STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

JONATHAN CRUZ,

Petitioner,

vs.

Case No. 19-6423MTR

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

This case came before Administrative Law Judge ("ALJ") John G. Van Laningham, Division of Administrative Hearings ("DOAH"), for final hearing by video teleconference on March 3, 2020, at sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Jason Dean Lazarus, Esquire
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For Respondent: Alexander R. Boler, Esquire
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STATEMENT OF THE ISSUES

The issues for determination are, first, whether a lesser portion of Petitioner's total recovery from a third-party tortfeasor should be designated as recovered medical expenses than the share presumed by statute; if so,

then the amount of Petitioner's recovery to which Respondent's Medicaid lien may attach must be determined.

PRELIMINARY STATEMENT

Petitioner Jonathan Cruz ("Cruz") settled a personal injury action for $300,000. Respondent Agency for Health Care Administration (the "Agency") asserted its intent to enforce a Medicaid lien in the amount of $111,078.65 against Cruz's recovery. The Agency relies, as is its right, on the formula set forth in section 409.910(11)(f), Florida Statutes, to determine that portion of the settlement which should be allocated as past medical expense damages.

Cruz objected to this presumptive allocation of the recovery, and, on December 5, 2019, he timely filed a petition with DOAH to contest the default amount designated by statute as recovered medical expense damages payable to the Agency.

On February 24, 2020, the parties filed a Joint Pre-hearing Stipulation, which contains a statement of facts that "are admitted and will require no proof at hearing." As a result, most, if not all, of the material historical facts of this case are undisputed.

At the final hearing, which took place as scheduled on March 3, 2020, with both parties present, Cruz testified on his own behalf, and he called trial attorneys Paul J. Layne and Guillermo Tabraue III as additional witnesses. Petitioner's Exhibits 1 through 6 were received in evidence without objection. The Agency rested without offering any evidence.

The final hearing transcript was filed on April 1, 2020. The parties timely filed proposed final orders, which have been considered.

Unless otherwise indicated, citations to the official statute law of the state of Florida refer to Florida Statutes 2019.

FINDINGS OF FACT

1. On June 17, 2018, Cruz, then age 28, went boating in Biscayne Bay, near Elliott Key. The boat belonged to Cruz's cousin, Victor Fonseca ("Fonseca"), who operated the vessel at all relevant times. Others were with them.

2. At some point during this outing, Fonseca's boat became stuck on a sandbar. Cruz, who was in the water, got close to the boat's engines, apparently intending to attempt to free the boat. As he did so, Fonseca, who knew or should have known of Cruz's whereabouts, engaged the engines. Cruz's clothes became caught in a moving propeller, which dragged him in. The result, predictably, was catastrophic, as the fast-spinning propeller chopped into Cruz's lower body, causing severe injuries.

3. The medical records describe Cruz's injuries as including extensive trauma to all muscles of the right thigh and left gluteal muscles, multiple significant fractures of bones in the right leg, a right thigh degloving injury, and a severe rectal injury, which required the surgical removal of his anal sphincter. Post injury, Cruz developed RLE compartment syndrome and underwent a fasciotomy. He suffered an acute pulmonary embolism for which an IVC filter was placed. He underwent multiple surgical debridements and closure procedures. An end-colostomy was also laced. He underwent eternal fixation of his femur fracture. Cruz remained in the hospital for more than one year.

4. The foregoing clinical description is amplified by emergency room photographs, which vividly depict the bodily destruction that the propeller caused. The words "gruesome" and "horrific," or others to that effect, come to mind when viewing these pictures. It is undisputed that Cruz's devastating injuries are disfiguring, permanently disabling, and chronically painful.

5. As a result of this accident, Cruz will require medical treatment for the rest of his life. He must use a wheelchair or walker to move about and has been fitted with orthotic devices. Cruz is unable to care for himself and depends upon others to assist him in all activities of daily living.

6. Before his injury, Cruz was employed as a heating, ventilation, and air conditioning ("HVAC") technician. He will not be able to resume working in this field, and, indeed, Cruz is unlikely ever to work again.

7. As mentioned, Cruz experiences chronic pain from his injuries, and he is unable to sit normally for extended periods without discomfort, due to the absence of gluteal muscles. His right thigh now consists, essentially, of skin-wrapped bone, because the muscle and connective tissue are gone. Not surprisingly, Cruz has suffered, and continues to suffer, adverse emotional effects, including depression.

8. Cruz's family suffers as well. He and his wife have two children, twins, who were three years old at the time of the accident. As a husband and father of young children, Cruz is no longer able to provide the same level of support and companionship to his family as before becoming disabled.

9. Cruz brought a personal injury lawsuit against Fonseca, the person whose negligence seems likely to have been the sole proximate cause of the accident. (There is no evidence of, nor any reason to infer, the involvement of a defective product or joint tortfeasor. Likewise, there is no persuasive evidence that Cruz's own negligence contributed to causing the accident.)

10. Unfortunately for Cruz, Fonseca was practically judgment proof. He had no assets upon which to levy and could discharge any judgment in bankruptcy. Fonseca's homeowner's policy, having limits of $300,000, was woefully inadequate to satisfy Cruz's damages, and the insurer initially denied coverage and refused to pay even this relatively scanty sum (as compared to Cruz's enormous loss) because Fonseca, allegedly, had failed properly to declare his ownership of the boat.

