2023 VA Workers' Compensation Inn of Court Annual Conference

K. Elizabeth ("Beth") O'Dea, Esq.
PennStuart
8550 Mayland Drive, Suite 100
Richmond, VA 23294
Direct: (804) 253-9483
bodea@pennstuart.com

MEDICARE LIENS AND MEDICARE SECONDARY PAYER COMPLIANCE

I. Medicare Conditional Payments

a. 120-day expected payment threshold to trigger Medicare conditional payments
b. Mandatory Insurer Reporting under MMSEA Section 111
    i. Responsible Reporting Entities ("RREs")
    ii. Determining Medicare Status
    iii. CMS Reporting Triggers
        1. Insurer assumption of ongoing responsibility for medical treatments ("ORM"), or
        2. After paying the total payment obligation to the claimant ("TPOC")
    iv. Penalties
        1. $1,000 per day fine
        2. But, Medicare has not yet imposed these penalties
        3. Penalty Regulations anticipated to be finalized no later than February 2023
c. Medicare's direct right of action to recover conditional payments → A "super lien"?
    i. Entities subject to Medicare's Right of Action
        1. Primary Payer
        2. Any entity that has received a primary payment
            a. "beneficiary, provider, supplier, physician, attorney, state agency, or private insurer"

    ii. Right of Action for Recovery is separate and in addition to CMS's subrogation rights

II. Types of Medicare Correspondence

i. Rights and Responsibilities Letter
ii. Conditional Payment Letter (CPL)
    1. Issued automatically within 65 days of issuance of the Rights and Responsibilities Letter

iii. Conditional Payment Notice (CPN)
    1. A CPN may be issued in place of CPL if:
        a. the BCRC has been alerted to a settlement, judgment, award, or other payment by the beneficiary or his or her attorney or other representative before the usual CPL has been issued.
        b. the BCRC is notified of a settlement, judgment, award, or other payment through Section 111 reporting rather than from the beneficiary or his or her attorney or other representative.
    2. After a CPN is issued, the BCRC allows 30 days for a response, which should include:
        a. All proof of representation documentation, if not already submitted.
        b. Proof of any items and/or services that are NOT related to your case, if applicable.
        c. All settlement documentation if you are providing proof of any items and/or services not related to your case.
        d. Procurement costs and fees paid by the beneficiary, if not already submitted.
        e. Documentation for any additional or pending settlements, judgments, awards, or other payments related to the same incident.
iv. Final Demand Letter
    1. Payment or appeal is due within 60 days of the letter
v. Triggers, obligations, and next steps

III. Appeals

a. Types of CMS determinations which provider for a right to appeal
    i. Existence of the overpayment
    ii. Amount of the overpayment
    iii. A less than fully favorable waiver (due to financial hardship) request
b. Appealing CMS's determination
    i. Lack of federal question jurisdiction under 28 U.S.C. § 1331
    ii. Exhaustion of all administrative remedies prior to appealing in federal court
c. Appeal procedure pursuant to *Cochran v. U.S. Health Care Fin. Admin.* [1]
    i. First, appeal the amount of the conditional payment obligation and/or request a waiver from Medicare as to its right to collect the expenses for medical items and services it paid related to the injury.
    ii. Second, if denied, seek review at a hearing before an administrative law judge ("ALJ").

[1] 291 F.3d 775 (11th Cir. 2002). Case Attached.

iii. Third, if the ALJ rules adversely, file a request for review with the Department of Health and Human Services Appeals Board (pursuant to 42 C.F.R. §§ 405.720, 405.724).[2]
iv. Fourth, if ruled against yet again, file a claim in federal court for review under 42 U.S.C. § 1395ff(b)(1).[3]

IV. Practice Tips

a. Use caution with voluntary payments made on cases involving a Medicare beneficiary
b. Use caution regarding ICD9/10 codes submitted to Medicare as accepted conditions
c. Monitor Claimant's beneficiary status throughout the claim
d. Social Security Administrators
e. CMS Form and compliance guidance
f. Review conditional payments and make your appeal request as early as possible.
g. 60-day time limit for appeals and payment following Final Demand Letter and settlement
    i. Interest accrual for late payments
    ii. Appeal denial for untimely appeals
a. Hardship Waivers
h. New tools to resolve Part C/D Conditional Payments
    i. PAID Act - provides RREs with Medicare Part C and D enrollment information to its claimants

V. 2022 Medicaid Update

i. Gallardo v. Marstiller[4]
    1. June 2022 SCOTUS
    2. Essentially allows for recovery of *future* payments similar to Medicare for state Medicaid
    3. Previously, Medicaid could only recover past payments
    4. State-by-state basis

[2] At this point, in addition to the original arguments, a Medicare beneficiary may now raise constitutional objections to CMS subrogation.

[4] 213 L. Ed. 2d 1, 142 S. Ct. 1751, 1752 (2022). Case Attached.

291 F.3d 775
United States Court of Appeals,
Eleventh Circuit.

Jessie D. COCHRAN, for herself and all other persons from whom Defendant has or will demand, under 42 USC 1395y (b)(2), subrogation for medical payments out of non-medical portions of their recoveries from personal injury lawsuits or settlements, Plaintiffs–Appellants,

v.

U.S. HEALTH CARE FINANCING ADMINISTRATION, of the U.S. Department of Health and Human Services, which operates the Medicare program (MEDICARE), Defendant–Appellee.

No. 01–13608.
|
May 16, 2002.

Synopsis

Medicare beneficiary brought action challenging constitutionality of secondary payor statute and regulations. The United States District Court for the Middle District of Alabama, No. 00-01607-CV-T-N, Myron H. Thompson, J., dismissed suit, and beneficiary appealed. The Court of Appeals, Carnes, Circuit Judge, held that beneficiary was not excused from requirement that she first exhaust administrative remedies by possibility that she might succeed on administrative claim.

Affirmed.

Attorneys and Law Firms

***776** William R. Murray, Northport, AL, for Plaintiffs–Appellants.

Kathleen A. Kane, Mark B. Stern, U.S.Dept. of Justice, App. Staff/Civil Div., Washington, DC, for Defendant–Appellee.

Appeal from the United States District Court for the Middle District of Alabama.

Before CARNES and FAY, Circuit Judges, and HUNT[*], District Judge.

Opinion

***777** CARNES, Circuit Judge:

This appeal brings us a paradoxical twist on the conventional argument that exhaustion of administrative remedies should not be required where it would be futile. We have before us a litigant who contends that she should be allowed to circumvent the administrative remedies available to her not because resort to them would be futile, but because it might well be successful. She fears that the agency she has sued would give her administratively everything to which she claims to be entitled, thus mooting her lawsuit and depriving her of the opportunity for victory through litigation. Her position is that the likelihood—she says it is a near certainty—that she would succeed in the administrative appeals process should excuse her from having to resort to it. Believing that what this litigant fears is one of the principal reasons for and benefits of the requirement that administrative remedies be exhausted, we reject her novel argument.

I. BACKGROUND

Jesse Cochran, a 70–year–old woman, was injured by an elevator door at the Tuscaloosa County Courthouse in Tuscaloosa, Alabama. She received medical treatment for those injuries, and is likely to require continued treatment for them. Her medical expenses, $ 7,659.88 at one point, have been paid by Medicare. She brought suit in state court against the company responsible for maintaining the elevator that injured her, seeking to recover for her medical expenses as well as for her pain and suffering and mental anguish. She also sued the County, but the state court dismissed that part of her case. Once Ms. Cochran brought her state court lawsuit, the United States Health Care Financing Administration (HCFA)[1] sent her a letter informing her that it was statutorily subrogated to her right of recovery against the elevator company. HCFA also later sent two letters to her lawyer asserting its subrogation rights, and telling him that he was required to send HCFA a copy of his representation agreement with Cochran.

