No. 20-1263

IN THE

Supreme Court of the United States

GIANINNA GALLARDO, AN INCAPACITATED PERSON, BY AND THROUGH HER PARENTS AND CO-GUARDIANS PILAR VASSALLO AND WALTER GALLARDO,
Petitioner,

v.

SIMONE MARSTILLER, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR PETITIONER

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QUESTION PRESENTED

Whether the federal Medicaid Act provides for a state Medicaid program to recover reimbursement for Medicaid's payment of a beneficiary's *past* medical expenses by taking funds from the portion of the beneficiary's tort recovery that compensates for *future* medical expenses.

PARTIES TO THE PROCEEDING

Petitioner Gianinna Gallardo, an incapacitated person, by and through her parents and co-Guardians Pilar Vassallo and Walter Gallardo, was the plaintiff-appellee below.

Respondent Simone Marstiller is, in her official capacity, the current Secretary of the Florida Agency for Healthcare Administration. Her predecessors (Mary Mayhew, Justin Senior, and Elizabeth Dudek) were—during their respective tenures and in their official capacities as Secretaries of the Florida Agency for Health Care Administration—previously named as the defendant-appellant below.

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INTRODUCTION

Many individuals require Medicaid's assistance because of injuries inflicted by third parties. Petitioner Gianinna Gallardo is one. When she was 13, a truck struck her after she stepped off her school bus, causing severe injuries requiring a lifetime of expensive care. Her parents sued those responsible, demanding compensation for her future medical expenses, lost earnings, and pain and suffering—and past medical expenses paid by Medicaid. Ms. Gallardo ultimately settled for a fraction of the damages she sought. Florida's Medicaid agency then imposed a lien to reimburse itself from the portions of the settlement representing both past and *future* medical expenses. Florida thereby sought to "pocket funds marked for things it never paid for." Pet. App. 28 (Wilson, J. dissenting).

The Medicaid Act proscribes such overreaching. Its anti-lien and anti-recovery provisions broadly prohibit States from seeking reimbursement for Medicaid expenditures from beneficiaries' tort recoveries and other property. *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 285, 292 (2006). The Act's third-party provisions are an exception to that prohibition—but one strictly limited by the provisions' terms. The most relevant provision, 42 U.S.C. § 1396a(a)(25)(H), gives a State the right to third-party payments only insofar as they represent liability for "health care items or services" that have been "furnished" by Medicaid. The third-party provisions give a State no right to payments for medical expenses Medicaid has not paid.

OPINIONS BELOW

The Eleventh Circuit's opinion, Pet. App. 1-60, is reported at 963 F.3d 1167, and its order denying rehearing en banc, Pet. App. 119-125, is reported at 977 F.3d 1366. The district court's summary judgment order, Pet. App. 88-115, is reported at 263 F. Supp. 3d 1247, and its unreported order addressing Respondent's motion to alter or amend the judgment, Pet. App. 61-85, is available at 2017 WL 3081816.

JURISDICTION

The Eleventh Circuit entered judgment on June 26, 2020, and denied Petitioner's timely petition for rehearing en banc on October 20, 2020. On March 19, 2020, this Court issued a blanket order extending the time to file a petition for a writ of certiorari to 150 days from the date of an order denying a timely petition for rehearing. The petition for certiorari was filed on March 9, 2021, and granted on July 2, 2021. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The question presented involves the following provisions, which are reproduced in the appendix:

1. the Supremacy Clause, U.S. Const. art. VI, cl. 2;
2. provisions of the Medicaid Act, 42 U.S.C. § 1396 *et seq.*:
    a. the "anti-lien provision," § 1396p(a)(1);
    b. the "anti-recovery provision," § 1396p(b)(1); and
    c. the "third-party provisions":

i. the "third-party liability provision," § 1396a(a)(25)(A)-(B);

ii. the "payment-recovery provision," § 1396a(a)(25)(H); and

iii. the "assignment/cooperation provision," § 1396k(a)-(b);

3. subsections (6), (11), (13), and (17) of Florida's Medicaid Third-Party Liability Act, Fla. Stat. § 409.910 (2016).

STATEMENT OF THE CASE

I. Legal Background

A. Federal Medicaid Statutes

Medicaid is a joint federal-state program that provides healthcare coverage for individuals who otherwise could not afford it. *Ahlborn*, 547 U.S. at 275. As a condition of receiving federal funds, a State must agree to administer its Medicaid program in accordance with the Medicaid Act's requirements. *See, e.g.*, § 1396a(a).[1] This case concerns the intersection of two Medicaid requirements regarding a State's reimbursement from a beneficiary's tort recovery—by settlement or judgment—for medical expenses paid by the State on the beneficiary's behalf: (i) a general prohibition and (ii) an implied exception to the prohibition.

First, the prohibition: A State may not impose a lien on a Medicaid beneficiary's property, or otherwise seek to recover the State's payments for medical assistance. This prohibition appears in the Medicaid Act's anti-lien and anti-recovery provisions, respectively:

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[1] All citations to sections of the federal Medicaid statutes in this brief are to the codification in U.S. Code title 42.

- "No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." § 1396p(a)(1).
- "No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made." § 1396p(b)(1).

See also § 1396a(a)(18) (requiring state Medicaid plans to comply with § 1396p's requirements for "liens" and "adjustments and recoveries of medical assistance correctly paid"). None of the enumerated exceptions to these two provisions applies to a beneficiary's tort recovery from a third party responsible for her injuries. *See* § 1396p(a), (b). Both provisions have been part of federal Medicaid law since its inception in 1965. Health Insurance for the Aged Act, Pub. L. No. 89-97, § 121(a), 79 Stat. 286, 347 (1965).

Next, the implied exception: When a third party has made a payment to a beneficiary on account of its liability to pay for medical expenses paid by Medicaid, a State may seek reimbursement of its past Medicaid payments to the extent of the third party's legal liability to pay for care and services paid for by Medicaid. The exception derives from the third-party provisions: the third-party liability, payment-recovery, and assignment/cooperation provisions, § 1396a(a)(25)(A)-(B), § 1396a(a)(25)(H), and § 1396k(a)-(b).

The third-party liability provision has been part of the Medicaid Act since 1968. *See* Social Security Amendments of 1967, Pub. L. No. 90-248, § 229(a), 81 Stat. 821, 904 (1968). It requires a State "to ascertain the legal liability of third parties … to pay for care and

services available under the plan." § 1396a(a)(25)(A). The State must "seek reimbursement for [medical] assistance to the extent of *such legal liability*" in "any case where such a legal liability is found to exist *after medical assistance has been made available* on behalf of the individual." § 1396a(a)(25)(B) (emphasis added).

The assignment/cooperation provision originated in a 1977 law, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, § 11(b), 91 Stat. 1175, 1196. It was amended in 1984 to make its terms mandatory. Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2367(b), 98 Stat. 494, 1109. "For the purpose of assisting in the collection of medical support payments and other *payments for medical care owed to recipients of medical assistance under the State plan*," this provision requires beneficiaries to assign the State "any rights … to *payment for medical care* from any third party." § 1396k(a)(1)(A) (emphasis added). It also requires beneficiaries to "cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services *available under the plan*." § 1396k(a)(1)(C) (emphasis added). A State may keep the payments "collected by [it] under an assignment … as is necessary to reimburse it for medical assistance *payments made* on behalf of an individual with respect to whom such assignment was executed … and the remainder of such amount collected shall be paid to such individual." §1396k(b) (emphasis added).

The most recently enacted provision—which speaks most directly to the question presented—is the payment-recovery provision. Added by the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66,

§ 13622(c), 107 Stat. 312, 632-33, it applies where "*payment has been made* under the State plan for medical assistance in any case where a third party has a legal liability to make payment for *such assistance*." § 1396a(a)(25)(H) (emphasis added). In that event, state Medicaid laws must provide that, "to the extent that *payment has been made* under the State plan for medical assistance for *health care items or services furnished* to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for *such health care items or services*." *Id.* (emphasis added). The payment-recovery provision specifically gives the State the right to a payment received by a beneficiary from a third party, but only to the extent that payment is "for such health care items or services"—that is, "health care items or services furnished to [the] individual" by Medicaid.

B. This Court's Decisions Interpreting the Medicaid Act

Twice before, this Court has interpreted the provisions at issue. *See Ahlborn*, 547 U.S. at 275-92; *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 633-44 (2013).

1. *Ahlborn*

In *Ahlborn*, the Court considered whether the Medicaid Act permitted a state agency to "recover the entirety of the costs it paid" on a beneficiary's behalf by claiming "more than just [the] portion of a judgment or settlement that represents payment for medical expenses." 547 U.S. at 278. The Arkansas Medicaid agency paid $215,645.30 for Heidi Ahlborn's care after she was injured in an auto collision. *Id.* at 279. Ahlborn sued the tortfeasor in state court and "claimed damages not only for past medical costs, but also for permanent physical injury; *future medical*

expenses; past pain and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future." *Id.* at 273 (emphasis added). The case settled for $550,000. *Id.* at 274. The state agency asserted a lien against the settlement for $215,645.30, the full cost of its payments for Ahlborn's medical care. *Id.*

Ahlborn sued the agency in federal court "seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of *compensation for injuries other than past medical expenses*." *Id.* (emphasis added). The parties stipulated that: Ahlborn's tort claim was worth $3,040,708.12; the $550,000 settlement represented approximately 1/6th of that sum; and "if Ahlborn's construction of federal law was correct, [the agency] would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made." *Id.*

This Court unanimously held that "[f]ederal Medicaid law does not authorize [Arkansas] to assert a lien on Ahlborn's settlement in an amount exceeding $35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so." *Id.* at 292. The Court reasoned that settlement proceeds are a beneficiary's property, *id.* at 285, and thus protected by the anti-lien provision except to the extent the Medicaid Act's third-party provisions "carve[] out" an "exception," *id.* at 284 (citing §§ 1396a(a)(25) & 1396k(a)). Because the parties did not argue the anti-recovery provision, the Court "[left] for another day the question of its impact on the analysis" but observed that, like the anti-lien provision, it "appear[ed] to forestall

any attempt by the State to recover benefits paid, at least from the 'individual.'" *Id.* at 284 n.13.

Relying on the third-party liability provision's direction that the State seek reimbursement for medical assistance "to the extent of such legal liability," the Court concluded that "'such legal liability' refers to 'the legal liability of third parties … *to pay for care and services available under the plan*.'" *Id.* at 280 (quoting § 1396a(a)(25)(A)-(B); emphasis added by Court). The Court held that the third-party tortfeasor's "relevant 'liability' extend[ed] no further than" the stipulated sum of $35,581.47, *id.* at 281, representing "reimbursement *for medical payments made*," *id.* at 274 (emphasis added). Likewise, the payment-recovery provision limited the State's recovery to "the third-party tortfeasor's particular liability for medical expenses"; that is, "'*for such health care items or services*'" that "'the State plan for medical assistance for health care items or services furnished to'" the beneficiary. *Id.* at 281 (quoting § 1396a(a)(25)(H); emphasis added by Court).

