No. 20-1263

In the Supreme Court of the United States

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

v.

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

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether the Medicaid Act permits a State to recover reimbursement for medical expenses paid by Medicaid by obtaining a portion of the recipient's tort recovery that represents medical expenses not paid by Medicaid.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases: Page

Statutes and regulations: Page

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INTEREST OF THE UNITED STATES

This case concerns the third-party-liability provisions of the federal Medicaid Act, which provide a source of compensation for that program at both the federal and state levels. Congress has vested the Secretary of Health and Human Services with broad authority to administer Medicaid. 42 U.S.C. 1302. The question presented directly involves the Secretary's interpretation and implementation of the statute.

STATEMENT

A. Legal Background

1. The Medicaid Act, 42 U.S.C. 1396 *et seq.*, creates a cooperative federal-state program to fund medical care for indigent people. Under Medicaid, the federal government pays a significant part of the costs incurred by the States, and the States in return comply with federal requirements. 42 U.S.C. 1396d(b). The Secretary of Health and Human Services administers the statute through the Centers for Medicare and Medicaid Services. 42 U.S.C. 1302; 66 Fed. Reg. 35,437 (July 5, 2001).

This case involves the Medicaid Act's anti-lien clause (42 U.S.C. 1396p(a)(1)) and third-party-liability provisions (42 U.S.C. 1396a(a)(25)(A)-(B) and (H) and 1396k). The anti-lien clause limits a State's power to acquire a Medicaid recipient's property to reimburse the State for care provided under the program. It provides, with exceptions not at issue here, that "[n]o 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." 42 U.S.C. 1396p(a)(1).

At the same time, the third-party-liability provisions permit—indeed, require—the State to pursue reimbursement from third parties, such as tortfeasors and insurers, that are liable for the costs of the medical care paid by the State under Medicaid. The State must "take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and medical services available under the plan." 42 U.S.C. 1396a(a)(25)(A). And "in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual," the State is generally obligated to "seek reimbursement for such assistance to the extent of such legal liability." 42 U.S.C. 1396a(a)(25)(B).

The third-party-liability provisions specify the legal tools that the state Medicaid plan must provide to enable the State to seek reimbursement from third parties. The state plan must provide for the recipient to "assign the State any rights * * * to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A). The plan must also provide that the State is "considered to have acquired the rights" of a recipient "to payment by any other party" for "health care items or services furnished" to the recipient under Medicaid. 42 U.S.C. 1396a(a)(25)(H).

2. More complex issues arise if the Medicaid recipient recovers money from a liable third party—for example, in a tort judgment or settlement. All agree that, in that situation, the third-party-liability provisions entitle the State to a portion of the recovery to reimburse it for the medical care it has previously provided. See Pet. Br. 25-28; Resp. to Pet. 1-2; see also *Tristani* v. *Richman*, 652 F.3d 360, 369 (3d Cir. 2011) (noting that lower courts have generally reached the same result). The question here is about how much the State may obtain, and from which portions of the recovery.

In *Arkansas Department of Health and Human Services* v. *Ahlborn*, 547 U.S. 268 (2006), Arkansas sought to answer that question with a blanket rule requiring "full reimbursement" for all costs incurred by the State, up to the total value of the tort recovery. *Id.* at 281. To illustrate, imagine that a Medicaid recipient recovered $100,000 from a tortfeasor: $25,000 to compensate for medical expenses, and the rest for other categories of damages, such as lost wages and pain and suffering. If Medicaid paid $40,000 for treating the recipient's injuries, Arkansas's rule would have allowed the State to recover the full $40,000 from the settlement, not just the

$25,000 portion that compensated for medical expenses. *Id.* at 272-275.

In *Ahlborn*, this Court held that the Medicaid Act preempted that approach. 547 U.S. at 280-292. The Court explained that the anti-lien clause generally bars a State from obtaining a right to a recipient's property to compensate the State for medical care provided under the program. *Id.* at 283-284. The Court further explained that the third-party-liability provisions carve out an "exception" to that rule, but only for "payments for medical care." *Id.* at 284-285. That limit follows from the text of the provisions, which refer to "payment for medical care from any third party," 42 U.S.C. 1396k(a)(1)(A), and to "payment * * * for * * * health care items or services," 42 U.S.C. 1396a(a)(25)(H). Applying those provisions, *Ahlborn* held that the State could provide for an assignment of "no more than * * * that portion of the settlement that represents payment for medical care." 547 U.S. at 282.

North Carolina tried a different approach in *Wos* v. *E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013). It acknowledged that it was entitled to only the part of a judgment or settlement that represents compensation for medical expenses, but it automatically attributed one-third of any tort recovery to such expenses. *Id.* at 630-632. Thus, if a recipient had recovered $100,000 from a tortfeasor, North Carolina would have attributed $33,333 of that recovery to medical expenses. *Ibid.*

This Court held that the Medicaid Act preempted that rule too. *E.M.A.*, 568 U.S. at 636-644. The Court observed that North Carolina had provided "no process for determining what portion of a beneficiary's tort recovery is attributable to medical expenses." *Id.* at 636. Rather, the Court continued, North Carolina had

"picked an arbitrary number" without any evidence "that the one-third allocation is reasonable in the mine run of cases" and without "a mechanism for determining whether it is a reasonable approximation in any particular case." *Id.* at 636-637.