HCFA's subrogation rights are defined by the Medicare Act, 42 U.S.C. 1395 *et seq.,* and the regulations interpreting it. Section 1395y(b)(2), known as the Medicare Secondary Payer statute, makes Medicare the secondary payer for medical services provided to Medicare beneficiaries whenever payment is available from another primary payer; primary payers include the beneficiary's private insurer or the private insurer of someone liable to the beneficiary. This means that if payment for covered services has been or is reasonably expected to be made by someone else, Medicare does not have to pay. In order to accommodate its beneficiaries, however, Medicare does make conditional payments for covered services, even when another source may be obligated to pay, if that other source is not expected to pay promptly. 42 U.S.C. § 1395y(b)(2)(A)(ii). Medicare's conditional payments are "conditioned on reimbursement [to Medicare] when notice or other information is received that payment for such item or service has been ... made." 42 U.S.C. § 1395y(b)(2)(B)(i).

The way the system is set up the beneficiary gets the health care she needs, but Medicare is entitled to reimbursement if and when the primary payer pays her. Among other avenues of reimbursement, Medicare is subrogated to the beneficiary's ***778** right to recover from the primary payer. 42 U.S.C. § 1395y(b)(2)(B)(iii). Medicare regulations extend that subrogation right to any judgments or settlements "related to" injuries for which Medicare paid medical costs, thereby casting the tortfeasor as the primary payer. 42 C.F.R. § 411.37 (2002). Those same regulations also provide that, when Medicare is reimbursed out of a judgment or settlement, the amount of money it takes is reduced by a pro-rata share of the "procurement costs," which include attorney's fees of the judgment or settlement. 42 C.F.R. § 411.37(c) (2002). That is why Medicare asks attorneys handling any related tort suits for its beneficiaries to supply the agency with a copy of the agreement setting out the share of the recovery they are to receive.

Once Cochran's lawyer received the letters from HCFA informing him of its statutory subrogation rights, he put Cochran's state court case, which was still in its pretrial stages, temporarily on hold.[2] He then brought this federal declaratory judgment lawsuit seeking to have the Medicare subrogation statute, or, alternatively, HCFA's regulations interpreting that statute, declared unconstitutional. The complaint, which sought class action status, alleged that it would be unconstitutional for Medicare to recover its costs from Cochran's entire personal injury settlement or judgment instead of from only that portion allocated—it did not say how or by whom—to medical expenses. The complaint also alleged that Cochran's lawyer was being forced into "involuntary legal servitude" by Medicare's statutory right to subrogation, that Medicare's requests for information on the case from the lawyer's files impermissibly interfered with the attorney-client relationship, and that Medicare should have to pay all of Cochran's attorney's fees in the case, rather than just the pro-rata share prescribed by current regulations.

The district court denied class certification early on, and Cochran does contest that denial. The district court then granted HCFA's motion to dismiss on the grounds that Cochran's suit was not yet ripe. Cochran contends that the court erred in failing to conduct an evidentiary hearing on the standing issue prior to ruling on HCFA's motion to dismiss, and that it erred in dismissing the suit for lack of ripeness. HCFA, in addition to meeting Cochran's two contentions head on, also argues that her lawsuit should have been dismissed for lack of subject matter jurisdiction, because she brought it without first exhausting the administrative remedies as required by the Medicare statute.[3] It is this latter ground on which we affirm the district court's dismissal of Cochran's lawsuit.[4]

II. DISCUSSION

The Medicare statute requires that any lawsuit which seeks "to recover on any ***779** claim arising under" it must first be brought through the Department of Health and Human Services' administrative appeals process before it can be taken to federal court. *See* 42 U.S.C. § 1395ii (adopting the Social Security statute 42 U.S.C. § 405(h), which strips federal courts of primary federal-question subject matter jurisdiction over Medicare claims); 42 U.S.C. § 1395ff(b)(1) (adopting the Social Security statute 42 U.S.C. § 405(g), which confers on federal courts the jurisdiction to hear Medicare claims after administrative review has been exhausted).

Until a claimant has exhausted her administrative remedies by going through the agency appeals process, a federal district court has no subject matter jurisdiction over her lawsuit seeking to "recover on any claim arising out of" the Medicare Act. This is true even when her claim includes a challenge to the constitutionality of the statute or the regulations interpreting it. *See, e.g., Shalala v. Illinois Council on Long Term Care, Inc.,* 529 U.S. 1, 12, 120 S.Ct. 1084, 1092, 146 L.Ed.2d 1 (2000); *Weinberger v. Salfi,* 422 U.S. 749, 762, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975).

HCFA has broad discretion to waive the right of subrogation when pursuing it "would defeat the purposes of the Medicare Act or the Social Security Act or would be against equity and good conscience." 42 U.S.C. § 1395gg(c). To exhaust her administrative appeals, Cochran would first have to request that the agency exercise its discretion to waive its right to collect from the proceeds of her tort suit the medical expenses it had paid on her behalf. If HCFA denied Cochran's request for a waiver, she would then have to seek review of that denial at a hearing before an administrative law judge, and request review of any unfavorable ALJ decision by the Department of Health and Human Services Appeals Board. 42 C.F.R. §§ 405.720, 405.724. During that process she could raise any constitutional objections she has to HCFA's subrogation practices. *See Illinois Council,* 529 U.S. at 12, 120 S.Ct. at 1093. After Cochran exhausted her remedies through that administrative appeals process, she could bring her claims to federal court. 42 U.S.C. § 1395ff(b)(1). That assumes, of course, that she would lose administratively. The problem according to Cochran is that she would not lose.

Cochran concedes that her claim is subject to the exhaustion requirement contained in the Medicare statute.[5] Her one and only argument that she should be allowed to forego exhaustion of her administrative remedies is that the agency charged with carrying out the Medicare statute should not be allowed to give her administratively what she is seeking in litigation. At oral argument, with lectern-pounding zeal and room-filling volume, Cochran's attorney railed against the injustice of allowing the agency to buy off his client by waiving any subrogation rights it might have against her, thereby depriving her of the right to have its subrogation "scheme" exposed in a lawsuit and declared unconstitutional to the benefit of others who may find themselves in the same position. It is, he made abundantly ***780** clear, a matter of principle with his client and him. Matters of principle are important in the promulgation of law, but once it is promulgated law is the basis on which courts decide cases. And the law insists that Cochran exhaust her administrative remedies before bringing this lawsuit.

It is true that in some contexts, administrative exhaustion requirements are tempered by judge-made exceptions, chief among which are that exhaustion of administrative remedies sometimes is not required if resort to them would be futile, or if the remedy they offer is inadequate. *Alexander v. Hawk* 159 F.3d 1321, 1326 (11th Cir.1998). Those judge-made exceptions do not apply, however, to a statutorily-mandated exhaustion requirement like the one involved in this case. *Weinberger v. Salfi,* 422 U.S. 749, 766, 95 S.Ct. 2457, 2467, 45 L.Ed.2d 522 (1975) (holding that where exhaustion is a statutorily specified jurisdictional prerequisite, "the requirement ... may not be dispensed with merely by a judicial conclusion of futility"); *Hawk* 159 F.3d at 1326 ("Mandatory exhaustion is not satisfied by a judicial conclusion that the requirement need not apply"). Besides, no court has ever held, so far as we know, that there is a non-futility or fear-of-success exception to any exhaustion of administrative remedies requirement. We decline to be the first.

III. CONCLUSION

Because Cochran failed to exhaust her administrative remedies before filing her lawsuit in federal court, the district court lacked subject matter jurisdiction over the case. Accordingly, the district court's dismissal of Cochran's lawsuit is

AFFIRMED.

All Citations

291 F.3d 775, 15 Fla. L. Weekly Fed. C 588

Footnotes

* Honorable Willis B. Hunt, Jr., U.S. District Judge for the Northern District of Georgia, sitting by designation.

1 The HCFA has since changed its name to the Center for Medicare Services, but because HCFA was the name of the agency when Cochran brought her suit that is what we will call it.

2 After the district court ruled in this case, Cochran settled with the elevator company, which paid with a check made out to her, her lawyer, and Medicare. She does, however, still have an appeal pending in the state courts involving her claim against Tuscaloosa County, which was dismissed by the state trial court.

3 HCFA did not make this argument to the district court, but it is not foreclosed from making it here, because lack of subject matter jurisdiction may be raised at any time, *Scarfo v. Ginsberg,* 175 F.3d 957, 960 (11th Cir.1999), and we may affirm for any reason supported by the record, even if not relied on by the district court, *United States v. $121,100 in United States Currency,* 999 F.2d 1503, 1507 (11th Cir.1999).

