No. 20-1263

In the Supreme Court of the United States

GIANINNA GALLARDO, BY AND THROUGH HER PARENTS PILAR VASSALO AND WALTER GALLARDO

Petitioner,

v.

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

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE U.S. COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

RESPONSE TO PETITION

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QUESTION PRESENTED

Because Medicaid is a payer of last resort, the Medicaid Act requires states to seek reimbursement from third parties that are liable for a Medicaid recipient's care. Section 1396k of the Act authorizes states to obtain, by assignment, a recipient's right to "*any* . . . payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A) (emphasis added). There is no dispute that this provision permits states to recover payments from tort settlements that are for past medical care.

The question presented is:

When the portion of a Medicaid recipient's tort settlement that is for past medical care is insufficient to reimburse a state, does the Medicaid Act permit reimbursement from the portion that is for future care?

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INTRODUCTION

Each year, Florida spends billions of dollars on medical care for Medicaid recipients. It has a duty under the Medicaid Act to seek reimbursement for those expenses from liable third parties. Therefore, like many states, Florida has a law requiring its Medicaid recipients to assign it any rights they have to payments for medical care from third parties, including tortfeasors.

Petitioner argues, and the Florida Supreme Court has held, that the Medicaid Act preempts Florida's law to the extent that it allows the state to seek reimbursement from payments in a tort settlement that are for future medical care. But in the decision below, the Eleventh Circuit held that the law is consistent with, and therefore not preempted by, the Act.

The Eleventh Circuit's decision is correct. Under Section 1396k of the Medicaid Act, states can seek assignment of a recipient's rights to "*any* . . . payment for medical care." 42 U.S.C. § 1396k(a)(1)(A) (emphasis added). That broad language affords states authority to recover any type of payment for medical care that a recipient receives from a tortfeasor—it does not distinguish between payments for past and future care. Petitioner relies on a different provision, Section 1396a(a)(25)(H) of the Act, but that provision in no way limits a state's clear, unequivocal right to assignment of tortfeasor payments for medical care. *See* Pet. 26–27. Rather, it provides states another tool for recovering third-party payments: subrogation. Section 1396a(a)(25)(H) requires states to have laws in effect that subrogate to the State payments for

specific medical services that insurers and other third parties owe on behalf of a recipient.

Respondent Florida Agency for Health Care Administration (AHCA) supports Petitioner Gianinna Gallardo's request for review. Review is necessary to resolve the split between the Eleventh Circuit and the Florida Supreme Court on this important question of federal law, which has significant implications for state and federal budgets.

STATEMENT

A. The Medicaid Act

Medicaid is "the primary federal program for providing medical care to the indigent at public expense." *Mem'l Hosp. v. Maricopa Cty.*, 415 U.S. 250, 262 n.19 (1974). "States are not required to participate in Medicaid, but all of them do." *Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006). It is a "cooperative" program in which the federal government "pays between 50% and 83% of the costs" that each state incurs for medical care. *Id.* In return, states must comply with "certain statutory requirements" designed to ensure, among other things, that Medicaid is "a payer of last resort." *See id.* at 275, 291 (quotations omitted).

Most notably, "Congress has directed States, in administering their Medicaid programs, to seek reimbursement for medical expenses incurred on behalf of" recipients from liable third parties. *See Wos v. E.M.A.*, 568 U.S. 627, 633 (2013). Under Sections 1396k and 1396a(a)(25) of the Medicaid Act, states must make reasonable efforts to secure—and enact laws that facilitate—such third-party reimbursement.

Under Section 1396k, which Congress enacted in 1977, states must require Medicaid recipients to assign them "any rights" they have "to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A); *see also id.* § 1396a(a)(45) (states must "provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k"). After a state makes a "medical assistance" payment on behalf of a recipient, it must retain any amount it collects under the recipient's assignment of rights "as is necessary to reimburse it for" the payment, while remitting to the recipient "the remainder of [the] amount collected." *Id.* § 1396k(b).