Similarly, the Court emphasized that the assignment/cooperation provision limited the assignment to rights "*to payment for medical care*." *Id.* at 280 (quoting § 1396k(a)(1)(A); emphasis added by Court). The Court read that limitation as coextensive with the limitation imposed by the payment-recovery provision and stated that the two provisions "reiterate[]" and "echo[]" one another in that regard. *Id.* at 276, 282. The specific bounds imposed on the State's rights by the third-party liability and payment-recovery provisions, the Court stated, "reinforce[] the limitation implicit in the assignment provision." *Id.* at 280.

In considering the assignment/cooperation provision's relevance, the Court assumed, without deciding, that a State could "fulfill its obligations" under the assignment/cooperation provision by "placing a lien on … [a] settlement that a Medicaid beneficiary procures on her own" rather pursuing claims against the third party directly. *Id.* at 280 n.9. A beneficiary's duty to cooperate under that provision, the Court observed, "arises principally, if not exclusively, in proceedings initiated *by the State* to recover from third parties." *Id.* at 287 (emphasis added by Court). The Court questioned whether subsection (b) of that provision—which concerns the allocation of medical expenses "collected by the State under an assignment"—applies where the State does not "actively pursue[] recovery from the third party." *Id.* at 281.

Finally, the Court rejected the State's argument that a rule of full reimbursement was necessary to avoid the risk of settlement manipulation. *Id.* at 288. No such concerns were present in *Ahlborn* because the State had stipulated to the amount of the settlement "properly" designated as payment for past medical expenses. *Id.* Even without such an agreement, the Court noted that any risk of manipulation could "be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision." *Id.*

In sum, *Ahlborn* recognized that the Medicaid statutes place "express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf." *Id.* at 283. "Read literally and in isolation, the anti-lien [provision] would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care." *Id.* at 284. Although the Court recognized "the possible exception of a lien

on payments for medical care," *id.* at 291-92, it concluded that the State could not assert a lien on the beneficiary's settlement in an amount greater than $35,581.47, *id.* at 292—the stipulated amount for "reimbursement for medical payments made," *id.* at 274.

2. *Wos*

The issue in *Wos* was whether the anti-lien provision preempted a North Carolina statute requiring that up to one-third of a beneficiary's tort recovery be paid to the State to reimburse it for past Medicaid payments. 568 U.S. at 630. The plaintiff, E.M.A., had suffered birth injuries, and her parents filed a tort suit on her behalf. *Id.* at 630-31. Her expert estimated damages of $42 million, including $37 million for "skilled home care." *Id.* at 631. During the state-court suit, the State informed E.M.A.'s parents that it would seek to recover the $1.9 million it had expended for her medical care. *Id.* The state court subsequently approved a $2.8 million, unallocated settlement and placed one third in escrow pending determination of the lien's amount. *Id.* at 631-32.

E.M.A.'s parents filed suit in federal court under 42 U.S.C. § 1983 and argued that the State's reimbursement scheme violated the anti-lien provision. *Id.* at 632. The district court disagreed. The Fourth Circuit vacated and remanded. It observed that, "[a]s the unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses." *E.M.A. ex rel. Plyler v. Cansler*, 674 F.3d 290, 307, 312 (4th Cir. 2012). Thus, the state statute violated federal law because it did not afford the beneficiary an opportunity to rebut the

presumption that one-third of every tort recovery was allocable to such medical expenses. *Id.* at 312.

This Court affirmed. Distilling *Ahlborn*'s holding, the Court recognized "that the Medicaid statute sets both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery." *Wos*, 568 U.S. at 633. The floor is the State's obligation under the Medicaid Act "to seek reimbursement for medical expenses paid on the beneficiary's behalf" and "'to recover that portion of a settlement that represents payments for medical care.'" *Id.* at 633-34 (quoting *Ahlborn*, 547 U.S. at 282). The ceiling is the anti-lien provision, which protects the beneficiary's "property right in the proceeds of the settlement" and thus "'precludes attachment or encumbrance of the remainder of the settlement.'" *Id.* at 633 (quoting *Ahlborn*, 547 U.S. at 284). Because the State in *Wos* had "no evidence to substantiate" that its irrebuttable presumption was "reasonable in the mine run of cases," and no process "for determining whether [such an allocation was] a reasonable approximation in any particular case," the State's allocation conflicted with the anti-lien provision. *Id.* at 637.

The Court rejected the State's arguments that "other methods for allocating a recovery would be just as arbitrary" and that there was "no ascertainable true value of a case that should control what portion of any settlement is subject to the State's third-party recovery rights." *Id.* at 640 (internal quotations and alterations omitted). "The task of dividing a tort settlement is a familiar one," the Court observed, and "objective benchmarks" could be devised to project the damages that "the plaintiff likely could have proved had the case gone to trial." *Id.* at 640, 642. The *Wos* facts showed why such settlement allocations were necessary: "[A] substantial share [of E.M.A.'s

damages] must be allocated to the skilled home care she will require for the rest of her life." *Id.* at 638-39.

Finally, the Court rejected the State's argument that regulating Medicaid liens fell within its traditional authority to regulate the tort system. *Id.* at 640. The challenged statute was "not an exercise of the State's general authority to regulate its tort system" because it did not determine a tort plaintiff's "ability to recover for certain types of … damages." *Id.* Rather, it "allocate[d] the share of damages attributable to medical expenses in tort suits brought by Medicaid beneficiaries." *Id.* The Court concluded that "[a] statute that singles out Medicaid beneficiaries in this manner cannot avoid compliance with the federal anti-lien provision merely by relying upon a connection to an area of traditional state regulation." *Id.*

C. Repealed Medicaid Act Amendments

Several months after *Wos,* Congress enacted the Bipartisan Budget Act of 2013, Pub. L. No. 113-67, 127 Stat. 1165. Section 202(b)—titled "recovery of Medicaid expenditures from beneficiary liability settlements"—amended the third-party and anti-lien provisions by:

- deleting "to the extent of such legal liability" from the third-party liability provision, § 1396a(a)(25)(B);
- substituting the phrase "any payments by such third party" for "payment by any other party for such health care items or services" in the payment-recovery provision, § 1396a(a)(25)(H);
- deleting "payment for medical care from any third party" from the assignment/cooperation provision, § 1396k(a)(1)(A), and replacing it

with "any payment from a third party that has a legal liability to pay for care and services available under the plan"; and

- amending the anti-lien provision, § 1396p, to allow the State to assert a lien on a Medicaid beneficiary's property to secure rights acquired under the payment-recovery and assignment/cooperation provisions.

127 Stat. at 1177.

These amendments would have permitted a State to reimburse itself from *any* payments a beneficiary received from a third party whose liability to the beneficiary included medical expenses. The Bipartisan Budget Act of 2018, however, retroactively repealed them "as if such amendments had never been enacted." Pub. L. No. 115-123, § 53102, 132 Stat. 64, 299.[2]

D. Florida's Medicaid Statute

As in *Ahlborn* and *Wos*, the question presented here asks whether a state Medicaid law conflicts with the federal Medicaid statutes. Florida's Medicaid Third-Party Liability Act purports to allow the State to recover its *past* payments for a Medicaid beneficiary's medical care from tort recoveries representing

[2] The amendments technically took effect (after two extensions of their effective date) in October 2017. *See* Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 220, 129 Stat. 87, 154; Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 211, 128 Stat. 1040, 1047.

past *and future* medical expenses. Fla. Stat. § 409.910 (17)(b) (2016).[3]

Florida's statute "automatically" grants subrogation and assignment rights to the Medicaid agency to recover "third-party benefits," *id.* § 409.910(6)(a)-(b), and further provides for an "automatic lien," in the amount of Medicaid's payments, on any claims, judgments, and settlements reflecting a third party's liability for a beneficiary's injury or illness, *id.* § 409.910(6)(c). Moreover, the agency may "institute," "intervene in," or "join" any legal or administrative proceedings "in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder." *Id.* §409.910(11).

To protect the State's rights, the statute requires a beneficiary to give written notice to the state agency within 30 days of filing an action against a third party. *Id.* § 409.910(11)(a). In addition, "[n]o judgment, award, or settlement" in which "the agency has an interest, shall be satisfied without first giving the agency notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and subrogation rights or proceed with any [other permitted] action." *Id.* § 409.910(11)(d).

When a beneficiary receives a tort recovery, a statutory formula establishes the presumptive amount payable to the State. *Id.* § 409.910(11)(f). The formula deducts from the tort recovery amounts for attorney's fees (25% of the recovery) and taxable costs, and the

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[3] A 2017 amendment to the Florida statute, Ch. 2017-129, § 19, Laws of Fla., is not material, as the statute still permits Florida to recover from the portion of a beneficiary's tort recovery "allocated as past and future medical expenses," Fla. Stat. § 409.910(17)(b) (2021).

State then receives the lesser of half of the net recovery or the total amount it actually paid. *Id.* § 409.910(11)(f)1.,3. The beneficiary receives the remainder. *Id.* 409.910(11)(f)2.

A beneficiary may commence an administrative proceeding to "contest the amount designated as recovered medical expense damages payable to [the State under] the formula." *Id.* § 409.910(17)(b). This procedure applies "when [the State] has not participated in or approved a settlement," and it determines "whether a lesser portion of a total recovery should be allocated as reimbursement for medical expenses in lieu of the [formula] amount." *Eady v. State*, 279 So. 3d 1249, 1255 (Fla. Dist. Ct. App. 2019). The beneficiary must first pay the proceeds to the State or place them in an interest-bearing trust account. *See* Fla. Stat. § 409.910(17)(a).

The Florida statute expressly provides that the allocation of damages in a settlement agreement between a beneficiary and a third party does not bind the agency: "No … settlement agreement … entered into or consented to by the [Medicaid] recipient or his or her legal representative shall impair the agency's rights." *Id.* § 409.910(13). Rather, the burden is on the beneficiary to rebut Florida's statutory allocation. *Id.* § 409.910(17)(b). To do so, the beneficiary must present "clear and convincing evidence[] that a lesser portion of the total recovery should be allocated as reimbursement for past *and future* medical expenses than the amount calculated by the agency pursuant to the formula." *Id.* (emphasis added). Thus, the statute effectively allows the State to recover its Medicaid payments from the amount of the tort recovery ultimately determined to be properly allocated to the third

party's liability for both past and future medical expenses.