4 As a result, we have no reason to consider Cochran's contention that the district court erred in dismissing her lawsuit without an evidentiary hearing on the ripeness issue, and in concluding that her claims were not yet ripe.

5 Because of this concession, we do not have occasion to decide (and express no view on) this issue of first impression in our circuit: whether a beneficiary's effort to avoid paying over to Medicare part of a tort judgment is subject to the administrative appeals process because it is a suit "to *recover* on any claim arising under" the Medicare act. 42 U.S.C. § 1395ii (emphasis added); *cf. United States v. Blue Cross and Blue Shield of Alabama, Inc.,* 156 F.3d 1098 (11th Cir.1998) (noting that previous Supreme Court cases interpreting the exhaustion requirement "involved suits brought *by beneficiaries* against the United States ... to recover benefits *not previously paid.*")(emphasis added). Consistent with Cochran's concession, we assume for present purposes that it is.

142 S.Ct. 1751
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

No. 20-1263
|
Argued January 10, 2022
|
Decided June 6, 2022

Synopsis

Background: Medicaid recipient, who suffered catastrophic injuries resulting in permanent disability when she was struck by vehicle after stepping off her school bus, brought § 1983 action, through her parents, against Secretary of Florida Agency for Health Care Administration (FAHCA), seeking declaration that FAHCA was violating Medicaid Act by trying to recover its Medicaid expenses, pursuant to Florida's Medicaid Third-Party Liability Act, from portions of settlement proceeds in personal injury action against responsible parties that compensated recipient for future, as opposed to past, medical expenses. The United States District Court for the Northern District of Florida, No. 4:16-cv-00116, Mark E. Walker, J., 263 F.Supp.3d 1247, granted recipient summary judgment, and, 2017 WL 3081816, granted in part and denied in part FAHCA's motion to alter or amend judgment. FAHCA appealed. The United States Court of Appeals for the Eleventh Circuit, Branch, Circuit Judge, 963 F.3d 1167, reversed and remanded, and, 977 F.3d 1366, denied rehearing and rehearing en banc. Certiorari was granted.

Holdings: The Supreme Court, Justice Thomas, held that:

Medicaid Act's anti-lien provision did not preempt Florida's Medicaid Third-Party Liability Act, and under Medicaid Act provision requiring a state to acquire from each Medicaid recipient an assignment of any rights of the individual to payment for medical care from any third party, a state may seek reimbursement of its Medicaid expenses from tort settlement amounts representing payment for medical care, past or future, abrogating *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53.

Affirmed.

Justice Sotomayor filed dissenting opinion, in which Justice Breyer joined.

***1752** *Syllabus*[*]

Petitioner Gianinna Gallardo suffered catastrophic injuries resulting in permanent disability when a truck struck her as she stepped off her Florida school bus. Florida's Medicaid agency paid $862,688.77 to cover Gallardo's initial medical expenses, and the agency continues to pay her medical expenses. Gallardo, through her parents, sued the truck's owner and driver, as well as the Lee County School Board. She sought compensation for past medical expenses, future medical expenses, lost earnings, and other damages. That litigation resulted in a settlement for $800,000, with $35,367.52 expressly designated as compensation for past medical expenses. The settlement did not specifically allocate any amount for future medical expenses.

The Medicaid Act requires participating States to pay for certain needy individuals' medical costs and then to make reasonable efforts to recoup those costs from liable third parties. 42 U.S.C. § 1396k(a)(1)(A). Under Florida's Medicaid Third-Party Liability Act, a beneficiary like Gallardo who "accept[s] medical assistance" from Medicaid "automatically assigns to the [state] agency any right" to third-party payments for medical care. Fla. Stat. § 409.910(6)(b). Applied to Gallardo's settlement, Florida's statutory framework entitled the State to $300,000—*i.e.,* 37.5% of $800,000, the percentage the statute sets as presumptively representing the portion of the tort recovery that is for "past and future medical expenses," absent clear and convincing rebuttal evidence. §§ 409.910(11)(f)(1), (17)(b). Gallardo challenged the presumptive allocation in an administrative proceeding. She also brought this lawsuit seeking a declaration that Florida was violating the Medicaid Act by trying to recover from portions of the settlement

compensating for future medical expenses. The Eleventh Circuit concluded that the relevant Medicaid Act provisions do not prevent a State from seeking reimbursement from settlement monies allocated for future medical care. 963 F.3d 1167, 1178.

Held: The Medicaid Act permits a State to seek reimbursement from settlement payments allocated for future medical care. Pp. 1757 - 1761.

(a) Gallardo argues that the Medicaid Act's anti-lien provision —which prohibits States from recovering medical payments from a beneficiary's "property," § 1396p(a)(1)—forecloses recovery from settlement amounts other than those allocated for past medical care paid for by Medicaid. But this Court has held that the provision does not apply to state laws "expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a)" of the Medicaid Act. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 284, 126 S.Ct. 1752, 164 L.Ed.2d 459. Here, Florida's Medicaid Third-Party Liability Act—under which Florida may seek reimbursement from settlement amounts representing "payment for medical care," past or future—"is expressly authorized by the terms of ... [§]1396k(a)" and thus falls squarely within the "exception to the anti-lien provision" that this Court has recognized. *Ibid.*

The plain text of § 1396k(a)(1)(A) decides this case. Nothing in § 1396k(a)(1)(A) limits a beneficiary's assignment to payments for *past* "medical care" already paid for by Medicaid. To the contrary, the grant of "any rights ... to payment for medical care" most naturally covers not only rights to payment for past medical expenses, but also rights to payment for future medical expenses. § 1396k(a)(1)(A); see *United States v. Gonzales*, 520 U.S. 1, 5, 117 S.Ct. 1032, 137 L.Ed.2d 132. The relevant distinction is thus "between medical and nonmedical expenses," *Wos v. E. M. A.*, 568 U.S. 627, 641, 133 S.Ct. 1391, 185 L.Ed.2d 471, not between past and future medical expenses.

Statutory context reinforces that § 1396k(a)(1)(A)'s reference to "payment for medical care" is not limited as Gallardo suggests. For example, when the Medicaid Act separately requires state plans to comply with § 1396k, it describes that provision as imposing a "mandatory assignment of rights of payment for *medical* support and other *medical* care owed to recipients." § 1396a(a)(45) (emphasis added). Section 1396a(a)(45) thus distinguishes only between medical and nonmedical care, not between past (paid) medical care payments and future (unpaid) medical care payments. If Congress had intended to draw such a distinction, "it easily could have drafted language to that effect." *Mississippi ex rel. Hood v. AU Optronics Corp.*, 571 U.S. 161, 169, 134 S.Ct. 736, 187 L.Ed.2d 654. In fact, Congress did include more limiting language elsewhere in the Medicaid Act. Section 1396a(a)(25)(H), which requires States to enact laws granting themselves automatic rights to certain third-party payments, contains precisely the limitation that Gallardo would read into the assignment provision. Thus, if § 1396k(a)(1)(A)'s broad language alone were not dispositive, its contrast with the limiting language in § 1396a(a)(25)(H) would be. Pp. 1757 - 1759.

(b) Gallardo's arguments that § 1396k(a)(1)(A) has a different meaning are unconvincing. Gallardo construes the prefatory clause to § 1396k(a)(1)(A)— which provides that the "purpose" of the assignment provision is to "assis[t] in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan"—to limit the assignment provision to payments that are already "owed" for "past medical care provided under the [state] plan." Brief for Petitioner 30. But the prefatory clause defines to whom the third-party payments are "owed"—"recipients of medical assistance under the State plan." It does not specify the purpose for which those payments must be made, referring to "medical support" and "medical care" payments, consistent with the adjacent language in § 1396k(a)(1)(A).