3. In this case, Florida has taken a third approach. Florida imposes an automatic lien on all claims that accrue to the recipient because of the injury that necessitated medical assistance under Medicaid. Fla. Stat. Ann. §§ 409.901(7), 409.910(6)(c) (West 2018). But unlike Arkansas's lien in *Ahlborn*, Florida's lien extends only to the portion of the recovery that represents compensation for medical expenses. Pet. App. 6. And unlike North Carolina in *E.M.A.*, Florida provides an administrative process for determining that amount. *Ibid.* Florida starts with a presumption that 37.5% of a settlement represents medical expenses, but it allows the recipient to challenge that figure in an administrative hearing. Fla. Stat. Ann. §§ 409.910(11)(f)(1), 409.910(17)(b) (West 2018). The recipient bears the burden of proving, "by clear and convincing evidence," that a lesser portion of the total recovery should be allocated to payment for medical expenses. *Id.* § 409.910(17)(b).

Florida claims the right to seek reimbursement not only from the portion of the settlement that represents "past * * * medical expenses," but also from the portion that represents "future medical expenses." Fla. Stat. Ann. § 409.910(17)(b) (West 2018). To illustrate that approach, suppose once more that a Medicaid recipient recovers money from a tortfeasor, including $15,000 for a knee surgery that the recipient has already undergone, and $10,000 for physical therapy that he will undergo in the future. Florida's rule means that, if the State has paid $25,000 for the knee surgery alone,

it may seek reimbursement for the surgery from *both* the $15,000 that corresponds to that surgery *and* the $10,000 that corresponds to the future physical therapy, because both portions still represent medical expenses. This case presents the question whether the Medicaid Act preempts that rule.

B. Facts And Proceedings Below

1. In 2008, petitioner Gianinna Gallardo, then a 13-year-old student, was hit by a pickup truck after getting off a school bus. Pet. App. 3, 95. The accident left her in a persistent vegetative state. *Id.* at 3. Florida's Medicaid program paid $862,688.77 for her medical care. *Ibid.*

Petitioner's parents sued the truck's owner, its driver, and the school district in state court. Pet. App. 3. The parties settled the case for $800,000. *Id.* at 4. Under Florida's Medicaid statute, that sum became subject to an automatic lien, with the State presumptively entitled to $300,000 (37.5% of $800,000). *Id.* at 7 n.7. Petitioner challenged that allocation in a state administrative hearing. *Id.* at 7.

2. While the state administrative action was pending, petitioner invoked 42 U.S.C. 1983 to sue respondent (the Secretary of the Florida Agency for Health Care Administration) in federal district court. See Pet. App. 8. Petitioner sought, inter alia, a declaration that Florida "is prohibited from recovering beyond that portion of [her] settlement representing * * * past medical expenses." J.A. 36. The state administrative law judge placed the administrative action in abeyance pending completion of the federal case. Pet. App. 116-118.

The district court granted summary judgment for petitioner and denied respondent's cross-motion for summary judgment. Pet. App. 88-115. The court held,

as relevant here, that the Medicaid Act bars Florida from obtaining "anything but a Medicaid recipient's recovery for past medical expenses." *Id.* at 98.

3. A divided panel of the court of appeals reversed. Pet. App. 1-60.

The court of appeals held, as relevant here, that "federal Medicaid law does not preempt [Florida's] practice of seeking reimbursement from portions of a settlement that represent *all* medical expenses." Pet. App. 14 (capitalization and emphasis altered); see *id.* at 15-23. The court read Section 1396k to mean that "Medicaid recipients must assign to the state 'any' of their rights to 'payment for medical care from any third party,'" without any distinction between payment for past medical care and payment for future medical care. *Id.* at 16. The court concluded that the language of Section 1396a(a)(25)(H) likewise "does not in any way prohibit [Florida] from seeking reimbursement from settlement monies for medical care allocated to future care." *Id.* at 18 (emphasis omitted). In the court's view, the presumption against preemption and principles of federalism reinforced those conclusions. *Id.* at 11-12.

Judge Wilson concurred in part and dissented in part. Pet. App. 27-60. As relevant here, Judge Wilson dissented from the court of appeals' conclusion that Florida "can pocket funds marked for things it never paid for." *Id.* at 28. He read Section 1396a(a)(25)(H) to mean that "the state acquires only the right to payment for the recipient's past medical care—the only care for which the state has paid." *Id.* at 32. He acknowledged that Section 1396k lacks similar limiting language but concluded that Section 1396a(a)(25)(H) takes precedence over it because it is more specific and was enacted later in time. *Id.* at 34-39.

SUMMARY OF ARGUMENT

The Medicaid Act's anti-lien clause prohibits a State from imposing a lien against a Medicaid beneficiary's tort judgment or settlement, except to the extent authorized by the Act's third-party-liability provisions. The latter provisions, in turn, entitle a State to receive the portions of the recipient's recovery that represents compensation for medical expenses paid by Medicaid. They do not, however, allow the State to obtain funds meant to cover expenses that Medicaid has not paid.

That conclusion follows from the text of the third-party-liability provisions. Section 1396a(a)(25)(A) and (B) direct the State to make reasonable efforts to seek reimbursement from third parties that are liable "to pay for care and services available" under Medicaid. 42 U.S.C. 1396a(a)(25)(A)-(B). Those provisions, by their terms, require the State to seek reimbursement from the portions of the recovery that represent care and services made available under Medicaid.

Section 1396a(a)(25)(H) provides that the State automatically acquires the recipient's rights to payments from third parties for "health care items or services furnished to an individual" under Medicaid. 42 U.S.C. 1396a(a)(25)(H). That provision, too, allows a State to recover from a third party (or from a Medicaid recipient who has recovered from a third party) only to the extent of the third party's liability for health care items and services furnished under Medicaid.

