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

BRIEF FOR RESPONDENT

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QUESTION PRESENTED

The Medicaid Act requires a state Medicaid program to obtain a beneficiary's right to "payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). Here, Medicaid paid $862,688.77 of petitioner's medical costs and she obtained an $800,000 settlement from a tortfeasor for her injuries. Petitioner contends that Medicaid is entitled to reimbursement of only $35,367.52 from that settlement because only that amount represents payment for past medical care.

The question presented is whether Medicaid may also seek reimbursement of its medical-assistance payments from the portion of petitioner's settlement representing payment for future medical care.

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INTRODUCTION

Medicaid is a federal-state partnership that pays out hundreds of billions of dollars annually in medical-assistance payments. The program is an important part of the social-safety net. Because health care is expensive, when a person suffers a sudden and acute injury, Medicaid often steps up to cover the medical costs. At the same time, Congress has made Medicaid the payer of last resort, meaning that other sources available to pay medical expenses must be exhausted before Medicaid pays for care. Consistent with that structure, state Medicaid programs must recover their costs from third parties who owe payments for medical care to the beneficiary, including from tortfeasors.

This case concerns Medicaid's authority to recover those costs from a tort settlement. Consider a Medicaid beneficiary with a tort claim for the following damages: $20,000 of immediate medical expenses—$19,000 paid by Medicaid and $1,000 paid by the beneficiary; $30,000 in medical care that will be necessary in the future; and $50,000 for pain and suffering. Of that $100,000 in total damages, 20% would be attributable to past medical expenses and 30% attributable to future medical expenses. Under the same allocation, if the case settled for $20,000, 20% of the settlement ($4,000) would be attributed to past medical expenses, while 30% ($6,000) would be attributed to future medical expenses. Medicaid could not recover its costs from the remaining 50% ($10,000) attributed to pain and suffering. *See Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 280-88 (2006). The question in this case is whether

Medicaid can recover some of its costs (in that example $19,000) from the portion of the medical damages in a tort settlement that represents compensation not only for past medical expenses ($4,000), but also for future medical expenses ($6,000).

The answer is yes, and it follows from the text of the Medicaid Act. Medicaid may obtain "any rights" a beneficiary has "to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). That broad language permits Medicaid to recover from any damages representing payment for "medical care." *Id*. In seeking reimbursement, Medicaid may never recover more than it paid out; any remaining amount after Medicaid's claim is satisfied is remitted to the beneficiary. *Id*. § 1396k(b). Medicaid, again, cannot recover from any non-medical damages. *See Ahlborn*, 547 U.S. at 280-88. But Medicaid is entitled to priority in obtaining reimbursement from all damages for medical expenses: "[W]hat § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care." *Id*. at 282. That result preserves Medicaid's status as the payer of last resort for medical expenses and fosters the program's fiscal integrity, so that the program will be there for the next beneficiary who needs it.

STATEMENT

A. The Medicaid Act

1. Medicaid is "the primary federal program for providing medical care to indigents 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). Medicaid 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 the "payer of last resort." *Id.* at 275, 291. That status "means that other available resources . . . must be used before Medicaid pays for services received by a Medicaid-eligible individual."[1]

The Medicaid Act contains provisions designed to preserve the program's status as the payer of last resort for medical costs. Since 1968, the statute has obliged state Medicaid plans to "ascertain the legal liability of third parties" to "pay for care and services available under the plan"—*i.e.*, to identify third parties potentially liable for Medicaid's costs, 42 U.S.C. § 1396a(a)(25)(A)—and to seek reimbursement from those parties for those costs, *see id.* § 1396a(a)(25)(B). Part of the reason for that obligation is that Medicaid will refuse to pay a claim if a third party is liable to pay the expenses. *See, e.g.*, 42 C.F.R. § 433.139(b)(1). Beneficiaries also are obliged to cooperate with the program in establishing the liability of third parties. A beneficiary must, for instance, help establish the paternity of an individual who may be liable to pay the beneficiary's medical expenses through spousal or child support. *See* 42

[1] 85 Fed. Reg. 87,000, 87,000 (2020); *see also* 80 Fed. Reg. 31,098, 31,175 (2015); S. Rep. No. 99-146, at 312 (1985).

U.S.C. § 1396k(a)(1)(B). More generally, beneficiaries have an obligation, absent good cause, to cooperate in helping the program pursue third parties who may be liable to pay for Medicaid's costs. *See id.* § 1396k(a)(1)(C).

Subsection (a) of Section 1396a of the statute contains two provisions that require state Medicaid plans to acquire a beneficiary's right to payment from third parties liable for Medicaid's costs. First, state plans must "provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k." 42 U.S.C. § 1396a(a)(45). Section 1396k—enacted in 1977 and made mandatory in 1984—in turn requires States to have laws that assign to the State "any rights" the beneficiary may have "to support . . . and to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). The second provision, added in 1993 to bolster the program's authority to recover third-party payments from private insurance companies, *see* U.S. Br. 28-29, requires state Medicaid plans to have laws allowing the State to acquire the "rights" of a beneficiary "to payment by any other party" for "health care items or services furnished" to the beneficiary. 42 U.S.C. § 1396a(a)(25)(H). If the Secretary of Health and Human Services concludes that a State does not comply with those requirements, the Secretary may withhold its Medicaid funds. *See* 42 U.S.C. § 1396c.

2. Medicaid's authority to acquire third-party payments is tempered by the "anti-lien" provision of the statute. 42 U.S.C. § 1396p(a)(1). That provision generally bars States from imposing liens on a

beneficiary's property, which includes money that the beneficiary is owed. *See Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 633 (2013). The payment rights required by Sections 1396k, 1396a(a)(45), and 1396a(a)(25), however, constitute exceptions to that general rule, "set[ting] both a floor and a ceiling on a State's potential share of" third-party payments. *Id.* States are therefore authorized to acquire third-party payments for medical care owed to a beneficiary as provided by Sections 1396k, 1396a(a)(45), and 1396a(a)(25) notwithstanding the anti-lien provision.

The Court addressed the scope of those provisions in *Ahlborn*, which involved the question whether the anti-lien provision prohibited Medicaid from recovering its costs from the portions of a tort settlement designed to compensate the beneficiary for non-medical damages, such as pain and suffering. The Court held that it does, concluding that the statute requires "assignment of no more than the right to recover that portion of a settlement that represents payments for medical care." *Ahlborn*, 547 U.S. at 282. The question this case presents is whether the State may recover out of all portions of a settlement representing payments for medical care, including compensation for past and future medical expenses.

B. Florida's Medicaid program

Florida provides Medicaid benefits to around four million people,[2] spending $28 billion per year on

[2] May 2021 Medicaid & Chip Enrollment Data, Medicaid.gov (Apr. 2, 2021), https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

Medicaid services,[3] which is 30% of Florida's annual budget.[4] Florida's Agency for Health Care Administration (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" beneficiaries. Fla. Stat. § 409.910(1). After AHCA "has provided medical assistance under the Medicaid program," it must "seek reimbursement from" any liable third parties. *Id.* § 409.910(4). Beneficiaries have a duty to "inform [AHCA] of any rights" they have to payments from third parties. *Id.* § 409.910(5). They must provide AHCA with "the name and address of any person [who] is or may be liable" for payments for their medical care. *Id.* For instance, if a third party injures a beneficiary, forcing the beneficiary to obtain medical care, the beneficiary must inform AHCA if the third party agrees to a settlement providing payments for medical expenses. *See id.*

AHCA recovers its expenses from liable third parties through a lien process. When a beneficiary "accept[s] medical assistance" from AHCA, the beneficiary "assigns" AHCA all rights to third-party payments for medical care—regardless of whether the payments are for past or future care. *Id.*

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[3] Medicaid Program Finance, AHCA, https://ahca.myflorida.com/medicaid/finance/finance/index.shtml (last visited Nov. 14, 2021).

[4] *See* Overview of State Budget, Executive Office of the Governor, https://www.flgov.com/wp-content/uploads/2020/06/2020-Budget-Highlights.pdf (last visited Nov. 14, 2021).

§ 409.910(6)(b). A lien "for the full amount of medical assistance provided by" AHCA "attaches automatically" to "the collateral," *id.* §§ 409.910(6)(c), (c)(1), which includes a settlement that stems from a tort suit related to an injury "that necessitated that Medicaid provide medical assistance," *id.* § 409.901(7). If a beneficiary learns that he is entitled to a third-party payment, the beneficiary must notify AHCA, at which point it may impose a lien on the recovery. *See id.* § 409.910(6)(c)(2).

C. Facts and procedural history

1. A third party injured petitioner in 2008, and AHCA provided $862,688.77 in benefits for medical expenses. JA 26, 37. A private insurer, WellCare of Florida, paid $21,499.30 of her medical costs. JA 26, 37. As a condition of eligibility for Medicaid, petitioner assigned to AHCA her rights to third-party payments for medical care. JA 31, 38.