Gallardo also proposes that the Court read the assignment provision to incorporate the more limited language in § 1396a(a)(25)(H). But the Court must give effect to, not nullify, Congress' choice to include limiting language in some provisions but not others, see *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17. *Ahlborn*, which Gallardo contends eliminated any daylight between § 1396a(a)(25)(H) and § 1396k(a)(1)(A), was clear that these two provisions "ech[o]" or "reinforc[e]" each other insofar as they both involve "recovery of payments for medical care," 547 U.S. at 282, 126 S.Ct. 1752, and not "payment for, for example, lost wages," *id.*, at 280, 126 S.Ct. 1752. *Ahlborn* did not suggest that these provisions must be interpreted in lockstep. Gallardo's idea that one of these two complementary provisions must "prevail" over the other is therefore mistaken. The complementary provisions concern different requirements; they do not conflict just because one is broader than the other.

Gallardo and the United States also argue that § 1396k(a)(1)(A) should be interpreted consistently with §§ 1396a(a)(25)(A) and (B), which require a State to seek reimbursement "to the extent of " a third party's liability "for care and services available under the plan." But the relevant language —"pay[ment] for care and services available under the plan"—could just as readily refer to payment for medical care "available" in the future. Regardless, Congress did not use this language to define the scope of an assignment under § 1396k(a)(1)(A), implying again that the provisions should not be interpreted the same way. This implication is strengthened by the fact that § 1396k(a)(1)(A) was enacted after §§ 1396a(a)(25)(A) and (B), and Congress did not use the existing language in §§ 1396a(a)(25)(A) and (B) to define the scope of the mandatory assignment.

Finally, Gallardo's two policy arguments for her preferred interpretation both fail. First, citing a footnote from *Ahlborn*, she contends that it would be " 'absurd and fundamentally unjust' " for a State to " 'share in damages for which it has provided no compensation.' " 547 U.S. at 288, n. 19, 126 S.Ct. 1752. But the Court's holding there was dictated by the Medicaid Act's "text," not by the Court's sense of fairness. *Id.*, at 280, 126 S.Ct. 1752. Second, Gallardo speculates that the Court's reading of § 1396k(a)(1)(A) would authorize a "lifetime assignment" covering not only the rights an individual has while a Medicaid beneficiary but also any rights acquired in the future when the individual is no longer a Medicaid beneficiary. Not so. The provision is most naturally read as covering those rights "the individual" possesses while on Medicaid. And given background legal principles about the scope of assignments, § 1396k(a)(1)(A) cannot be read to cover the sort of "lifetime assignment" Gallardo invokes. Pp. 1759 -1761.

963 F.3d 1167, affirmed.

THOMAS, J., delivered the opinion of the Court, in which ROBERTS, C. J., and ALITO, KAGAN, GORSUCH, KAVANAUGH and BARRETT, JJ., joined. SOTOMAYOR, J., filed dissenting opinion in which, BREYER, J., joined.

Attorneys and Law Firms

Bryan S. Gowdy, Jacksonville, FL, for petitioner

Vivek Suri, New York, NY, for United States as amicus curiae, by special leave of the Court, supporting petitioner.

Henry C. Whitaker, Solicitor General, for respondent.

Scott L. Nelson, Public Citizen Litigation Group, Washington, DC, Bryan S. Gowdy, Counsel of Record, Meredith A. Ross, Creed & Gowdy, P.A., Jacksonville, FL, Floyd Faglie, Staunton & Faglie, PL, Monticello, FL, for petitioner.

Ashley Moody, Attorney General of Florida, Henry C. Whitaker, Solicitor General, Counsel of Record, Daniel W. Bell, Chief Deputy Solicitor General, Christopher J. Baum, Senior Deputy Solicitor General, Office of the Attorney General, Tallahassee, FL, Tracy Cooper George, Chief Appellate Counsel, Florida Agency for Health, Care Administration, Tallahassee, FL, for respondent.

Opinion

Justice THOMAS delivered the opinion of the Court.

Medicaid requires participating States to pay for certain needy individuals' medical costs and then to make reasonable efforts to recoup those costs from liable third parties. Consequently, a State must require Medicaid beneficiaries to assign the State "any rights ... to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). That assignment permits a State to seek reimbursement from the portion of a beneficiary's private tort settlement that represents "payment for medical care," *ibid.*, despite the Medicaid Act's general prohibition against seeking reimbursement from a beneficiary's "property," § 1396p(a)(1). The question presented is whether § 1396k(a)(1)(A) permits a State to seek reimbursement from settlement payments allocated for future medical care. We conclude that it does.

I

A

States participating in Medicaid "must comply with [the Medicaid Act's] requirements" or risk losing Medicaid funding. *Harris v. McRae*, 448 U. S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980); see ***1756** 42 U.S.C. § 1396c. Most relevant here, the Medicaid Act requires a State to condition Medicaid eligibility on a beneficiary's assignment to the State of "any rights ... to support ... for the purpose of medical care" and to "payment for medical care from any third party." § 1396k(a)(1)(A); see also § 1396a(a)(45) (mandating States'

compliance with § 1396k). The State must also enact laws by which it automatically acquires a right to certain third-party payments "for health care items or services furnished" to a beneficiary. § 1396a(a)(25)(H). And the State must use these (and other) tools to "seek reimbursement" from third parties "to the extent of [their] legal liability" for a beneficiary's "care and services available under the plan." §§ 1396a(a)(25)(A)–(B).

The Medicaid Act also sets a limit on States' efforts to recover their expenses. The Act's "anti-lien provision" prohibits States from recovering medical payments from a beneficiary's "property." § 1396p(a)(1); see also § 1396a(a)(18) (requiring state Medicaid plans to comply with § 1396p). Because a "beneficiary has a property right in the proceeds of [any] settlement," the anti-lien provision protects settlements from States' reimbursement efforts absent some statutory exception. *Wos v. E. M. A.*, 568 U.S. 627, 633, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013). State laws "requir[ing] an assignment of the right ... to receive payments [from third parties] for medical care," as "expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a)," are one such exception. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 284, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). Accordingly, a State may seek reimbursement from the portion of a settlement designated for the "medical care" described in those provisions; otherwise, the anti-lien provision prohibits reimbursement. *Id.*, at 285, 126 S.Ct. 1752.

B

To satisfy its Medicaid obligations, Florida has enacted its Medicaid Third-Party Liability Act, which directs the State's Medicaid agency to "seek reimbursement from third-party benefits to the limit of legal liability and for the full amount of third-party benefits, but not in excess of the amount of medical assistance paid by Medicaid." Fla. Stat. § 409.910(4) (2017).[1] To this end, the statute provides that when a beneficiary "accept[s] medical assistance" from Medicaid, the beneficiary "automatically assigns to the [state] agency any right" to third-party payments for medical care. § 409.910(6)(b). A lien "for the full amount of medical assistance provided" then "attaches automatically" to any settlements related to an injury "that necessitated that Medicaid provide medical assistance." §§ 409.910(6)(c), (6)(c)(1), 409.901(7)(a).

Rather than permit the State to recover from a beneficiary's entire settlement, the statute entitles Florida to half a beneficiary's total recovery, after deducting 25% for attorney's fees and costs (*i.e.*, 37.5% of the total). See § 409.910(11)(f)(1). This amount presumptively represents the portion of the tort recovery that is for "past and future medical expenses." § 409.910(17)(b). Beneficiaries can rebut that presumption by proving with 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." *Ibid.*

***1757** C

In 2008, a truck struck then-13-year-old petitioner Gianinna Gallardo after she stepped off her school bus. Gallardo suffered catastrophic injuries and remains in a persistent vegetative state. Florida's Medicaid agency paid $862,688.77 to cover her initial medical expenses, after WellCare of Florida, a private insurer, paid $21,499.30. As a condition of receiving Medicaid assistance, Gallardo had assigned Florida her right to recover from third parties. Because Gallardo is permanently disabled, Medicaid continues to pay her medical expenses.

Gallardo, through her parents, sued the truck's owner and driver, as well as the Lee County School Board, seeking compensation for past medical expenses, future medical expenses, lost earnings, and other damages. Although Gallardo sought over $20 million in damages, the litigation ultimately settled for $800,000—a 4% recovery. The settlement expressly designated $35,367.52 of that amount as compensation for past medical expenses—4% of the $884,188.07 paid by Medicaid and WellCare. The settlement also recognized that "some portion of th[e] settlement may represent compensation for future medical expenses," App. 29, but did not specifically allocate any amount for future medical expenses.