Section 1396a(a)(25) imposes on states various requirements related to "health insurers, self-insured plans, group health plans . . . , service benefit plans, managed care organizations, pharmacy benefit managers, [and] other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." *Id.* § 1396a(a)(25)(A); *id.* § 1396a(a)(25)(E) (states must make a payment for "preventive pediatric care" if the recipient's insurer "has not made payment within 90 days after . . . the provider . . . submitted a claim"); *id.* § 1396a(a)(25)(G) (states must prohibit insurers and similar parties from denying coverage based on a person's Medicaid eligibility); *id.* § 1396a(a)(25)(I) (states must have "in effect laws" that require insurers and similar parties to cooperate with Medicaid recovery efforts).

In 1993, sixteen years after Congress enacted Section 1396k, it added to Section 1396a(a)(25) a few

provisions to "improve[]" states' "identification and collection" of payments from insurers and similar third parties. *See* H.R. Rep. 103-111, at 209–10 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 536–37. Section 1396a(a)(25)(H) was one of the provisions. *Id.* It gives states a "right to subrogation" of payments that a third party owes a medical provider for services furnished to a Medicaid recipient. *Id.* Under Section 1396a(a)(25)(H), states must have laws "under which, to the extent that" they have paid "for health care items or services furnished to" a recipient, they "*acquire[] the rights* . . . to payment by any other party for such health care items or services." 42 U.S.C. § 1396a(a)(25)(H) (emphasis added); *see also Subrogation Clause*, Black's Law Dictionary (11th ed. 2019) ("A provision . . . whereby [a party] *acquires certain rights* upon paying a claim." (emphasis added)).

As a result, since 1993, states have had not only a broad right to assignment of payments for medical care (per Section 1396k) but also an express right to subrogation against insurers and other third parties (per Section 1396a(a)(25)(H)). That right to "[s]ubrogation" ensures that states can "pursue [a] claim against" insurers for payments that they owe on behalf of a recipient. *See Coventry Health Care v. Nevils*, 137 S. Ct. 1190, 1194 (2017); *Pivonka v. Corcoran*, 165 N.E.3d 1098, 1101–02 (Ohio 2020) (explaining that under Section 1396a(a)(25)(H), the state has "the right to seek reimbursement" directly from a third party, while under Section 1396k, it may "seek reimbursement from a [recipient] who received payment from [a] third party for . . . medical costs").

The Medicaid Act, however, does not give states carte blanche to recover from recipients and third parties. Even though Medicaid is a payer of last resort, states may not recover their expenses by acquiring "the property of" a Medicaid recipient. 42 U.S.C. § 1396p(a)(1). They may acquire only recipients' rights to third-party payments, and they can acquire them only to the extent permitted by Sections 1396k and 1396a(a)(25). *See Ahlborn*, 547 U.S. at 284.

B. Florida's Medicaid Program

Florida provides Medicaid benefits to around four million people,[1] spending $28 billion per year on Medicaid services,[2] which is 30% of the state's annual budget.[3] AHCA administers the state's Medicaid program.

Consistent with the Medicaid Act, Florida has structured its program so that Medicaid is the payer "of last resort for medically necessary goods and services furnished to" recipients. *See* § 409.910(1), Fla. Stat. After AHCA "has provided medical assistance under the Medicaid program," it must "seek reimbursement from" any liable third parties. *Id.*

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[1] Nov. 2020 Medicaid & Chip Enrollment Data, Medicaid.gov (May 29, 2021): https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

[2] Medicaid Program Finance, AHCA (May 29, 2021): https://ahca.myflorida.com/medicaid/finance/finance/index.shtml.

[3] *See* Overview of State Budget, Executive Office of the Governor (May 29, 2021): https://www.flgov.com/wp-content/uploads/2020/06/2020-Budget-Highlights.pdf.

§ 409.910(4). And recipients have a duty to "inform [AHCA] of any rights" they have to payments from third parties. *Id.* § 409.910(5). They must provide AHCA "the name and address of any person that is or may be liable" for payments for their medical care. *Id.* For example, if a third party injures a recipient, forcing her to obtain medical care, the recipient has a duty to inform AHCA if she and the third party enter a settlement providing her payments for her care. *See id.*

AHCA recovers its expenses from liable third parties through a lien process. When a recipient "accept[s] medical assistance" from AHCA, she "assigns" it all her rights to third-party payments for medical care—regardless whether the payments are for past or future care. *Id.* § 409.910(6)(b). And a lien "for the full amount of medical assistance provided by" AHCA "attaches automatically" to any such payment. *Id.* § 409.910(6)(c), (c)(1). If a recipient learns that she is entitled to a third-party payment, she must notify AHCA, at which point it "is authorized to file a verified claim of lien" with "the clerk of the circuit court in the recipient's last known county of residence." *See id.* § 409.910(6)(c)(2).

