume Transcript of the proceedings was filed with DOAH on January 29, 2018. The parties requested, and were granted, two extensions of time to file proposed final

orders, and filed their respective Proposed Final Orders on February 28, 2018.[1/] The parties' Proposed Final Orders were taken into consideration by the undersigned in the preparation of this Final Order.

## FINDINGS OF FACT

1. On November 14, 2013, Petitioner Angela Mojica (Petitioner), who was then eight years old, suffered catastrophic brain damage during a tonsillectomy. As a result of this permanent and catastrophic brain damage, Petitioner is unable to eat, speak, toilet, ambulate, or care for herself in any manner.

2. Petitioner's medical care related to the accident was paid by Medicaid. The Medicaid program through AHCA provided $322,048.83 in benefits. The Medicaid program through the Department of Health Children's Medical Services Title XIX MMA – Pedicare (DOH), provided $195,207.33 in benefits, and the Medicaid program through a Medicaid Managed Care Organization known as Amerigroup Community Care (Amerigroup) provided $77,821.29 in benefits.

3. As a condition of Petitioner's eligibility for Medicaid, Petitioner assigned to AHCA her right to recover from liable third parties' medical expenses paid by Medicaid. See 42 U.S.C. § 1396a(a)(25)(H) and § 409.910(6)(b), Fla. Stat.

4. Petitioner's mother, Glexys Mojica, brought a medical malpractice action against the hospital and medical staff responsible for Petitioner's care (Defendant medical providers) to recover all of Petitioner's damages, as well as her own individual damages associated with Petitioner's injuries.

5. During the pendency of Petitioner's medical malpractice action, AHCA was notified of the action and AHCA asserted a $322,048.83 Medicaid lien against Petitioner's cause of action and settlement of that action.

6. Petitioner's mother settled all her claims through a series of settlements with the Defendant medical providers totaling $8.8 million.[2/]

7. Petitioner's claims against the hospital were settled by execution of a "Settlement Agreement and Release" in the amount of $7 million.

8. The hospital release contains the following language:

> The parties agree that ANGELA MOJICA and her mother's alleged damages have a value in excess of $25,000,000, of which $595,077.45 represents ANGELA MOJICA's claim for past medical expenses. Given the facts, circumstances and nature of ANGELA MOJICA's injuries and this settlement, the parties have agreed to allocate $166,621.68 of this settlement to ANGELA MOJICA's claim for past medical expenses and allocate the remainder of the settlement towards the satisfaction of claims other than past medical expenses. This allocation is a reasonable and proportionate allocation based on the same ratio this settlement bears to the total

> monetary value of all ANGELA MOJICA and her mother's damages.

9. The hospital release contains no signature line for, and was not executed by, AHCA.

10. Petitioner's claims against the medical staff were resolved by Petitioner's mother's execution of a "Release of Claims" in the amount of $800,000 (medical practice release).

11. The medical practice release includes the following language:

> The undersigned specifically warrants and represents that at the time of the signing of this General Release, there are no liens or claims related to the treatment of Angela Mojica, from MEDICARE or MEDICAID . . . .
>
> To the extent that MEDICARE and MEDICAID may have paid medical expenses for or on behalf of injured party Angela Mojica, the undersigned warrants and represents that MEDICARE and MEDICAID have been notified of this settlement and that any claims or liens have been satisfied or in the alternative, MEDICARE or MEDICAID have waived said claims or liens, or in the alternative, MEDICARE and MEDICAID have given written consent and authorization for Releasor to enter into this settlement and sign this General Release.

12. The medical practice release contains no signature line for, and is not executed by, AHCA.

13. A third Defendant medical provider tendered his insurance policy in the amount of $1 million without requiring a release.

14. By letter of August 19, 2016, Petitioner's attorney notified AHCA of the settlement and provided AHCA with a copy of the executed Release, a copy of the Final Order Approving Settlement of Minor's Claim, and itemization of $84,480.85 in litigation costs. This letter explained that Petitioner's damages had a value in excess of $25 million and the settlement represented only a 35.2% recovery of Petitioner's $595,077.45 claim for past medical expenses. This letter requested AHCA to advise as to the amount AHCA would accept in satisfaction of its Medicaid lien.