Under Florida's statutory formula, the State was presumptively entitled to $300,000 of Gallardo's settlement (37.5% of $800,000). Gallardo, citing the settlement's explicit allocation of only $35,367.52 as compensation for past medical expenses, asked Florida what amount it would accept to satisfy its Medicaid lien. When Florida did not respond, Gallardo put $300,000 in escrow and challenged the presumptive allocation in an administrative proceeding. There, Florida defended the presumptive allocation because,

in its view, it could seek reimbursement from settlement payments for past *and* future medical expenses, and so was not limited to recovering the portion Gallardo had allocated for past expenses.

While the administrative proceeding was ongoing, Gallardo brought this lawsuit seeking a declaration that Florida was violating the Medicaid Act by trying to recover from portions of the settlement compensating for future medical expenses. The U. S. District Court for the Northern District of Florida granted Gallardo summary judgment. See *Gallardo v. Dudek*, 263 F.Supp.3d 1247, 1260 (2017). The Eleventh Circuit reversed, concluding that "the text and structure of the federal Medicaid statutes do not conflict with Florida law" because they "only prohibit a State from asserting a lien against any part of a settlement not 'designated as payments for medical care.' " *Gallardo v. Dudek*, 963 F.3d 1167, 1176 (2020) (quoting *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752). The Eleventh Circuit explained that the relevant Medicaid Act provisions "d[o] not in any way prohibit [a State] from seeking reimbursement from settlement monies for medical care allocated to future care." 963 F.3d at 1178 (emphasis deleted). Judge Wilson dissented, contending that the Medicaid Act "limit[s] the state to the part of the recovery that represents payment for past medical care." *Id.*, at 1184.

Because the Supreme Court of Florida came to the opposite conclusion of the Eleventh Circuit, see *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53, 56 (2018), we granted certiorari, 594 U. S. ——, 141 S.Ct. 2884, 210 L.Ed.2d 990 (2021).

II

Gallardo argues that the Eleventh Circuit erred by permitting Florida to seek reimbursement for medical expenses ***1758** from settlement amounts representing payment for future medical care. According to Gallardo, the Medicaid Act's anti-lien provision in § 1396p forecloses recovery from settlement amounts other than those allocated for past medical care paid for by Medicaid. Thus, Gallardo concludes, the anti-lien provision preempts any state law that permits additional recovery.

We disagree. Under § 1396k(a)(1)(A), Florida may seek reimbursement from settlement amounts representing "payment for medical care," past or future. Thus, because Florida's assignment statute "is expressly authorized by the terms of ... [§]1396k(a)," it falls squarely within the "exception to the anti-lien provision" that this Court has recognized. *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752.

A

The plain text of § 1396k(a)(1)(A) decides this case. This provision requires the State to acquire from each Medicaid beneficiary an assignment of "any rights ... of the individual ... to support ... for the purpose of medical care ... and to payment for medical care from any third party." § 1396k(a)(1)(A). Nothing in this provision purports to limit a beneficiary's assignment to "payment for" *past* "medical care" already paid for by Medicaid. To the contrary, the grant of "*any* rights ... to payment for medical care" most naturally covers not only rights to payment for past medical expenses, but also rights to payment for future medical expenses. *Ibid.* (emphasis added); see *United States v. Gonzales*, 520 U.S. 1, 5, 117 S.Ct. 1032, 137 L.Ed.2d 132 (1997) ("[T]he word 'any' has an expansive meaning"). The relevant distinction is thus "between medical and nonmedical expenses," *Wos*, 568 U.S. at 641, 133 S.Ct. 1391, not between past expenses Medicaid has paid and future expenses it has not.

Statutory context reinforces that § 1396k(a)(1)(A)'s reference to "payment for medical care" is not limited as Gallardo suggests. First, when § 1396k(a)(1)(A) limits the kind of "support" (*e.g.*, child support) covered by a beneficiary's assignment, the statute does not single out support allocated for past expenses that a State has already paid. Instead, it requires only that support payments be "specified as support *for the purpose of medical care*" generally. § 1396k(a)(1)(A) (emphasis added). Second, when the Medicaid Act separately requires state plans to comply with § 1396k, it describes that provision as imposing a "mandatory assignment of rights of payment for *medical* support and other *medical* care owed to recipients." § 1396a(a)(45) (emphasis added). In short, § 1396k(a)(1)(A) and § 1396a(a)(45) distinguish only between medical and nonmedical care, not between past (paid) medical care payments and future (unpaid) medical care payments. If Congress had intended to draw such a distinction, "it easily could have drafted language to that effect." *Mississippi ex rel. Hood v. AU Optronics Corp.*, 571 U.S. 161, 169, 134 S.Ct. 736, 187 L.Ed.2d 654 (2014).

In fact, Congress did include such limiting language elsewhere in the Medicaid Act. Section 1396a(a)(25)(H), which requires States to enact laws granting themselves

automatic rights to certain third-party payments, contains precisely the limitation that Gallardo would read into the assignment provision. That provision applies only when "payment has been made under the State plan for medical assistance for health care items or services *furnished* to an individual," and covers only third-party payments "for *such* health care items or services." § 1396a(a)(25)(H) (emphasis added). Thus, if § 1396k(a)(1)(A)'s ***1759** broad language alone were not dispositive, its contrast with the limiting language in § 1396a(a)(25)(H) would be. "Had Congress intended to restrict" § 1396k(a)(1)(A) to past expenses Medicaid has paid, it "would have done so expressly as it did in" § 1396a(a)(25)(H). *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983).

In sum, because the plain meaning of § 1396k(a)(1)(A), informed by statutory context, allows Florida to seek reimbursement from settlement amounts representing past or future "payments for medical care," Florida's assignment provision falls within the "exception to the anti-lien provision." *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752.[2]

B

Gallardo nevertheless argues that § 1396k(a)(1)(A) has a different meaning, largely by discounting the text of § 1396k(a)(1)(A) and then relying on other differently worded provisions or on policy arguments, none of which we find convincing.

Insofar as she confronts § 1396k(a)(1)(A) itself, Gallardo largely focuses on its prefatory clause, which provides that the "purpose" of the assignment provision is to "assis[t] in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan." § 1396k(a). Gallardo construes this language to limit the assignment provision to payments that are already "owed" for "*past* medical care provided under the [state] plan." Brief for Petitioner 30.

Gallardo's argument misreads the statutory text. The prefatory clause does not refer to payments "owed" "under the State plan," but rather to "payments owed *to recipients of medical assistance* under the State plan." § 1396k(a) (emphasis added). In other words, the prefatory language Gallardo invokes defines *to whom* the third-party payments are "owed"—"recipients of medical assistance under the State plan." It does not specify *the purpose* for which those payments must be made. On that score, the prefatory clause refers to "medical support" and "medical care" payments, consistent with the adjacent language in § 1396k(a)(1)(A).

With little support in the text of § 1396k(a)(1)(A), Gallardo proposes that we read the assignment provision to incorporate § 1396a(a)(25)(H)'s more limited language. But as explained above, see *supra*, at 1758 - 1759, we must give effect to, not nullify, Congress' choice to include limiting language in some provisions but not others, see *Russello*, 464 U.S. at 23, 104 S.Ct. 296. Gallardo responds that our decision in *Ahlborn* eliminated any daylight between § 1396a(a)(25)(H) and § 1396k(a)(1)(A), because we said there that these provisions "reiterat[e]," "reinforc[e]," and "ech[o]" each other. 547 U.S. at 276, 280, 281, 126 S.Ct. 1752. But *Ahlborn* was clear that these two provisions "ech[o]" or "reinforc[e]" each other insofar as they both involve "recovery of payments ***1760** for medical care," *id.*, at 282, 126 S.Ct. 1752, and not "payment for, for example, lost wages," *id.*, at 280, 126 S.Ct. 1752. *Ahlborn* did not suggest that we must otherwise interpret these provisions in lockstep.