Florida has distinct procedures for recovering payments from (1) tortfeasors and (2) insurers and other parties that are "legally responsible for payment of a claim for a health care item or service." *Id.* § 409.910(20)(a).

First, Florida has "special rules and procedures" designed "to ensure a prompt and fair allocation of" any tort recovery. *See Wos*, 568 U.S. at 639–41. Once a recipient obtains a recovery from a tortfeasor, either

through a settlement or judgment, she must deposit into a trust account half of the recovery (after first deducting 25% for her "attorney's fees and taxable costs"). § 409.910(11)(f), (17)(a), Fla. Stat. That amount is presumed to represent the portion of the recovery that is for past and future medical expenses. *See id.* § 409.910(17)(b). The presumption, however, is rebuttable. After depositing the amount, the recipient may file a petition with the Florida Division of Administrative Hearings asserting that "the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by [Florida's] formula." *Id.* That "procedure is the exclusive method for challenging the amount of third-party benefits payable to" AHCA. *Id.*

Second, Florida requires health insurers, "health maintenance organizations," "prepaid health clinics," "third-party administrators, pharmacy benefits managers, and any other third parties . . . which are legally responsible for payment of a claim for a health care item or service" to regularly provide AHCA the "records and information" necessary to discern the payments that they owe for recipients' care. *Id.* § 409.910(20)(a); *see also* 42 U.S.C. § 1396a(a)(25)(A)(i) (requiring states to collect such records and information). Upon learning that a payment is owed, AHCA must request it from the third party, and if the third party does not "pay or deny [the] claim within 140 days," "an uncontestable obligation to pay the claim" is created. § 409.910(20)(b), Fla. Stat.

C. Facts and Procedural History

1. This case involves the first procedure; it arises from a dispute between AHCA and Petitioner over her tort settlement.

In 2008, a third party injured Petitioner, and AHCA paid $862,688.77 of her medical costs. Pet. App. 3. Petitioner's guardians sued the third party, and pursuant to Florida's third-party-recovery laws, AHCA "attached a lien for $862,688.77 on [the] cause of action." *Id.* at 7. Petitioner's guardians ultimately settled the case for $800,000. *Id.* at 4. They did not inform AHCA of the settlement until after they executed it, so AHCA "did not participate in or agree to the terms of the settlement." *Id.* at 5.

At the time of the settlement, case law in Florida was unsettled as to whether, under the Medicaid Act, AHCA can recover from tort settlements payments for only past care or instead payments for both past and future care. Against that backdrop, Petitioner's guardians drafted the settlement agreement to say that only $35,367.52 of the $800,000 is for past medical care. *Id.* at 4. In contrast, they included no specific figure for future care; the agreement states only that "some portion of th[e] settlement may represent compensation for future medical expenses." *Id.* at 5 n.6.

Under Florida's tort-recovery formula, Petitioner had to deposit $300,000 into a trust account once she received the settlement funds. *Id.* at 7. After she did, she filed a petition with the Florida Division of Administrative Hearings contesting the amount and arguing that under the Medicaid Act, AHCA can

recover only from the portion of the settlement that represents payment for past care. *See id.* at 96.

Florida's third-party-recovery laws, she asserted, "conflict[] with federal law . . . to the extent that [they] allow[] AHCA to satisfy its lien from a Medicaid recipient's recovery for future medical expenses." *Id.* at 98. That conclusion flows from Section 1396a(a)(25)(H), she claimed. According to Petitioner, Section 1396a(a)(25)(H) sets forth the only exception to the Medicaid Act's bar on states seeking reimbursement from recipients, and the exception is narrow, permitting states to obtain reimbursement solely from payments for past care. *See* Pet. 26–27.