II. This Case

A. Facts

In 2008, Gianinna Gallardo—then a 13-year-old student—was struck by a truck after her school bus dropped her off. JA 25 ¶29; JA 37 ¶1. She suffered catastrophic physical injuries and brain damage, and she remains in a persistent vegetative state. *Id*. Medicaid paid $862,688.77 for a portion of her past medical expenses. JA 26 ¶31; JA 37 ¶1. The remainder of her past medical expenses, $21,499.30, were paid by a private insurer. JA 26 ¶31; JA 37 ¶1.

Ms. Gallardo's parents sued in state court to recover damages against the truck's owner and driver and the school board. JA 26 ¶33; JA 37 ¶1. The state-court action sought recovery of Ms. Gallardo's past medical expenses, future medical expenses, lost earnings, and other damages. JA 41 ¶3; JA 44 ¶1. The action eventually settled, with court approval, for $800,000. JA 27 ¶35; JA 38 ¶4. According to Ms. Gallardo, the settlement represented only a small fraction of the total damages she sought, which exceeded $20 million. *See* JA 41-42 ¶¶4, 6, 7; JA 44 ¶1.

Florida's Medicaid agency received the statutorily required notice of Ms. Gallardo's tort action and the settlement. JA 32 ¶¶42, 44; JA 37 ¶1. The State never filed an action to set aside, void, or otherwise dispute the settlement. Nor did it exercise its authority to seek reimbursement directly from the third party. Instead, it exercised its rights as a lienholder. JA 32 ¶¶42, 46; JA 37 ¶1. Specifically, it asserted a lien against Ms. Gallardo's cause of action—and any settlement of that

action—for the amount it had paid for past medical expenses: $862,688.77. JA 32 ¶42; JA 37 ¶1. No portion of the lien represented expenditures for Ms. Gallardo's future medical care. JA 32 ¶43; JA 37 ¶1. According to Florida's statutory formula, the agency was entitled to approximately $300,000 of the $800,000 settlement.[4] JA 32-33 ¶¶47, 49; JA 37 ¶1.

Ms. Gallardo contested the lien through the procedure in Florida Statute § 409.910(17)(b): She deposited $300,000, the approximate formula amount, into an interest-bearing trust account for the benefit of the agency and filed an administrative petition. JA 42 ¶10; JA 44 ¶1. Consistent with the Florida statute, the agency took the position that it is entitled to recover its past medical expenses from the portion of Ms. Gallardo's settlement representing compensation for both past *and future* medical expenses. JA 42 ¶11; JA 44 ¶1. The administrative proceeding has been held in abeyance during the pendency of the federal-court proceedings in this case. Pet. App. 116-18.

B. District Court's Decision

Like the beneficiary in *Wos*, 568 U.S. at 632, Ms. Gallardo invoked 42 U.S.C. § 1983 to seek a federal-court determination of her rights under the Medicaid Act. JA 16-36. She sought an injunction and declaratory judgment that Florida's Medicaid Third-Party Liability Act violated the federal Medicaid Act to the extent it allowed the State to satisfy its lien for *past* medical expenses from the portion of her tort recovery compensating her for *future* medical expenses. JA 36.

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[4] The district court mistakenly calculated the amount as $323,508.29, Pet. App. 96, as it apparently applied the formula to the amount paid by Medicaid ($862,688.77), rather than the settlement amount ($800,000).

The parties agreed that the State was seeking recovery of its past Medicaid payments from the portion of Ms. Gallardo's settlement compensating her for future medical expenses. JA 33 ¶49; JA 37 ¶1.

The district court resolved the case on cross-motions for summary judgment. Pet. App. 88-115. It agreed with Ms. Gallardo that the federal Medicaid Act preempted Florida law insofar as it allowed the agency "to satisfy its lien from a Medicaid recipient's recovery for future medical expenses." *Id*. 98. The court rested its conclusion on a "plain reading" of the "unambiguous" text of the federal Medicaid Act. *Id*. 98-100. It also relied on the reasoning of *Ahlborn* and *Wos*, though it concluded neither directly controlled. *Id*. 100-01. The court issued a declaratory judgment that the federal Medicaid Act prohibits Florida from "seeking reimbursement of past Medicaid payments from portions of a recipient's recovery that represents future medical expenses," *id*. 86-87, and enjoined the agency from enforcing the portion of the Florida statute purporting to allow such reimbursement. *Id*.[5]

C. Eleventh Circuit's Decision

In a 2-1 decision, the Eleventh Circuit reversed. Pet. App. 1-60. The majority held that the federal Medicaid Act does not preclude the State from seeking reimbursement of past medical expenses from

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[5] In the lower courts, Ms. Gallardo also challenged Florida's statute insofar as it imposes on the beneficiary the burden of proving that the allocation of settlement funds to medical expenses is something other than the formula amount. Before this Court, Ms. Gallardo does not advance that argument. She challenges the statute's validity only insofar as it allows Florida to recover past Medicaid payments from tort recoveries for future medical expenses. *See* Fla. Stat. § 409.910 (17)(b).

settlement amounts representing future medical expenses. *Id.* 14-23.

The majority began its analysis by rejecting a straw-man argument: that the parties' unilateral settlement allocation should bind the State. *Id.* 13. Ms. Gallardo, however, always has agreed with both the Eleventh Circuit majority and the dissent that this is a "bad argument." *Id*. 31 n.3. She has never challenged the Florida statute's express prohibition on use of an allocation in the underlying tort settlement to impair the State's rights. *See* Fla. Stat § 409.910(13).

The majority also anchored its holding on the "presumption against preemption," *id.* 11-13, although the State never argued that presumption below and *Ahlborn* and *Wos* did not apply it, *see Ahlborn*, 547 U.S. at 268-92; *Wos*, 568 U.S. at 627-44. Indeed, the majority's reasoning for applying the presumption—that Florida's reimbursement statute implicated its "traditional authority … 'to provide tort remedies to [its] citizens'"—was the same reasoning *rejected* in *Wos*. *Compare* Pet. App. 11 (quoted), *with Wos*, 568 U.S. at 639-40. The panel majority stated that "[t]he very existence of [a] dispute about the federal statutory text answer[ed] the preemption question" because it showed there was no "'clear and manifest purpose' to supersede the states' traditional powers over health care and tort law." Pet. App. 18-19 n.16.

The majority proceeded from the premise that both the payment-recovery provision and the assignment/cooperation provision apply to a Medicaid beneficiary's tort recovery compensating for medical expenses—a premise the State now rejects. *Id*. 5, 16-23; Resp. to Pet. for Cert. 18-20. The majority then "harmonized" the Medicaid Act by concluding the

payment-recovery provision provided "*for what* the state can get reimbursed," while the assignment/cooperation provision controlled "*from*" what it can get reimbursed. Pet. App. 16-23, 18 n.15.

The dissent, Judge Wilson, relied on the Medicaid Act's text to conclude that the State could not "pocket funds marked for things it never paid for." *Id.* 28-39. This textual conclusion, the dissent opined, was compelled by *Ahlborn* and consistent with the decisions of most courts, including the unanimous Florida Supreme Court. *Id.* 39-50; *see Giraldo v. Agency for Health Care Admin.*, 248 So. 3d 53, 56-59 (Fla. 2018). The Eleventh Circuit denied rehearing and rehearing en banc over Judge Wilson's dissent. Pet. App. 119-125.

SUMMARY OF ARGUMENT

Do federal Medicaid statutes authorize a State to reimburse Medicaid's payment of *past* medical expenses by taking funds from the portion of a tort recovery compensating a beneficiary for *future* medical expenses? No. The statutory text plainly provides—and *Ahlborn* confirms—this answer. Neither the presumption against preemption nor Florida's argument that the most relevant statutory language is inapplicable overrides the Medicaid statutes' text or *Ahlborn*'s reasoning. Read as an integrated whole, with effect given to each provision, the Medicaid statutes permit States to reach only funds representing third-party liabilities for what Medicaid has paid.

The statutes' anti-lien and anti-recovery provisions prohibit a State from taking a Medicaid beneficiary's property absent a statutory exception. *Ahlborn* recognized an implied statutory exception rooted in

the third-party provisions. But that exception extends no further than what those provisions allow.

The payment-recovery provision speaks most directly to the question presented by specifying when and to what extent a State acquires a beneficiary's right to third-party payments. It provides that, "to the extent that payment *has been made* under the State plan for medical assistance *for health care items or services furnished* to an individual, the State is considered to have acquired the rights of such individual to payment by any other party *for such health care items or services*." § 1396a(a)(25)(H) (emphasis added). Its plain language limits the State to third-party payments for medical care for which "payment has been made" by Medicaid—*past* medical expenses. The third-party liability provision likewise limits States to seeking payments by third parties with liability "to pay for care and services *available under the plan*." § 1396a(a)(25)(A) (emphasis added). And the assignment/cooperation provision, § 1396k(a)-(b), "echoes" and "reinforces" these limits—as this Court held in *Ahlborn*. If any conflict exists, the more specific and later-enacted payment-recovery provision controls over the assignment/cooperation provision.

Ahlborn's reasoning and result resolve any possible doubt about the statutory text's meaning. *Ahlborn* reasoned that a State may not reimburse its past medical expenditures by taking funds compensating for *other* damages—like future medical expenses—that Medicaid never incurred. *Ahlborn's* result was that the State could reach only the portion of the tort recovery that, the parties stipulated, compensated for past medical expenses.

The Eleventh Circuit reached its contrary result based on an interpretive tie-breaker—the presumption against preemption—that Florida never argued, *Ahlborn* never applied, and *Wos* expressly held inapplicable. Authority to pursue reimbursement of funds paid under a federal program is not a field traditionally occupied by state law. Moreover, no matter how the Medicaid provisions are construed, some state laws will be preempted because the relevant provisions set both a ceiling and a floor on recoveries that States *must* seek.

Rejecting the Eleventh Circuit's view of the statutes, Florida now argues that the payment-recovery provision concerns only the States' subrogation rights to payments from other insurers, not from tortfeasors. This argument contravenes *Ahlborn*, which applied the payment-recovery provision to a State's lien against a recovery from a tortfeasor. And the argument ignores the ordinary meaning of the statutory term "third party," which unambiguously encompasses tortfeasors. In addition, the now-repealed Bipartisan Budget Act of 2013 recognized the applicability of the payment-recovery provision by amending it to expand a State's ability to place liens on tort recoveries.