Petitioner's guardians sued the third party in state court. Pursuant to Florida's third-party-recovery laws and the assignment of rights, AHCA "asserted a $862,688.77 Medicaid lien against [her] cause of action." JA 32, 37. Petitioner's guardians ultimately settled the case for $800,000. JA 27, 38. They drafted the settlement agreement to (1) estimate total damages of at least $20,000,000, (2) resolve all claims for 4% of that estimate—$800,000, and (3) allocate $35,367.52 of the $800,000 to compensation for past medical care (4% of the $884,188.07 that Medicaid and WellCare had paid for petitioner's medical expenses). JA 28, 32. As for future medical expenses, the agreement stated only that "some portion of th[e]

settlement may represent compensation for future medical expenses." JA 31.

Under Florida's tort-recovery formula, when a beneficiary obtains a recovery from a tortfeasor, either through a settlement or judgment, AHCA is presumptively entitled to half of the recovery (after first deducting 25% for "attorney's fees and taxable costs"). Fla. Stat. §§ 409.910(11)(f), (17)(a). The resulting net amount (37.5%) is presumed to represent the portion of the recovery that is for all medical expenses, past and future. *See id.* § 409.910(17)(b). The presumption, however, is rebuttable. After depositing that amount, the beneficiary may demonstrate in a proceeding before the Florida Division of Administrative Hearings, by clear and convincing evidence, that "the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by [Florida's] formula." *Id.*

Invoking this procedure, petitioner deposited $300,000 of her settlement (37.5% of $800,000) into a trust account and petitioned to challenge AHCA's entitlement to that amount. JA 42. In the administrative proceeding, petitioner argued that the Medicaid Act preempted Florida's third-party-recovery law to the extent it allowed recovery of more than $35,367.52, the portion of the settlement that, she alleged, was compensation for her past medical expenses. JA 42.

2. Petitioner pursued her administrative case only briefly. After she drew an administrative law judge she perceived as unfavorable to her case, JA 33-34, petitioner sued AHCA in federal district court under

42 U.S.C. § 1983. She also moved to stay the administrative proceedings pending resolution of the district court case, which the ALJ did. JA 43. Petitioner asked the district court to declare Florida's scheme preempted to the extent it allowed recovery from more than her past medical expenses. JA 35-36; *see* Pet. App. 98. The district court obliged and granted summary judgment for petitioner. Pet. App. 114-15.

3. The Eleventh Circuit reversed.[5] The court held that the Medicaid Act permits Medicaid to seek reimbursement of third-party payments for both past and future medical expenses. The court noted that, under the presumption against preemption, it could hold Florida's third-party-recovery law preempted only if it concluded that federal law clearly conflicted with the Medicaid Act. Pet. App. 10-12. It then held that nothing in the Medicaid Act clearly preempted Florida's decision to allow recovery from the portion of a tort settlement representing both past and future medical expenses. It relied on the "broad[]" language of the assignment provision, which "requires States to provide that Medicaid recipients must assign to the state 'any' of their rights to 'payment for medical care from any third party.'" Pet. App. 16 (quoting 42 U.S.C. § 1396k(a)(1)(A)).

Judge Wilson dissented on that issue. He would have held that Medicaid was entitled to recover from

[5] While AHCA's 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 to the extent that they permit recovery from payments for future medical expenses.

petitioner's tort settlement only "the amount of the recovery that represents payment for past medical care." Pet. App. 31.

SUMMARY OF THE ARGUMENT

To keep Medicaid as the payer of last resort for medical costs, Congress requires state Medicaid programs to seek reimbursement from third parties liable for beneficiaries' medical care. Over the years, Congress has updated the Medicaid Act to provide ever more effective tools for Medicaid to fully capture such third-party liabilities. This case involves one such mechanism, which Congress has required States to have for nearly four decades: mandatory assignment of "any rights . . . to support . . . for the purpose of medical care . . . and to payment for medical care from any third party" as a condition of eligibility for Medicaid. 42 U.S.C. § 1396k(a)(1)(A); *see also id.* § 1396a(a)(45) (requiring State plans to "provide for mandatory assignment of rights of payment for medical support and other medical care").

The text of the assignment provision demonstrates that Medicaid may obtain reimbursement of its costs from the portion of a tort settlement attributable to "medical care," whether designated for past or future medical expenses, up to the amount that Medicaid paid in medical assistance. 42 U.S.C. § 1396k(a)(1)(A). That conclusion is confirmed by other language in Section 1396k requiring the program to recover its costs from medical "support" payments owed by an absent spouse to a Medicaid beneficiary. *Id.* It also draws support from this Court's decision in *Ahlborn*, which not only many times characterized the State's assignment of rights as extending to damages for

"medical care," 547 U.S. at 280-88, but also noted that the State must be "paid first out of any damages representing payments for medical care"—with the remainder going to the beneficiary, pursuant to Section 1396k(b), *id.* at 282.

Contrary to the suggestions of petitioner and the United States, there is no basis for engrafting onto Section 1396k limits derived from the other third-party-liability provisions in Section 1396a(a)(25). Those provisions impose no temporal restriction on the State's rights. In any event, the limiting language that petitioner and the United States see in Section 1396a(a)(25) is nowhere present in Section 1396k, which, as Section 1396a(a)(45) makes clear, is an independent requirement of the Medicaid Act. The history and structure of the statute reflect that the additional payment tools Congress gave Medicaid in Section 1396a(a)(25) supplement, rather than supplant or restrict, the broad language of the assignment provision in Section 1396k, which dates from 1977. An assignment is a transfer of rights, but rights can also arise from an automatic right of subrogation that attaches when a payment is made. There is no good reason to think that, when Congress in 1993 gave Medicaid an automatic right of subrogation when it makes payments, *see* 42 U.S.C. § 1396a(a)(25)(H), it limited Medicaid's authority to acquire such rights by the separate mechanism of assignment under Section 1396k.

Congress' design of the Medicaid Act, providing States with overlapping tools to recover payments from liable third parties, parallels the payment-recovery provisions in the Medicare program. And

allowing Medicaid to recover its costs from all medical damages preserves Medicaid's role as the payer of last resort for medical costs. That result is consistent with other federal programs, several of which permit the government full reimbursement out of all damages from liable third parties.

If the statute were ambiguous on the question presented, the Court should apply the presumption against preemption and affirm. Interpreting the statute to permit recovery only from past medical expenses would preempt Florida's law (along with the laws of other States) under the anti-lien provision of the statute. But affirming would result in no preemption. If other States, unlike Florida, are not complying with Section 1396k's directive to have laws allowing recovery from both past and future medical damages, the remedy would be for the Secretary to withhold their Medicaid funding—not immediate judicial invalidation of any such laws.

The judgment should be affirmed.

ARGUMENT

I. THE MEDICAID ACT PERMITS THE STATE TO RECOVER THIRD-PARTY PAYMENTS FOR BOTH PAST AND FUTURE "MEDICAL CARE."

The Medicaid Act requires States to have laws giving the program a right to reimbursement of Medicaid payments made if another person is potentially liable for medical costs, such as a third-party tortfeasor, insurer, or other individual. *See* 42 U.S.C. §§ 1396k(a)(1)(A), 1396a(a)(45). But the program can recover no more than it paid out in benefits. *See id.* § 1396k(b).

The question here is thus not whether Medicaid can obtain recovery for "medical expenses Medicaid has not paid," Pet. Br. 1; the program can never do that. Rather, the question is whether, when a beneficiary receives money for medical expenses from third parties—including for past and future medical expenses—Medicaid is entitled to reimbursement from those amounts for benefits it *did* pay (and has priority over others who may have medical-expense claims). It is, as demonstrated by the text of Sections 1396k and 1396a(a)(45), the history and structure of the Medicaid Act, and the purpose of the statute of preserving Medicaid's status as the payer of last resort for medical costs.

A. Sections 1396k and 1396a(a)(45) permit States to obtain the assignment of rights to payments for medical care, past or future, from any third party.

The Medicaid Act generally prohibits the program from imposing a lien to recover previous Medicaid payments made to a beneficiary. *See* 42 U.S.C. § 1396p(a)(1); *see also Ark. Dep't of Health & Hum. Servs. v. Ahlborn*, 547 U.S. 268, 283-85 (2006). But the statute contains an exception to that rule in Sections 1396k and 1396a(a)(45), which allow States to acquire the rights of beneficiaries to receive payment for medical care. *See Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 633-34 (2013); *Ahlborn*, 547 U.S. at 283-84. Section 1396k resolves this case: It permits Medicaid to impose a lien, up to the amount of its outlays, on a tort settlement that represents compensation for medical care—past or future.