But Petitioner litigated her administrative case only briefly. The Division of Administrative Hearings assigned to the case an administrative law judge who had held in a prior case that AHCA may obtain payments for both past and future care, and within weeks of the assignment, Petitioner requested a stay of her case and filed this action under 42 U.S.C. § 1983 in district court. *See* Complaint at 1, 19, *Gallardo v. AHCA*, No. 16-cv-00116 (N.D. Fla. Feb. 22, 2016).

2. Petitioner sought a "judgment declaring that under federal Medicaid law AHCA is prohibited from recovering beyond that portion of [her] settlement representing . . . past medical expenses." *Id.* at 22.

The court granted Petitioner summary judgment, endorsing her interpretation of the Medicaid Act. Pet. App. 90, 99. It concluded that Section 1396a(a)(25)(H) and this Court's decision in *Ahlborn* are dispositive.

Section 1396a(a)(25)(H), the court stated, provides that, "'to the extent *that payment has been made*

under the State plan for medical assistance,' AHCA may assert a lien or otherwise acquire a Medicaid recipient's rights 'to payment by any other [third] party for *such [furnished] health care items or services.*'" *Id.* at 99 (emphases and modifications in original). According to the court, "[t]hat necessarily suggests that AHCA may only seek reimbursement from funds representing payments for medical expenses that it previously made on the beneficiary's behalf." *Id.*

Then, relying on *Ahlborn*, the court rejected AHCA's argument that Section 1396a(a)(25)(H)—which addresses states' right to subrogation as to insurers and similar third parties—does not control here. AHCA argued that Section 1396k instead controls and that under Section 1396k, it can obtain payments for both past and future care because Section 1396k "requires . . . recipient[s] 'to assign the State *any* rights . . . to payment for medical care.'" *Id.* at 102 (emphasis added). The court, however, concluded that language in *Ahlborn* forecloses that argument. *Ahlborn* noted that Section 1396a(a)(25)(H) "echoes the requirements of mandatory assignment rights in [Section] 1396k(a)," so Section 1396k, in the court's view, must be read as mirroring Section 1396a(a)(25)(H) and thus cannot be construed as permitting recovery from payments for future care. *Id.* at 102–03 (citing *Ahlborn*, 547 U.S. at 281).

Consequently, the court held that "federal law prohibits" Florida's third-party-recovery laws to the extent that they allow AHCA to "seek[] reimbursement . . . from portions of a recipient's

recovery that represent future medical expenses." *Id.* at 103.

3. AHCA appealed to the Eleventh Circuit. While the appeal was pending, the Florida Supreme Court decided *Giraldo v. AHCA*, 248 So. 3d 53 (Fla. 2018), in which it held—like the district court—that the Medicaid Act preempts Florida's third-party-recovery laws. In so holding, the Florida Supreme Court considered only Section 1396a(a)(25)(H), presuming that it controls without addressing Section 1396k. *Giraldo*, 248 So. 3d at 56.

Soon after *Giraldo* was decided, Petitioner filed a motion in the Eleventh Circuit arguing that *Giraldo* rendered her preemption claim moot and that she should be able to go back to the Division of Administrative Hearings and rely on *Giraldo.* Pet. App. 23. The Eleventh Circuit denied the motion. *Id.*

And it ruled against her on the merits, reversing the district court in a split decision. The majority held that "the text and structure of the [Medicaid Act] do not conflict with Florida law and thereby do not preempt it." *Id.* at 15. According to the majority, the district court misinterpreted the Act because it failed to read Sections 1396k and 1396a(a)(25)(H) *in pari materia*. *See id.* at 16–20. Under a proper reading of those provisions, states are permitted to assert a lien against any part of a settlement that represents payment for a recipient's medical care. *Id.*

Sections 1396k and 1396a(a)(25)(H), the majority explained, work together, establishing a two-step process for recovering third-party payments for medical care. *See id.* at 16–18. Section 1396k sets

forth the first step. Under Section 1396k, a state must require its "Medicaid recipients [to] assign [it] 'any' of their rights to 'payment for medical care from any third party' as a condition of their acceptance of benefits." *Id.* at 16 (quoting Section 1396k(a)(1)(A)). In other words, the state must ensure that its recipients—as a threshold matter before receiving benefits—"broadly" assign it all rights to third-party payments that they may later obtain. *Id.* Once the state actually makes payments on behalf of a recipient, the second step—set forth in Section 1396a(a)(25)(H)—kicks in. Under Section 1396a(a)(25)(H), the state must take action on its broad assignment and assert a lien "to the extent that payment has been made under the State [Medicaid] plan." *Id.* at 17 (quotations and emphasis omitted).