Conceding the provisions' scope could differ, Gallardo argues that the later enacted § 1396a(a)(25)(H) should "prevai[l]" over the earlier enacted § 1396k(a)(1)(A). Brief for Petitioner 34. But Gallardo does not identify any conflict requiring one of the provisions to prevail. Both provisions require the State to obtain rights—either by assignment or by statute—to certain third-party payments. Because they concern different requirements, they do not conflict just because one is broader in scope than the other. In fact, the provisions complement each other. Section 1396k(a)(1)(A) provides a broad, but not foolproof, contractual right to third-party payments for medical care. See Brief for Respondent 33–34 (explaining circumstances when an assignment under § 1396k(a)(1)(A) might be ineffective). By contrast, § 1396a(a)(25)(H) provides a more targeted statutory right for when the assignment might fail. See Brief for United States as *Amicus Curiae* 28–29 (explaining that, prior to § 1396a(a)(25)(H)'s enactment, insurers were "thwarting [§ 1396k(a)(1)(A)] by refusing to recognize assignments and arguing that their insurance contracts forbade assignments" (internal quotation marks omitted)).[3] Thus, the idea that one of these two complementary provisions must "prevail" over the other is mistaken.

Gallardo and the United States also invoke §§ 1396a(a)(25)(A) and (B), which require States to "take all reasonable measures to ascertain the legal liability of third parties ... to

pay for care and services available under the [Medicaid] plan" and to "seek reimbursement ... to the extent of such legal liability." They argue that these provisions are the Medicaid Act's "main" or "anchor" third-party liability provisions and limit the State's recovery under any other provision "to the extent of " a third party's payments "for care and services available under the plan," §§ 1396a(a)(25)(A)–(B), which they interpret to include only payments for medical care that Medicaid has already covered. Reply Brief 6 (internal quotation marks omitted); see Brief for United States as *Amicus Curiae* 18.

This argument suffers from several problems. To begin, it is far from clear that §§ 1396a(a)(25)(A) and (B) refer only to past expenses the State has already paid. The relevant language—"pay[ment] for care and services available under the plan"—could just as readily refer to payment for medical care "available" in the future. Regardless, even if this language means what Gallardo says it does, Congress did not use this language to define the scope of an assignment under § 1396k(a)(1)(A), implying again that the ***1761** provisions should not be interpreted the same way. See *supra*, at 1758 - 1759. This implication is strengthened by the fact that § 1396k(a)(1)(A) was enacted after §§ 1396a(a)(25)(A) and (B). It would have been easy for Congress to use the existing language in §§ 1396a(a)(25)(A) and (B) to define the scope of the mandatory assignment. But it did not.[4]

Finally, Gallardo relies on two policy arguments for her preferred interpretation. First, citing a footnote from *Ahlborn*, she contends that it would be " 'absurd and fundamentally unjust' " for a State to " 'share in damages for which it has provided no compensation.' " 547 U.S. at 288, n. 19, 126 S.Ct. 1752 (quoting *Flanigan v. Department of Labor and Industry*, 123 Wash.2d 418, 426, 869 P.2d 14, 17 (1994)). Although *Ahlborn* noted possible unfairness if States were given "absolute priority" to collect from the entirety of a tort settlement, 547 U.S. at 288, 126 S.Ct. 1752, our holding there was dictated by the Medicaid Act's "text," not by our sense of fairness, *id.*, at 280, 126 S.Ct. 1752. Had the text of the Medicaid Act authorized "absolute priority," *Ahlborn* would have been decided differently.

Second, Gallardo speculates that our reading of § 1396k(a)(1)(A) would authorize a "lifetime assignment" covering not only the rights an individual has while he is a Medicaid beneficiary but also any rights he acquires in the future when he is no longer a Medicaid beneficiary. Brief for Petitioner 32. Not so. Section 1396k(a)(1)(A) only assigns "any rights ... *of the individual*" (emphasis added), which is most naturally read as covering those rights "the individual" possesses while on Medicaid. We must also read § 1396k(a)(1)(A)'s text in light of background legal principles, and it is blackletter law that assignments typically cover "only [those] rights possessed by the assignors at the time of the assignments," *United States v. Central Gulf Lines, Inc.*, 974 F.2d 621, 629 (C.A.5 1992); see also 6A C. J. S., Assignments § 88 (2022), or those rights "expected to arise out of an existing ... relationship," see Restatement (Second) of Contracts § 321(1) (1981); see also 9 A. Corbin, Contracts § 50.1 (2022). Given that legal backdrop, § 1396k(a)(1)(A) cannot cover the sort of "lifetime assignment" Gallardo invokes.[5]

* * *

For these reasons, we affirm the judgment of the Court of Appeals.

It is so ordered.

Justice SOTOMAYOR, with whom Justice BREYER joins, dissenting.

Where a Medicaid beneficiary recovers an award or settlement from a tortfeasor for medical expenses, specific provisions of the Medicaid Act direct a State to reimburse itself from that recovery for care for which it has paid. These provisions constitute a limited exception to the Act's default rule prohibiting a State from imposing a lien against the beneficiary's property or ***1762** seeking to use any of that property to reimburse itself. Accordingly, a State may claim portions of the beneficiary's tort award or settlement representing payments for the beneficiary's medical care, but not those representing other compensation to the beneficiary (*e.g.,* damages for lost wages or pain and suffering). *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 282–286, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006). This statutory structure recognizes that it would be " 'fundamentally unjust' " for a state agency to " 'share in damages for which it has provided no compensation.' " Id., at 288 126 S.Ct. 1752.

Today, however, the Court permits exactly that. It holds that States may reimburse themselves for medical care furnished on behalf of a beneficiary not only from the portions of the beneficiary's settlement representing compensation for Medicaid-furnished care, but also from settlement funds that compensate the Medicaid beneficiary for future medical care

for which Medicaid has not paid and might never pay. The Court does so by reading one statutory provision in isolation while giving short shrift to the statutory context, the relationships between the provisions at issue, and the framework set forth in precedent. The Court's holding is inconsistent with the structure of the Medicaid program and will cause needless unfairness and disruption. I respectfully dissent.

I

Congress conditions a State's receipt of federal Medicaid funding, see 42 U.S.C. § 1396d(b), on compliance with federal requirements for the program. The Court today details at length one of these requirements: that a state Medicaid plan pursue reimbursement for the State's payments where reimbursement is available from a third party. See *ante,* at 1755 - 1756. It devotes comparatively little attention to another central requirement: that a State not assert claims against the property of Medicaid beneficiaries or recipients.

Under the Medicaid Act's anti-lien provision, enacted in 1965 as part of the original Act, "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance" provided under the state Medicaid plan, whether "paid or to be paid." § 1396p(a)(1); see *Ahlborn*, 547 U.S. at 283–284, 126 S.Ct. 1752. In addition, the Act's anti-recovery provision, also enacted in 1965, provides that "[n]o adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made." § 1396p(b)(1). Together, the anti-lien and anti-recovery provisions establish that acceptance of Medicaid does not render a beneficiary indebted to the State or give the State any claim to the beneficiary's property. In other words, Medicaid is not a loan. If a Medicaid beneficiary's financial circumstances change and a beneficiary gains the ability to pay for his or her own medical expenses, the beneficiary is not obligated to repay the State for past expenses, no matter the magnitude of the change in circumstances. Rather, the ordinary consequence is that the individual simply becomes ineligible for benefits moving forward.[1]

***1763** In *Ahlborn*, this Court held that the Medicaid provisions enabling the State to seek reimbursement from third parties liable for a beneficiary's medical care (discussed in detail below) establish a narrow exception to the anti-lien provision. The exception applies where the beneficiary directly sues a tortfeasor for payment of medical costs.[2] As a threshold matter, the Court held that a beneficiary's settlement proceeds qualified as beneficiary "property" protected by the anti-lien provision unless an exception to that provision applied. *Id.*, at 285–286, 126 S.Ct. 1752. The Court further held that Medicaid's assignment to the State of rights to reimbursement from third parties "carved out" an "exception to the anti-lien provision" permitting the State "to recover that portion of a settlement that represents payments for medical care." *Id.*, at 282, 284–285, 126 S.Ct. 1752.