11. Eventually, the insurer tendered its policy limits pursuant to a confidential and complete settlement of Cruz's claims and the derivative claims of his wife and children for loss of consortium, which the parties entered into on October 17, 2019. Of the $300,000 in insurance proceeds, which were not differentiated between claims or items of damages, the sum of $220,210.98 ("Gross Recovery") was allocated, by Cruz's attorney, to the settlement of Cruz's cause(s) of action. The balance was allocated to the derivative claims of Cruz's wife and children. Cruz's Gross Recovery will be further reduced by attorney's fees in the amount of $44,934.20 and costs totaling $2,842.70, leaving him a Net Recovery of $172,434.08.

12. As mentioned, the recovery was an undifferentiated lump sum. It would be reasonable to infer that the defendant (and his carrier) had little or no interest in negotiating the manner of the plaintiffs' distribution, between themselves, of the $300,000 settlement. There is no evidence of such bargaining, in any event. Consequently, an allocation of the recovery needed to be made, on the plaintiffs' side, between the four injured parties (Cruz, his wife, and two children), each of whom had discrete losses for which Fonseca was liable.

13. This is how the Gross Recovery wound up being exactly equal to the amount of medical assistance expenditures made on Cruz's behalf by Medicaid. Cruz's attorney testified that he had divided the $300,000 this way to give Cruz's family members some recovery, albeit a small one, on their consortium claims. Since any allocation of the very limited, and arbitrarily capped, recovery of $300,000 between Cruz, on the one hand, and his family members, on the other, would necessarily be, at best, only very loosely related to the intrinsic value of each injured person's individual claims; and because the Agency presented no evidence supporting an allocation that would have been as or more reasonable, the undersigned finds, based on the uncontested testimony of Cruz's attorney, that setting aside approximately three-quarters

of the insurance proceeds for the Gross Recovery, to match the Medicaid payments, was a reasonable and rational decision under the circumstances.

14. The Agency was properly notified of Cruz's personal injury action, and it informed the parties that medical assistance expenditures totaling $220,210.98 had been paid by Medicaid on Cruz's behalf. The Agency asserted a lien for the reduced amount of $111,078.65 against Cruz's settlement proceeds, pursuant to the formula found in section 409.910(11)(f).

15. In their Joint Pre-hearing Stipulation, the parties stipulated to certain facts "which are admitted and require no proof at hearing," including that the "application of the formula in [section] 409.910(11)(f) requires Mr. Cruz to pay back Medicaid $111,078.65 on its $220,210.98 lien … ." Given that Cruz's litigation costs totaled $2,842.70, it is mathematically indisputable, based on the section 409.910(11)(f) equation, that the parties used the sum of $300,000 as Cruz's gross settlement recovery.[1] Therefore, although the evidence shows that Cruz's Gross Recovery was, in fact, $220,210.98, his gross "Stipulated Recovery" is $300,000.[2]

16. The Medicaid payments for Cruz's immediate, post-injury care comprise the lion's share of his past medical expenses, there being, in addition, only the negligible sum of approximately $2,000, which was paid to the University of Miami Medical Group ("UMMG"). Thus, it is reasonable to treat the Medicaid payments of $220,210.98 as Cruz's past medical expense damages, as Cruz has done without the Agency's objection, for simplicity's sake.[3] There is no dispute that, under the anti-lien provision in the federal

[1] $[(300{,}000 \times 0.75) - 2{,}842.70)] \div 2 = 111{,}078.65$.

[2] Had the Gross Recovery, rather than the Stipulated Recovery, been used as the value of the settlement for purposes of computing the default allocation under section 409.910(11)(f), the Agency's statutory lien would have been reduced further, to $81,157.77.

[3] Any difference, mathematically, in the lien amount which would result from adding in the UMMG payment is de minimus, in any event.

Medicaid statute, the Agency's lien attaches only to the portion of Cruz's recovery attributable to past medical expenses.

17. The ultimate question presented is whether the Agency's default distribution, in the stipulated amount of $111,078.65, reflects "the portion of the total recovery which should be allocated"[4] to Cruz's recovery of past medical damages, or whether a lesser sum, from the total settlement, "should be allocated" to the recovery of past medical damages. It is Cruz's burden to prove that the statutory allocation is greater than the amount which "should be" distributed to the Agency, and that the Agency's default lien amount "should be" adjusted to better reflect the portion of his total recovery attributable to past medical expenses. For purposes of determining the portion of the "total recovery" that "should be allocated" to past medical expense damages, the undersigned will use the Stipulated Recovery as the value of the "total recovery," even though that figure is greater than Cruz's actual Gross Recovery, because the parties stipulated to a "total recovery" value of $300,000.

18. To meet his burden, Cruz presented evidence at hearing, as is now typically done in cases such as this, with the goal of establishing the "true value" of his damages. Usually, and again as here, this evidence comes in the form of opinion testimony, from a trial attorney who specializes in personal injury law and represents plaintiffs in negligence actions. Cruz called two experienced plaintiff's personal injury lawyers, one of whom is also a medical doctor, to give opinions on the valuation of his damages. The undersigned finds their opinions in this regard to be credible and persuasive. Moreover, the Agency did not offer any evidence to challenge Cruz's valuation; no expert testimony was given, for example, by an attorney specializing in personal injury defense, which might have provided a different perspective on the value of Cruz's case. Having no evidential basis for discounting or

[4] *See* § 409.910(17)(b), Fla. Stat.

disregarding the opinions of Cruz's expert witnesses, the undersigned bases the findings on valuation that follow upon their unchallenged testimony.