The final provision, Section 1396k, requires the recipient to assign to the State the right to receive certain payments from third parties. Although that provision is less explicit than the other clauses just discussed, context makes clear that it, too, covers only third-party

payments that correspond to expenses paid under Medicaid. For example, Section 1396k provides a tool for implementing the general obligation set forth in Subparagraphs (A)-(B), and those subparagraphs are in turn limited to third parties that are liable to pay for care and services available under Medicaid. A contrary reading of Section 1396k would lead to implausible results: it would seemingly require a Medicaid recipient to assign the State *any* recovery of medical expenses he has ever obtained or will ever obtain during his life, even medical expenses that have nothing to do with the incident that prompted resort to Medicaid.

The rule embodied in the third-party-liability provisions makes sense. It reflects the traditional rule in insurance law, under which an insurer is entitled only to the portions of the beneficiary's tort recovery that represent payment of the same expenses that the insurer covered. It ensures that recipients are not paid twice for the same medical expenses, once by Medicaid and again by a liable third party. At the same time, it ensures that the State does not share in funds that are meant to cover expenses it has not paid. By contrast, there is no apparent reason for Congress to have limited a State to the portions of a recipient's tort recovery that represent medical expenses, but then to take no account of whether the State has paid those expenses.

Regulations adopted by the Secretary of Health and Human Services reflect that reading of the third-party-liability provisions just discussed. For the reasons given above, that reading is correct. At a minimum, that reading is reasonable, and therefore warrants judicial deference under *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

ARGUMENT

A. A State May Impose A Lien Only On The Portions Of A Recipient's Recovery That Represent Compensation For Medical Expenses Paid By Medicaid

The parties and the courts below have framed this case as a dispute about whether the Medicaid Act allows a State to be reimbursed for past medical expenses, not only from the portions of a recipient's recovery that represent compensation for those expenses, but also from the portions that represent compensation for future medical expenses. See Pet. Br. i, 24; Resp. to Pet. ii, 1, 13, 20; Pet. App. 2-3 (court of appeals); *id.* at 89 (district court). The answer to that question is no, but distinguishing between funds for "past" and those for "future" medical expenses emphasizes the wrong thing.

The Medicaid Act entitles a State to the portions of a recipient's recovery that represent compensation for the medical expenses paid by Medicaid, but not to the portions that represent compensation for medical expenses (past or future) not paid by Medicaid. If, as in this case, a State has paid past expenses in full, it is entitled to the portion of the recovery that represents past expenses. But if, as in *Doe* v. *Vermont Office of Health Access*, 54 A.3d 474 (Vt. 2012), a State has paid some past expenses but not other past expenses, it is entitled only to the portions of the recovery that represent the past expenses it has actually paid. The critical question, in other words, is not whether the expense occurred in the past or will occur in the future, but whether Medicaid has paid for it. A State may not "pocket funds marked for things it never paid for." Pet. App. 28 (Wilson, J., concurring in part and dissenting in part).

1. The anti-lien clause bars liens against a recipient's settlement or judgment, except as authorized by the third-party-liability provisions

The Medicaid Act's anti-lien clause provides (with exceptions not at issue here):

> 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.

42 U.S.C. 1396p(a)(1). As this Court explained in *Arkansas Department of Health and Human Services* v. *Ahlborn*, 547 U.S. 268 (2006), a Medicaid recipient's judgment or settlement qualifies as "property" to which the anti-lien clause applies. *Id.* at 284-285. The clause, moreover, applies to past and future expenses alike; it refers to "medical assistance *paid or to be paid* on the recipient's behalf." 42 U.S.C. 1396p(a)(1) (emphasis added).

A court should read the anti-lien clause alongside the third-party-liability provisions. See *Ahlborn*, 547 U.S. at 284-285. Those provisions require the State to make reasonable efforts to identify liable third parties and to seek reimbursement from them. See 42 U.S.C. 1396a(a)(25)(A)-(B). They also require the state Medicaid plan to provide for the transfer to the State—whether by assignment (see 42 U.S.C. 1396k) or by operation of law (see 42 U.S.C. 1396a(a)(25)(H))—of the recipient's right to receive certain payments from third parties. That transfer enables the State to stand in the recipient's shoes and to sue liable third parties directly. And if the recipient sues the third parties and obtains a judgment or settlement, the transfer of rights entitles the State to a portion of the recovery.

To the extent that the third-party-liability provisions entitle the State to a portion of a third-party payment, they operate as an implicit "exception to the anti-lien provision." *Ahlborn*, 547 U.S. at 284. But beyond that entitlement, "the anti-lien provision applies." *Id.* at 285. To prevail in this case, then, Florida must show that the third-party-liability provisions entitle it not only to the portions of a recovery marked for the same medical expenses that Medicaid paid, but also to any portions marked for other medical expenses as well.

2. The third-party-liability provisions entitle the State only to the portions of a recovery that represent medical expenses already paid by Medicaid

The third-party-liability provisions include 42 U.S.C. 1396a(a)(25)(A)-(B) and (H) and 1396k. Subparagraphs (A)-(B) set forth the State's general duty to seek reimbursement from third parties, while subparagraph (H) and Section 1396k specify the legal tools the State must have for carrying out that duty. Taken individually and as a whole, the third-party-liability provisions entitle the State only to the portions of a recovery that represent compensation for medical expenses paid by Medicaid.

a. Subparagraphs (A)-(B). In establishing the general duty to seek reimbursement, subparagraphs (A)-(B) specify that a "state plan for medical assistance must * * * provide," among other things—

> (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties * * * to pay for care and services available under the plan * * * ; [and]
>
> (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[.]