1. "The plain text" of the Medicaid Act should "begi[n] and en[d] [the Court's] analysis." *Puerto Rico v. Franklin Cal. Tax-Free Tr.*, 136 S. Ct. 1938, 1946 (2016). Section 1396k(a)(1)(A) requires state plans to provide that, "as a condition of eligibility for" Medicaid, an individual is required "to assign the State *any 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*." (emphasis added). As the Eleventh Circuit observed, that "broad[]" language permits recovery from payments for medical care without differentiation and without temporal limit. Pet. App. 16. The statute applies to "any" such "rights." 42 U.S.C. § 1396k(a)(1)(A). And "[r]ead naturally, the word 'any' has an expansive meaning, that is, 'one or some indiscriminately of whatever kind.'" *United States v. Gonzales*, 520 U.S. 1, 5 (1997) (quoting Webster's Third New International Dictionary 97 (1976)). "Congress did not add any language limiting the breadth of that word, and so [courts] must read [Section 1396k(a)(1)(A)] as referring to all" payments for medical care. *Id.*

In the same breath, Congress permitted States to acquire rights to "support (specified as support for the purpose of medical care by a court or administrative order)." 42 U.S.C. § 1396k(a)(1)(A); *see also id.* § 1396a(a)(45) (requiring state plans to "provide for mandatory assignment of rights of payment for medical support and *other* medical care owed to recipients" (emphasis added)). That language confirms that Section 1396k applies to all medical damages. A right to "support for the purpose of medical care" includes a right to child or spousal

support relating to medical care; a beneficiary must, absent good cause, cooperate with the State in establishing "paternity . . . if the child is born out of wedlock," and make best efforts to obtain a spousal-support order. *Id.* § 1396k(a)(1)(B); *see* 42 C.F.R. § 433.147(b). Just as Medicaid may recover from spousal-support obligations owed to beneficiaries—whether for past or future medical expenses—so too Medicaid may recover other third-party payments for medical care without temporal limit.

Section 1396a(a), which sets forth requirements for state Medicaid plans, likewise tells States to "provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k." 42 U.S.C. § 1396a(a)(45). So Sections 1396k(a)(1)(A) and 1396a(a)(45) mandate the same thing: that States have laws allowing them to obtain by assignment any rights to third-party payments for medical care. Neither limits the program to recovering from only funds representing compensation for past medical expenses.

2. This Court's decision in *Ahlborn* points to the same conclusion.

In *Ahlborn*, the Court considered whether the Medicaid Act permitted Arkansas' Medicaid program to recover more than the "portion . . . that represented payments for medical care" from a tort settlement. 547 U.S. at 275. Ahlborn had been injured by a tortfeasor, and Medicaid had paid $215,645.30 of her medical bills. *Id.* at 273. Ahlborn then settled with the tortfeasor for $550,000. *Id.* at 274. When a dispute arose concerning the portion of the settlement from

which Arkansas could receive reimbursement, the parties stipulated that "if Ahlborn's construction of federal law was correct," Arkansas "would be entitled to only the portion of the settlement ($35,581.47) that constituted reimbursement for medical payments made." *Id.*

This Court held that Medicaid could receive reimbursement from only the medical damages subject to that stipulation. The Court construed the Medicaid Act, including Section 1396k, to forbid Medicaid from recovering from the pool of funds representing payments for damages other than medical care, such as pain and suffering and other noneconomic damages. *Ahlborn*, 547 U.S. at 280-85. But in reaching that holding, the Court made clear that there was "no question that the State can require an assignment of the right . . . to receive payments for medical care." *Id.* at 284. The Court many times characterized the statute as extending to payments for "medical care." *Id.* at 280-88. And the Court repeated that characterization in *Wos*, 568 U.S. at 633-36. Not "*past* medical expenses." Pet. Br. 20. Not "the portions of a recovery that represent compensation for medical expenses paid by Medicaid." U.S. Br. 12. Payments for "medical care," *Ahlborn*, 547 U.S. at 284, full stop.

The Court also concluded that the State's assigned rights under Section 1396k extend beyond third-party payments that represent compensation for expenses paid by Medicaid. While explaining that under Section 1396k(b) the "'amount recovered . . . under an assignment' is not, as [Arkansas] assume[d], the entire settlement," the Court held that "the State's

assigned rights extend only to recovery of *payments for medical care*." *Id.* at 282 (emphasis added). "[W]hat § 1396k(b) requires," this Court explained, "is that the State *be paid first out of any damages representing payments for medical care* before the recipient can recover any of her own costs for medical care." *Id.* (emphasis added). In other words, because reimbursing the program takes priority, "[a]t the very least, . . . the federal third-party liability provisions" (including Section 1396k) "*require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care." *Id.* The Court read the statute, in short, to give Medicaid a priority right to recover from damages for "medical care" without differentiation.

3. Petitioner errs in contending that Section 1396k permits recovery from only damages for past medical care.

First, petitioner highlights Section 1396k's "introductory clause," (Pet. Br. 30), which states that its "purpose" is to "assist[] 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." 42 U.S.C. § 1396k(a). Petitioner posits that because that clause uses the term "owed," and "[b]ecause beneficiaries are not 'owed' coverage for future care for which they may never be eligible," Section 1396k must exclusively concern "*past* medical care provided under the plan." Pet. Br. 30. That mistakenly assumes that "owed" refers to payments *Medicaid* owes the beneficiary. In fact, "medical support payment and other payments for medical care" refers to payments

that *third parties* may "owe" the beneficiary. 42 U.S.C. § 1396k(a). Section 1396k "assist[s]" the *State*'s ability to "collect[]" such payments to defray Medicaid's costs. And amounts that third parties may "owe" a beneficiary include not only damages for past medical care, but also damages for future medical care.

Second, petitioner points (Pet. Br. 31) to Section 1396k(a)(1)(C), which provides that a beneficiary must, as a condition of eligibility for Medicaid, "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." 42 U.S.C. § 1396k(a)(1)(C). Petitioner argues that this provision does not require identification of parties who may be liable for "*future* medical care." Pet. Br. 31.

The statute draws no such temporal distinction. Section 1396k(a)(1)(C) is one of at least two provisions in the statute contemplating that Medicaid plans should identify parties who are potentially liable for Medicaid's costs, the other being Section 1396a(a)(25)(A), which requires Medicaid programs to "ascertain" third parties who may have a "legal liability . . . to pay for care and services available under the plan." 42 U.S.C. § 1396a(a)(25)(A). Both provisions apply to parties who may be liable to pay a beneficiary's future medical costs as well. A potentially liable third-party would include, for example, an individual who has been ordered to pay "support" to his spouse, or for his child, "for the purpose of medical care." 42 U.S.C. § 1396k(a)(1)(A). It would also include a private insurer providing primary health-insurance coverage to the beneficiary;

such an insurer must be identified as a party potentially liable for the beneficiary's medical expenses in the future. *See* 42 U.S.C. § 1396a(a)(25)(A) (mentioning "health insurers, self-insured plans, group health plans . . . service benefit plans, managed care organizations, [and] pharmacy benefit managers" as potentially liable third parties). Medicaid regulations require beneficiaries to provide private-insurance information at the time of eligibility because—consistent with Medicaid's role as the payer of last resort—Medicaid can deny a claim that is also covered by private insurance. *See* 42 U.S.C. § 1396b(o); 42 C.F.R. §§ 433.138(b)(1), 433.139(b). The statute fully applies to both past and future medical expenses.

Third, petitioner implies that Section 1396k is inapplicable because it is "directed primarily" at the situation where the Medicaid program "actively participate[s] in . . . litigation," Pet. Br. 28, 29, whereas here petitioner's guardians settled the case. But as Judge Hardiman explained for the Third Circuit, and as this Court correctly "assume[d]" in *Ahlborn*, 547 U.S. at 281, Section 1396k gives Medicaid a right to recover costs by imposing a lien on a tort recovery obtained, as happened here, through the efforts of a beneficiary. *See Tristani v. Richman*, 652 F.3d 360, 374-75 (3d Cir. 2011). The statute requires an "assignment," 42 U.S.C. § 1396k(a)(1)(A), which is just a transfer of rights, *see Black's Law Dictionary* 115 (7th ed. 1999). And "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." Pet. Br. 42 (citing cases); *see also Tristani*, 652 F.3d at 374

(explaining that "a partial assignment typically creates a lien on a portion of the recovery in favor of the assignee" and citing additional cases). The statute also provides ample authority to consider the beneficiary to have transferred to Medicaid her right to receive medical-care payments directly from the settlement itself. Here, petitioner assigned her rights to payments for medical care to Medicaid to the extent needed to reimburse what the program paid on her behalf. JA 31, 38. Those rights include the right to payment for medical care from petitioner's settlement.

4. Petitioner also errs in seeking support from *Ahlborn* for her distinction between past and future medical expenses.

Though *Ahlborn* read the "text of the federal third-party liability provisions" to "focus[] on recovery of payments for medical care," 547 U.S. at 280, petitioner thinks this meant only payments for past medical care. Pet. Br. 34-36. Petitioner cites (Pet. Br. 35) a lone footnote in *Ahlborn*, which noted the unfairness of allowing a state workers' compensation program to receive reimbursement from damages paid from a third-party tortfeasor for "loss of consortium" because the workers' compensation program had provided "no compensation" for loss of consortium. 547 U.S. at 288 n.19. But *Ahlborn* recognized that the same unfairness does not arise where, as here, Medicaid seeks recovery from tort damages that are for medical expenses, which Medicaid generally covers. That is why the Court stated that Medicaid may recover its costs out of medical damages—even if some of those damages represent the beneficiary's "own costs for medical care" rather than Medicaid's.