Importantly, the *Ahlborn* Court rejected the State's claim that it could seek reimbursement more broadly from the remainder of the settlement funds. It held that "the anti-lien provision applies" to bar a State's assertion of a lien beyond the portion of a settlement representing payments for medical care. *Id.*, at 285, 126 S.Ct. 1752; accord, *Wos v. E. M. A.*, 568 U.S. 627, 636, 133 S.Ct. 1391, 185 L.Ed.2d 471 (2013). As relevant to the case before it, the *Ahlborn* Court concluded that the State could not recover from portions of a settlement representing compensation "for damages distinct from medical costs—like pain and suffering, lost wages, and loss of future earnings." 547 U.S. at 272, 126 S.Ct. 1752. The Court noted that it would be "unfair to the recipient" and " 'absurd' " for the State to " 'share in damages for which it has provided no compensation.' " *Id.,* at 288, and n. 19, 126 S.Ct. 1752.

II

The Court summarizes Florida's Medicaid Third-Party Liability Act and the facts of petitioner Gianinna Gallardo's case. See *ante*, at 1756 - 1758. The question presented is whether the exception to the anti-lien provision recognized in *Ahlborn* extends to permit Florida to claim the share of Gallardo's settlement allocated for her future medical expenses as compensation for the State's expenditures for her past medical expenses.

Before answering that question, a note is in order about what is not in dispute. Consider a hypothetical example in which Florida has spent $1,000 on a beneficiary's medical care, after which the beneficiary secures a $1,500 tort settlement, $200 of which is allocated for those already-incurred medical expenses, $500 of which is allocated for future medical care, and the remainder of which ($800) compensates for nonmedical expenses. The parties agree, as they must, that Florida cannot recover anticipated expenses for services it has not furnished, but may pursue reimbursement only for expenses it has paid (*i.e.*, Florida can recover no more than

$1,000). The parties further agree that Florida can recover these expenses from the portion of the beneficiary's settlement allocated for ***1764** these expenses (*i.e.*, the $200), and that Florida can challenge the allocation of the settlement if it contends that too low a portion was designated for past medical expenses. The parties also do not dispute that Florida cannot recover from the $800 representing nonmedical expenses. The only dispute is whether Florida also may recover its past medical costs from the distinct portion of the beneficiary's settlement representing future medical expenses (*i.e.*, the $500)—expenses it has not paid and might never pay. Under a proper reading of the applicable statutory provisions in context, Florida may not do so.

As *Ahlborn* explains, Florida's ability to seek reimbursement from Gallardo's settlement hinges on establishing that an exception to the anti-lien and anti-recovery provisions applies. Several provisions, enacted over a span of decades, set forth the exception relevant here. The first, §§ 1396a(a)(25)(A) and (B) (collectively, the third-party liability provision), was enacted three years after the Medicaid Act and the anti-lien and anti-recovery provisions. The third-party liability provision authorizes a State only to recover for "medical assistance" that "*has been made* available on behalf of the individual," and only "*after* medical assistance has been made available." § 1396a(a)(25)(B) (emphasis added). And it authorizes recovery only "to the extent of," *ibid.*, "the legal liability of third parties ... to pay for care and services available under the plan," § 1396a(a)(25)(A). In this context, the provision's reference to care "available under the plan" can only be understood to refer to care that is available by virtue of having been paid under the plan, not care that theoretically may or may not be made available in the future. Put differently, as a textual matter, this provision extends only to a third party's liability to pay for services actually furnished by a state plan.

Congress subsequently enacted two legal tools for a State to use when seeking reimbursement, consistent with the third-party liability provision, for services paid.

The first of these tools is the assignment provision, § 1396k(a)(1)(A), enacted in 1977 and made mandatory in 1984. In that provision, to "assis[t] in the collection of ... payments for medical care," § 1396k(a), Congress required each state Medicaid plan to condition eligibility on assignment of "any rights" of the beneficiary "to payment for medical care from any third party," § 1396k(a)(1)(A). Florida rests its argument on the understanding that this language confers upon it a right to recover payments designated for medical care regardless of whether those payments compensate for medical care for which Florida actually has paid.

Several textual signals foreclose Florida's interpretation of the assignment provision. For one, the provision, by its terms, does not stand alone. Instead, Congress enacted it "[f]or the purpose of assisting in [a State's] collection of " payments for medical care owed to beneficiaries. § 1396k(a). It would be anomalous, then, to read the provision to reach beyond the third-party liability provision it "assist[s]" in implementing. *Ibid.*; see *Guam v. United States*, 593 U. S. ——, ——, 141 S.Ct. 1608, 1613–1614, 209 L.Ed.2d 691 (2021) (similarly interpreting a statutory provision in light of an earlier "anchor provision"). Supporting that understanding, Congress later amended the statute containing the assignment provision to require beneficiaries "to cooperate with the State in identifying ... any third party who may be liable to pay for care and services available under the plan." § 1396k(a)(1)(C) (the cooperation provision). The cooperation provision echoes the third-party liability provision's focus on care "available under the plan." *Ibid.* It would be bizarre for ***1765** Congress to mandate a more far-reaching assignment of a beneficiary's right to payment for all medical support, paid or unpaid, but limit the beneficiary's duty to cooperate only to services paid. Finally, another provision of the Act directs each State to pass laws requiring insurers to "accept ... the assignment to the State of any right of an individual or other entity to payment ... for an item or service for which payment has been made under the State plan." § 1396a(a)(25)(I)(ii). In this insurer acceptance provision, Congress described the assignment provision's mandate as specific to third-party payments for services the State plan has funded. Taken together, these textual indicators establish that the assignment provision reaches only a third party's liability for services made available by Medicaid, not liability for services for which Medicaid has not paid and may never pay.

The second tool Congress enacted to implement the third-party liability provision is the acquisition provision, § 1396a(a)(25)(H). A 1990 General Accounting Office report found that some health insurers were "thwart[ing]" the assignment provision by "refusing to pay [States] for any of several reasons," including by declining to recognize Medicaid assignments or by insisting that such assignments conflicted with their insurance contracts. Medicaid: Legislation Needed to Improve Collections From Private Insurers 5 (GAO/HRD–91–25, Nov.). Congress addressed this in 1993 by directing each State to enact laws

under which the State automatically acquires a beneficiary's rights to third-party payments specifically "for health care items or services furnished" to the beneficiary, without the need for separate assignments. § 1396a(a)(25)(H). The text of this acquisition provision, too, clearly restricts a State's acquisition to the portion of a third-party payment pertaining to "health care items or services" for which "payment has been made under the State plan" and does not extend to third-party payments for services the plan has not furnished. *Ibid.*; see *ante,* at 1758 - 1759.

This Court's task is to interpret these provisions " 'as a symmetrical and coherent regulatory scheme' " while " 'fit[ting] ... all parts into an harmonious whole.' " *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133, 120 S.Ct. 1291, 146 L.Ed.2d 121 (2000). Doing so here leads to only one "symmetrical and coherent" conclusion: that the assignment and acquisition provisions work in tandem to effectuate the third-party liability provision. As explained by the United States as *amicus curiae* in support of Gallardo, Congress "added the belt" (the acquisition provision) "because it feared that the suspenders" (the assignment provision) "were not doing their job." Brief for United States as *Amicus Curiae* 29. The two provisions take different paths toward the same goal, and each reinforces the other. All of the provisions enable a State to reimburse itself for expenses it has paid, not for expenses it may or may not incur in the future. None of the provisions authorize a State to seek such reimbursement from the portions of a beneficiary's tort settlement representing payments for care for which the State has not paid.

This interpretation is also consistent with the structure of the Medicaid program as a whole, under which a State's recovery from a beneficiary's compensation in tort is permissible under a narrow exception to the general, asset-protective rule established by the anti-lien and anti-recovery provisions. *Ahlborn* further explained that the third-party liability provision and acquisition provision both "reinforce[d] the limitation implicit in the assignment provision." 547 U.S. at 280, 126 S.Ct. 1752. In particular, the ***1766** Court described the acquisition provision's requirement (that a State enact laws under which it acquires a beneficiary's rights to third-party payments for "health care items or services furnished to an individual" "under the State plan," § 1396a(a)(25)(H)) as "reiterat[ing]" and "echo[ing]" the assignment provision's requirement (that a state plan condition eligibility on a beneficiary's assignment of rights to payment). *Id.,* at 276, 281, 126 S.Ct. 1752. *Ahlborn*'s repeated recognition of the relationships between these three provisions cannot be squared with Florida's primary argument, which would sever the provisions and read the assignment provision to eclipse the limitations of the other two.