42 U.S.C. 1396a(a)(25)(A)-(B). Together, those provisions require the State to seek reimbursement for the expenses paid by Medicaid, but they do not provide for it to recover from amounts attributable to *other* medical expenses. As recovery from those amounts is not authorized by subparagraphs (A)-(B), it is prohibited by the anti-lien clause. See pp. 11-12, *supra*.

Subparagraph (B) identifies the expenses that are eligible for reimbursement. It directs the State to seek "reimbursement for such assistance"—*i.e.*, for the "medical assistance [that] *has been made available* on behalf of the individual." 42 U.S.C. 1396a(a)(25)(B) (emphasis added).

Subparagraph (B) then identifies the pool from which the State may obtain reimbursement. The provision directs the State to seek reimbursement from a third party (and by extension, from a Medicaid recipient who has recovered money from a third party) "to the extent of such legal liability"—*i.e.*, to the extent of the third party's "liability to pay for care and services *available under the plan*." 42 U.S.C. 1396a(a)(25)(A)-(B) (emphasis added). Thus, the State may obtain reimbursement only out of the third party's liability for the expenses covered by Medicaid. Contra Florida's scheme, subparagraph (B) does not provide for the State to obtain reimbursement out of the amount attributable to the third party's liability for other medical expenses not covered by Medicaid.

Subparagraph (A) reinforces that reading. It directs the State to take reasonable measures to ascertain third parties' liability "to pay for care and services *available under the plan*." 42 U.S.C. 1396a(a)(25)(A) (emphasis added). That directive confirms that the State is entitled only to the portions of the recovery from the third party that represent compensation for the care that has been made available under Medicaid. It would have made little sense for Congress to entitle the State to third-party payments for *all* medical care, but then to direct the State to ascertain third parties' liability only for the medical care made "available under the plan." *Ibid.*

An example illustrates the operation of those provisions. Suppose a Medicaid recipient undergoes knee surgery and plans to undergo physical therapy, but Medicaid has paid only for the knee surgery. In that scenario, the State must make reasonable efforts to ascertain the liability of third parties for the costs of the knee surgery—the care that has been made "available under the plan." 42 U.S.C. 1396a(a)(25)(A). The State then must seek reimbursement "to the extent" of "such liability"—*i.e.*, to the extent of third parties' liability for the costs of *that surgery*. 42 U.S.C. 1396a(a)(25)(B). Subparagraph (B) does not provide for the State to seek reimbursement for the knee surgery by holding tortfeasors liable for the physical therapy as well. And just as the State may not recover the costs of the physical therapy directly from the tortfeasors, it also may not recover that amount from a Medicaid recipient who has obtained the funds from the tortfeasors in a judgment or settlement for the costs of physical therapy.

b. Subparagraph (H). In subparagraph (H), the Medicaid Act further requires a "State plan for medical assistance" to provide

> 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[.]

42 U.S.C. 1396a(a)(25)(H). The provision has a complex structure. The front half requires the State, as a condition of participating in Medicaid, to have certain laws in place: "A State plan * * * must * * * provide * * * that * * * the State has in effect [certain] laws." *Ibid.* The back half specifies the contents of the required laws: "laws under which * * * the State is considered to have acquired [certain] rights." *Ibid.* Together, the two halves require the State to have in effect laws under which the State acquires the recipient's rights to certain third-party payments.

Subparagraph (H), like subparagraphs (A)-(B), limits a State to the portion of the recovery that compensates for medical expenses paid by Medicaid. Start with the first half. It requires the State to have the specified laws in effect only to the extent that "payment *has been made under the State plan* for medical assistance" and "a third party has a legal liability to make payment *for such assistance*." 42 U.S.C. 1396a(a)(25)(H) (emphases added). Said more plainly, the State must have in place

acquisition-of-rights laws only to the extent of third parties' liability for expenses paid by Medicaid.

The second half of subparagraph (H) is even clearer. Under it, the state laws must provide that the State acquires the recipient's rights "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*," and that the acquisition extends to rights "to payment by any other party *for such health care items or services*." 42 U.S.C. 1396a(a)(25)(H) (emphases added). In other words, subparagraph (H) provides only that the State may seek reimbursement after Medicaid has paid the recipient's medical expenses, and even then, only to the extent of the third parties' liability for those expenses. The anti-lien clause prohibits the State from ranging any farther. See pp. 11-12, *supra*.

The court of appeals believed that subparagraph (H) limits the category of expenses that is eligible for reimbursement, but not the pool of funds from which the State may obtain the reimbursement. Pet. App. 17-20. That was error. Subparagraph (H) no doubt specifies the category of expenses eligible for reimbursement: "health care items and services furnished to an individual" under Medicaid. 42 U.S.C. 1396a(a)(25)(H). But subparagraph (H) *also* specifies the pool of funds from which the State may obtain the reimbursement: third-party payments "for *such* health care items or services," *i.e.*, for the particular health care items or services that have already been furnished under Medicaid. *Ibid.* (emphasis added).

c. Section 1396k. The final provision at issue here, Section 1396k, provides in relevant parts as follows:

> (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 * * * 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;
>
> * * * 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[.]

42 U.S.C. 1396k(a). Like subparagraph (H), Section 1396k requires the state plan to provide for transfers from the recipient to the State of the right to certain third-party payments. Under subparagraph (H), the transfer occurs automatically, by operation of law, but under Section 1396k, it occurs by assignment.