Id. at 282. That logic equally applies to damages that are for medical costs a beneficiary may (or may not) incur in the future.

Petitioner also argues that *Ahlborn* implicitly held that Medicaid cannot recover from future medical damages, because "[t]he tort recovery in *Ahlborn* included compensation for both past and *future* medical expenses," and the Court held that the State could not recover "anything more than the stipulated amount," which included only past medical expenses. Pet. Br. 35. Yet that disposition followed not from any distinction between past and future medical expenses, but from Arkansas' stipulation that "if Ahlborn's construction of federal law was correct," then Arkansas "would be entitled to only the portion of the settlement . . . that constituted reimbursement for medical expenses made." *Ahlborn*, 547 U.S. at 274.

5. Petitioner is supported by the United States. Though it stands to gain the lion's share of Medicaid's recovery here, the United States advocates for a more aggressive rule of preemption than petitioner has advanced in this litigation. It believes that Medicaid cannot recover from "the portions of a recipient's recovery . . . that represent compensation for medical expenses (past or future) not paid by Medicaid." U.S. Br. 10.[6] By contrast, petitioner has not disputed that Medicaid may recover from the portions of her

[6] The United States does not explain how this rule would account for instances in which Medicaid pays for a beneficiary's future medical expenses following a tort judgment or settlement. In this case, for instance, it is Florida's understanding that Medicaid has continued to pay petitioner's medical expenses even after her 2015 settlement.

settlement that represent compensation for all past medical expenses, even though a private insurer paid some of those costs. *See* JA 27, 32, 35; Pet. Br. 16.[7]

The United States' late-breaking theory is inconsistent with Section 1396k(b)'s remainder provision. It states:

> 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 . . . and the remainder of such amount collected shall be paid to such individual.

42 U.S.C. § 1396k(b). The "assignment made under" Section 1396k(a)(1)(A), this Court held in *Ahlborn*, "does not sanction an assignment for payment for anything other than medical expenses." 547 U.S. at 281. Section 1396k(b) thus entitles the beneficiary to any balance that remains after Medicaid's claim to reimbursement is fully paid: Medicaid "collect[s]" amounts from total medical expenses that are "necessary to reimburse it for medical assistance payments," and the beneficiary gets "the remainder of such amount collected." 42 U.S.C. § 1396k(b).

To illustrate, suppose Medicaid pursues its assigned right for a total of $50,000 in damages for medical expenses, $45,000 of which were paid by Medicaid, $2,500 of which the beneficiary paid out of

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[7] The United States is thus mistaken that "in this case" Medicaid "paid past expenses in full." U.S. Br. 10.

pocket, and $2,500 for future medical expenses. Suppose Medicaid recovers only half of the total medical expenses ($25,000). Medicaid would keep the full $25,000 because it is "necessary to reimburse [Medicaid] for medical assistance payments" that it made. 42 U.S.C. § 1396k(b). Because Medicaid was not fully reimbursed, there is no "remainder of such amount collected," so nothing is paid to the beneficiary. *Id.* But suppose Medicaid instead succeeds in recovering all total medical expenses ($50,000). In that case, Medicaid would keep the $45,000 necessary to reimburse its medical-assistance payments and remit the $5,000 balance of medical expenses to the beneficiary.

This scheme presumes that the amount of medical expenses that Medicaid may "collect[]" on its "assignment" (in that example, a claim for $50,000 in medical expenses) is not equivalent to "the medical assistance payments" Medicaid made (in that example, $45,000), 42 U.S.C. § 1396k(b). The remainder provision contemplates, instead, that Medicaid may collect out of all damages for medical expenses. Only after Medicaid is fully reimbursed for the medical-assistance payments it has made may the beneficiary be reimbursed for any medical expenses the beneficiary may also have incurred (or receive compensation for any future medical expenses). Section 1396k(b) thus demonstrates that Medicaid's assignment permits recovery from medical damages other than those representing amounts that it paid.

The interpretation of the United States, by contrast, is inconsistent with the remainder provision. Under the United States' view, Medicaid may not

collect from any medical damages representing expenses Medicaid did not pay. To build on the example set forth in the preceding paragraph, Medicaid could never, according to the United States' interpretation, hope to collect more than $45,000 in medical damages—the amount of its medical-assistance payments. But that would leave no remainder for the beneficiary even in the event of maximum recovery on Medicaid's assigned right to medical expenses. The position of the United States thus violates the "cardinal principle of interpretation that courts must give effect, if possible, to every clause and word of a statute." *Parker Drilling Mgmt. Servs., Ltd. v. Newton*, 139 S. Ct. 1881, 1890 (2019) (cleaned up).

The United States' position is also inconsistent with how this Court in *Ahlborn* read the remainder provision. *Ahlborn* rejected Arkansas' argument that there can be no "'remainder'" if "all the State has been assigned is the right to damages for medical expenses." 547 U.S. at 282 n.11. That argument was wrong, the Court explained, because Medicaid may not have "paid all the recipient's medical expenses." *Id.* Instead, the beneficiary may also have "paid medical expenses out of her own pocket." *Id.* In that scenario, where both Medicaid and the beneficiary have paid medical expenses, a remainder will exist if the "portion of any third-party recovery earmarked for medical expenses" exceeds "Medicaid's expenses." *Id.* The Court also explained that, in the case of health insurance, "the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses." *Id.* No remainder would exist in those scenarios if Medicaid's

assignment extended only to the "portions of a recipient's recovery that represent compensation for medical expenses paid by Medicaid." U.S. Br. 10.

B. The history and structure of the Medicaid Act confirm that States may obtain the assignment of rights to payments for past and future medical care.

The history and structure of the Medicaid Act reinforce that an assignment under Section 1396k extends to all portions of a tort recovery that represent compensation for medical expenses. Section 1396k(a)(1)(A), applicable to "payment for . . . medical care," is an independent requirement that state Medicaid plans must satisfy alongside the others in the statute respecting third-party liability. *See* 42 U.S.C. § 1396a(a)(45). And there is no basis for reading Section 1396k as "subordinate" to (Pet. Br. 33), or otherwise atextually limited by (U.S. Br. 17-21, 27-28), the other third-party-liability provisions in Section 1396a(a)(25).

1. The Medicaid Act's third-party-liability provisions "focus[] on recovery of payments for medical care." *Ahlborn*, 547 U.S. at 280.

In 1968, Congress for the first time directed state Medicaid plans to have provisions addressing third-party liability, requiring them to "take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability," and to seek reimbursement of that liability. Social Security Amendments of 1967, Pub. L. No. 90-248, § 229(a), 81 Stat. 821, 904 (1968) (codified as amended

at 42 U.S.C. § 1396a(a)(25)(A)). In the same amendment, Congress also instructed Medicaid programs to treat such liability as a resource available to an individual in evaluating eligibility for Medicaid. *Id.*[8] That "liability" thus was concerned with liability for medical costs generally—the kind of liability that would be relevant for evaluating Medicaid eligibility. The federal government interpreted this statute the same way immediately after its enactment, defining a liable third party as any "individual, institution, corporation, public or private agency who is or may be liable to pay all or part of the *medical cost* of injury, disease or disability of an applicant or recipient of medical assistance."[9]

The focus on liability for medical costs continued when Congress enacted Section 1396k in 1977. In

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[8] When it was enacted, the provision requiring Medicaid to treat third-party liability as a resource when evaluating Medicaid eligibility was codified at 42 U.S.C. § 1396a(a)(25)(B). *See* § 229(a), 81 Stat. at 904. It was later repealed. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9503(a)(1), 100 Stat. 82, 205 (1986).

[9] *Payments for Medical Services and Care by Third Party*, 34 Fed. Reg. 752, 752 (1968) (codified at 45 C.F.R. § 250.31(c)) (emphasis added); *see also* 42 C.F.R. § 250.31(c) (1970) (same); 42 C.F.R. § 433.136 (1980) (defining "[t]hird party" to mean "any individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient"); *Third Party Liability for Medical Assistance*, 50 Fed. Reg. 46,652, 46,658 (1985) (defining a third party's "probable liability" as "the presence of an indicator in the case record that suggests a possible third party resource that is or may be liable for a recipient's *medical expenses*") (emphasis added).

doing so, it characterized Section 1396a(a)(25)(A) as requiring States "to take all reasonable measures to ensure that third parties legally liable to pay for *any medical care rendered to medicaid recipients* meet their legal obligations." S. Rep. No. 95-453, at 30 (1977) (emphasis added). Then, as today, Section 1396k granted States authority to acquire by assignment "any rights" beneficiaries have "to support . . . and to payment for medical care from any third party." *Medicare-Medicaid Anti-Fraud and Abuse Amendments*, Pub. L. No. 95-142, § 11, 91 Stat. 1175, 1196 (1977). And Section 1396k was enacted against the backdrop of the federal government's regulation interpreting a "third party" as someone liable for the "medical costs" of a Medicaid applicant or beneficiary.[10]

In the Deficit Reduction Act of 1984, Congress reinforced that reading. There, Congress required, rather than merely authorized, States to obtain a broad assignment of rights to payment for "medical care." *See* Pub. L. No. 98-369, § 2367, 98 Stat. 494, 1108 (1984). Underscoring the point, Congress in the same law also amended Section 1396a(a)—which governs the required contents of state Medicaid plans, of which the liability-identification provision, Section 1396a(a)(25)(A), is also a part. Specifically, Congress added Section 1396a(a)(45) to that subsection to require a state Medicaid plan to "provide for mandatory assignment of rights of payment for medical support and other *medical care owed to recipients* in accordance with" Section 1396k. § 2367, 98 Stat. at 1108 (emphasis added). The focus thus

[10] 45 C.F.R. § 250.31(c) (1976); 42 C.F.R. § 450.31(c) (1977).

continued to be on recovering payments for medical care.