Florida's distinction between assignment and subrogation also contradicts common-law and equitable principles; both concepts apply to claims against tortfeasors. Moreover, Florida's assertion that Congress enacted the payment-recovery provision in 1993 solely to grant subrogation rights against insurers ignores that States participating in Medicaid exercised subrogation and assignment rights—against health insurers and tortfeasors—before the payment-recovery provision was enacted or the assignment/cooperation

provision was made mandatory. Pre-*Ahlborn* courts read the States' subrogation and assignment rights as coextensive, and *Ahlborn* confirmed that reading. Florida's contrary reading renders the payment-recovery provision a nullity that does no identifiable work.

Properly read, all the third-party provisions do their own work without negating one another. Each builds on prior provisions to form a cohesive, unified body of law. The 1968 third-party liability provision authorized States to seek reimbursement of third-party payments without specifying the extent of their rights. States accordingly enacted subrogation statutes to seek such reimbursement. The assignment/cooperation provision granted States procedural rights not found in the other third-party provisions. It supersedes state laws prohibiting assignment of personal-injury claims and requires beneficiaries to assist the State in pursuing such claims. Finally, the payment-recovery provision clarifies the States' authority to enact Medicaid subrogation statutes and explicitly defines their right to third-party payments received by beneficiaries.

In sum, the payment-recovery provision's plain meaning—reinforced by the other third-party provisions and *Ahlborn*'s reasoning and result—does not authorize the State to take the portion of a tort recovery compensating the beneficiary for future medical expenses. The anti-lien and anti-recovery provisions' prohibition therefore bars a State from taking that portion of the tort recovery.

ARGUMENT

I. The Medicaid Act's plain text limits a State to the portion of a beneficiary's recovery that represents payment for past medical care.

"Statutory interpretation, as [this Court] always say[s], begins with the text." *Ross v. Blake*, 136 S. Ct. 1850, 1856 (2016). Here, it ends there too. The Medicaid Act's plain text resolves the question presented.

A. The anti-lien and anti-recovery provisions broadly restrict a State's authority to seek reimbursement from a beneficiary's tort recovery.

The anti-lien and anti-recovery provisions, on their face, apply directly to Florida's attempt to recoup its Medicaid payments from Ms. Gallardo's tort recovery. Those provisions unequivocally preclude a State from taking a Medicaid beneficiary's property, or otherwise seeking to recover payments from her, except to the extent authorized by the statute. *See* § 1396p(a)(1) ("No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid *or to be paid* on his behalf under the State plan." (emphasis added)); § 1396p(b)(1) ("No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made."). "Property" includes the proceeds of a beneficiary's tort settlement with a third party. *Ahlborn*, 547 U.S. at 285.

Thus, absent an exception, the anti-lien and anti-recovery provisions preclude Florida from taking Ms. Gallardo's tort recovery. These provisions enumerate several express exceptions, but none authorizes the State to take a beneficiary's tort recovery. *See*

§§ 1396p(a)(1)(A)-(B), (b)(1)(A)-(C); *accord Ahlborn*, 547 U.S. at 283. "Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied in the absence of a contrary legislative intent." *Hillman v. Maretta*, 569 U.S. 483, 496 (2013) (internal quotations omitted).

Accordingly, as *Ahlborn* stated, "[r]ead literally and in isolation, the anti-lien prohibition … would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care." 547 U.S. at 284. That reading is reinforced by Congress's express repeal of the 2013 legislation that would have amended the enumerated exceptions to the anti-lien provision to include liens securing a State's rights under the payment-recovery and assignment/cooperation provisions. Pub. L. No. 113-67, § 202(b)(3), *repealed*, Pub, L. No. 115-123, § 53102; *see supra* pp. 12-13

Nonetheless, as *Ahlborn* recognized, the third-party provisions in §§ 1396a(a)(25) and 1396k(a) represent an implied statutory "exception to the anti-lien provision." 547 U.S. at 284. But given the breadth of the prohibitions in the anti-lien and anti-recovery provisions and the absence of an applicable express exception, any such exception must be limited to payment recoveries "expressly authorized by the terms of" the Medicaid Act's third-party provisions. *Id*.

B. The implied exception: The Medicaid Act permits and obligates the State to recover third-party payments for health care items or services furnished by the State.

Though each of the third-party provisions plays a role in the implied exception recognized by *Ahlborn*, the payment-recovery provision speaks most directly

to the question presented. It is the only provision that explicitly defines the circumstances in which States are authorized—and indeed required—to acquire a beneficiary's right to a payment received from a third party on account of the third party's liability for medical expenses paid by Medicaid. Specifically, the provision requires States to provide by law that, "to the extent that payment *has been made* under the State plan for medical assistance *for health care items or services furnished* to an individual, the State is considered to have acquired the rights of such individual to payment by any other party *for such health care items or services*." *Id.* (emphasis added).

"Such" means "[t]hat or those; having just been mentioned." *Black's Law Dictionary* 1732 (11th ed. 2019). In the payment-recovery provision, "such health care items or services" refers to those "health care items or services" that were just described in the only other use of that phrase in the subparagraph: items or services "furnished" by the State to the beneficiary. Stated differently, the State acquires a beneficiary's right to payments for medical expenses from a third party only to the extent that party is liable to pay for medical care for which "payment has been made" under the state Medicaid plan—that is, payment for *past* medical expenses. Had Congress intended to provide for acquisition of rights to third-party payments on account of liabilities for medical assistance *to be paid* by Medicaid in the future, it would have done so explicitly, especially given its use of exactly that phrase in the anti-lien provision, which forbids liens "on account of medical assistance paid or to be paid." § 1396p(a)(1).

The payment-recovery provision's text therefore leaves no doubt that the State's right to payments by

a third party is limited to payments reflecting that party's legal liability for health care items or services already furnished to the Medicaid beneficiary and for which the State has made payment. Liens against payments made to satisfy a third party's liability for anything else, including other health care items or services (such as future medical expenses), do not fall within the scope of the payment-recovery provision and are barred by the otherwise applicable anti-lien and anti-recovery provisions.

The third-party liability provision confirms this conclusion. It requires the State to "take all reasonable measures to ascertain the legal liability of third parties … to pay for care and services *available under the plan*." § 1396a(a)(25)(A) (emphasis added); *accord* 42 C.F.R. § 433.136 ("Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures *for medical assistance furnished under a State plan*.") (emphasis added). It further provides that, "in any case where *such* a legal liability is found to exist *after medical assistance has been made available on behalf of the individual* and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will *seek reimbursement for such assistance to the extent of such legal liability*." § 1396a(a)(25)(B) (emphasis added). "[S]uch a legal liability" and "such legal liability" as used in subparagraph (B) refer to the only prior use of "legal liability" in the third-party liability provision: namely, subparagraph (A)'s reference to "the legal liability of third parties … to pay for care and services available under the plan." § 1396a(a)(25)(A)-(B). Thus, consistent with the payment-recovery provision, the third-party liability provision directs a State to seek

reimbursement for its past medical expenses, but only to the extent of the third party's liability for medical assistance that "has been made available" by Medicaid. § 1396a(a)(25)(B).

In sum, the payment-recovery and third-party liability provisions authorize and require a State to seek reimbursement of its past medical expenses, but only to the extent of the third party's liability to pay for care and services provided by Medicaid. § 1396a(a)(25)(A)-(B), (H). Nothing more.

C. The assignment/cooperation provision reinforces the payment-recovery provision's limits on the State's rights.

The assignment/cooperation provision directs States to require that beneficiaries, as a condition of Medicaid eligibility, "assign" to the State "any rights … to payment for medical care from any third party." § 1396k(a)(1)(A). As *Ahlborn* explains, § 1396k is directed primarily at authorizing the State to assert a beneficiary's rights of action against potentially liable third parties by initiating and actively pursuing claims against them. Thus, it defines the rights and obligations of the State and the beneficiary when the State pursues its rights against the third party. *See* 547 U.S. at 280 n.9, 281-82; 286-87. Given the provision's focus on authorizing the State to pursue claims against third parties, some courts have concluded that it is inapplicable where, as here, the State seeks reimbursement from a tort recovery obtained by a beneficiary's own efforts. *See Doe v. Vt. Off. of Health Access*, 54 A.3d 474, 482 (Vt. 2012); *S.W. Fiduciary v. Ariz. Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1109-10 (Ariz. Ct. App. 2011). This Court in *Ahlborn* merely assumed, without deciding, that the

assignment/cooperation provision applied to a State's lien against a beneficiary's own tort recovery. 547 U.S. at 280 n.9, 281, 284.

In this case, Florida did not exercise its assignment rights to pursue third parties directly: It did not institute, intervene in, join, or otherwise actively participate in the litigation against the tortfeasors. Instead, it relied on Ms. Gallardo "to act as [a] private attorney[] general," *Ahlborn*, 547 U.S. at 268, and then sought to recover on its lien against the funds collected by Ms. Gallardo. *Cf.* § 1396k(b) (permitting State to reimburse itself out of "amount *collected by the State under an assignment*") (emphasis added). Under such circumstances, the payment-recovery provision's language concerning the State's acquisition of rights to payments received by the beneficiary is more directly applicable than the assignment/cooperation provision.

This Court need not, however, hold the assignment/cooperation provision to be irrelevant to the State's right to recover from a third-party payment. Rather, as *Ahlborn* recognized, the assignment/cooperation provision—read in light of the principle that "[i]t is this Court's duty to interpret Congress's statutes as a harmonious whole," *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1619 (2019)—reinforces the limitations on the State's rights stated in the payment-recovery provision. Moreover, even if there were tension, or conflict, between those provisions, the more recently enacted and specifically applicable payment-recovery provision would control.

1. The assignment/cooperation provision must be read consistently with the payment-recovery and third-party liability provisions.

Florida reads a solitary subparagraph of the assignment/cooperation provision in isolation—from the remainder of that provision and the other third-party provisions—to require a beneficiary to "assign the State any rights … to payment for medical care from any third party"—regardless of whether the third-party payment is for past or future medical care. § 1396k(a)(1)(A); *see* Resp. to Pet. for Cert. 1. But "the meaning of a statute is to be looked for, not in any single section, but in all the parts together and in their relation to the end in view." Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 168 (2012) (alteration omitted) (quoting *Panama Ref. Co. v. Ryan*, 293 U.S. 388, 439 (1935) (Cardoza, J. dissenting)).

Begin by examining the *entire* assignment/cooperation provision—not just subparagraph (a)(1)(A), on which Florida focuses. The phrase "payment for medical care" in subparagraph (a)(1)(A) must bear the same meaning it bears in the provision's introductory clause. *See id.* at 170 ("A word or phrase is presumed to bear the same meaning throughout a text[.]"). The introductory clause refers to "payments for medical care owed to recipients of medical assistance under the State plan." § 1396k(a). Because beneficiaries are not "owed" coverage for future care for which they may never be eligible, this reference to "payments for medical care" must mean *past* medical care provided under the plan. And, thus, subparagraph (a)(1)(A)'s almost identical reference to "payment for medical care" must mean the same thing.