Section 1396k's assignment provision is less explicit than subparagraphs (A)-(B) and (H). Section 1396k requires the recipient to assign the State rights "to payment for medical care from any third party," 42 U.S.C. 1396k(a)(1)(A), but unlike the other provisions discussed above, it does not expressly state that the relevant third-party payments must be for care funded by Medicaid. Even so, context shows that it incorporates the same limitation.

First, Section 1396k does not stand alone; rather, it provides one means of fulfilling the State's broader duty, set out in subparagraphs (A)-(B), to seek reimbursement from third parties. The opening words of Section 1396k underscore that facilitating role: "For the purpose of *assisting* in the collection * * * of * * * payments for medical care." 42 U.S.C. 1396k(a) (emphasis added). Subparagraphs (A)-(B), as shown above, entitle the State to pursue third parties only to the extent of those parties' liability for the medical expenses paid by Medicaid. See pp. 12-14, *supra*. Since the main provision is limited to third-party compensation for expenses paid by Medicaid, the ancillary provision is best read to be so limited as well. See, *e.g.*, *Territory of Guam* v. *United States*, 141 S. Ct. 1608, 1613 (2021) (reading a provision to incorporate the limitations set forth in an earlier "anchor provision").

Second, Section 1396k itself requires the recipient to cooperate with the State's pursuit of "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) (emphasis added). It would have been strange for Congress to require the recipient to assign the State his rights to third-party payments for *all* medical care, yet at the same time require the recipient to cooperate with the State only with respect to third-party payments for the portion of medical care "available under the plan." *Ibid.*

Third, a separate provision of the Medicaid Act requires the State to provide assurances that it has in effect laws requiring insurers to "accept," as a "condition of doing business in the State," "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) (emphasis added). That provision suggests that Congress understood the assignment of rights under Section 1396k to be limited to third-party payments for services covered by Medicaid. It would have made little sense for Congress to require the recipient to assign to the State the rights to all payments for medical care, yet to require insurers to accept the assignment condition only as to payments for services covered by Medicaid.

The contrary reading, if taken to its logical conclusion, would lead to implausible results. It would seemingly require the recipient to assign to the State *any* recovery of medical expenses he has ever obtained or will ever obtain during his life, even medical expenses that have nothing to do with the incident that prompted resort to Medicaid. For example, if the State pays for medical care after a recipient has a car accident, and the recipient then suffers an unrelated slip and fall years later, the State could seemingly look to the medical-expenses portion of the slip-and-fall judgment to reimburse it for the costs of the car-accident care. No sound reason exists to believe that Congress meant the assignment of the recipient's rights to reach that far.

The court of appeals nonetheless read Section 1396k more broadly because the provision requires the recipient to assign the State "any" rights to third-party payments for medical care. Pet. App. 16. But the court put too much weight on the word "any." Although "use of the word 'any' will sometimes indicate that Congress intended particular statutory text to sweep broadly," "whether it does so necessarily depends on the statutory context." *National Association of Manufacturers* v. *Department of Defense*, 138 S. Ct. 617, 629 (2018). Time and again, this Court has recognized contextual

limitations on a statutory provision's scope, notwithstanding its use of the word "any." See, *e.g.*, *Small* v. *United States*, 544 U.S. 385, 388 (2005); *United States* v. *Alvarez-Sanchez*, 511 U.S. 350, 357 (1994); *United States* v. *Palmer*, 16 U.S. (3 Wheat.) 610, 631-632 (1818) (Marshall, C.J.). And the statutory context here shows that Section 1396k requires the recipient to assign the State only the rights to payment associated with the medical expenses paid by Medicaid.

d. The third-party-liability provisions as a whole. Reading the third-party-liability provisions together leads to the same result as reading them one at a time. As shown above, all the following clauses contain express references to the liability of third parties for the medical expenses that are *paid by Medicaid*:

- The provision that requires the State to ascertain third parties' liability. 42 U.S.C. 1396a(a)(25)(A).
- The provision that requires the State to seek reimbursement from third parties. 42 U.S.C. 1396a(a)(25)(B).
- The provision under which the State acquires, by operation of law, the recipient's rights to third-party payments. 42 U.S.C. 1396a(a)(25)(H).
- The provision that requires insurers to accept the recipient's assignment of rights to the State. 42 U.S.C. 1396a(a)(25)(I).
- The provision that requires the recipient to cooperate with the State's efforts to pursue third parties. 42 U.S.C. 1396k(a)(1)(C).

In short, the third-party-liability provisions resolutely focus on third parties' liability for the expenses covered

by Medicaid. They nowhere mention third parties' liability for other medical expenses not covered by Medicaid.

One clause, of course, is worded differently: the clause that requires the recipient to assign the State his right to seek payment from third parties. 42 U.S.C. 1396k(a)(1)(A). That provision, unlike the others just discussed, lacks an express reference to whether Medicaid has paid the relevant medical expenses. But as shown above, context shows that that clause, too, incorporates the same limitation as the other provisions discussed above. See pp. 16-20, *supra*. Refusing to recognize that limitation would create a severe mismatch between that one provision and the rest of the statutory framework. But courts should endeavor to read a statute's provisions "as a symmetrical and coherent regulatory scheme" and to fit "all parts into an harmonious whole." *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (citations omitted). "There can be no justification for needlessly rendering provisions in conflict if they can be interpreted harmoniously." *Maracich* v. *Spears*, 570 U.S. 48, 68 (2013) (brackets omitted) (quoting Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 180 (2012)).