19. Cruz is requesting—and his expert witnesses opined that—the Medicaid lien should be adjusted according to a method that will be referred to herein as a "proportional reduction." A proportional reduction adjusts the lien so that the Agency's recovery is discounted in the same measure as the plaintiff's recovery. In other words, if the plaintiff recovered 25% of the "true value" of his damages, then, under a proportional reduction, the Medicaid lien is adjusted so that the Agency recovers 25% of the medical assistance expenditures.

20. The mathematical operation behind a basic proportional reduction is simple and requires no expertise. Using "***r***" to signify the plaintiff's recovery; "***v***" to represent the "value" of his damages; "***m***" for medical assistance expenditures; and "***x***" as the variable for the adjusted lien amount, the equation is: $(\boldsymbol{r} \div \boldsymbol{v}) \times \boldsymbol{m} = \boldsymbol{x}$. In these cases, the only unknown number (usually) is ***v***," i.e., the "value" of the plaintiff's total damages.

21. "True value," sometimes also called "full value" or "total value," is an elusive concept, given that the *true* value of damages which have not been liquidated by a judgment is not, and cannot be, known in a case that settles before the entry of a judgment. For purposes of this discussion, the undersigned will hereafter use the term "true value" to mean liquidated damages, i.e., damages reduced to judgment.

22. To be clear, this is not how Cruz's expert witnesses used the term. They used the term to refer to the amount that, had the personal injury case been tried to conclusion, Cruz's attorneys would have "boarded" for the jury at trial and argued, in closing, that the jury should award the plaintiff for his total damages. For purposes of this discussion, the undersigned will use the term "plaintiff's best-case value," or "PBCv" for short, instead of "true value," to refer to the amount that the plaintiff would have requested at trial in closing argument.

23. Naturally, where there is a PBCv, there is also a "defendant's best-case value," or "DBCv." In a jury trial, DBCv might well be $0, if the defendant is contesting liability, and it will nearly always be, in any event, less than PBCv. As mentioned above, the Agency chose not to present expert witness testimony as to DBCv, or any value.

24. There are other constructs that might be considered in regard to value, such as, for example, the "fair market value" of the plaintiff's case, or "MKTv" for short. As the undersigned will use the term herein, MKTv means the theoretical amount upon which the plaintiff and a solvent defendant, negotiating at arm's length and without the constraint of an arbitrary financial cap on the defendant's ability to pay, such as insurance policy limits or sovereign immunity, would agree to settle the case. MKTv reflects the strengths and weakness of the plaintiff's case, both legal and factual, the strengths and weaknesses of the defendant's case, both legal and factual, and all of the other considerations and motives driving the parties to reach a settlement agreement, except the defendant's ability to pay. Generally speaking, MKTv should be a number greater than DBCv and less than PBCv. A plaintiff who has settled for MKTv effectively has made a full recovery.

25. As the undersigned is using the term, MKTv is similar, but not identical, to the term "settlement value" as described in *Mojica v. State, Agency for Health Care Administration*, 285 So. 3d 393, 395 (Fla. 1st DCA 2019), which is yet another value construct. "Settlement value," in the *Mojica* sense, which is how the undersigned will use the term herein, takes into account, among other factors, the "defendant's ability to pay." *Id*. Because a personal injury plaintiff does not have the option of negotiating with someone other than the potentially liable defendant to get a better deal, however, the "defendant's ability to pay" does not seem like an appropriate factor to consider in establishing the MKTv of the plaintiff's case. Put differently, while a settlement for MKTv can fairly be considered a full recovery, a settlement for "settlement value" would arguably not be a full recovery, if the

plaintiff were required to accept a settlement discount attributable, in part, to the defendant's ability to pay. This distinction makes no difference in this case, because Cruz did not recover even the "settlement value" of his case; he had no alternative but to accept the defendant's limited insurance coverage as payment in full. In other words, in Cruz's situation, the defendant's ability to pay was not merely *a* factor in determining settlement value, it was the *only* factor.

26. Cruz's recovery, thus, was arbitrarily capped at $300,000, the coverage limit of the defendant's only available insurance policy. For purposes of this discussion, the undersigned will refer to a settlement such as Cruz's as an "arbitrary discount settlement." An arbitrary discount settlement is "arbitrary" in the sense that the amount of the settlement bears no relationship to MKTv; the plaintiff is simply forced to accept what is, for him, a random haircut owing to a hard limit on the defendant's ability to pay, which has nothing to do with the plaintiff's damages or the defendant's liability therefor.[5]

27. The uncontested and unimpeached expert testimony in this case establishes, by any standard of proof, that Cruz's PBCv is no less than $6 million, which is the conservative figure presented by Cruz's witnesses. The undersigned, frankly, would not have hesitated to find that Cruz's noneconomic damages for past and future pain and suffering, *alone*, should be valued at $6 million, at a minimum, given the severity of the bodily destruction involved here.