15. AHCA, through the Medicaid program, spent $322,048.83 on behalf of Petitioner, all of which represents expenditures paid for Petitioner's past medical expenses.

16. Application of the formula at section 409.910(11)(f) to Petitioner's settlement requires payment to AHCA of the full $322,048.83 Medicaid lien.

17. The Petitioner has deposited the full Medicaid lien amount in an interest bearing account for the benefit of AHCA pending an administrative determination of AHCA's rights, and this constitutes "final agency action" for purposes of chapter 120, Florida Statutes, pursuant to section 409.910(17).

18. Petitioner underwent a routine tonsillectomy/adenoidectomy at a surgery center. During this surgical procedure, Petitioner suffered an arrest causing a lack

of oxygen to her brain and resulting in catastrophic brain damage. Prior to the incident, Petitioner was an eight year old who enjoyed life and was an excellent student. Subsequent to the accident, Petitioner is unable to speak, ambulate, and requires assistance in all aspects of daily life.

19. Petitioner's injury has had a devastating impact on Petitioner's mother, who had difficulty becoming pregnant with Petitioner. Petitioner's mother has suffered damages due to her daughter's requirement for round-the-clock assistance with every activity of daily living, her daughter's inability to communicate, as well as her daughter's inability to attend school and associate with friends.

20. Hector More represented Petitioner and her mother from the initial investigation to the final settlement of the medical malpractice claim. During his representation, he reviewed Petitioner's extensive medical records, met with her doctors, ordered and reviewed her Life Care Plan, reviewed the Economist Report, and met with Petitioner and her mother numerous times.

21. Petitioner's experts testified, convincingly, that her damages have a value far in excess of $25 million. Petitioner's Life Care Plan was prepared projecting Petitioner's future needs and providing an assessment that Petitioner would never be able to be gainfully employed.

22. Petitioner’s Life Care Plan was not introduced in evidence.

23. An economist reviewed Petitioner’s Life Care Plan and prepared an Economist Report calculating the present value of Petitioner’s future needs and lost earning capacity. The economist placed the present value of Petitioner’s future needs, lost earning capacity, and claim for past medical expenses at above $25 million.

24. Neither party introduced testimony documenting the specific cost projections establishing Petitioner’s economic damages, other than past medical expenses.

25. Petitioner’s non-economic damages have a value between $15 to $25 million. In arriving at his valuation of Petitioner’s non-economic damages, Mr. More compared Petitioner’s case to a similar case his firm handled where an eight year old with a brain injury was awarded $16 million in non-economic damages. Further, Mr. More reviewed the jury verdicts in Petitioner’s Exhibit 12, which he described as comparable to Petitioner’s case and supportive of his valuation of Petitioner’s non-economic damages. Mr. More consulted with other attorneys in his law firm and they agreed with his assessment of the value of Petitioner’s damages.

26. Mr. More’s valuation of Petitioner’s total damages at $25 million was conservative.

27. The $8.8 million settlement did not fully compensate Petitioner and her mother for the full value of their damages and in the settlement they only recovered a fraction of the total monetary value of their damages. Based on a valuation of all damages of $25 million, the $8.8 million settlement represented a recovery of 35.2% of the value of all damages.

28. Mr. More testified that because Petitioner and her mother recovered only 35.2% of the value of their damages, they recovered only 35.2% of each element of damages including only 35.2% of the $595,077.45 claim for past medical expenses, or $209,467.26.

29. Petitioner did not establish the value of any element of damages other than past medical expenses. The record does not support a finding of the individual value of Petitioner's damages for other economic damages (e.g., lost earning capacity, future medical expenses) or non-economic damages (e.g., pain and suffering, loss of consortium).

30. Mr. More outlined that if the case had gone to a jury verdict, and the jury had determined the value of all damages was $25 million with a line item of $595,077.45 for past medical expenses, but determined one of the Defendant medical providers was only 35.2% liable, that Defendant medical provider would only be liable for paying 35.2% of each line item of damage including only 35.2% of the claim for past medical expenses, or

$209,467.26. Mr. More testified that it would be reasonable to allocate $209,467.26 of the settlement to past medical expenses. He testified that because the allocation is based on a conservative valuation of all damages of $25 million, the allocation of $209,467.27 to past medical expenses is very conservative.