3. It makes sense that Congress would limit the State to the portions of the recovery associated with the expenses paid by Medicaid

It makes sense that Congress would allow a State to obtain the portions of the recovery that represent medical expenses paid by Medicaid, but no more. Insurance law draws a similar line. In 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." 16 Steven Plitt et al., *Couch on Insurance* § 222:1 (3d ed. 2021). That is, the insurer may obtain only the portions of the settlement that "represent expenses paid by the insurer." *Ibid.* It is natural for Congress to have followed that model in designing Medicaid, which is a form of "state-operated insurance." *California* v. *Texas*, 141 S. Ct. 2104, 2117 (2021).

Congress's judgment makes sense even apart from the analogy to insurance law. Medicaid exists to help needy individuals, not to provide benefits to people "whose needs are [already] being met by a third party under a legal or contractual obligation." *Tristani* v. *Richman*, 652 F.3d 360, 373 (3d Cir. 2011) (citation omitted). Allowing recipients to be "paid twice" for the same care—once through Medicaid and again through a judgment against or settlement with a third party—would be "discriminatory," "wasteful," and an "inefficient" use of "public funds." *Ibid.* (citation omitted).

At the same time, the Medicaid Act—particularly the anti-lien provision—seeks to protect the property of Medicaid recipients. In *Ahlborn*, this Court noted the concern that it might be "unfair" for the State to share in damages for which it has provided no compensation. 547 U.S. at 288. That concern arose in *Ahlborn* because the State had paid only medical expenses but then sought to share in the recipient's recovery of pain and suffering, lost wages, and loss of future earnings. *Id.* at 272. A similar concern arises here because the State has paid only *some* of the recipient's medical expenses but seeks to share in the recipient's recovery of compensation for *all* medical expenses.

By contrast, it would have made little sense for Congress to adopt the approach advocated by Florida. There is no apparent reason for Congress to limit a State to the portions of a recipient's tort recovery that represent medical expenses, but then to take no account of whether the State has paid those expenses.

4. At a minimum, the federal agency's reading of the statute deserves deference

In *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), this Court held that a court owes deference to an agency's reasonable interpretation of an ambiguous statute that the agency administers. *Id.* at 843-844. Deference is especially appropriate when a case involves "matters of detail related to [the statute's] administration." *Barnhart* v. *Walton*, 535 U.S. 212, 225 (2002). That description fits well a case about how much money a State may obtain from a Medicaid recipient's tort recovery. "[T]he question focuses upon a comparatively minor matter of statutory detail, not a major issue of far-reaching statutory policy. It concerns everyday administration. It calls for expertise of a kind that the administering agency is more likely than a court to possess." *Wos* v. *E.M.A. ex rel. Johnson*, 568 U.S. 627, 644 (2013) (Breyer, J., concurring).

The regulations implementing the Medicaid Act embody the understanding that a State is entitled only to the portion of the recovery that represents the medical expenses paid by Medicaid. The regulations describe the third-party-liability provisions as "requirements concerning * * * [t]he legal liability of third parties to pay for services *provided under the plan*." 42 C.F.R. 433.135(a) (emphasis added). They define the very term

"[t]hird party" to mean a person "that is or may be liable to pay all or part of the expenditures for medical assistance *furnished under a State plan*." 42 C.F.R. 433.136 (emphasis altered). They require the State to take reasonable steps "for identifying third parties liable for payment of services *under the plan*," 42 C.F.R. 433.137(a) (emphasis added), and for "determin[ing] the legal liability of the third parties who are liable to pay for services *furnished under the plan*," 42 C.F.R. 433.138(a) (emphasis added). They also require Medicaid recipients to cooperate with the State "in pursuing third parties who may be liable to pay for care and services *under the plan*." 42 C.F.R. 433.147(a)(2) (emphasis added). And they clarify that the assignment of the recipient's rights to the State is "effective only *for services that are reimbursed by Medicaid*." 42 C.F.R. 433.145(c) (emphasis added); see *Barton* v. *Summers*, 293 F.3d 944, 952 (6th Cir. 2002) (explaining that the regulation confirms that "the States are only assignees to the degree that they have paid out for services, and no more"). The regulations thus focus on the liability of third parties for medical expenses paid under Medicaid. They nowhere suggest that a State may, in addition, obtain portions of settlements that have nothing to do with those expenses.

The federal government also advanced this reading of the Medicaid Act in *E.M.A.* It argued there that "[t]he anti-lien provision * * * prohibits States from recovering portions of a lump-sum settlement between a Medicaid beneficiary and a third party that do not represent compensation for medical expenses *paid by Medicaid*." U.S. Br. at 9, *E.M.A.*, *supra* (No. 12-98). (The federal government had previously defended a broader

conception of the State's authority in *Ahlborn*, but this Court rejected that argument. See 547 U.S. at 287-288.)

For the reasons explained above, the Secretary's reading of the Medicaid Act represents the best reading of the statutory text. At a minimum, it constitutes a reasonable reading, and so warrants deference under *Chevron*.

* * * * *

In this case, Florida paid for petitioner's past medical expenses, but not for her future medical expenses. The third-party-liability provisions thus entitle Florida only to the portion of petitioner's tort settlement that represents past medical expenses. Yet Florida has imposed a lien even against the portion that represents future medical expenses. As in *Ahlborn*, because "none of the federal third-party liability provisions excepts that lien from operation of the anti-lien provision, its imposition violates federal law." 547 U.S. at 286.

B. The Contrary Interpretations Lack Merit

1. The court of appeals' interpretation is incorrect

The court of appeals concluded that both Section 1396k and subparagraph (H) permit Florida to impose a lien against the portion of petitioner's settlement that represents future medical expenses. As shown above, however, the court misread both provisions.