28. With respect to the economic damages of lost earning capacity and future medical expenses, Cruz's evidence persuasively established significant losses, albeit without exactitude. Before his accident, Cruz had been earning

[5] The amount of an arbitrary discount settlement should ordinarily be less than the settlement value of the plaintiff's case, because the defendant's limited ability to pay is the *only* relevant factor in determining the amount of an arbitrary discount settlement, whereas settlement value takes other factors into account, including but not limited to the defendant's ability to pay.

approximately $20 per hour as an HVAC technician. Assuming he were able to work full time at the same rate, without a raise, for the next 35 years, his wages would total $1.4 million, more or less. A sophisticated economic analysis would take into account wage growth over time, and it would discount future earnings to present value. As Cruz's lawyers testified at hearing, however, money was simply not available, given Fonseca's extremely limited insurance for Cruz's substantial losses, to justify the expense of hiring an economist to perform such an analysis. The undersigned finds that the evidence is sufficient to prove that the present value of Cruz's lost wages is at least $1 million, conservatively calculated, in view of the relatively young age (28) at which this previously fit working man became permanently disabled. Specificity in this regard is unnecessary in any event, because Cruz's pain and suffering damages are easily $6 million.

29. Similarly, Cruz's evidence proves that he will incur future medical expenses "over six figures." There is no genuine dispute about this, the Agency having offered no evidence to the contrary. It is undisputed that Cruz will require ongoing medical care, for the rest of his life, to treat complications arising from his severe injuries. To take just one example, the evidence shows that Cruz has yet to undergo a final surgical repair of his rectum. To be sure, in an ideal case, Cruz would have presented a life care plan developed by a suitable expert, cataloguing his future medical needs and estimated expenses, aggregated to a specific dollar amount, reduced to present value, and calculated to a reasonable degree of economic certainty. Unfortunately, paying such an expert for this kind of analysis would further have reduced Cruz's already limited Net Recovery. The undersigned cannot fault Cruz's attorneys for electing to forego such an expense, especially since, again, specificity in regard to future medical damages is unnecessary because Cruz's noneconomic losses, without more, meet or exceed $6 million.

30. Once Cruz made a prima facie showing of PBCv by adducing competent substantial evidence thereof, the Agency, if it wanted to prove that

the PBCv in question, $6 million, is an inflated figure, needed to adduce some evidence that would have given the fact-finder an evidentiary basis for discounting or rejecting this value.[6] Here, the Agency elected not to present evidence of value, but instead it chose to argue that Cruz has failed to prove that the particular medical-expense allocation he advocates should be made, and that, as a result, the default, statutory allocation should be made.

31. As far as the evidence goes, therefore, the undersigned has no reasonable basis for rejecting the value of $6 million that Cruz's witnesses testified was a conservative appraisal of Cruz's total damages. Fonseca's negligence was likely the sole proximate cause of the accident; there are, accordingly, no obvious weaknesses in Cruz's case from the standpoint of establishing liability. Cruz testified ably in this proceeding and likely would have proved an excellent witness in the personal injury action, had it gone to trial. The ghastly nature of Cruz's injuries, and Fonseca's rather obvious liability for those injuries, likely would have resulted in a substantial plaintiff's verdict, likely not less than $6 million, as the evidence persuasively shows.

32. The undersigned finds, based on the unrebutted and unimpeached expert testimony adduced, that a proportional reduction methodology identifies the "portion of the total recovery which should be allocated" in this

[6] To be clear, the undersigned is not shifting the burden of proof to the Agency. A petitioner, however, does not have the *initial* burden of putting on the personal injury *defense* case, in order to prove DBCv, nor does the petitioner have the initial burden of establishing matters, such as comparative negligence, which the defense might have relied upon in an arms-length negotiation to settle the case for value. Defense arguments are matters that the Agency may address in its case, if it wants to show that PBCv is inflated. But the Agency is not *required* to put on any such evidence. The Agency is free to present no evidence, rely solely on cross-examination of the petitioner's witnesses to undermine the testimony elicited by the petitioner on direct, and then argue that the petitioner has failed to meet his burden of proof—as the Agency has done in this case. If the Agency takes this approach, however, it loses the opportunity affirmatively to prove that PBCv is too high, and it risks a finding that the unrebutted evidence of PBCv is a fair reflection of value. If, however, the Agency presents evidence of DBCv, MKTv, settlement value, or some alternative value, then the petitioner must rebut the evidence and try to overcome it, for the petitioner bears the ultimate burden of persuasion with regard to establishing the value of the petitioner's damages.

case as past medical expense damages. The undersigned considers Cruz's unchallenged proof of PBCv sufficient to establish the probable "value" of his case, i.e., ***v*** in the proportional reduction formula, where, as here, such evidence, in addition to being unchallenged and unimpeached, is otherwise persuasive to the fact-finder.

33. Although the use of a proportional reduction to determine the portion of the total recovery that "should be allocated" to past medical expenses is justified by the competent substantial evidence presented in this case, it is found that Cruz has advocated using an incorrect *value* in the proportional reduction formula. Cruz would apply the following values to the variables in the equation: ***r*** = $300,000; ***v*** = $6 million; and ***m*** = *$111,078.65*. Using these numbers results in a value of $5,553.93 for ***x***, which is the amount of his recovery Cruz would allocate to past medical expense damages and thereby expose to the Medicaid lien.

34. It is incorrect, however, to use the sum of $111,078.65 as the value for ***m***, as Cruz urges. This figure is the amount produced by the statutory formula, which reduces the Agency's recovery of actual Medicaid expenditures, by default. To use this figure in the proportional reduction formula would impose a *double* reduction on the Agency—an obvious injustice. The correct number for ***m*** is $220,210.98, the amount that Medicaid actually expended on Cruz's behalf, without reduction.