In 1993, Congress required state Medicaid plans to add another payment-recovery tool to their kit. Congress was concerned "that insurers were 'thwarting' Section 1396k by refusing to recognize assignments and by arguing that their insurance contracts forbade assignments." U.S. Br. 28-29 (quoting U.S. Gen. Accounting Off., GAO/HRD-91-25, *MEDICAID: Legislation Needed to Improve Collection from Private Insurers* 5 (Nov. 1990)) (cleaned up). Congress therefore enacted Section 1396a(a)(25)(H) as part of a suite of provisions directed at improving third-party collections from insurers.[11] That provision requires state Medicaid plans to have

> in effect laws under which, to the extent 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.

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[11] Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13622(c), 107 Stat. 312, 632 (1993). Along with Section 1396a(a)(25)(H), the amendment also required state Medicaid plans to identify liabilities owed by insurance plans operated under the Employee Retirement Income Security Act of 1974. *Id.* § 13622(a)(1) (amending 42 U.S.C. § 1396a(a)(25)(A)). It also prohibited state Medicaid plans from making payments for services also covered by an insurance company regulated under ERISA that limits insurance payments to a Medicaid beneficiary on account of the insured's Medicaid coverage. *Id.* § 13622(a)(2) (amending 42 U.S.C. § 1396b(o)).

42 U.S.C. § 1396a(a)(25)(H).

Before that provision was added, Section 1396k already required States to have beneficiaries assign Medicaid their rights to payment for medical care. But in addition to arising through "assignment" (a transfer of rights), a payment right can also arise automatically through "subrogation" ("the substitution of one party for another"). *Black's Law Dictionary* 115, 1440 (7th ed. 1999). Pertinent here, "on paying a loss, an insurer is subrogated in a corresponding amount to the insured's right of action against any other party responsible for the loss." 16 Steven Plitt et al., *Couch on Insurance* § 222.5 (3d ed. 2021). Congress deployed that concept in Section 1396a(a)(25)(H) to address the problem of private insurers that were evading the assignment provision in Section 1396k. Specifically, Section 1396a(a)(25)(H) required States to attach an automatic right of subrogation to the extent Medicaid makes payments for medical assistance. *See* H.R. Rep. 103-111, at 209-10 (1993) (describing Section 1396a(a)(25)(H) as a "right to subrogation" of payments that a third party owes a Medicaid beneficiary).

Section 1396a(a)(25)(H) thus left intact States' authority to acquire third-party payment rights by assignment under Section 1396k but added protection for Medicaid in the event an insurance contract purported to invalidate its assignment. Unlike the new right to payment established by Section 1396a(a)(25)(H)—which was tied to the making of Medicaid payments—the preexisting assignment authority in Section 1396k continued to authorize the acquisition of rights regardless of whether Medicaid

made a specific payment. The Eleventh Circuit was thus correct that there is no indication that, when Congress enacted Section 1396a(a)(25)(H), it limited Section 1396k. *See* Pet. App. 18 n.15.

2. Petitioner and the United States rely heavily on Section 1396a(a)(25)(H), which they read to be narrower than Section 1396k. Whereas Section 1396k applies to rights to payment for "medical costs," they stress, Section 1396a(a)(25)(H) applies to "rights . . . to payment by any other party for such health care items and services." 42 U.S.C. § 1396a(a)(25)(H). "Such," in turn, is a reference to the earlier part of that provision: "health care items or services furnished to an individual." *Id.* Petitioner draws from the past-tense wording of that language—the reference to "items or services furnished"—a distinction between past and future medical costs. Pet. Br. 26. On the other hand, the United States contends that Section 1396a(a)(25)(H) has a more complex meaning: that it authorizes state Medicaid plans to acquire payment rights "only to the extent of third-parties' liability for" Medicaid's "expenses." U.S. Br. 16.

But Section 1396a(a)(25)(H) might just as well authorize the acquisition of payments for "medical expenses" more broadly. *Ahlborn*, 547 U.S. at 281. Combining the two statutory phrases—"health care items or services furnished to an individual" plus "rights to payment for such health care items or services," 42 U.S.C. § 1396a(a)(25)(H)—yields a directive to States to acquire "rights" to payment by any other party "for health care items or services furnished to an individual." The question, then, turns

on what it means for a right to be "for" such things. Petitioner and the United States assume that a right that includes damages for "items or services furnished to an individual" (e.g., past medical expenses) ceases to be "for" those items or services simply because the right *also* encompasses damages for other items that were not furnished (e.g., a right to payment for future medical expenses). But that is not so. To say that a payment is "for" one purpose does not mean it is "for" *only* that purpose; a right can serve two different purposes at once.[12]

In any event, even if Section 1396a(a)(25)(H) were narrower than Section 1396k, that would not show that Section 1396k is so limited. Neither petitioner nor the United States acknowledges Section 1396a(a)(45)—the provision is not cited once in their 82 pages of briefing—which establishes that the assignment requirement of Section 1396k stands on footing equal with Section 1396a(a)(25)(H). Both are part of the same subsection of Section 1396a. Yet as the United States admits, U.S. Br. 17, 21, what petitioner and the United States see as the limiting language in Section 1396a(a)(25)(H) is not in Section 1396k. The Court "usually presumes differences in language like this convey differences in meaning." *Wisc. Cent. Ltd. v. United States*, 138 S. Ct. 2067, 2071 (2018).

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[12] A payment is "for" something when it is "with the purpose or object of" that thing or that the payment is "in respect to" or "concerning" that thing. *Webster's Third New International Dictionary* 886 (1976).

3. Contrary to petitioner's suggestion, Pet. Br. 25-26, 33; *see also* U.S. Br. 20, there is no basis for reading Section 1396a(a)(25)(H) to have implicitly restricted the scope of Section 1396k when it was enacted in 1993. Far from being "ancillary," U.S. Br. 18, Section 1396k was the only provision in the Medicaid Act that expressly authorized States to establish rights to acquire third-party payments for medical care during the 16 years before Section 1396a(a)(25)(H) was enacted.[13] *See supra* pp. 25-28. If Section 1396a(a)(25)(H) imposed an important restriction on Medicaid's authority to recover third-party payments across-the-board, Congress would not have waited so long to establish it—16 years after the enactment of Section 1396k and 25 years after Congress first added to the Medicaid Act provisions addressing third-party liability. Section 1396a(a)(25)(H) is "more recently enacted" than Section 1396k, Pet. Br. 34, but it could be read to narrow preexisting payment rights only through "clear and manifest" language. *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 662 (2007) (quotations omitted). Nothing in it limits Medicaid's other third-party-payment authority.

Quite the opposite, in fact. Congress enacted Section 1396a(a)(25)(H) to supplement, not restrict, Medicaid's payment rights—particularly against health care insurers that were evading the assignment provision of Section 1396k. *See supra* pp. 28-30. And when enacting Section 1396a(a)(25)(H),

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[13] State Medicaid programs were authorized to recover third-party payments even before then, *see* Pet. Br. 45, 48, but Section 1396k made that authorization unmistakable.

Congress treated it as distinct from Section 1396k. It amended not only the Medicaid Act but also the Employment Retirement Income Security Act of 1974, which regulates group health insurance plans. *See* § 4301, 107 Stat. at 374. Congress added 29 U.S.C. § 1169(b)(1) and (3) to ERISA to ensure that "State laws enforcing" third-party-reimbursement rights under Medicaid would "be honored by group health plans." H.R. Rep. No. 103-213, at 469 (1993) (Conf. Rep.). Sections 1169(b)(1) and (3) distinguish Sections 1396k and 1396a(a)(25)(H), recognizing that they have different functions. Section 1169(b)(1) directs group health plans to honor States' "assignment of rights" under Section 1396k, while Section 1169(b)(3) directs group health plans to honor States' acquisition of rights under Section 1396a(a)(25)(H). Congress thus made clear that the two provisions are distinct.