In reaching its contrary interpretation, the court of appeals relied on the presumption against reading federal laws to preempt state law. See Pet. App. 11. But this Court has explained that, when a statute "'contains an express preemption clause,'" a court should not "invoke any presumption against pre-emption but instead 'focus on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent.'" *Puerto Rico* v. *Franklin California Tax-Free*

Trust, 136 S. Ct. 1938, 1946 (2016) (citation omitted). In this case, States are expressly forbidden by the anti-lien clause from imposing certain liens, and expressly required by the third-party liability provisions to seek certain payments from third parties. The best way to interpret those express directives to the States is to focus on what they say, not to rely on generic presumptions.

The court of appeals likewise relied on the proposition that Congress must give States clear notice before attaching conditions to grants of federal funds. See Pet. App. 11. That, too, was incorrect. This Court has explained that, although Congress must provide clear notice "that *some* conditions [a]re placed on the receipt of federal funds," it "need not 'specifically identify and pr[e]scribe' each condition in the legislation." *Jackson* v. *Birmingham Board of Education*, 544 U.S. 167, 183 (2005) (brackets omitted) (describing the "holding" of *Bennett* v. *Kentucky Department of Education*, 470 U.S. 656, 665-666 (1985)). The Medicaid Act provides ample notice that States must comply with federal requirements as a condition of receiving federal money. See, *e.g.*, 42 U.S.C. 1396a, 1396c.

In any event, neither the presumption against preemption nor the clear-statement requirement for Spending Clause legislation can help this Court choose between the parties' readings of the Medicaid Act. Under petitioner's and the United States' reading of the statute, the State is *forbidden* from obtaining reimbursement from the portion of the recovery that corresponds to medical expenses not paid by Medicaid. Laws such as Florida's, which go further, would be preempted under that reading. But Florida's reading would *require* the State to seek reimbursement from the portion of the recovery that corresponds to medical expenses not paid

by Medicaid. Under that reading, laws such as California's, which do not go that far, would be preempted. See Cal. Welfare & Institutions Code § 14124.76(a) (West 2018) (limiting the State to the portion of the recovery that "represents payment for medical expenses * * * provided on behalf of the beneficiary"). Either reading would impose conditions on the States, and both would preempt contrary state laws. The propositions invoked by the court of appeals thus provide no basis for preferring one reading over the other.

2. Florida's interpretation is incorrect

Florida's interpretation of the Medicaid Act differs from that of the court of appeals. Whereas the court concluded that both subparagraph (H) and Section 1396k permit the lien imposed in this case, Florida has focused on Section 1396k alone. It contends (Resp. to Pet. 1-2) that, even if subparagraph (H) has a narrower reach, that provision cannot limit the broader terms of Section 1396k's assignment clause. But Florida's reading is also flawed.

As an initial matter, subparagraph (H) is not the only relevant provision that focuses on third parties' liability for medical expenses paid by Medicaid. As discussed above, *many* provisions of the Medicaid Act do so, and the Court should not read Section 1396k's assignment clause to have a markedly different scope from all the others. See pp. 20-21, *supra*.

Even putting aside the other provisions, it would make little sense to read Section 1396k to mean something far different from subparagraph (H). Each provision (as Florida itself recognizes) provides a "tool for recovering third-party payments." Resp. to Pet. 1. Under each, the State acquires the recipient's rights to certain third-party payments, whether through mandatory

assignment (Section 1396k) or by operation of law (subparagraph (H)). Each allows the State, if it so chooses, to stand in the recipient's shoes and to sue a liable third party directly. Each also allows the State, if the recipient sues the third party and wins a recovery, to obtain a share of that recovery. No sound reason exists to suppose that Congress meant the State's share to vary depending on the tool that the State used.

What is more, Florida's understanding of how the third-party-liability provisions fit together is in tension with *Ahlborn*. There, this Court stated that "[t]he obligation to enact assignment laws" in Section 1396k is "reiterated" in subparagraph (H). 547 U.S. at 276. It also stated that the automatic transfer of rights under subparagraph (H) "echoes the requirement of a mandatory assignment of rights in § 1396k(a)." *Id.* at 281. *Ahlborn* thus indicates that subparagraph (H) and Section 1396k(a) should be interpreted in tandem, not read to have substantially different meanings.

Florida objects (Resp. to Pet. 21) that this reading fails to give Section 1396k and subparagraph (H) independent effect. But the history of the Medicaid Act shows why that argument is wrong. A previous version of the statute included the assignment provision now codified in Section 1396k, but not the acquisition-of-rights provision now codified in subparagraph (H). See Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, § 11(b), 91 Stat. 1196 (1977). A government report later found, however, that insurers were "thwart[ing]" Section 1396k by refusing to recognize assignments and by arguing that their insurance contracts forbade assignments. Human Resources Division, United States General Accounting Office, GAO/HRD-91-25, *MEDICAID: Legislation Needed to*

Improve Collections from Private Insurers 5 (Nov. 1990). Congress responded in 1993 by enacting what is now subparagraph (H), thereby requiring States to have in effect laws by which they acquire recipients' rights to third-party payments by operation of law, without the need for separate assignments. See Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13622(c), 107 Stat. 632. Congress thus meant for Section 1396k and subparagraph (H) to serve overlapping functions; it added the belt because it feared that the suspenders were not doing their job. Contrary to Florida's theory, there is no reason to infer that Congress meant the two provisions to perform markedly different roles.