Thus, Section 1396a(a)(25)(H), the majority concluded, does not limit states' recovery to the portion of a settlement that represents past medical expenses; it "simply provides *for what* [a] state can get reimbursed" ("medical expenses it has already paid") once "it has a general assignment" of a recipient's third-party payments. *Id.* at 17–18 (emphasis in original).

After the Eleventh Circuit issued its decision, Petitioner moved for rehearing en banc, but "[n]o judge . . . requested that the [c]ourt be polled" on the motion, so it was denied. *Id.* at 120. Petitioner then filed her Petition in this Court.

AHCA supports her request for review.

REASONS FOR GRANTING THE WRIT

I. THE DECISION BELOW PRESENTS A CONFLICT—BETWEEN THE ELEVENTH CIRCUIT AND THE FLORIDA SUPREME COURT—THAT SUBJECTS THE STATE TO INCONSISTENT STANDARDS.

This Court should grant review to resolve the split between *Giraldo* and the decision below. Because of the split, the State of Florida is subject to competing Medicaid regimes. Under *Giraldo*, the State cannot recover settlement payments designated for future medical care, but under the decision below, it must do so. If the State "fails to recover" third-party payments that it has authority to recover, "it violates" the Medicaid Act. *See Wos*, 568 U.S. at 649 (Roberts, C.J., dissenting, joined by Scalia, Thomas, J.J.). So under the decision below, the State has a duty to recover payments for future care. But if it fulfills that duty, it defies the Florida Supreme Court's ruling in *Giraldo*.

That is untenable.

In *Wos*, this Court granted review under similar circumstances. There, the Fourth Circuit struck down North Carolina's procedure for recovering third-party payments after the North Carolina Supreme Court had upheld the procedure. *Id.* at 632. As a result, North Carolina—like Florida here—faced conflicting decisions from its state supreme court and the federal court of appeals that exercises jurisdiction over it. *See id.* This Court granted review solely "[t]o resolve th[at] conflict." *See id.*

Resolving the split here is no less important. This, too, is one of the rare cases warranting review.

II. LOWER COURTS ACROSS THE COUNTRY ARE SPLIT ON THE QUESTION PRESENTED.

Giraldo and the decision below are just two of several decisions addressing the issue whether the Medicaid Act preempts states from recovering from settlement payments for future care. Courts across the country are split on the issue.

There is a three-to-two split among state supreme courts and federal courts of appeals, with the West Virginia, Utah, and Florida Supreme Courts holding that laws like Florida's are preempted, and the Idaho Supreme Court and the Eleventh Circuit holding otherwise. *Compare In re E.B.*, 729 S.E.2d 270, 299 (W. Va. 2012); *Latham v. Office of Recovery Servs.*, 448 P.3d 1241, 1246 (Utah 2019), *cert. denied*, 140 S. Ct. 852 (2020) (denying review before the split between the Eleventh Circuit and the Florida Supreme Court arose), *with In re Matey*, 213 P.3d 389, 393 (Idaho 2009); *see also* Pet. 16–18 (further discussing the lower-court split).[4]

District courts are also split. *Compare I.P. v. Henneberry*, 795 F. Supp. 2d 1189, 1197 (D. Colo.

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[4] Petitioner suggests that the split is deeper and that the Eleventh Circuit's decision is an outlier. Pet. 17–18. But in doing so, she relies on decisions from the Fourth Circuit and the Vermont Supreme Court that did not address whether states can seek reimbursement from settlement payments for future medical care. *See Doe v. Vt. Office of Health Access*, 54 A.3d 474, 482 (Vt. 2012) (holding that "§ 1910 [of the Vermont Statutes] allows the State to assert its lien only insofar as the State has made payments to the recipient"); *E.M.A. v. Cansler*, 674 F.3d 290, 293 (4th Cir. 2012) (holding that "the unrebuttable presumption inherent in [North Carolina's] one-third cap on . . . recovery" violates the Medicaid Act).