Any other reading would make no sense because a beneficiary who recovers a tort settlement or judgment often becomes ineligible *in the future* for any "medical assistance under the State plan." *See* Robert Kruger, *Paying a Medicaid Lien after Cricchio v. Pennisi*, 69 N.Y. St. B.J. 58 & n.3 (Dec. 1997) ("When a recovery or settlement is achieved in a tort action, the recipient usually receives a sum of money … which is sufficiently large to make him Medicaid-ineligible."). It would be sheer speculation to presume that "payments for medical care," as used in the introductory clause and subparagraph (a)(1)(A), included third-party payments for *future* medical care because today's Medicaid beneficiary may not be tomorrow's Medicaid beneficiary. As subsection (b) of the assignment/cooperation provision confirms, a State may collect "under an assignment" only "as is necessary to reimburse it *for medical assistance payments made*," §1396k(b) (emphasis added). A State may not collect for "medical assistance … *to be paid*" in the future. § 1396p(a)(1) (emphasis added).

Another subparagraph of the assignment/cooperation provision, § 1396k(a)(1)(C), further shows that the phrase used in subparagraph (a)(1)(A)—"payment for medical care from any third party"—refers to a third-party liability for *past* medical expenses paid by Medicaid, not for *future* medical expenses. Subparagraph (a)(1)(C) requires a beneficiary to "cooperate with the State … to assist the State in pursuing[] any third party *who may be liable to pay for care and services available under the plan*" (emphasis added). A beneficiary's *future* medical care for which a third party may be liable is not currently "available under the plan."

Next, looking outside the assignment/cooperation provision, the payment-recovery provision requires the State to acquire the rights of the beneficiary to payment for "health care items or services *furnished* to an individual" under the State plan and, conversely, does not permit the State to acquire the rights to payment for medical care that has not yet been furnished to the individual. § 1396a(a)(A)(25)(H) (emphasis added). Correspondingly, the third-party liability provision directs the State to "take all reasonable measures to ascertain the legal liability of third parties … to pay for *care and services available under the plan*," and then limits the State's reimbursement to the third party's liability to pay for "care and services available under the plan." § 1396a(a)(25)(A), (B) (emphasis added). Read in context, the assignment/cooperation provision "reiterate[s]" the obligations of these related provisions, and the payment-recovery and third-party liability provisions "reinforce[] the limitation implicit in the assignment provision." *Ahlborn*, 547 U.S. at 276, 280.

Florida's contrary reading of the assignment/cooperation provision is anomalous in the context of the previously enacted third-party liability provision and the subsequently enacted payment-recovery provision. *See W. Va. Univ. Hosps., Inc. v. Casey*, 499 U.S. 83, 100-01 (1991) ("[W]e construe [an ambiguous statute] to contain that permissible meaning which fits most logically and comfortably into the body of both previously and subsequently enacted law."). Florida's reading—that a State is entitled to *all* payments for medical care, with no temporal limitation—amounts to a lifetime assignment. A person who went on Medicaid as a teenager would have to assign the State her rights to all third-party payments for future medical

care—including, for example, her right to reimbursement from an employer-provided health insurance for a surgery performed decades later. Such a reading would be nonsensical. The future medical expenses at issue in this case are no different. The assignment/cooperation provision does not compel an assignment of a beneficiary's rights to a tort recovery for future medical care for which Medicaid has not yet paid and may never pay at all.

2. The more specific, later-enacted payment-recovery provision controls in any event.

Even if the assignment/cooperation provision conflicted with the payment-recovery provision, canons of statutory interpretation would subordinate the assignment/cooperation provision to the payment-recovery provision.

First, because the payment-recovery provision "comes closer to addressing the very problem posed by the case at hand," it is "more deserving of credence" than the more general assignment/cooperation provision. Scalia & Garner, *supra* 183; *see D. Ginsberg & Sons v. Popkin*, 285 U.S. 204, 208 (1932) ("General language of a statutory provision, although broad enough to include it, will not be held to apply to a matter specifically dealt with in another part of the same enactment."). The assignment/cooperation provision speaks generally to assignment of rights against third parties "[f]or the purpose of assisting in the collection of … payments for medical care owed to recipients of medical assistance under the State plan." § 1396k(a). In contrast, the payment-recovery provision speaks directly to the question of the State's right to a *payment* from a third party. *See Latham v. Off. of Recovery*

Servs., 448 P.3d 1241, 1247 (Utah 2019) ("Section 1396a(a)(25)(H) speaks more specifically to the issue presented here[,] … [a]nd the specific provision controls over the general."); Pet. App. 34-36 (Wilson, J., dissenting).

Second, the clear directive of the more recently enacted payment-recovery provision must be interpreted as clarifying, and prevailing over, any ambiguity that existed in the earlier enacted assignment/cooperation provision. *See* Scalia & Garner, *supra* 330 (later-enacted laws "will often change the meaning that would otherwise be given to an earlier provision that is ambiguous"); *United States v. Fausto*, 484 U.S. 439, 453 (1988) ("Th[e] classic judicial task of reconciling many laws enacted over time, and getting them to 'make sense' in combination, necessarily assumes that the implications of [an earlier] statute may be altered by the implications of a later statute.").

II. *Ahlborn* reinforces what the statutory text makes clear.

The Medicaid Act's plain text is determinative. But if there is any doubt about the text's meaning, *Ahlborn* resolves it. *Ahlborn*'s reasoning and result compel the conclusion that the Act precludes the State from taking that portion of a tort recovery compensating for future medical expenses.

As *Ahlborn* explains, "the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance." 547 US. at 281. *Ahlborn* emphasizes that it would make no sense, and be "unfair," to allow the State to recover reimbursement for past medical expenses by taking funds paid to compensate the beneficiary for *other* injuries. 547 U.S. at

288. The Court illustrated its point with an example: a state-court worker's compensation case concluding that a state agency could not satisfy its lien out of loss-of-consortium damages because it would be "absurd and fundamentally unjust" for it to "share in damages *for which it has provided no compensation*." *Id.* at 288 n.19 (emphasis added) (internal quotations omitted).

Ahlborn's logic "fit[s]" here. *Latham*, 448 P. 3d at 1241. Just as a State cannot recover from the portion of a tort recovery representing damages for pain and suffering, lost wages, or loss of consortium because it has not paid for those damages, it cannot recover from the portion of a tort recovery representing *future* medical expenses because it has not paid for those expenses either. *See* Pet. App. 39-42 (Wilson, J. dissenting). Yet that is exactly what the Eleventh Circuit permits: It "tells Florida that it can pocket funds marked for things it never paid for." *Id.* at 28.

The Eleventh Circuit's ruling contravenes not only *Ahlborn*'s logic, but also its result. The tort recovery in *Ahlborn* included compensation for both past and *future* medical expenses. *Ahlborn*, 547 U.S. at 273. The parties stipulated to the amount representing *past* medical expenses, *id.* at 274, and the Court referred to that stipulated amount by using the term "medical expenses," *e.g., id.* at 280. The Court held that the Medicaid Act prohibited the State from recovering anything more than the stipulated amount. *Id.* at 292. That is, *Ahlborn* limited the State to the portion of the settlement constituting payment for past medical care. Pet. App. 43-45 (Wilson, J., dissenting). Here, as in *Ahlborn*, "federal Medicaid law does not authorize [the State] to assert a lien on [Ms. Gallardo's] settlement in an amount exceeding" the portion of the settlement representing her past medical expenses, "and

the federal anti-lien provision affirmatively prohibits it from doing so." 547 U.S. at 292. Florida's "third-party liability provisions are unenforceable insofar as they compel a different conclusion." *Id.*

III. The Eleventh Circuit erred by applying the presumption against preemption.

The Eleventh Circuit applied a "presumption against preemption" and decided that the assignment/cooperation provision created enough ambiguity to preclude a finding of preemption. Pet. App. 12-22. Florida—correctly—never relied on that presumption below. The presumption is inapplicable for three reasons.

First, this Court has applied a presumption against preemption when Congress has "legislated … in a field which the States have traditionally occupied." *Medtronic v. Lohr*, 518 U.S. 470, 485 (1996) (citation omitted). This case does not concern such a field. It instead concerns the scope of the State's authority and duty to pursue reimbursement of funds paid under a federal statutory program. As this Court has held, "no presumption against pre-emption obtains" in such an "inherently federal" context. *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 347-48 (2001).

Second, the presumption cannot apply because the Medicaid provisions at issue here preempt state law *no matter how they are construed*. The Eleventh Circuit seemed to believe its construction authorizes, but does not require, a State to seek reimbursement from the portion of a tort recovery representing future medical expenses. Pet. App. 19. But as *Wos* explained, "the Medicaid statute sets both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery."

568 U.S. at 633. The third-party provisions *require* a State to seek the authorized recoveries, and the anti-lien and anti-recovery provisions *prohibit* a State from seeking anything more.

Thus, if the Eleventh Circuit has interpreted the Medicaid Act correctly, every State *must* enact laws like Florida's. State statutes that do not permit reimbursement from tort recoveries for future medical expenses—like West Virginia's and California's—will be preempted if this Court affirms. *See, e.g.,* W. Va. Code Ann. § 9-5-11(b)(1) (limiting recipient's assignment of rights to recover from third parties to "past medical expenses paid for by the Medicaid program"); Cal. Wel. & Inst. Code § 14124.76(a) ("Recovery …. from an injured beneficiary's action or claim is limited to that portion of a settlement, judgment, or award that represents payment for medical expenses, or medical care, provided on behalf of the beneficiary.") Because federal law will preempt state laws no matter how the interpretive dispute is resolved, the presumption against preemption provides no assistance.

Third, *Ahlborn* and *Wos* confirm that the presumption against preemption does not apply. Both decisions resolved closely related preemption questions, and neither applied the presumption. *Wos* specifically declined to do so, emphasizing that the law at issue there was not "an exercise of the State's general authority to regulate its tort system" because it was specific to "suits brought by Medicaid beneficiaries." 568 U.S. at 639-40. So too here.[6]

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[6] The *Wos* dissent would have applied the presumption for reasons that do not apply here. The state law there concerned the method for allocating a tort recovery among different injuries. (*Footnote continued*)

IV. Florida's argument that the payment-recovery provision is inapplicable because it addresses subrogation is wrong.

Florida argues that the payment-recovery provision is inapplicable to this case because, it asserts, that provision applies only to a State's subrogation rights against health insurers and the like. According to Florida, this case does not involve subrogation rights at all. Instead, Florida asserts, the extent of its lien against amounts recovered from a tortfeasor liable for a beneficiary's injuries is determined solely by the assignment/cooperation provision. *See* Resp. to Pet. for Cert. 1-7, 18-19, 22. Florida's argument is flawed for many reasons.