4. Petitioner is incorrect that this understanding of Section 1396a(a)(25)(H) reads its 1993 addition to the statute to have been an "empty gesture." Pet. Br. 46. Sections 1396k and 1396a(a)(25)(H) have overlapping, though distinct, functions. Under Section 1396k, Medicaid obtains, through assignment, beneficiaries' rights to third-party payments for medical care. Beneficiaries agree to assign those rights to the program "as a condition of [Medicaid] eligibility." 42 U.S.C. § 1396k(a)(1)(A). A right to payment that arises through assignment, however, is not bulletproof. For example, the Medicaid program is not allowed to acquire by assignment rights of payment owed to a beneficiary who cannot "legally assign his own rights," when his guardian refuses to assign them, or when a State has failed to inform a beneficiary of the consequences of assignment. *See* 42

C.F.R. § 433.148; 42 U.S.C. § 1396k(a)(1)(A) (requiring only those "who ha[ve] the legal capacity to" assign their rights to execute an assignment as a condition of eligibility); *Ex parte S.C. Dep't of Health & Hum. Servs.*, 614 S.E.2d 609, 611 (S.C. 2005) (concluding that federal law provides a "safeguard": A Medicaid assignment is not valid if the State did not "inform[] the recipients of the consequences" of it (relying on 42 C.F.R. § 433.146(c)).

An assignment might also be defeated by a private-insurance contract that purports to override the assignment as a matter of state law. For example, as GAO explained in 1990, third parties "may thwart" the assignment provision "by refusing to pay for any of several reasons," including when "[t]he insurer does not recognize the Medicaid assignment" or when "[t]he contract permits payment to be made only to the policyholder." GAO/HRD-91-25, at 5. Section 1396a(a)(25)(H) filled that gap by requiring States to have laws providing for an automatic right of subrogation arising when Medicaid makes a payment when a third party is also liable to pay a beneficiary's medical expenses. Consistent with 50 years of amendments designed to strengthen the Medicaid Act's third-party-reimbursement provisions, Congress enacted Section 1396a(a)(25)(H) to expand States' recovery rights, in an effort to mitigate Medicaid's costs and reduce the deficit. *See* H.R. Rep. No. 103-111, at 209-10 (1993).

Petitioner is also wrong that Section 1396a(a)(25)(H) is more "directly" applicable here than Section 1396k. Pet. Br. 26. In fact, Section 1396a(a)(25)(H) most naturally applies to insurers,

not tortfeasors. If a private health insurer, for instance, also covers specific "items or services furnished to an individual," then the provision gives Medicaid a right to receive payment from that insurer for those items and services, if Medicaid has also paid for those items and services, 42 U.S.C. § 1396a(a)(25)(H)—reflecting that an insurer generally becomes liable for payments for medical care as costs are incurred. By contrast, tort settlements and judgments usually provide a one-time allocation of liability for medical care. Congress sensibly provided the program with both payment tools: one, in Section 1396k, for the program to obtain efficient reimbursement from tort judgments without fluctuation based on the timing of payments, and another, in Section 1396a(a)(25)(H), for insurers to pay-as-they-go. Section 1396k is therefore not tied to the making of particular Medicaid payments, while Section 1396a(a)(25)(H) is. Nothing in the statute reflects that, in solving a problem regarding insurers, Congress created another one regarding tortfeasors.

5. A similar flaw infects the United States' contention that 42 U.S.C. § 1396a(a)(25)(I)(ii) "suggests that Congress understood the assignment of rights under Section 1396k to be limited to third-party payments for services covered by Medicaid." U.S. Br. 19. Added to the statute by the Deficit Reduction Act of 2005, *see* Pub. L. No. 109-171, § 6035, 120 Stat. 4, 79 (2006), this provision was enacted to combat still more efforts by private insurance companies to deny Medicaid third-party payments, which Section 1396a(a)(25)(H) had not extirpated. Insurers were "sometimes deny[ing] Medicaid claims based on procedural requirements (e.g., on the grounds that the

plan provides benefits only if the plan's card was used for billing at the 'point of sale' (POS) or only if the claim is filed using a particular claim format)."[14] In requiring insurers to "accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan," 42 U.S.C. § 1396a(a)(25)(I)(ii), Congress created another tool of recovery designed for insurance companies.

6. The United States also argues that "context" shows that Section 1396k possesses the same "limitation," U.S. Br. 17, it sees in Section 1396a(a)(25)(H). The United States theorizes that otherwise there would be a "severe mismatch" between the provisions. U.S. Br. 21. But it is not unusual for statutes to have different, but overlapping, functions. It is especially unsurprising that Section 1396k, which requires beneficiaries to assign rights, would provide broader authority than Section 1396a(a)(25)(H), which requires States to establish an automatic subrogation right upon making a Medicaid payment. An assignment generally provides more than a mere right of subrogation. "[W]hile subrogation is a designation of proceeds recovered from a wrongdoer, an assignment transfers the entire cause of action." 16 *Couch on Insurance* § 222:53; *see also* Pet. Br. 43 n.9; *Rolling*

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[14] Centers for Medicare and Medicaid Services, *Guidance on Implementing the DRA Third Party Liability Provisions, Questions and Answers (Qs & As)* 4, *https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd121506qanda.pdf* (last visited Nov. 14, 2021).

Fashion Mart, Inc. v. Mainor, 341 S.E.2d 61, 64 (N.C. Ct. App. 1986). An assignment under Section 1396k can *also* result in the program's being "subrogated" to the rights of the beneficiary to recover against a third party—the two rights are not "mutually exclusive." Pet. Br. 42. The important point, however, is that Section 1396k is, on its face, broader.

The United States also thinks it makes "little sense" to read Section 1396k to have a different scope than Section 1396a(a)(25)(H). U.S. Br. 27. But the structure the United States thinks is senseless in Medic*aid* parallels the payment-recovery provisions in the Medi*care* program, which, as suggested by the government report cited by the United States (U.S. Br. 28-29), served as the model for adding Section 1396a(a)(25)(H) to the statute in 1993. *See* GAO/HRD-91-25, at 11 (recommending that Congress enact Medicaid legislation modeled on "the Medicare secondary payer . . . provision" to improve third-party payments). Medicare has a provision, like Section 1396k, permitting the program to receive an assignment of a tort claim the beneficiary may have against a third-party who injures the beneficiary. *See* 42 U.S.C. § 2651(a). Meanwhile, its secondary-payer provision, like Section 1396a(a)(25)(H), gives Medicare an automatic right of subrogation if Medicare pays out benefits for an "item or service" that is also covered by a private insurance company. *Id*. § 1395y(b)(2)(B)(iv). It was entirely reasonable for Congress to have adapted the same kind of dual-provision payment structure to Medicaid.

The United States also says that reading Sections 1396k and 1396a(a)(25)(H) to have a different scope is

"in tension" with *Ahlborn*. U.S. Br. 28. But *Ahlborn* just said that Section 1396a(a)(25)(H) "echoes the requirement of a mandatory assignment of rights in § 1396k(a)," 547 U.S. at 281, not that the two have precisely the same scope. An echo often sounds different from the original sound.

7. The United States insists (U.S. Br. 12-13, 20) that, when the statute requires state Medicaid plans to "ascertain the legal liability of third-parties" who may be liable "to pay for care and services available under the plan," it means only those liabilities that are attributable to items or services for which Medicaid paid. *Cf.* Pet. Br. 27-28, 32. Similarly, the United States relies on Section 1396k(a)(1)(C), which requires a beneficiary to cooperate with Medicaid's efforts in obtaining recovery from potentially liable third parties to "pay for care and services available under the plan," to suggest that Medicaid may recover only from damages that are attributable to specific Medicaid payments.

That interpretation conflicts with the history of the statute, including with how the United States itself has defined liable third parties under the statute over the years, which reflects that third parties are those liable for a beneficiary's medical costs. *See supra* pp. 25-28. As recently as last year, the United States understood liable "third parties" broadly to include

> Private insurance companies through employment-related or privately purchased health insurance; casualty coverage resulting from an accidental injury; payment received directly from an individual who has voluntarily accepted or been assigned legal responsibility

> for the health care of one or more Medicaid recipients; fraternal groups, unions, or state workers' compensation commissions; and medical support provided by a parent under a court or administrative order.[15]

That includes parties who incur liabilities that are not necessarily for services for which Medicaid has paid—such as an individual ordered to pay for his spouse or child's medical support, or an individual who otherwise has been assigned (or accepted) financial responsibility for a Medicaid beneficiary.

C. Medicaid's role as the payer of last resort supports permitting the program to recover costs from all medical damages.

Congress made a reasonable judgment when it guaranteed Medicaid priority for reimbursement of its costs from damages for medical expenses.

1. Medicaid is the "payer of last resort" of medical costs. *Ahlborn*, 547 U.S. at 291 (quotation marks omitted). That "means that other available resources . . . must be used before Medicaid pays for services received by a Medicaid-eligible individual."[16] "Medicaid exists to help needy individuals, not to provide benefits to people 'whose needs are being met by a third party under a legal or contractual obligation.'" U.S. Br. 22 (quoting *Tristani*, 652 F.3d at 373) (alteration omitted). Thus, "[t]o the extent that health care protection is being provided from sources

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[15] 85 Fed. Reg. 87,000, 87,000 (2020); *see also* 80 Fed. Reg. 31,098, 31,175 (2015) (similar).