2011) (taking the same view as the Eleventh Circuit); *K.C.S. v. Folkemer*, 2011 WL 1231319, at *12 (D. Md. Mar. 28, 2011) (same), *with McKinney v. Phila. Hous. Auth.*, 2010 WL 3364400, at *9 (E.D. Pa. Aug. 24, 2010) (taking the same view as the Florida Supreme Court); *Price v. Wolford*, 2008 WL 4722977, at *2 (W.D. Okla. Oct. 23, 2008) (same).

This Court's review is thus necessary not only to resolve the split between the Eleventh Circuit and the Florida Supreme Court but also to ensure uniformity among lower courts more broadly.

III. THE QUESTION IS EXCEPTIONALLY IMPORTANT.

Beyond Florida's significant interest in resolving the split between the Eleventh Circuit and the Florida Supreme Court, this case implicates at least two other important state interests.

First, states, the federal government, and Medicaid recipients have a substantial interest in state Medicaid agencies obtaining full reimbursement from liable third parties. Ensuring that Medicaid is a payer of last resort is critical not only to state and federal budgets but also to Medicaid's longevity. *See Trainor v. Hernandez*, 431 U.S. 434, 444 (1977) (recognizing the important state interest in "safeguarding the fiscal integrity of [public-benefits] program[s]").

Giraldo and the other decisions striking down laws like Florida's jeopardize that interest. They hobble states' recovery efforts by drastically shrinking the pool of medical payments from which states are permitted to recover. For example, after the Utah Supreme Court's decision in *Latham*, Utah estimated

that "funds from third-party settlements available to reimburse [the state] might decrease by as much as 90 percent." Pet. for Cert. at 15, *Latham*, No. 19-539 (U.S. Oct. 21, 2019). And in *Giraldo*, AHCA would have recovered $321,720 of a $1 million tort settlement had the Florida Supreme Court permitted it to recover from payments for past and future care. 248 So. 3d at 54. Instead, it recovered just $13,881. *Id.* at 56. Finally, in *E.B.*, Chief Justice Ketchum noted in his dissent that, due to the majority's conclusion that states can recover from only payments for past care, "West Virginia will only be reimbursed" $96,080 of the $557,104 "that [it] paid on the plaintiff's medical bills," whereas if it "had been allowed to be reimbursed from that portion of [the] settlement representing . . . *all* medical expenses, past and future, it would have been reimbursed all of the $557,104." 729 S.E.2d at 306 (Ketchum, C.J., dissenting) (emphasis in original).

Second, states have a substantial interest in crafting their own rules for tort recovery—indeed, this Court has long recognized states' traditional authority over tort law. *See Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) ("The issue addressed by the court below is important [because] it affects . . . the states' traditional authority to provide tort remedies to its citizens."). *Giraldo* and similar decisions, however, invade that authority, restricting states' ability to design their own tort-recovery rules.

Laws requiring Medicaid recipients to assign the State the portion of their tort recoveries that represent payments for past and future care are an exercise of states' traditional authority over tort law.

The laws establish rules about "who may recover in particular circumstances": recipients who have chosen to receive Medicaid payments from their state may not recover medical payments from a tortfeasor—instead, the state is entitled to recover the payments to the extent necessary to make it whole. *See Wos*, 568 U.S. at 652 (Roberts, C.J., dissenting) (explaining that a state exercises its authority over tort law when it "set[s] rules about who may recover in particular circumstances").

Giraldo and related cases nullify states' decision to impose that tort-recovery rule, thereby interfering with their traditional authority over tort law—even though the Medicaid Act "says nothing about how [s]tates must define the recovery available to a Medicaid beneficiary suing a third party." *Id.* (stating that the "silence is a good indication that Congress did not mean to strip [s]tates of their traditional authority to regulate torts").

IV. THIS CASE PRESENTS AN OPPORTUNITY FOR THE COURT TO CLARIFY *AHLBORN*.

The Court should also grant review because this case presents an opportunity to clarify *Ahlborn*, which lower courts have cited in (incorrectly) presuming that Section 1396a(a)(25)(H) is relevant in disputes over a state's right to assignment of settlement payments.