35. The undersigned finds, based on the evidence presented, including the stipulation as to Cruz's total settlement recovery, that the correct values for the variables in the proportional reduction equation are: ***r*** = $300,000; ***v*** = $6 million; and ***m*** = $220,210.98. Using these numbers, the value of ***x*** is $11,010.55—or, 5% of $220,210.98.[7]

[7] The ratio of 300,000 to 6,000,000 is 0.05.

36. Because the unchallenged expert testimony persuasively shows that a proportional reduction is the appropriate method of adjusting the lien in this case; and because Cruz's mistaken use of $111,078.65 as the value of ***m*** does not undermine the validity of the *methodology*, which is merely the mathematical expression of an analytical framework whose existence and underlying logic are independent of any specific values for ***r***, ***v***, ***m***, and ***x***, the undersigned does not believe that he must "throw out the baby with the bathwater" and make *no* lien adjustment simply because Cruz used the wrong value for ***m***. This mistake may easily be corrected based on the evidence of record; and, ordinarily, evidence-based adjustments of a factual nature would be within the province of the fact-finder to make.[8]

37. The undersigned determines as a matter of ultimate fact, therefore, that the portion of the Stipulated Recovery that "should be allocated" to past medical expense damages is $11,010.55.

CONCLUSIONS OF LAW

38. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding, as well as final order authority, pursuant to section 409.910(17)(b).

39. Section 409.910(1) provides as follows:

> 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

[8] The undersigned realizes, however, that existing case law leaves some room for uncertainty here. If the reviewing court reverses on this point, the undersigned hopes that some guidance would be given as to whether—as a bright-line rule, or under what circumstances—the ALJ must either accept the petitioner's case *in toto*, or reject it *in toto*.

> the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid. Principles of common law and equity as to assignment, lien, and subrogation are abrogated to the extent necessary to ensure full recovery by Medicaid from third-party resources. It is intended that if the resources of a liable third party become available at any time, the public treasury should not bear the burden of medical assistance to the extent of such resources.

40. Section 409.910(6)(c) provides, in relevant part, as follows:

> The agency is entitled to, and has, an automatic lien for the full amount of medical assistance provided by Medicaid to or on behalf of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable, upon the collateral, as defined in s. 409.901[, which includes "[a]ny and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services that necessitated that Medicaid provide medical assistance."]

41. Section 409.910(11)(f) provides, in pertinent part, as follows:

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

> 3. For purposes of calculating the agency's recovery of medical assistance benefits paid, the fee for services of an attorney retained by the recipient or his or her legal representative shall be calculated at 25 percent of the judgment, award, or settlement.

42. Section 409.910(17)(b) provides as follows:

> 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.

43. Section 409.910 provides no guidance, instructions, or criteria that the ALJ is required to consider in determining the portion of a recipient's total recovery which "should be allocated" as medical expenses, nor does it prohibit the ALJ from considering any specific criteria or from using any particular methodology. This lack of specific, statutory standards limiting the decision-maker's discretion extends to the recipient, as well, who must prove that some amount less than the default allocation "should be allocated" to medical expense damages, without any clear statutory direction as to what must be proved to make the required showing.

44. The U.S. Supreme Court has interpreted the anti-lien provision in federal Medicaid law as imposing a bar which, pursuant to the Supremacy Clause, precludes "a state from asserting a lien on the portions of a settlement not allocated to medical expenses." *See, e.g.*, *Mobley v. State*, 181 So. 3d 1233, 1235 (Fla. 1st DCA 2015).

45. In 2017, the United States District Court for the Northern District of Florida enjoined the Agency from enforcing section 409.910(17)(b) to seek "reimbursement of past Medicaid expenses from portions of a recipient's recovery that represents future medical expenses of past Medicaid expenses," and from advocating that "a Medicaid recipient [must] affirmatively disprove § 409.910(17)(b)'s formula-based allocation with clear and convincing evidence." *Gallardo v. Senior*, No. 4:16cv116-MW/CAS, 2017 U.S. Dist. LEXIS 112448, at *24 (N.D. Fla. July 18, 2017). The Agency appealed the *Gallardo* decision, which is currently under review in the U.S. Eleventh Circuit Court of Appeals. As a result of *Gallardo*, the parties have stipulated that the standard of proof in this case shall be the greater weight, or preponderance of the evidence, standard.

46. Independent of *Gallardo*, the Florida Supreme Court ruled, in *Giraldo v. Agency for Health Care Administration*, 248 So. 3d 53, 54 (Fla. 2018), that, under preemptive federal law, the state's Medicaid lien may attach only to that portion of a recipient's settlement recovery attributable to

past medical expense damages. Thus, the court held that section 409.910(17)(b) is invalid and unenforceable to the extent it would allow the Agency to recover from future medical expense damages.

47. In regard to the methodology for determining that portion of the total recovery which should be allocated to past medical expense damages, recent appellate decisions have moved towards acceptance of the proportional reduction as a valid, albeit nonexclusive, basis for making the required distribution. As the First District Court of Appeal explained:

> [W]hile not established as the only method, the pro rata [or proportional reduction] approach has been accepted in other Florida cases where the Medicaid recipient presents competent, substantial evidence to support the allocation of a smaller portion of a settlement for past medical expenses than the portion claimed by AHCA. *See Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53 (Fla. 2018); *Mojica v. Agency for Health Care Admin.*, 285 So. 3d 393 (Fla. 1st DCA 2019); *Eady v. State*, 279 So. 3d 1249 (Fla. 1st DCA 2019). *But see Willoughby v. Agency for Health Care Administration*, 212 So. 3d 516 (Fla. 2d DCA 2017) (quoting *Smith v. Agency for Health Care Administration*, 24 So. 3d 590, 591 (Fla. 5th DCA 2009)) (explaining that the pro rata formula is not the "required or sanctioned method to determine the medical expense portion of an overall settlement amount").