C. States Retain Broad Discretion To Establish Procedures For Allocating Settlements

Although the Medicaid Act entitles a State only to the portions of the recipient's recovery that represent medical expenses paid by Medicaid, the State retains a substantial interest in ensuring that recipients do not manipulate the terms of a settlement to reduce the amount of money that the State may obtain. The United States shares that interest, for it is entitled to a portion of any third-party recovery obtained by the State. See 42 U.S.C. 1396k(b). As this Court has observed, however, States already have appropriate tools for safeguarding that interest. See *E.M.A.*, 568 U.S. at 642-643; *Ahlborn*, 547 U.S. at 288 & n.18.

In the first place, a State may protect its interest in reimbursement by conducting or participating in litigation against a third party before any settlement is finalized. See *Ahlborn*, 547 U.S. at 288. For example, a State could pass a law requiring or permitting the State to join or intervene in a Medicaid recipient's case

against a third party. See U.S. Br. at 33, *E.M.A.*, *supra* (No. 12-98). A State could also choose to participate at the settlement stage, and to that end could require advance notice of settlement negotiations. See *ibid.* Or a State could require its advance consent to any allocation of damages in the settlement. See *ibid.*

Even after a settlement is finalized, the State need not take at face value the settlement's allocation of the award among categories of damages; it may instead hold a judicial or administrative hearing to calculate the appropriate allocation. See *E.M.A.*, 568 U.S. at 641; *Ahlborn*, 547 U.S. at 288. The State may (as Florida has done here) apply a rebuttable presumption that the State is entitled to a specified share of the recovery and shift the burden to the recipient to show at the hearing that a different allocation is appropriate. See Pet. App. 24-27. None of that is new; this Court's decisions in *Ahlborn* and *E.M.A.* already contemplate such procedures for allocating settlements. A ruling for petitioner in this case would simply clarify the ground rules governing the allocation. And hearings may not always prove necessary; the State could avoid the need for a hearing by negotiating an appropriate allocation with the recipient. See U.S. Br. at 32, *E.M.A.*, *supra* (No. 12-98).

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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* The Acting Solicitor General is recused in this case.

APPENDIX

1. 42 U.S.C. 1396a provides in pertinent part:

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

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including 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, as a condition of doing business in the State, to—

* * * * *

(ii) 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;

* * * * *

2. 42 U.S.C. 1396k(a) provides:

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.

3. 42 U.S.C. 1396p(a)(1) provides:

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).

4. 42 C.F.R. 433.135 provides:

Basis and purpose.

This subpart implements sections 1902(a)(25), 1902(a)(45), 1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting forth State plan requirements concerning—

(a) The legal liability of third parties to pay for services provided under the plan;

(b) Assignment to the State of an individual's rights to third party payments; and

(c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

5. 42 C.F.R. 433.136 provides in pertinent part:

Definitions.

For purposes of this subpart—

* * * * *

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

* * * * *

6. 42 C.F.R. 433.137(a) provides:

State plan requirements.

(a) A State plan must provide that the requirements of §§ 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

7. 42 C.F.R. 433.138(a) provides:

Identifying liable third parties.

(a) *Basic provisions.* The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (1) of this section.

8. 42 C.F.R. 433.145 provides:

Assignment of rights to benefits—State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or beneficiary is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in § 435.116 of this chapter (pregnant women), who are exempt from cooperating in establishing the identity of a child's parents and obtaining medical support and payments from, or derived from, the non-custodial parent of a child; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under §§ 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or beneficiary is effective only for services that are reimbursed by Medicaid.

9. 42 C.F.R. 433.147(a)(2) provides:

Cooperation in establishing the identity of a child's parents and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

(a) *Scope of requirement.* The agency must require the individual who assigns his or her rights to cooperate in—

* * * * *

(2) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan.

10. Fla. Stat. 409.901(7) provides:

Definitions, ss. 409.901-409.920

As used in ss. 409.901-409.920, except as otherwise specifically provided, the term:

* * * * *

(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.

11. Fla. Stat. 409.910 provides in pertinent part:

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.

* * * * *

(11)(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her

legal representative is a party which results in a judgment, award, or settlement from a third party, the amount recovered shall be distributed as follows:

1. After attorney's fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the agency up to the total amount of medical assistance provided by Medicaid.

2. The remaining amount of the recovery shall be paid to the recipient.

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

4. Notwithstanding any provision of this section to the contrary, the agency shall be entitled to all medical coverage benefits up to the total amount of medical assistance provided by Medicaid. For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

* * * * *

(17)(b) If federal law limits the agency to reimbursement from the recovered medical expense damages, a recipient, or his or her legal representative, may contest the amount designated as recovered medical expense damages payable to the agency pursuant to the

formula specified in paragraph (11)(f) by filing a petition under chapter 120 within 21 days after the date of payment of funds to the agency or after the date of placing the full amount of the third-party benefits in the trust account for the benefit of the agency pursuant to paragraph (a). The petition shall be filed with the Division of Administrative Hearings. For purposes of chapter 120, the payment of funds to the agency or the placement of the full amount of the third-party benefits in the trust account for the benefit of the agency constitutes final agency action and notice thereof. Final order authority for the proceedings specified in this subsection rests with the Division of Administrative Hearings. This procedure is the exclusive method for challenging the amount of third-party benefits payable to the agency. In order to successfully challenge the amount designated as recovered medical expenses, the recipient must prove, by clear and convincing evidence, that the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f). Alternatively, the recipient must prove by clear and convincing evidence that Medicaid provided a lesser amount of medical assistance than that asserted by the agency.

* * * * *