In *Ahlborn*, this Court considered whether states can recover Medicaid expenses from settlement "proceeds meant to compensate [a] recipient for damages distinct from medical costs." *Ahlborn*, 547 U.S. at 272. Because both Section 1396a(a)(25)(H) and Section 1396k allow states to recover only from

payments for medical care, that question did not require the Court to decide whether Section 1396a(a)(25)(H) limits a state's right to assignment of settlement payments—whichever provision controlled, the answer to the question was the same. *Cf. Wos*, 568 U.S. at 650 (Roberts, J., dissenting) (stating that the question in *Ahlborn* "was an easy one" because it is plain that "[t]he State is only entitled to recover medical expenses"). Even so, since *Ahlborn*, a number of lower courts have presumed that Section 1396a(a)(25)(H) indeed limits states' right to assignment. *See, e.g.*, *Giraldo*, 248 So. 3d at 55–56 (relying on *Ahlborn* in explaining Medicaid's statutory scheme and assuming without analysis that Section 1396a(a)(25)(H) applies to the assignment of tort settlements); *Latham*, 448 P.3d at 1244–45 (same).

The decision below is instructive. The Eleventh Circuit began its analysis by citing *Ahlborn* and presuming that both Section 1396a(a)(25)(H) and Section 1396k are relevant here, *see* Pet. App. 14–16, even though AHCA argued that Section 1396a(a)(25)(H) addresses only states' subrogation rights as to insurers and similar third parties, *see* AHCA Init. Br. 19 ("[S]ubparagraph (H) contemplates the straightforward case in which a health insurer or similar third party is legally responsible to pay for services for which the State has already paid.").

Yet under the plain text of the Medicaid Act, Section 1396a(a)(25)(H) does not restrict a state's authority to recover by assignment part of a recipient's tort settlement. Section 1396a(a)(25)(H) provides that, when an insurer or other third party

has a "legal liability" to pay for "health care items or services furnished to" a recipient, and the state pays the medical provider before the insurer does, the state "acquire[s] the rights" to the payment that the insurer owes. *See* 42 U.S.C. § 1396a(a)(25)(H); *id.* § 1396a(a)(25)(A) (requiring states to seek payment from "health insurers, self-insured plans, . . . or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service"). That right to subrogation against insurers and other parties that have a legal liability to pay for medical services does not somehow limit a state's broad right to require a recipient to assign it medical payments that she has received from a tortfeasor. *See id.* § 1396k(a)(1)(A).

Indeed, when a tortfeasor pays out a settlement, it is not a third party that has a "legal liability" to pay for "health care items or services," *id.* § 1396a(a)(25)(H), and the state does not seek to "stand in the shoes of [the recipient] and assert [her] rights against" the tortfeasor, *see Subrogation*, Black's Law Dictionary (11th ed. 2019) (quoting Dan B. Dobbs, Law of Remedies § 4.3(4), at 604 (2d ed. 1993)). Instead, the state seeks only to recover part of the settlement from the recipient.

In short, granting review, analyzing the text of Section 1396a(a)(25)(H), and clarifying *Ahlborn* is important for two reasons. First, it will ensure that moving forward, Congress' intent—as embodied in the text of the Medicaid Act—governs lower courts' application of the Act. Second, lower courts' reading of *Ahlborn* has led them astray, laying the foundation for the split presented here. Presuming that Section

1396a(a)(25)(H) bears on states' right to assignment of settlement payments, the Florida Supreme Court and other courts have incorrectly held that Section 1396a(a)(25)(H) bars states from recovering payments for future care.

V. THE DECISION BELOW, NOT THE FLORIDA SUPREME COURT'S DECISION IN *GIRALDO*, IS CORRECT.

1. Although the Eleventh Circuit proceeded from the premise that Sections 1396a(a)(25)(H) and 1396k both bear on states' right to assignment of tort settlements, it reached the right result. The Medicaid Act does not preempt Florida's third-party-recovery laws. Section 1396k permits states to obtain by assignment "*any* . . . payment for medical care from" a tortfeasor—not just those designated for past care. *See* 42 U.S.C. § 1396k(a)(1)(A). Florida's laws are therefore consistent with, and not preempted by, the Medicaid Act.