Ag. for Health Care Admin. v. Rodriguez, No. 1D19-1454, 2020 Fla. App. LEXIS 5263, at *5-6 (Fla. 1st DCA Apr. 17, 2020) (opinion not final).

48. To the cases cited by the court in *Rodriguez* may be added another recent decision, *Bryan v. Agency for Health Care Administration*, 45 Fla. L. Weekly D569, 2020 Fla. App. LEXIS 3183 (Fla. 1st DCA Mar. 12, 2020) (opinion not final). In *Bryan*, the recipient settled a medical malpractice action arising out of a catastrophic brain injury for $3 million, and then initiated an administrative proceeding to adjust the Medicaid lien, which the Agency asserted should be payable in the full amount of approximately

$380,000. *Bryan*, 2020 Fla. App. LEXIS 3183, at *3. At hearing, the recipient "offered the testimony of two trial attorneys who were both admitted as experts in the valuation of damages." *Id*. These witnesses relied upon a life care plan and an economist's report, which were filed as exhibits, as well as jury verdicts in similar cases, to support their opinion that "the value of [the recipient's] damages exceeded $30 million." *Id.*

49. The "experts both testified that, using the conservative figure $30 million, the $3 million settlement only represented a 10% recovery," and that, "based on that figure, it would be reasonable to allocate 10% of [the recipient's approximately $380,000] claim for past medical expenses—[or, approximately $38,000]—from the settlement to settle [the Agency's] lien." *Id*. at *3-4. The recipient also "submitted an affidavit of a former judge," who affirmed that the proportional allocation was a reasonable, rational, and logical "method of calculating the proposed allocation." *Id*. at *4.

50. Regarding the Agency's case, the court wrote:

> In turn, AHCA did not: (1) call any witnesses, (2) present any evidence as to the value of Ms. Bryan's damages, (3) propose a differing valuation of the damages, or (4) present evidence contesting the methodology used to calculate the $38,106.28 allocation to past medical expenses.

Id.

51. The ALJ rejected the recipient's proposed proportional reduction methodology as a "'one size fits all' approach which place[s] each element of [the recipient's] damages at an equal value." *Id*. The ALJ determined that it was the recipient's burden to "prove that it was more probable than not" that the parties in the personal injury action had intended to allocate only 10% of the settlement recovery as past medical expenses, and that the recipient had failed to do that. *Id*. at *5. Accordingly, the ALJ ordered the recipient to pay the Medicaid lien in full. *Id*.

52. The court reversed the ALJ's order, explaining:

> [I]n this case, [the recipient] presented unrebutted competent substantial evidence to support that the value of her case was at least $30 million. She also presented unrebutted competent substantial evidence that her pro rata methodology did indeed support her conclusion that $38,106.28 was a proper allocation to her past medical expenses. Such methodology was similar to the methodology employed in *Giraldo*, *Eady*, and *Mojica*. [The Agency] did not present any evidence to challenge [the recipient's] valuation, nor did it present any alternative theories or methodologies that would support the calculation of a different allocation amount for past medical expenses. Without any evidence to contradict the pro rata methodology proposed by [the recipient], the ALJ's rejection of that methodology was not warranted.

Id.

53. There are a number of similarities between this case and *Bryan*. Here, as in *Bryan*, two trial attorneys gave unrebutted testimony that, using a conservative (and uncontested) appraisal of the recipient's case ($6 million), the settlement ($300,000) represented only a small fraction (5%) of the recipient's recovery. They expressed the opinion, as in *Bryan*, that, conceptually, a proportional reduction was the proper method of determining the portion of the recipient's recovery which should be allocated as past medical expenses. As in *Bryan*, the Agency did not present testimony or other evidence as to: (i) the value of the recipient's case; (ii) an alternative appraisal of the recipient's damages; or (iii) the weaknesses, if any, in the proportional reduction methodology as applied to the particular facts.

54. The factors which distinguish this case from *Bryan* are that (i) Cruz advocated the use of an incorrect value for ***m*** in the proportional reduction formula, and (ii) the recipient in *Bryan* offered *more* evidence of value, i.e., the economist's report, the life care plan, and the former judge's affidavit. As discussed above, however, the undersigned finds that the first factor is not a

fatal error because the fact-finder can easily correct the mistake based on the evidence in the record. The second factor, the undersigned concludes, is not a material distinction because Cruz's evidence of value was sufficient to persuade the fact-finder and thus to satisfy his burden of proof.[9]

55. The undersigned concludes that *Bryan* is applicable and controlling. Following that court's lead, the undersigned accepts the premise that the basic proportional reduction methodology, when established, as here, by unrebutted, competent substantial evidence, provides a valid formula for determining the portion of the recipient's recovery which should be allocated as past medical expense damages.