Most notably, the argument contravenes *Ahlborn*'s holding. There, this Court determined that the third-party liability and payment-recovery provisions—which Florida claims are inapplicable—determine the proper extent of a State's lien against a beneficiary's recovery from a tortfeasor. *Ahlborn* held that these provisions limited the State to recovering amounts representing the tortfeasor's liability for medical care paid by Medicaid. Pointing specifically to the

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Wos, 568 U.S. at 634-35. The dissent believed the law could be construed as an exercise of the State's traditional regulatory authority over tort judgments. *Id.* at 652 (Roberts, C.J., dissenting). Not so here: The Florida statute does not govern the allocation of tort recoveries, but instead concerns the respective rights of a Medicaid agency and a Medicaid beneficiary. Stated another way, *Wos* addressed *how* to allocate the tort recovery, whereas this case addresses *what* portions of the recovery—after the allocation is done—belong to the State. Indeed, both Ms. Gallardo's and the State's positions require determining settlement amounts allocable to past medical expenses, future ones, and other damages; they disagree only on whether future medical expenses belong on the State's side of the line.

payment-recovery provision, the Court stated that the "statute does not sanction" a lien on anything beyond payments for medical care. 547 U.S. at 281. Rather than reading the third-party provisions as covering different, mutually exclusive circumstances, *Ahlborn* looked to all the third-party provisions as the source of congruent limits on a State's right to assert a lien on a beneficiary's tort recovery. *See id.* at 280-82. And, *Ahlborn* instructed, the label "assignment" does not allow the State to escape the anti-lien provision's limits: "The terms that [the State] employs to describe the mechanism by which it lays claim to the settlement proceeds do not, by themselves, tell us whether the statute violates the anti-lien provision." *Id.* at 286.

Florida's assertion that the payment-recovery and third-party liability provisions do not apply to recoveries from tortfeasors also contradicts the provisions' unambiguous text. Both provisions—and the assignment/cooperation provision—apply broadly to payment liabilities of a "third party" or "third parties." § 1396a(a)(25)(A), (B), (H); § 1396k(a)(1)(A), (C). The term "third party" denotes anyone other than the beneficiary. *See Black's Law Dictionary* 1782 (11th ed. 2019) ("someone other than the principal parties"). Medicaid regulations make explicit that "[t]hird party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan." 42 CFR § 433.136; *see Ahlborn*, 547 U.S. at 276 n.5 (quoting the regulation). *Ahlborn* and *Wos* gave the words their plain meaning in applying the payment-recovery provision to payments from "third-party tortfeasors." *Ahlborn*, 547 U.S. at 281, *Wos*, 568 U.S. at 533.

Florida's Medicaid Third-Party Liability Act uses an even broader definition of "third party" than the

federal regulation. *See* Fla. Stat. § 409.901(27) ("an individual, entity, or program … that is, may be, could be, should be, or has been liable for all or part of the cost of medical services related to any medical assistance covered by Medicaid"). The statute explicitly defines a "third-party benefit" subject to subrogation to include a tort recovery—that is, a "court award, judgment, [or] settlement … for personal injury or for death of the recipient"—as well as a payment of health insurance benefits. *Id*. § 409.901(28). When the State has paid for a Medicaid beneficiary's medical care, the statute provides that: (i) the State is subrogated to the beneficiary's rights to third-party benefits and that the beneficiary is "deemed" to have assigned those same rights; and (ii) the assignment and subrogation rights are to "be construed together to provide the greatest recovery from third-party benefits." *Id*. § 409.910(6)(a)-(c). Not surprisingly, Florida courts have long viewed the State's right to seek reimbursement from tort recoveries as being based on subrogation principles and have held that any lien on the recovery's proceeds goes no further than the rights granted by the coextensive subrogation and assignment provisions. *See Underwood v. Dep't of Health & Rehab. Servs.*, 551 So. 2d 522, 526 (Fla. Dist. Ct. App. 1989).[7]

Florida's argument—that the payment-recovery provision does not apply—also cannot be reconciled with the now-repealed provisions of the Bipartisan Budget Act of 2013. That legislation would have

[7] Though the Florida statute has been amended since 1989, the statute from 1982 until today has had provisions allowing the Medicaid agency to be reimbursed, to exactly the same extent, under both subrogation and assignment principles. *See infra* pp. 45-46.

expanded a State's ability to assert liens over tort recoveries by (among other things) deleting the key language in the payment-recovery provision limiting the States' recoveries of third-party payments, and amending the anti-lien provision to allow liens on tort recoveries to secure the States' expanded rights under the payment-recovery provision. *See supra* pp. 12-13. If, as Florida asserts, the payment-recovery provision were inapplicable to a beneficiary's tort recovery, Congress would not have amended that provision and referred to it in the anti-lien provision when it sought to expand the States' lien rights.

Florida's distinction between the applicability and extent of its "assignment" and "subrogation" rights also has no basis in common-law and equitable principles. Under those principles, an insurer who pays medical expenses of an injured beneficiary is subrogated to the beneficiary's right to payments from tortfeasors who are liable for those expenses. The boundaries of subrogation are not narrowly restricted to rights to payment from third parties (like other insurers) who are contractually obligated to pay for such care. Rather, subrogation is "the insurer's right to proceed against a third party responsible for a loss which the insurer has compensated." 16 Couch on Insurance § 222:2 (3d ed. updated 2021); *see also Black's Law Dictionary* 1726 (11th ed. 2019). A classic instance of subrogation is an insurer's attempt to "recover payments made pursuant to its policy from a third party which caused the loss," i.e., "the tortfeasor, the wrongdoer, the primarily liable party, the defendant, the party who caused the loss, [or] the responsible party." 16 Couch, *supra* § 222:2; *see*, *e.g.*, *United States v. Aetna Cas. & Surety Co.*, 338 U.S. 366, 367-80 (1949)

(allowing an insurer subrogated to its policyholder's tort claim to sue the United States as a tortfeasor).

An insurer's subrogation rights may give rise to a right to reimbursement when a beneficiary receives payment directly from a tortfeasor on claims to which the insurer is subrogated, and that reimbursement right may be secured by a lien on proceeds of a settlement or judgment. *See* 16 Couch, *supra* §§ 222:2, 226:17, 226:19; *see*, *e.g.*, *Coventry Health Care of Mo., Inc. v. Nevils*, 137 S. Ct. 1190, 1195 (2017) (health insurer asserted a lien to enforce a subrogation right over the insured's tort recovery). The extent of such a lien is limited both by the scope of the insurer's underlying subrogation rights and by any applicable statutory or contractual limits. *See*, *e.g., Underwood*, 551 So. 2d at 525.

"Assignment" likewise does not create rights directly against a beneficiary. Like subrogation, assignment allows an insurer to step into the shoes of a beneficiary to assert claims against third parties that are liable to the beneficiary (under tort, contract, or other laws) for the losses covered by the insurer. *See* 16 Couch, *supra* § 222:62. And like subrogation, an assignment may give rise to a claim for reimbursement, secured by a lien, when a beneficiary receives payment from a tortfeasor on claims subject to an assignment. *See*, *e.g.*, *Montanile v. Bd. of Trustees of Nat'l Elevator Indus. Health Ben. Plan*, 577 U.S. 136, 144 (2016); *Sereboff v. Mid Atlantic Med. Servs., Inc.,* 547 U.S. 356, 363-64 (2006). The rights granted by subrogation and assignment are similar—not, as Florida suggests, mutually exclusive.

Subrogation and assignment most commonly differ in their *source* rather than the *nature* of the rights

conferred.[8] Subrogation rights arise from payment by the insurer and may be created by principles of equity if statutory or contractual terms do not govern. In contrast, assignment arises from a transfer of ownership of all or part of an insured's claim against third parties, typically by agreement. *See* 16 Couch, *supra* § 222:53. But the practical differences between the two are generally insignificant. *See id*. at §222:54. Thus, parties asserting subrogation rights are often referred to as "equitable assignees," *Vt. Agency of Nat. Resources v. United States ex rel. Stevens*, 529 U.S. 765, 774 (2000) (brackets omitted), or "partial assignee[s]," *Doleman v. Levine*, 295 U.S. 221, 225 (1935).[9] Similarly, insurers asserting assignment rights are often said to be "subrogated" to the rights of the insured against third parties. *See* 16 Couch, *supra* § 222:54 & n.3. Moreover, subrogation rights, like assignment rights, are often created by contract. *See id*. at §§ 222:41; 222:53, 222:54. And both types of rights may be entirely creatures of statute. *See id*. at § 222:41 (discussing subrogation); *Doleman*, 295 U.S. at 224 (addressing an assignment provision in a federal worker's compensation act). This Court has

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[8] Subrogation and assignment rights may also differ in their procedural consequences. *See infra* pp. 48-49.

[9] While "an insurer may, by assignment, acquire an insured's total claim if the assignment so declares, even though the insurer had not made payment in full," the scope of the assignment depends on the assignment's text, and "any question as to the meaning of an assignment is to be construed in favor of the insured, so as to entitle the insurer to recover only the amount of the payment made." 16 Couch, *supra* § 222:63 & nn.1, 7. Absent clear text to the contrary, an insurer is a "*partial* assignee of the [insured's] chose in action, and as such is entitled to his *share* of the proceeds of the action when recovered." *Doleman*, 295 U.S. at 225 (emphasis added).

therefore referred to statutory rights to proceed against liable third parties interchangeably as "subrogation" and "assignment" rights. *See Doleman*, 295 U.S. at 225; *see also Aetna Cas. & Surety Co.*, 338 U.S. at 370-71 (discussing the government's position that a subrogation right was an "assignment[] by operation of law"); *Ahlborn*, 547 U.S. at 276 (referring to both payment-recovery and assignment/cooperation provisions as involving "assignment").

The Medicaid Act is like the statute in *Doleman*: Subrogation to the beneficiary's right to third-party payments, and assignment of the beneficiary's claims against third parties, both occur by operation of law as a consequence of the beneficiary's acceptance of medical benefits. The payment-recovery provision states that the State is "considered to have acquired the rights" of beneficiaries to third-party payments for health care paid by the State. § 1396a(a)(25)(H); *accord* Fla. Stat. § 409.910(6)(a) (providing State is "automatically subrogated" to a beneficiary's rights against third parties). Similarly, the assignment/cooperation provision requires beneficiaries to assign rights against third parties. § 1396k(a); *accord* Fla. Stat. § 409.910(6)(b) (providing beneficiaries are deemed to have assigned rights "automatically").