2. But even assuming that Section 1396a(a)(25)(H) applies here, this Court should uphold the Eleventh Circuit's decision and overrule *Giraldo*. The Eleventh Circuit's reading of the Medicaid Act is the better reading.

First, the Florida Supreme Court's reading cannot be reconciled with the whole text of the Act. *See Mont v. United States*, 139 S. Ct. 1826, 1833–34 (2019) ("[T]he whole-text canon requires consideration of the entire text, in view of its structure and logical relation of its many parts." (quotations omitted)). Unlike the Eleventh Circuit, the Florida Supreme Court did not take into account Section 1396k in interpreting the

Act. It considered only Section 1396a(a)(25)(H). The Act, the court concluded, limits "Florida's assignment rights" to settlement payments "allocable to past medical expenses" because there is "no reasonable way to read" Section 1396a(a)(25)(H)—which refers to payments for "'services' already 'furnished'"—"as giving states a right to assignment of" payments for future care. *Giraldo*, 248 So. 3d at 56.

That interpretation, however, reads Section 1396k out of the Act, ignoring that it gives states a right to assignment of "any . . . payment for medical care." 42 U.S.C. § 1396k(a)(1)(A).

In contrast, the Eleventh Circuit's reading is consistent with the whole text of the Act: it effectuates—and reconciles—(1) Section 1396a(a)(25)(H)'s language, and (2) Section 1396k's language allowing states to acquire any of a recipient's rights to third-party medical payments. Under the reading, a state is "allowed to seek reimbursement for payments" that it already made for medical services (per Section 1396a(a)(25)(H)) "from settlement monies allocated to all medical care" (per Section 1396k). Pet. App. 20. "[T]he only limitation on [a state's] recovery is that it cannot seek reimbursement from settlement amounts allocated to categories other than medical care." *Id.*

Second, the history of the Medicaid Act belies the Florida Supreme Court's reading. Congress did not enact Section 1396a(a)(25)(H) until 1993, sixteen years after it enacted Section 1396k. During those sixteen years, Section 1396k controlled states' recovery efforts, permitting them to recover from "any" payment for medical care. *See, e.g.*, *N.Y. Dep't of*

Soc. Servs. v. Bowen, 846 F.2d 129, 133 (2d Cir. 1988) ("[T]he Medicaid statute mandates that states require applicants and recipients to 'assign the State any rights . . . to payment for medical care from any third party.'" (quoting 42 U.S.C. § 1396k(a)(1)(A))). Under the Florida Supreme Court's reading, then, Section 1396a(a)(25)(H) effected a sea change in the Medicaid Act, supplanting Section 1396k and substantially narrowing states' rights to recovery. Before Section 1396a(a)(25)(H), states could recover from payments for past or future care, but now, they can recover from payments only for past care.

But nothing suggests that in passing Section 1396a(a)(25)(H), Congress intended to partially abrogate Section 1396k or otherwise weaken the rights of states to obtain reimbursement from third parties. To the contrary, Congress enacted Section 1396a(a)(25)(H) to expand states' recovery rights, arming them with an express right to subrogation of insurer payments. *See* H.R. Rep. 103-111, at 209–10 (1993), *reprinted in* 1993 U.S.C.C.A.N. 378, 536–37.

3. At the very least, though, the Medicaid Act is ambiguous, so the presumption against preemption applies. Pet. App. 18–19. Given that states are "independent sovereigns in our federal system," *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996), when the text of a statute "is susceptible [to] more than one plausible reading, courts ordinarily accept the reading that disfavors preemption," *Altria Grp., Inc. v. Good*, 555 U.S. 70, 77 (2008) (quotations omitted).

Indeed, the only Florida Supreme Court justice in *Giraldo* who took into account Section 1396k—Justice

Polston—concluded that the "Medicaid Act, considered as a whole," is not "clear and unambiguous regarding whether AHCA can place a lien on the portions of a settlement that represent past and future medical damages." *Giraldo*, 248 So. 3d at 57 (Polston, J., concurring in part, dissenting in part).

CONCLUSION

The petition for a writ of certiorari should be granted.

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