[16] 85 Fed. Reg. 87,000, 87,001 (2020).

other than under [Medicaid], the resulting duplication is discriminatory and a wasteful, inefficient use[] of public funds." *Tristani*, 652 F.3d at 373 (citation omitted).

As the United States told this Court in *Ahlborn*, when Medicaid "pays first in circumstances like [petitioner's] unfortunate sudden and serious accident," its "status as the payer of last resort can only be preserved" if "Medicaid's third-party liability provisions are stringently enforced." Br. for the United States 11, *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) (*Ahlborn* U.S. Br.). To accomplish this purpose, "when those same beneficiaries later recover payments from third parties, the Medicaid Act requires them to reimburse the Medicaid program *to the extent of the third parties' liability for medical damages*, before retaining funds for themselves." *Id.* (emphasis added); *accord Ahlborn*, 547 U.S. at 282. In allowing state Medicaid programs to obtain rights of payment for "medical care," 42 U.S.C. § 1396k(a)(1)(A), Congress reasonably judged that, if a beneficiary is entitled to payments for medical expenses, the Medicaid program should receive those payments to reimburse any expenses it has paid on the beneficiary's behalf before the beneficiary or other payer (like a private insurer) receives any remaining funds for medical expenses. That result preserves Medicaid funds for those "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1.

2. The United States declares that it can think of "no apparent reason" for permitting the Medicaid

program to recover out of all medical damages. U.S. Br. 23. The cost-recovery structure that the United States finds unfathomable is in fact a common feature of federal programs. Several such programs provide that "the amount of the reimbursement generally does not depend on how the proceeds of the third-party settlement are allocated among categories of damages." Br. for the United States 12 n.1, *Wos*, 568 U.S. 627 (citing this Court's decisions involving the Longshore and Harbor Workers' Compensation Act, the Federal Employees' Compensation Act, and ERISA). For example, *see id.*, parts of the Medicare secondary-payer statute entitle the program to reimbursement from tort settlements regardless of how they are allocated. *See* Br. for the United States in Opp. 9-12, *Hadden v. United States*, No. 11-1197, *cert. denied*, 568 U.S. 813 (2012); *see also* 42 U.S.C. § 2651(a); *U.S. Airways, Inc. v. McCutchen*, 569 U.S. 88, 96 (2013) (rejecting the argument that ERISA required limiting an ERISA plan's reimbursement suit to "the amount the insured has received from a third party to compensate for the same loss the insurance covered").

To take another example, insurance contracts issued to provide health insurance to federal employees commonly contain reimbursement provisions that permit insurance plans (and derivatively the federal government, which pays most of the premiums), to receive from tort recoveries "[r]eimbursement" of the full costs of payments previously made from "the proceeds yielded by a tort claim." *Coventry Health Care v. Nevils*, 137 S. Ct. 1190, 1194 (2017). Those contracts, which must be approved by the U.S. Office of Personnel

Management, *see* 5 U.S.C. § 8903, commonly allow the program to receive reimbursement from a beneficiary's entire unallocated tort recovery. *See, e.g.*, *Blue Cross Blue Shield v. Cruz*, 495 F.3d 510, 511 (7th Cir. 2007) (describing one such contract). Section 1396k does not go this far: It permits recovery only from medical damages. *See Ahlborn*, 547 U.S. at 280-88. But given that federal-government programs routinely provide for reimbursement from *all* damages, it was not anomalous for Congress to authorize the Medicaid program to recover costs from at least all medical damages.

Relying on "[i]nsurance law," the United States claims that "[i]n general, if an insurer pays benefits to an insured, and the insured then recovers a settlement from a third party, the insurer 'has a right to reimbursement from the insured' only 'to the extent that the settlement duplicates the . . . benefits already paid." U.S. Br. 21-22 (quoting 16 *Couch on Insurance* § 223:94).[17] The United States then quotes the same treatise as stating that "the insurer may obtain only the portions of the settlement that 'represent expenses paid by the insurer.'" *Id.*[18] In

[17] The full quotation provides: "It has been held that when a no-fault insured settles his or her claims against a tortfeasor, the insurer has a right to reimbursement from the insured to the extent that the settlement duplicates the no-fault benefits already paid, but the insured has the latitude to structure a settlement to include only nonduplicative losses." 16 *Couch on Insurance* § 223:94.

[18] The full quotation provides: "For example, under a reimbursement agreement entitling a health insurer to reimbursement in the amount of medical expenses paid from the proceeds of the insured's settlement from a third-party

truth, "[a]s a general rule, an insurer is entitled to reimbursement to the extent of its payment under a policy where an insured has received payment from both the insurer and the tortfeasor for the same loss." 16 *Couch on Insurance* § 226:41; *see also id.* § 225:107 ("The no-fault insurer's recovery generally is measured by the amount the insurer paid to its insured."). The general rule, in other words, is that the insurer is entitled to full recovery of its costs—not recovery of only certain portions of damages.

3. Moreover, the aggressive rule of preemption advocated by the United States would "enable[] long-term financial windfalls." *Ahlborn* U.S. Br. 11. For example, many States apply the "collateral source" rule of tort law to injuries paid for by Medicaid, under which benefits paid to a tort victim do not reduce the victim's recovery. That rule permits the beneficiary to recover from the tortfeasor not only amounts that Medicaid paid to the provider, but also amounts that the provider billed to Medicaid yet were not actually paid. *See, e.g., Bynum v. Magno*, 101 P.3d 1149, 1157

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tortfeasor, a settlement agreement, which did not break down the amount of settlement attributable to the insured's medical expenses, was deemed to have fully compensated the insured for his or her medical expenses, where the insured dismissed his or her claim for medical expenses against the tortfeasor under the settlement, and, since the health insurer was entitled to the lesser of either the amount it paid or the amount the third-party tortfeasor paid that represented expenses paid by the insurer, it was irrelevant whether the medical expenses paid by the third-party tortfeasor actually exceeded the amount paid by the health insurer." 16 *Couch on Insurance* § 223:94.

(Haw. 2004).[19] In such States, under the United States' position, a Medicaid beneficiary could receive substantial damages for medical expenses, even after paying zero out of pocket, while Medicaid recovers little.

For instance, suppose a Medicaid provider "billed" Medicaid for $100,000 for medical care provided to a beneficiary injured by a tortfeasor, but Medicaid paid only a discounted amount (say, $50,000) in full satisfaction of the provider's claim. *See* 42 C.F.R. 447.15 (requiring Medicaid plans to limit participation in the program to providers willing to accept Medicaid payments as payment of a claim in full). Suppose the beneficiary settled the claim for 20 cents on the dollar ($20,000). Even if that recovery is allocated entirely to medical expenses, only half of it would be "marked for the same medical expenses that Medicaid paid." U.S. Br. 12. Medicaid would thus get only $10,000 of the $50,000 it paid out, though the beneficiary paid nothing for medical care. Congress surely did not intend that curious result.

4. Petitioner and the United States object that reading Section 1396k to permit reimbursement from all medical costs would "amount[] to a lifetime assignment." Pet. Br. 32; *see* U.S. Br. 19. They posit hypotheticals in which Medicaid might attempt to

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[19] *See also S.W. Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1108-10 (Az. Ct. App. 2011); *Haselden v. Davis*, 579 S.E.2d 293, 294 n.3 (S.C. 2003); *Brandon HMA, Inc. v. Bradshaw*, 809 So. 2d 611, 618 (Miss. 2001); *Ellsworth v. Schelbrock*, 611 N.W.2d 764, 767 (Wis. 2000); *Cates v. Wilson*, 361 S.E.2d 734, 738 (N.C. 1987).

recover costs for medical payments from a tort settlement arising from an injury unrelated to what Medicaid paid for or an unrelated insurance payment that a beneficiary might receive "decades later." Pet. Br. 33. If that is truly a problem, ruling for petitioner is not the solution, as petitioner asks the Court to limit recovery to past medical expenses—not those medical expenses related to an injury paid for by Medicaid.

Regardless, such hypotheticals are not a basis for limiting Florida's lien. Florida's lien, by statute, extends only to "collateral," Fla. Stat. § 409.910(6)(c), which means rights "related to any covered injury, illness, or necessary medical care, goods, or services that necessitated that Medicaid provide medical assistance," *id.* § 409.901(7)(a), or any "settlements . . . related to such" claims, *id.* § 409.901(7)(b). Florida's lien therefore would not attach to the proceeds of a tort settlement arising from an injury for which Medicaid did not pay.

II. IF THE COURT CONCLUDES THAT THE STATUTE IS AMBIGUOUS, IT SHOULD APPLY THE PRESUMPTION AGAINST PREEMPTION AND AFFIRM.

The Court need not resort to interpretive presumptions to affirm. But any statutory ambiguity should be resolved in Florida's favor under the presumption against preemption of state law, as the Eleventh Circuit correctly concluded. Pet. App. 10-13.