Despite these parallels between the payment-recovery and assignment/cooperation provisions, Florida asserts that the limits imposed by the payment-recovery provision do not apply under the assignment/cooperation provision if a State claims to be asserting assignment rather than subrogation rights. Resp. to Pet. for Cert. 18-19, 21-22. Florida further asserts that "Congress enacted [the payment-recovery provision] to expand states' recovery rights, arming them with an express right to subrogation of insurer

payments." *Id.* 22. Florida's argument, however, is unavailing for two reasons (in addition to the reasons previously discussed).

First, Florida's arguments conflict with the history of Medicaid administration in Florida and elsewhere. In 1978—fifteen years before the enactment of the payment-recovery provision—Florida granted an express subrogation right to its Medicaid agency to recover third-party payments (including tort settlements). *See* Fla. Stat. § 409.266(3)(b) (1978 supp.). Similarly, other States had Medicaid subrogation laws long before Congress enacted § 1396a(a)(25)(H) in 1993. *See, e.g., Smith v. Ala. Medicaid Agency*, 461 So. 2d 817, 818-20 (Ala. Civ. App. 1984); *State v. Cowdell*, 421 N.E.2d 667, 668-71 (Ind. Ct. App. 1981); *White v. Sutherland*, 585 P.2d 331, 332-34 (N.M. Ct. App. 1978). Four years *after* granting its Medicaid agency a subrogation right, Florida's legislature added to its agency's tool bag an automatic assignment right. *See* Fla. Stat. § 409.266(3)(c) (1982 supp.). Florida was not alone in adding such a tool shortly before or after the federal assignment/cooperation provision made assignment mandatory. *See Kahrs v. Sanchez*, 956 P.2d 132, 133-36 (N.M. Ct. App. 1997) (discussing state assignment statute enacted to comply with the federal assignment/cooperation provision). Yet, even before *Ahlborn*, no court read these newly granted assignment rights as expanding the pool of third-party payments *from which* a State could seek reimbursement. To the contrary, consistent with what *Ahlborn* later decided, pre-*Ahlborn* courts read a State's subrogation and assignment rights as coextensive in terms of the available pool of third-party payments from which a State could recover. *See Kahrs*, 956 P.2d at 135-36 (holding the addition of assignment rights authorized

by § 1396k "did not mandate a greater return to the State than the amount available by subrogation"); *cf. Underwood*, 551 So. 2d at 525 (reading a Florida Medicaid agency's statutory subrogation *and assignment* rights as authorizing reimbursement "in accord with general principles of subrogation").

Second, Florida's reading makes Congress's 1993 enactment of the payment-recovery provision an empty gesture in light of the 1984 enactment of the mandatory assignment/cooperation provision. Under Florida's reading, the assignment/cooperation provision already authorized and required states to obtain *greater* recoveries from any third party (including co-insurers) who had any legally enforceable liability to make payments for the beneficiary's medical care—and continued to provide that authority even after the later statute's enactment. Florida's attempt to limit the payment-recovery provision to "subrogation" claims while permitting States to obtain broader recoveries just by calling their claims "assignments" would render the payment-recovery provision a nullity. *Cf.* Scalia and Garner, *supra* 174 ("If possible, every word and every provision is to be given effect …. None should be ignored.")

That consequence of Florida's argument confirms the correctness of *Ahlborn*'s and *Wos*'s contrary reading of the assignment/cooperation provision. Those decisions give effect to the entire Medicaid Act by requiring a State's efforts to collect from a tort recovery to comply with all the third-party provisions, as well as the anti-lien and anti-recovery provisions. And those decisions' readings are fully consistent with the Act's language and history and with long-standing legal principles of subrogation and assignment. As *Ahlborn* recognized, the statutory scheme does not enable a

State to ignore its limits merely by calling its claim an "assignment." 547 U.S. at 286.

V. The proper reading of the third-party provisions gives effect to each and integrates them into a workable whole.

Ahlborn stated that the payment-recovery provision "echoes the requirement of a mandatory assignment of rights" in the assignment/cooperation provision. 547 U.S. at 281. Some state Medicaid agencies, however, question the soundness of this statement. Utah's agency, for instance, has criticized its high court—which reads the Medicaid statutes and *Ahlborn* as the Florida Supreme Court and the Eleventh Circuit dissent do—for rendering the assignment/cooperation provision a "nullity" that "does no identifiable work." Pet. 18, *Off. of Recovery Servs. v. Latham*, (U.S. No. 19-539), *cert. denied*,140 S. Ct. 852 (2020).

Reading the assignment/cooperation provision to allow States to evade the limits imposed by the language of the payment-recovery provision, however, is not necessary to give it meaning. A proper reading of the provisions gives each its own work to do without negating any of them. And the history of the statutes shows how, in enacting each, Congress built on the work of a prior provision to create an integrated body of law.

The third-party liability provision, enacted in 1968, was Congress's first attempt to authorize States to recover third-party payments. But it was a modest effort. It failed to specify the scope of a State's authority and merely directed the States to "take all reasonable measures to ascertain" third-party liabilities and to "*seek* reimbursement … to the extent of such legal liability." § 1396a(a)(25)(A), (B) (emphasis added).

What were "reasonable measures?" And what amount of reimbursement was a State *entitled* to obtain? The third-party liability provision—by itself—did not say. *See White*, 585 P.2d at 334 (citing the 1974 third-party liability provision and noting: "As to the amount of reimbursement, this statute says nothing.") Nonetheless, relying solely on this provision, States enacted statutes grounded in subrogation principles to seek reimbursement of third-party payments. *See, e.g., Hedgebeth v. Medford*, 378 A.2d 226, 227-28 (N.J. 1977) (discussing state Medicaid statute that parroted the federal third-party liability provision but also contained additional subrogation language not in the federal provision); *supra* p. 45 (citing cases from Alabama, New Mexico, and Indiana, and Florida's 1978 Medicaid statute).

Later came the assignment/cooperation provision, first enacted in 1977 and made mandatory in 1984. *See supra* p. 5. The assignment/cooperation provision works by granting States procedural protections not available under the previously enacted third-party liability provision or the later-enacted payment-recovery provision. Specifically, the assignment/cooperation provision overrides subtle distinctions in some States' laws between assignment and subrogation—for example, state laws that prohibit the assignment of a right of action for personal injury. *See* 16 Couch, *supra* §§ 222:54, 222:72. The assignment/cooperation provision preempts these state laws by granting a State the right to own and control a beneficiary's cause of action against a tortfeasor for the beneficiary's medical expenses—even before a recovery by the beneficiary. *See* § 1396k(a)-(b).

A New Mexico case illustrates the procedural protections created—and the work performed—by the

assignment/cooperation provision. *See Kahrs*, 956 P.2d at 137. New Mexico's Medicaid assignment statute—enacted to conform to the federal statute—granted the State the "undisputable right to require" a beneficiary to assign settlement proceeds "for reimbursement of medicaid expenditures," notwithstanding that the state "common law prevented assignment of a person's cause of action to recovery for personal injuries." *Id.* at 135-37. Moreover, under that same state statute, the State's "right to reimbursement receive[d] greater protection" than it had under New Mexico's earlier subrogation statute because "[o]nce [such] rights [were] assigned, they [could not] be revoked without [the State's] permission." *Id.* at 137. While recognizing that "[a]ssignment and subrogation [were] equally capable of providing reimbursement," the New Mexico court observed that "not every medicaid recipient [would] notify [the State] of a claim against a third party"; however, because of the state assignment statute, "a liable third party with notice ... was required to contact [the State]" or bear liability to the State if it paid the beneficiary "in violation of the assignment." *Id.*

The assignment/cooperation provision also works by requiring a Medicaid beneficiary "to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." § 1396k(a)(1)(C). No such requirement exists in the other third-party provisions.

The assignment/cooperation provision did not, however, specifically grant a State a right to a payment received by a beneficiary or define the limits of any such right. Nor did it expressly authorize the subrogation statutes many States had previously enacted

based on their arguable, implicit authority under the third-party liability provision. The 1993 enactment of the payment-recovery provision filled those gaps. The identifiable—and independent—work performed by the payment-recovery provision has been fully explained above and can be put in two buckets. First, building on the foundation laid by the earlier third-party provisions, the payment-recovery provision made explicit the scope of a State's right to a third-party payment received by a beneficiary, and it established express limits on that right. Second, the payment-recovery provision clarified that the States that already had enacted subrogation Medicaid statutes were authorized to do so.

In sum, each third-party provision in the Medicaid Act does its own identifiable work, even as the provisions echo, reiterate, and reinforce one another as to the extent of the State's and the beneficiary's respective rights. No provision is a nullity. And the clear terms of the payment-recovery provision, bolstered by the other third-party provisions, preclude recovery of payments that do not represent a third party's liability for medical expenses already paid by Medicaid.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

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APPENDIX

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Supremacy Clause, U.S. Const. art. VI, cl. 2

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby; any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

42 U.S.C. § 1396a (excerpts)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

* * *

(25) provide —

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval

systems required under section 1396b(r) of this title;

(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

* * *

(H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

* * *

42 U.S.C. § 1396k

§ 1396k. Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the

Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical

assistance), and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396p (excerpts)

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home,

except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek

adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

(C)(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role

of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer

protection standards which are no less stringent than the consumer protection standards which applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than

paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII)Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and

probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National

Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision

* * * .

Fla. Stat. § 409.910 (2016) (excerpts)

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

* * *

(6) When the agency provides, pays for, or becomes liable for medical care under the Medicaid program, it has the following rights, as to which the agency may assert independent principles of law, which shall nevertheless be construed together to provide the greatest recovery from third-party benefits:

(a) The agency is automatically subrogated to any rights that an applicant, recipient, or legal representative has to any third-party benefit for the full amount of medical assistance provided by Medicaid. Recovery pursuant to the subrogation rights created hereby shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, but is to provide full recovery by the agency from any and all third-party benefits. Equities of a recipient, his or her legal representative, a recipient's creditors, or health care providers shall not defeat, reduce, or prorate recovery by the agency as to its subrogation rights granted under this paragraph.

(b) By applying for or accepting medical assistance, an applicant, recipient, or legal representative automatically assigns to the agency any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law.

1. The assignment granted under this paragraph is absolute, and vests legal and equitable title to any such right in the agency, but not

in excess of the amount of medical assistance provided by the agency.

2. The agency is a bona fide assignee for value in the assigned right, title, or interest, and takes vested legal and equitable title free and clear of latent equities in a third person. Equities of a recipient, the recipient's legal representative, his or her creditors, or health care providers shall not defeat or reduce recovery by the agency as to the assignment granted under this paragraph.