56. That said, the undersigned notes that there appears to be some tension between *Bryan* and *Gray v. Agency for Health Care Administration*, 288 So. 3d 95 (Fla. 1st DCA 2019), which is yet another relatively recent decision. In *Gray*, the recipient sustained a spinal cord injury in a car accident, sued the driver, and was "awarded a jury verdict of over $2.8 million." *Id.* at 98.[10] The verdict itemized each element of the recipient's damages, awarding a specific dollar amount for each item, including $128,760.56 for past medical treatment. Medicaid had provided the recipient $65,610.05 in medical assistance payments. *Id.* The default lien under section 409.910(11)(f) was $3,750, which the recipient sought to reduce by requesting a hearing under section 409.910(17)(b).

57. At hearing, the recipient moved the verdict form and final judgment into evidence, among other documentation. *Id.* at 99. He argued that the presumptive amount under the statute should be adjusted using a basic

[9] That a recipient whose several-million-dollar settlement was ten times greater than Cruz's six-figure recovery had the resources to retain an economist and other experts on valuation, in addition to the trial attorneys who testified, should not be surprising. More important, however, is that the court in *Bryan* did not hold that the recipient's evidence, as described in the opinion, established a threshold quantum of proof, which other recipients, going forward, must meet or exceed.

[10] The total award was $2,859,120.56.

proportional reduction approach, whereby the lien would be limited to the same ratio (0.003498) that his recovery ($10,000) bore to the judgment ($2,859,120.56), "which would equate to $229.49." *Id*. at 98. The recipient conceded at hearing "that no case law or other statute authorized the ALJ to apply a pro rata formula instead of the formula provided in the statute." [11] *Id*. The ALJ rejected the pro rata approach, ruling that the Agency was entitled to $3,750, because he "found no evidence in the record to show that 'the $10,000 recovery does not include at least $3,750 that could be attributed to [the recipient's] medical costs.'" *Id*.

58. The court upheld the ALJ's decision. It wrote:

> The record supports the ALJ's conclusion that Gray failed to show that the $10,000 recovery was anything other than a lump-sum payment, with no allocations for any category of Gray's damages. Because the $10,000 recovery was unallocated, Gray's argument that the lien was improperly imposed on future medical expenses must fail.
>
> * * *
>
> The evidence offered by Gray consisted of the verdict form, the final judgment, and letters providing the amount of the liens imposed by Florida's Medicaid Program, Georgia's Medicaid Program, and Florida's Brain and Spinal Cord Injury Program. None of these records showed that the $10,000 recovery was allocated in any way between different categories of damages, costs, or attorney's fees. Gray could not show—even by a preponderance of the evidence—that an amount other than the total recovery of $10,000 should be

[11] It should be mentioned that the ALJ's final order was entered on December 29, 2016. *See Gray v. Ag. for Health Care Admin*., Case No. 16-5582MTR, 2016 Fla. Div. Admin. Hear. LEXIS 649 (Fla. DOAH Dec. 29, 2016). The recipient's concession would not likely not be made today, because many cases decided since 2016, as discussed herein, have authorized the use of a pro rata formula. Indeed, it is probably accurate to say that, under the present state of the law, an ALJ is practically required to accept the use of a proportional reduction, provided certain conditions are met, e.g., where unrebutted expert testimony is received both as to the value of the recipient's damages and as to the use of the pro rata methodology.

> considered when applying the statutory formula to determine the amount of the Medicaid lien.
>
> * * *
>
> [I]n situations such as this case, when the plaintiff fails to produce evidence or present testimony showing that the lien amount should be reduced, the plain language of section 409.910(11)(f) requires the ALJ to apply the statutory formula. The ALJ did exactly that here and did not err in calculating the lien amount.

Id. at 99.

59. The *Gray* decision comes close to announcing, as a rule, that the default lien amount which attaches to the recovery of an undifferentiated, lump-sum insurance payment is irreducible in a section 409.910(17)(b) proceeding, precisely because the payment was unallocated. This impression is reinforced by the *Rodriguez* case, in which the court distinguished *Gray* as follows:

> Unlike *Gray*, … , the documentary evidence admitted in this case pertained to the settlement itself. In *Gray*, the recipient's lawsuit resulted in a jury verdict of over $2.8 million but he recovered only $10,000 from the defendant's insurer. *Id*. at 98. There was no evidence in *Gray* that the insurance payout was based on anything other than the total coverage limits. In *Gray*, we found no ground to set aside the ALJ's rejection of the recipient's (17)(b) petition to reduce [the Agency's] recovery. In contrast here, Rodriguez's pre-trial settlement was based on an offer of settlement enumerating the various types of damages, admitted into evidence by the ALJ, and the defense in the civil suit accepted the plaintiff's assertions of the various types of damages. No lump-sum insurance proceeds were at issue here.

Rodriguez, 2020 Fla. App. LEXIS 5263, at *7 n.4.

60. It is possible to derive from *Gray*, as illumined by *Rodriguez*, the proposition that the portion of a lump-sum, coverage-limits insurance payout which *must* be allocated to past medical expense damages is the presumptive lien amount under section 409.910(11)(f). Under such a rule, a recipient who has accepted an arbitrary discount settlement (as described herein) and later seeks an administrative allocation of his or her unallocated recovery would be doomed to fail in the section 409.910(17)(b) proceeding.

61. The undersigned, however, hesitates to conclude that *Gray* goes that far. For one thing, although the Agency relies on *Gray*, it has not argued in favor of a bright-line rule against adjusting the default lien attaching to an arbitrary discount settlement. Indeed, to its credit, in discussing *Gray*, the Agency calls attention to language in that opinion which cuts against such a bright-line rule, in which the court explained that "without an agreement about the allocation, the parties may resolve the dispute in an administrative proceeding." *Gray*, 288 So. 3d at 97.