1. "[T]he historic police powers of the States [are] not to be superseded by [a] [f]ederal [a]ct unless that was the clear and manifest purpose of Congress." *Altria Grp., Inc. v. Good*, 555 U.S. 70, 77 (2008). As a

result, "when the text of a [federal statute] is susceptible of more than one plausible reading, courts ordinarily accept the reading that disfavors preemption." *Id.* (cleaned up). Moreover, the Medicaid Act is Spending Clause legislation, which is "binding on States only insofar as it is 'unambiguous.'" *Wos*, 568 U.S. at 654 (Roberts, C.J., dissenting) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). Indeed, "[w]here coordinate state and federal efforts exist within a complementary administrative framework, and in the pursuit of common purposes, the case for federal pre-emption becomes a less persuasive one." *N.Y. Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 421 (1973).

Here, the reading that disfavors preemption permits Florida's Medicaid program to recover all damages for medical care. Petitioner and the United States contend that Florida's third-party-recovery laws are unauthorized by Sections 1396k and 1396a(a)(25)(H) and thus violate the Medicaid Act's anti-lien provision, Section 1396p(a)(1). *See Wos*, 568 U.S. at 636. Reversing would therefore result in the preemption of state law.

2. Petitioner contends that the presumption is inapplicable because Sections 1396k and 1396a(a)(25)(H) preempt "state law *no matter how they are construed*." Pet. Br. 36; *see also* U.S. Br. 26-27. If this Court affirms, petitioner asserts, state laws permitting recovery only of payments for past medical expenses would be preempted, because they would conflict with Section 1396k. Pet. Br. 37.

But the premise of that argument—that Sections 1396k and 1396a(a)(25)(H) have preemptive effect—is

wrong. Those provisions do not forbid States from taking any action. *See Mut. Pharm. Co. v. Bartlett*, 570 U.S. 472, 486 (2013) (a "federal law" has preemptive effect when it "forbids an action"). Instead, they impose requirements that a state Medicaid plan must comply with to receive federal Medicaid funding. *See* 42 U.S.C. § 1396k(a) ("[A] State plan for medical assistance shall . . . ."); *id.* § 1396a(a) ("A State plan for medical assistance must . . . ."). The Medicaid "Act itself contemplates the existence of state plans that do not comply with the requirements of [Sections] 1396a(a)" and 1396k. *Pharm. Rsch. & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 679 n.3 (2003) (Thomas, J., concurring in the judgment) (citing 42 U.S.C. § 1396c). The statute provides that the remedy for noncompliance is for the Secretary of Health and Human Services to withhold Medicaid funds "until the Secretary is satisfied that there will no longer be any such failure to comply." 42 U.S.C. § 1396c.

"State plans that do not meet" the Medicaid Act's "requirements are to be defunded by the [federal government]—they are not void under the Supremacy Clause." *Pharm. Rsch.*, 538 U.S. at 679 n.3 (Thomas, J., concurring in the judgment). In other words, "the sole remedy Congress provided for a State's failure to comply with Medicaid's requirements . . . is the withholding of Medicaid funds by the" federal government. *Armstrong v. Exceptional Child Ctr.*, 575 U.S. 320, 328 (2015). The remedy is not immediate judicial invalidation of any such law. Sections 1396k and 1396a(a)(45) therefore "cannot meaningfully be interpreted to invalidate state laws . . . that do not comply with [their] express terms." *Pharm. Rsch.*, 538

U.S. at 679 n.3 (Thomas, J., concurring in the judgment).

By contrast, in *Wos*, the Court characterized *Ahlborn* as holding that the anti-lien provision, Section 1396p(a)(1), has preemptive effect. 568 U.S. at 636. That provision *forbids* States from taking a particular action. It says: "No lien may be imposed against the property of [a beneficiary] on account of medical assistance paid or to be paid on his behalf under the State plan." 42 U.S.C. § 1396p(a)(1). If this Court affirmed, that prohibition would not preempt state laws limiting recovery to payments for past medical expenses because those laws would not "directly conflict" with it. *See PLIVA, Inc. v. Mensing*, 564 U.S. 604, 617 (2011).[20]

3. The United States claims that any interpretive ambiguity should be resolved in *favor* of preemption of state law. So far as Florida is aware, it has never been argued that a federal-government interpretation resolves the question presented. But the United States says it has discovered one in "regulations implementing the Medicaid Act," which, it says, "embody the understanding that a State is entitled only to the portion of the recovery that represents the medical expenses paid by Medicaid," and asks the Court to defer to that supposed interpretation under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). U.S. Br. 23-25.

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[20] The United States characterizes the anti-lien provision as an "express preemption clause" to which the presumption against preemption is inapplicable. U.S. Br. 25. But nothing in Section 1396p mentions "preemption." *See* 42 U.S.C. § 1396p.

The regulations do no such thing. They at most parrot the statutory provisions at issue here. *See* U.S. Br. 23-24. An agency interpretation of a regulation that parrots a statute is entitled to no deference. *See Gonzales v. Oregon*, 546 U.S. 243, 256-58 (2006). There is even less reason to defer to an agency regulation that parrots a statute, which is no interpretation at all.

The regulations add nothing to the analysis. For example, the United States relies on a regulation relating to assignment under Section 1396k; that parroting regulation provides—like Section 1396k—that States must require beneficiaries to "[a]ssign to the Medicaid agency his or her rights . . . to payment for medical care from any third party." 42 C.F.R. 433.145(a)(1). The United States emphasizes (U.S. Br. 24) subsection (c), which provides that "the assignment of rights to benefits obtained from an applicant or beneficiary is effective only *for services that are reimbursed by Medicaid*." Yet just as subsection (a) mirrors Section 1396k(a)(1)(A), this subsection mirrors Section 1396k(b), which provides that States can receive reimbursement under an assignment only up to the "amount" that Medicaid has "paid for services." *Barton v. Summers*, 293 F.3d 944, 952 (6th Cir. 2002). In any event, that and other cryptic language in the regulations relied on by the United States does not remotely reflect an interpretation that under Section 1396k the State is "entitled only to the portions of the recovery that represent the past expenses it actually paid." U.S. Br. 10.

In fact, the only time the United States has taken a position on this issue was in *Ahlborn*, in which it took the opposite view. (Its regulations have not materially changed since that time.) The United States waves away the inconsistency because *Ahlborn* "rejected" its argument, U.S. Br. 24-25, but that is only half right. *Ahlborn* did reject the United States' suggestion, *see Ahlborn* U.S. Br. 14-15, that the beneficiary there had waived any claim she had to retain damages *other than medical expenses* because she had breached her duty of cooperation by settling Medicaid's claim without giving the State an opportunity to participate in the settlement to protect its rights. *See* 547 U.S. at 287-88. But the United States also argued in *Ahlborn* that Medicaid is entitled to recovery for all medical damages, noting that "the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages." *Ahlborn*, U.S. Br. 12. "The State's claim, however, has priority. Only after the State retains the amount 'necessary to reimburse it for medical assistance payments made' will the 'remainder' 'be paid to such individual.'" *Id.* at 12-13 (quoting 42 U.S.C. § 1396k(b)). This Court agreed, in similar phrasing, that "what § 1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs."[21] *Ahlborn*,

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[21] The United States also argues that it "advanced this reading of the Medicaid Act in" its brief in *Wos*. U.S. Br. 24. The factual premise is dubious, but the suggestion that the Court should defer is even more so. "[I]t is clear that 'an interpretation contained in a [legal brief], not one arrived at after, for example,

547 U.S. at 282. It is one thing for the United States to reverse its litigation positions. It is something else entirely for it to advocate deference to an interpretation that does not exist, in opposition to one that it successfully urged this Court to endorse.

There is no basis for deference to the United States. Instead, in the face of any ambiguity, the Court should apply the presumption against preemption.

CONCLUSION

The judgment should be affirmed.

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a formal adjudication or notice-and-comment rulemaking[,] . . . do[es] not warrant *Chevron*-style deference.'" *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 911 (2000) (Stevens, J., dissenting) (quoting *Christensen v. Harris Cty.*, 529 U.S. 576, 587 (2000)).

Respectfully submitted.

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APPENDIX

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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

* * *

(45) provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients, in accordance with section 1396k of this title;

* * *

42 U.S.C. § 1396c

§ 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

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).

* * *

Fla. Stat. § 409.901 (2016) (excerpts)
§ 409.901. Definitions; ss. 409.901-409.920—

* * *

(7) "Collateral" means:

(a) Any and all causes of action, suits, claims, counterclaims, and demands that accrue to the recipient or to the recipient's legal representative, related to any covered injury, illness, or necessary medical care, goods, or services that necessitated that Medicaid provide medical assistance.

(b) All judgments, settlements, and settlement agreements rendered or entered into and related to such causes of action, suits, claims, counterclaims, demands, or judgments.

(c) Proceeds, as defined in this section.

* * *

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:

* * *

(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.