3. By accepting medical assistance, the recipient grants to the agency the limited power of attorney to act in his or her name, place, and stead to perform specific acts with regard to third-party benefits, the recipient's assent being deemed to have been given, including:

a. Endorsing any draft, check, money order, or other negotiable instrument representing third-party benefits that are received on behalf of the recipient as a third-party benefit.

b. Compromising claims to the extent of the rights assigned, provided that the recipient is not otherwise represented by an attorney as to the claim.

(c) 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.

1. The lien attaches automatically when a recipient first receives treatment for which the

agency may be obligated to provide medical assistance under the Medicaid program. The lien is perfected automatically at the time of attachment.

2. The agency is authorized to file a verified claim of lien. The claim of lien shall be signed by an authorized employee of the agency, and shall be verified as to the employee's knowledge and belief. The claim of lien may be filed and recorded with the clerk of the circuit court in the recipient's last known county of residence or in any county deemed appropriate by the agency. The claim of lien, to the extent known by the agency, shall contain:

a. The name and last known address of the person to whom medical care was furnished.

b. The date of injury.

c. The period for which medical assistance was provided.

d. The amount of medical assistance provided or paid, or for which Medicaid is otherwise liable.

e. The names and addresses of all persons claimed by the recipient to be liable for the covered injuries or illness.

3. The filing of the claim of lien pursuant to this section shall be notice thereof to all persons.

4. If the claim of lien is filed within 1 year after the later of the date when the last item of medical care relative to a specific covered injury or illness was paid, or the date of discovery by the agency of the liability of any third party, or the date of discovery of a cause of action against

a third party brought by a recipient or his or her legal representative, record notice shall relate back to the time of attachment of the lien.

5. If the claim of lien is filed after 1 year after the later of the events specified in subparagraph 4., notice shall be effective as of the date of filing.

6. Only one claim of lien need be filed to provide notice as set forth in this paragraph and shall provide sufficient notice as to any additional or after-paid amount of medical assistance provided by Medicaid for any specific covered injury or illness. The agency may, in its discretion, file additional, amended, or substitute claims of lien at any time after the initial filing, until the agency has been repaid the full amount of medical assistance provided by Medicaid or otherwise has released the liable parties and recipient.

7. No release or satisfaction of any cause of action, suit, claim, counterclaim, demand, judgment, settlement, or 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. An acceptance of a release or satisfaction of any cause of action, suit, claim, counterclaim, demand, or judgment and any settlement of any of the foregoing in the absence of a release or satisfaction of a lien created under this paragraph shall prima facie constitute an impairment of the lien, and the agency is entitled to recover damages on account of such impairment. In an action on account of impairment of a lien, the agency may

recover from the person accepting the release or satisfaction or making the settlement the full amount of medical assistance provided by Medicaid. Nothing in this section shall be construed as creating a lien or other obligation on the part of an insurer which in good faith has paid a claim pursuant to its contract without knowledge or actual notice that the agency has provided medical assistance for the recipient related to a particular covered injury or illness. However, notice or knowledge that an insured is, or has been a Medicaid recipient within 1 year from the date of service for which a claim is being paid creates a duty to inquire on the part of the insurer as to any injury or illness for which the insurer intends or is otherwise required to pay benefits.

8. The lack of a properly filed claim of lien shall not affect the agency's assignment or subrogation rights provided in this subsection, nor shall it affect the existence of the lien, but only the effective date of notice as provided in subparagraph 5.

9. The lien created by this paragraph is a first lien and superior to the liens and charges of any provider, and shall exist for a period of 7 years, if recorded, after the date of recording; and shall exist for a period of 7 years after the date of attachment, if not recorded. If recorded, the lien may be extended for one additional period of 7 years by rerecording the claim of lien within the 90-day period preceding the expiration of the lien.

10. The clerk of the circuit court for each county in the state shall endorse on a claim of

lien filed under this paragraph the date and hour of filing and shall record the claim of lien in the official records of the county as for other records received for filing. The clerk shall receive as his or her fee for filing and recording any claim of lien or release of lien under this paragraph the total sum of $2. Any fee required to be paid by the agency shall not be required to be paid in advance of filing and recording, but may be billed to the agency after filing and recording of the claim of lien or release of lien.

11. After satisfaction of any lien recorded under this paragraph, the agency shall, within 60 days after satisfaction, either file with the appropriate clerk of the circuit court or mail to any appropriate party, or counsel representing such party, if represented, a satisfaction of lien in a form acceptable for filing in Florida.

* * *

(11) The agency may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(a) If either the recipient, or his or her legal representative, or the agency brings an action against a third party, the recipient, or the recipient's legal representative, or the agency, or their attorneys, shall, within 30 days after filing the action, provide to the other written notice, by personal delivery or registered mail, of the action, the name of the court in which the case is brought, the case number of such action, and a copy of the pleadings. If an

action is brought by either the agency, or the recipient or the recipient's legal representative, the other may, at any time before trial on the merits, become a party to, or shall consolidate his or her action with the other if brought independently. Unless waived by the other, the recipient, or his or her legal representative, or the agency shall provide notice to the other of the intent to dismiss at least 21 days prior to voluntary dismissal of an action against a third party. Notice to the agency shall be sent to an address set forth by rule. Notice to the recipient or his or her legal representative, if represented by an attorney, shall be sent to the attorney, and, if not represented, then to the last known address of the recipient or his or her legal representative.

(b) An action by the agency to recover damages in tort under this subsection, which action is derivative of the rights of the recipient or his or her legal representative, shall not constitute a waiver of sovereign immunity pursuant to s. 768.14.

(c) In the event of judgment, award, or settlement in a claim or action against a third party, the court shall order the segregation of an amount sufficient to repay the agency's expenditures for medical assistance, plus any other amounts permitted under this section, and shall order such amounts paid directly to the agency.

(d) No judgment, award, or settlement in any action by a recipient or his or her legal representative to recover damages for injuries or other third-party benefits, when the agency has an interest, shall be satisfied without first giving the agency notice and a reasonable opportunity to file and satisfy its lien, and satisfy its assignment and

subrogation rights or proceed with any action as permitted in this section.

(e) Except as otherwise provided in this section, notwithstanding any other provision of law, the entire amount of any settlement of the recipient's action or claim involving third-party benefits, with or without suit, is subject to the agency's claims for reimbursement of the amount of medical assistance provided and any lien pursuant thereto.

(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.

(g) In the event that the recipient, his or her legal representative, or the recipient's estate brings an action against a third party, notice of institution of legal proceedings, notice of settlement, and all other notices required by this section or by rule shall be given to the agency, in Tallahassee, in a manner set forth by rule. All such notices shall be given by the attorney retained to assert the recipient's or legal representative's claim, or, if no attorney is retained, by the recipient, the recipient's legal representative, or his or her estate.

(h) Except as otherwise provided in this section, actions to enforce the rights of the agency under this section shall be commenced within 5 years after the date a cause of action accrues, with the period running from the later of the date of discovery by the agency of a case filed by a recipient or his or her legal representative, or of discovery of any judgment, award, or settlement contemplated in this section, or of discovery of facts giving rise to a cause of action under this section. Nothing in this paragraph affects or prevents a proceeding to enforce a lien during the existence of the lien as set forth in subparagraph (6)(c)9.

(i) Upon the death of a recipient, and within the time prescribed by ss. 733.702 and 733.710, the agency, in addition to any other available remedy, may file a claim against the estate of the recipient for the total amount of medical assistance provided

by Medicaid for the benefit of the recipient. Claims so filed shall take priority as class 3 claims as provided by s. 733.707(1)(c). The filing of a claim pursuant to this paragraph shall neither reduce nor diminish the general claims of the agency under s. 414.28, except that the agency may not receive double recovery for the same expenditure. Claims under this paragraph shall be superior to those under s. 414.28. The death of the recipient shall neither extinguish nor diminish any right of the agency to recover third-party benefits from a third party or provider. Nothing in this paragraph affects or prevents a proceeding to enforce a lien created pursuant to this section or a proceeding to set aside a fraudulent conveyance as defined in subsection (16).

* * *

(13) No action of the recipient shall prejudice the rights of the agency under this section. No settlement, agreement, consent decree, trust agreement, annuity contract, pledge, security arrangement, or any other device, hereafter collectively referred to in this subsection as a "settlement agreement," entered into or consented to by the recipient or his or her legal representative shall impair the agency's rights. However, in a structured settlement, no settlement agreement by the parties shall be effective or binding against the agency for benefits accrued without the express written consent of the agency or an appropriate order of a court having personal jurisdiction over the agency.

* * *

(17)(a) A recipient or his or her legal representative or any person representing, or acting as agent for, a recipient or the recipient's legal representative, who has notice, excluding notice charged solely by reason

of the recording of the lien pursuant to paragraph (6)(c), or who has actual knowledge of the agency's rights to third- party benefits under this section, who receives any third-party benefit or proceeds for a covered illness or injury, must, within 60 days after receipt of settlement proceeds, pay the agency the full amount of the third-party benefits, but not more than the total medical assistance provided by Medicaid, or place the full amount of the third-party benefits in an interest-bearing trust account for the benefit of the agency pending an administrative determination of the agency's right to the benefits under this subsection. Proof that such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed to pay the agency the full amount required by this section or to hold the full amount of third- party benefits or proceeds in an interest-bearing trust account pending an administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 414.39(4)(b), and acted with the intent set forth in s. 812.014(1).

(b) A recipient may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the

third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. In order to successfully challenge the amount payable to the agency, the recipient must prove, by clear and convincing evidence, that a lesser portion of the total recovery should be allocated as reimbursement for past and future medical expenses than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f) or that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

(c) The agency's provider processing system reports are admissible as prima facie evidence in substantiating the agency's claim.

(d) Venue for all administrative proceedings pursuant to this subsection lies in Leon County, at the discretion of the agency. Venue for all appellate proceedings arising from the administrative proceeding outlined in 3this subsection lies at the First District Court of Appeal in Leon County, at the discretion of the agency.

(e) Each party shall bear its own attorney fees and costs for any administrative proceeding conducted pursuant to paragraphs (b)-(e).

(f) In cases of suspected criminal violations or fraudulent activity, the agency may take any civil action permitted at law or equity to recover the greatest possible amount, including, without limitation, treble damages under ss. 772.11 and 812.035(7).

(g) The agency may investigate and request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 414.39 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Attorney General or to any state attorney. Pursuant to s. 409.913, the Attorney General has primary responsibility to investigate and control Medicaid fraud.

(h) In carrying out duties and responsibilities related to Medicaid fraud control, the agency may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(i) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft is confidential and exempt from s. 119.07(1):

1. Until such time as the agency takes final agency action;

2. Until such time as the Department of Legal Affairs refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

* * *

[footnotes omitted]