31. Because the record contains no valuation of the damages other than past medical expenses, there is no evidence of the recovery for "each line item of damage" other than past medical expenses. The record does not support a finding of how the remaining $8.5 million of the recovery was allocated among the other elements of damages.

32. The hospital, which tendered the majority of the settlement ($7 million), agreed to an allocation to past medical expenses as part of the settlement. The hospital agreed that Petitioner and her mother's damages had a value in excess of $25 million, of which $595,077.45 represented the claim for past medical expenses. The hospital agreed to allocate $116,621.68 of the settlement to past medical expenses because that $7 million settlement represented a 28% recovery of the $25 Million value of all damages. The hospital's allocation to past medical expenses was memorialized in the Release.

33. The remaining Defendant medical providers made no allocation from their settlements to any element of damages.

34. R. Vinson Barrett testified in support of Petitioner's allocation of damages. In support of Petitioner's method of allocation of the settlement, Mr. Barrett outlined that if a jury had determined the value of damages at $25 million, but found the Defendant medical providers were only 35.2% liable for these damages, the judge would award only 35.2% of each line item on the jury verdict form, including only 35.2% of the line item for past medical expenses. Mr. Barrett testified that method is "the method that I've seen in practice used and, really, the most accurate and fair method of doing it that I can think of." Mr. Barrett testified that allocation of $209,467.26 of the settlement to past medical expenses would be reasonable, rational, and conservative.

35. AHCA introduced the testimony of Jesse Suber, a medical malpractice attorney of some 30 years. Mr. Suber's testimony was that the settlement amount represents the value of the case "considering the limitations of liability, causation, the defendant's ability to pay, risk of trial, and other limiting factors." Mr. Suber did not provide an opinion of the value of Petitioner's damages.

36. Based on the methodology of applying the same ratio the settlement bore to the total monetary value of all the damages to the $595,077.45 claim for past medical expenses,

$209,467.26 of the settlement represents compensation for past medical expenses.

37. However, the methodology fails to establish the amount actually recovered by Petitioner for her past medical expenses. The testimony is insufficient to support a finding that the amount allocated to past medical expenses is the amount Petitioner recovered for past medical expenses. Without a breakout of the allocation of the settlement to other elements of damages, the undersigned cannot determine that the amount allocated to past medical expenses is reasonable.

38. The undersigned respects the experts' valuation of the total amount of Petitioner's damages, but is not persuaded by their conclusory testimony that the allocation of 35.2% of Petitioner's total payment for past medical expenses is reasonable. The only other evidence supporting the reasonableness of that allocation was the agreement between Petitioner and the hospital in the Release of claims that the allocation of $166,621.68 of the settlement to Petitioner's claim for past medical expenses was reasonable. The hospital had no interest in the allocation of portions of the settlement to any specific element of damages. The only advantage of that clause in the settlement was to afford Petitioner's retainer of more of the settlement amount.

39. Following Petitioner's theory out to its logical conclusion, Petitioner would have received only 35.2%, or $6.8 million, of her $19.4 million claim for non-economic damages; leaving roughly $1.7 million of the settlement allocable to Petitioner's other economic damages, including future medical care and lost earning potential. $1.7 million is 35.2% of roughly $5 million. Under Petitioner's theory of allocating damages, the value of Petitioner's economic damages would have been around $5 million.

40. Given the expert testimony of the extent of Petitioner's injuries, her need for round-the-clock assistance with all activities of daily living, the costs of future doctor visits, attendant care, and other considerations factored into Petitioner's Life Care Plan, it is not reasonable that Petitioner's economic damages (other than past medical expenses) would have been valued at a mere $5 million. In fact, this flies in the face of the economist's determination, based on the Life Care Plan, that the present value of Petitioner's economic damages was in excess of $25 million. This exposes the flaw in Petitioner's method of allocating damages.[3/]

41. Petitioner did not prove that allocation of $209,467.26 to Petitioner's past medical expenses was reasonable.

42. Petitioner did not prove that the portion of the total amount of recovery which should be allocated to past medical expenses is less than AHCA's Medicaid lien of $322,048.83.

CONCLUSIONS OF LAW

43. DOAH 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.

44. AHCA is the agency authorized to administer Florida's Medicaid program.

45. 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 requirement of the program. Id.