62. Moreover, as the court stated in *Eady*, "a Medicaid recipient is entitled to put on evidence to prove that he is entitled to a reduction of the Medicaid lien." *Eady*, 279 So. 3d at 1259. A strict reading of *Gray* would effectively deprive some Medicaid recipients of that entitlement. Notably, as well, the court in *Eady* distinguished *Gray*, not because "[n]o lump-sum insurance proceeds were at issue" in the case before it, but because the "evidentiary infirmities" which had caused the recipient's case to fail in *Gray* were not present, as the instant recipient had "presented expert testimony directed towards the appropriate share of the settlement funds to be allocated to past medical expenses[, and the Agency had] not present[ed] any evidence to refute the experts' opinions." *Id.*

63. It should be emphasized that in *Gray*, the recipient did *not* present the testimony of trial attorneys to support the pro rata allocation he advocated, relying instead on the verdict form and judgment as his evidentiary grounds.

This would be a bold move in the wake of the Supreme Court's decision in *Giraldo*. Remember, however, that the final hearing in *Gray* had taken place in 2016, nearly two years before *Giraldo*, at a time when the strategy would not have seemed so risky. At any rate, the recipient in *Gray* had depended heavily on the *argument* that the basic proportional reduction should be applied to reduce the default lien, probably anticipating that the ALJ would adopt the approach as a legal conclusion.

64. Even as a legal argument, however, methodology urged by the recipient in *Gray* was flawed because a *basic* proportional reduction, on its face, would have been problematic. This is because the jury had determined the exact amount of each item of the recipient's damages, effectively allocating the total award between such items. The appellate court described the breakdown as follows: "Specifically, the jury awarded [the recipient] $1,301,268 for future medical expenses, $202,670 for loss of past earnings, $916,422 for loss of future earnings, $50,000 for past loss of enjoyment of life, $260,000 for future loss of enjoyment of life, and $128,760.56 for past medical treatment." *Gray*, 288 So. 3d at 98. Medicaid, recall, had provided $65,615.05 in medical assistance.

65. Where a jury has itemized a recipient's damages, as in *Gray*, a basic proportional reduction will be logically (if not evidentially) sound, provided that, as is not uncommon, the Medicaid expenditures comprise the totality of the recipient's past medical expense damages. This can easily be shown mathematically, using the numbers from *Gray*. The ratio of $65,615.05 (which, for illustrative purposes, will be assumed as equaling the sum of the recipient's total past medical expenses) to $2,859,120.56 (the actual total judgment) is 0.02295. When that factor (0.02295) is multiplied against the recovery of $10,000, the result is $229.50—the same amount

produced by a basic proportional reduction.[12] But, in *Gray*, the recipient's past medical expenses were *greater than* the Medicaid expenditures. In such a scenario, the *basic* proportional reduction *under*-allocates the portion of the recovery fairly attributable to past medical expense damages, which is also easily shown.

66. Suppose the recipient in *Gray* had argued for a variation on the basic pro rata allocation, based on the ratio of past medical expenses (***p***) to the total judgment (***j***). Such an approach would have accounted for the fact that the recipient's past medical expenses exceeded Medicaid expenditures. The equation would have been: $(\boldsymbol{p} \div \boldsymbol{j}) \times \boldsymbol{r} = \boldsymbol{x}$, where ***r***, recall, is the recipient's recovery, and ***x*** is the adjusted lien amount. In *Gray*, this formula would have produced a lien amount of $450.35, which (despite the small difference in dollars versus a basic proportional reduction) is almost twice the amount the recipient actually sought. Had the recipient made this argument, he still might not have prevailed, due to the absence of expert testimony in support of such a methodology, but his proposed pro rata allocation would not have suffered from the additional infirmity of under-allocation.

67. In sum, although this case is like *Gray* in that there is "no evidence … that the insurance payout was based on anything other than total coverage limits," *Rodriguez*, 2020 Fla. App. LEXIS 5263, at *7 n.4, the undersigned distinguishes *Gray* on the grounds that (i) Cruz presented unrebutted expert testimony both as to the value of his damages and in support of the basic proportional reduction methodology, thereby avoiding the "evidentiary infirmities" which doomed the recipient's case in *Gray*; and (ii) the basic proportional reduction advocated here does not, as in *Gray*, on its face appear to under-allocate the portion of the recipient's recovery which should be designated as past medical expenses.

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[12] A basic proportional reduction applies the ratio of the recovery ($10,000) to the total value ($2,859,120.56) against the past medical expenditures (assumed, for this illustration, to be $65,615.05), which equates to $229.49.

68. Accordingly, as found above, Cruz carried his burden, as a matter of fact, by proving that the portion of his total recovery which should be designated as compensation for past medical expenses is $11,010.55.

DISPOSITION

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

ORDERED that the amount payable to the Agency for Health Care Administration in satisfaction of its Medicaid lien for medical assistance provided to Cruz is $11,010.55.

DONE AND ORDERED this 29th day of April, 2020, in Tallahassee, Leon County, Florida.

JOHN G. VAN LANINGHAM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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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 appeal with the Clerk of the Division of Administrative Hearings and a copy, accompanied by filing fees prescribed by law, with the First District Court of Appeal in Leon County, or with the District Court of Appeal in the Appellate District where the party resides. The notice of appeal must be filed within 30 days of rendition of the order to be reviewed.