46. 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).

47. In an effort to comply with this federal requirement, the Florida Legislature has 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).

48. 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, as follows:

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

49. As stipulated by the parties, if payment was made under the formula, AHCA would be reimbursed the full $322,048.38 Medicaid lien. The issue then becomes whether a lesser amount than the amount actually expended should be recovered by AHCA.

50. Section 409.910(1) 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 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 . . . . 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.

51. 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.").

52. 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.").

53. There are restrictions on AHCA's ability to recoup its expenditures on Petitioner's behalf. AHCA 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 court 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 AHCA. The purpose of a hearing is to establish, with evidence, that the lien amount exceeds the amount recovered for medical expense. The court stated:

> Ahlborn and Wos [v. E.M.A. ex rel Johnson, 133 S.Ct. 1391, 185 L.Ed. 2d 471 (2013)] make it 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 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 524, 526 (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 added); see also Harrell v. State, 143 So. 3d 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 formulas 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.

54. 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 expended by Medicaid, or the amount calculated pursuant to the formula in 409.910(11)(f).

55. Section 409.910(17)(b) provides, in pertinent part, as follows:

> (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 [DOAH]. 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 [DOAH]. 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).

56. While 409.910(17)(b) provides a burden of proof and the ultimate conclusion to be reached when challenging the amount of AHCA'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, but rather on whether the lien amount exceeds the amount actually recovered for past medical expenses.[4/]

57. In recent years, there has been a lively debate in both state and federal courts, as well as at DOAH, regarding whether the 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.

58. Of more concern is the decision in Gallardo v. Dudek, 263 F. Supp. 3d 1247 (N.D. Fla. 2017). In that case, Judge Walker 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.

59. 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 the 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 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.[5/]

60. 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.

263 F. Supp. 3d at 1260.

61. 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.

62. 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.

63. The court acknowledged that, with regard 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. 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.

64. 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.

65. 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.

66. 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." 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. Dist. v. RLI Live Oak, LLC, 139 So. 3d 869, 871 (Fla. 2014).

67. 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, 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 does not exceed the settlement amount. Moreover, the lien 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.

68. Third, 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 "the parties have agreed to allocate $166,621.68 of this settlement to [Petitioner's] claim for past medical expenses," although it does not specifically allocate any amount to compensation for future medical expenses. As noted in Smith, the formula need only come into play where there is no allocation in the settlement agreement.

69. Further, in Gallardo, AHCA was clearly seeking to satisfy the lien amount from funds designated for both past and future medical expenses. While the settlement in the case at hand does allocate a specific amount to past medical expenses, it does not specify what amount is allocated to future medical

expenses, as opposed to other economic damages and non-economic damages. According to Petitioner's theory (reducing each element of damages by the same percentage that the settlement represents as a ratio of the overall value), AHCA's claim for satisfaction of its $322,048.83 lien amount is by necessity to be satisfied from some portion of the settlement other than the amount of $166,621.68 allocated for past medical expenses. Because the remainder of the settlement is unallocated, the evidence does not support a finding, as in Gallardo, that AHCA seeks payment from portions allocated to future medical expenses.

70. 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. Here, AHCA does not agree to either the valuation of Petitioner's underlying personal injury claim or to Petitioner's theory of reducing the amount recovered for past medical expenses by the same ratio as the percentage the settlement amount represents to the total valuation of Petitioner's underlying claim. AHCA's theory is that the settlement amount of $8.8 million is the best valuation of the underlying claim, because it takes into consideration the risks associated with litigation: issues of liability and causation, how the plaintiff and defendant will be perceived by the jury, the plaintiff's financial hardship, insurance policy limits, and

the defendants' ability to pay. Under AHCA's theory of the case, Petitioner recovered the full value of the damages; thus the full amount of the past medical expenses should be used to repay the lien.

71. Many administrative law judges, including the undersigned, have previously accepted the premise that the amount to be paid should be measured by a percentage of the "fair value" of the claim. 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.

72. The amount of a settlement allocated to past medical expenses does not necessarily equate to the amount recovered for past medical expenses. See Agras v. Ag. for Health Care Admin., DOAH Case No. 14-2403 (Fla. DOAH Oct. 30, 2014)(finding an

allocation to past medical expenses in a particular settlement "self-serving" and a deliberate attempt to limit the amount allocated to past medical expenses in order to preserve the majority of settlement proceeds for the Petitioner). The difficulty of proving the amount allocated to past medical expenses is the amount recovered for past medical expenses is exacerbated in cases where, as here, the settlement is otherwise undifferentiated.

73. In the underlying settlement, Petitioner and Defendants agreed to allocate $166,621.68 of the settlement to Petitioner's claim for past medical expenses and "the remainder . . . towards the satisfaction of claims other than past medical expenses." Further, the parties agreed that the allocation was a "reasonable and proportionate allocation based on the same ratio this settlement bears to the total monetary value of all [Petitioner's] and her mother's damages."

74. AHCA did not join in the settlement and release and is not bound by the allocation to past medical expenses contained therein. See § 409.910(13), Fla. Stat.

75. In Wos, the Supreme Court addressed the difficulty of allocating undifferentiated settlements:

> A question the Court had no occasion to resolve in Ahlborn is how to determine what portion of a settlement represents payment for medical care. The parties in that case stipulated that about 6 percent of

> respondent Ahlborn's tort recovery (approximately $35,600 of a $550,000 settlement) represented compensation for medical care. Id., at 274, 126 S. Ct. 1752. The Court nonetheless anticipated the concern that some settlements would not include an itemized allocation. It also recognized the possibility that Medicaid beneficiaries and tortfeasors might collaborate to allocate an artificially low portion of a settlement to medical expenses.

Wos v. E.M.A., 133 S.Ct. 1391, 568 U.S. 627, 634 (emphasis added).

76. Petitioner argues that, based on a total value of the underlying claim "in excess of $25 million," Petitioner recovered only 35.2% of her damages in the $8.8 million settlement. Thus, Petitioner argues that it is fair and reasonable to award only 35.2% of Petitioner's claim for past medical expenses to providers of that medical care.

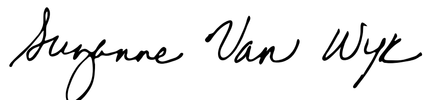
77. Here, Petitioner has not proven that AHCA should be reimbursed at a lesser amount than its full lien for past medical care provided by Medicaid. The evidence supports a finding that the amount expended for past medical care does not exceed the total amount recovered, nor does reimbursement of the full amount of the lien require use of funds allocated for Petitioner's future medical care. Petitioner's "allocation" of 35.2% of her claim for past medical expenses as the amount "recovered for past medical expenses" is rejected as unreasonable.

## ORDER

Upon consideration of the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that:

The amount of Petitioner's settlement payable to the Agency for Health Care Administration in satisfaction of its Medicaid lien is $322,048.83.

DONE AND ORDERED this 20th day of April, 2018, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of April, 2018.

## ENDNOTES

[1/] Because the parties agreed to a deadline for filing proposed final orders more than 10 days after the Transcript was filed, the parties waived the requirement that the undersigned issue a final order within 30 days after the Transcript was filed. See Fla. Admin. Code R. 28-106.216.

[2/] The medical malpractice action sought damages on behalf of both Petitioner and her mother. The $8.8 million settlement compensated Petitioner and her mother for their individual claims for damage. While some portion of this $8.8 million settlement rightfully belongs to Petitioner's mother as

compensation for her loss, the Petitioner in this proceeding did not make a sub-allocation of the settlement to the mother for her damages.

[3/] The undersigned is not suggesting that petitioners in Medicaid Third Party Reimbursement cases change their strategy by proving a "less conservative" value of total damages. The undersigned recognizes the length to which the petitioners in these cases have gone to estimate a "conservative" value of damages in order to avoid further diminishing the amount of past medical expenses would be recovered under this theory. It is just that extraordinary effort on behalf of the petitioners which, in part, leads the undersigned to conclude that the theory is flawed. For example, the testimony in this case was that the total value of economic damages was "well in excess of $25 million," excluding past medical expenses, and the total value of non-economic damages was around $19 million. Thus, it is difficult to find now the petitioner proved a total value of $25 million. The adjective "arbitrary" or "convenient" seems more appropriate than "conservative."

[4/] 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.

[5/] Florida has a 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."

[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.

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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.