Moreover, Medicaid is an insurance statute, and *Ahlborn*'s discussion of the unfairness that would ensue from a State's " 'shar[ing] in damages for which it has provided no compensation,' " *id.,* at 288, n. 19, 126 S.Ct. 1752, tracks background principles of insurance law. Under those principles, recovery by an insurer against a third party "is generally limited to the same elements as those for which [the insurer] has made payment," absent contractual terms to the contrary. 16 S. Plitt, D. Maldonado, J. Rogers, & J. Plitt, Couch on Insurance § 226:36 (3d ed. 2021); see Brief for United States as *Amicus Curiae* 21–22. This, too, supports a cohesive reading of these provisions as allowing States to recover their past expenses only from sources that compensate for the care and services state plans actually have furnished.[3]

An additional absurdity would flow from an overbroad reading of the assignment provision decoupled from its companions. Florida maintains that the assignment provision's reference to "any rights ... to payment for medical care from any third party," § 1396k(a)(1)(A), permits recovery from settlement funds compensating for all medical expenses, past or future. If this provision were interpreted in isolation to sweep so broadly, however, its text would place no temporal limitation on the rights assigned to the State. For example, if Medicaid were to fund an individual's medical care as a teenager, the State would be entitled to recover the costs of that care from any unrelated future tort settlement for medical expenses, regardless of whether the individual remained on Medicaid or the state plan furnished any services related to those future injuries. Such a nonsensical "lifetime assignment," Brief for Petitioner 32, would constitute an "unfair" erosion of the anti-lien provision, *Ahlborn*, 547 U.S. at 288, 126 S.Ct. 1752, contravening Congress' careful design. In contrast, a harmonious reading of the statute, consistent with *Ahlborn*, limits the funds from which a State may recover to those awarded for expenses paid and therefore presents no such concern.

III

Despite the foregoing, the Court reads the assignment provision standing alone to establish, unlike all the other

provisions of the Act at issue, a substantially broader right to recover from payments for all medical care, whether paid by the State or ***1767** not. The Court commits several errors on the path to its holding, which departs from the statutory scheme as understood in *Ahlborn* and forces the Court to adopt an implausible workaround in order to mitigate the absurd consequence, discussed above, of its acontextual reading.

A

The Court's analysis starts off backward. The Court states first that the Act requires a State to condition Medicaid eligibility on assignment of rights, and only then notes that the anti-lien provision "also" limits States' recovery efforts. *Ante,* at 1755 - 1756. In fact, the anti-lien and anti-recovery provisions establish a general rule, and the subsequently enacted third-party liability provision and its companions create a limited exception. That exception, in turn, should not be construed "to the farthest reach of [its] linguistic possibilit[y] if that result would contravene the statutory design." *Maracich v. Spears*, 570 U.S. 48, 60, 133 S.Ct. 2191, 186 L.Ed.2d 275 (2013). The Court's misframing, however, causes it to displace the background principle of the anti-lien and anti-recovery provisions by relying on language in the assignment provision that is vague at best.

The Court places great weight on the assignment provision's use of the word "any" in its reference to "rights ... to payment for medical care." § 1396k(a)(1)(A); see *ante,* at 1758. The Court presumes that " '[t]he word "any" has an expansive meaning.' " *Ibid.* But whether the word "any" indicates an intent to sweep broadly "necessarily depends on the statutory context." *National Assn. of Mfrs.* v. *Department of Defense*, 583 U. S. ——, ——, 138 S.Ct. 617, 629, 199 L.Ed.2d 501 (2018). Here, as explained, statutory context establishes that the word "does not bear the heavy weight the [Court] puts upon it." *Ibid.* To the extent the Court suggests the word "any" supersedes all other contrary contextual indications, it ignores precedent. See, *e.g., United States v. Alvarez-Sanchez*, 511 U.S. 350, 356–358, 114 S.Ct. 1599, 128 L.Ed.2d 319 (1994) (relying on context to interpret " 'any law-enforcement officer or law-enforcement agency' " as limited to those making arrests under federal law).

The Court also repeatedly relies on the fact that the acquisition provision and third-party liability provision use specific language to limit the pool from which a State may recover to funds that compensate for expenses Medicaid has paid, whereas the assignment provision uses different language. See *ante,* at 1758 - 1759, 1759 - 1760, 1760 - 1761. The Court invokes the presumption that " '[w]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion.' " *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983). This is unpersuasive. Putting aside the many contextual clues that support Gallardo's reading of the assignment provision, see *supra,* at 1764 - 1765, the presumption the Court cites is " 'strongest' in those instances in which the relevant statutory provisions were 'considered simultaneously when the language raising the implication was inserted.' " *Gómez-Pérez* v. *Potter*, 553 U.S. 474, 486, 128 S.Ct. 1931, 170 L.Ed.2d 887 (2008). It has less force where, as here, different Congresses enacted the provisions at issue over the course of multiple decades. The presumption is especially unhelpful in this case because it cuts both ways: Since 1965, the anti-lien provision has specified that a State may not impose a lien against a beneficiary's property "on account of medical assistance paid *or to be paid* on his behalf." § 1396p(a)(1) (emphasis added). ***1768** Accepting the Court's logic, Congress should have required an assignment that unambiguously reached payments for both furnished and unfurnished care using this existing "paid or to be paid" language, but it failed to do so in the assignment provision. See *ante,* at 1760 - 1761.

Meanwhile, the Court fails to give due regard to the clear textual limitations imposed by the Act as a whole. For instance, as to the assignment provision's mirror image in the insurer acceptance provision, see *supra,* at 1764 - 1765, the Court reasons that the latter's "narrower focus on health insurers, who typically pay only once medical services are rendered, explains its application to a narrower category of third-party payments," *ante,*at 1760, n. 3. This is beside the point. In the assignment provision, Congress required beneficiaries to assign certain rights to the State; in the insurer acceptance provision, it required insurers to accept that assignment. It makes no sense that Congress would require insurers to accept only a sliver of the mandatory assignment, regardless of how insurers typically pay.

Ultimately, "[s]tatutory construction ... is a holistic endeavor." *United Sav. Assn. of Tex. v. Timbers of Inwood Forest Associates, Ltd.*, 484 U.S. 365, 371, 108 S.Ct. 626, 98 L.Ed.2d 740 (1988). Yet rather than reading the assignment provision

in a manner "compatible with the rest of the law," *ibid.*, the Court disconnects it from much of the Act. The Court does not hold that the third-party liability provision extends as far as its reading of the assignment provision. See *ante,* at 1760 - 1761; see also *supra,* at 1763 - 1764. The Court also agrees that the acquisition provision is "more limited," meaning that the scope of that provision, too, "differ[s]" from that of the assignment provision. *Ante,* at 1759 - 1760. To justify these anomalies, the Court asserts that Congress, in enacting the acquisition provision, saw fit to "provid[e] a more targeted statutory right for when the assignment might fail." *Ibid.* The Court offers little explanation, however, for why Congress might have narrowed such a necessary backstop in this way. The statutory hodgepodge the Court perceives contrasts sharply with the reasonable scheme Congress actually crafted.

B

The Court's reasoning also contradicts precedent. The Court distinguishes *Ahlborn* because that case did not squarely hold that the relevant provisions "must" be interpreted in "lockstep," and it reduces *Ahlborn*'s concern about fairness to a disfavored "policy argumen[t]" that must yield to text. *Ante,* at 1759 -1760, 1760 - 1761. But *Ahlborn*'s analysis reflected the Court's view of the text and context of the Act as a cohesive whole. It is not only "our sense of fairness," *ante,* at 1761, but Congress' sense of fairness, as codified in the Act's anti-lien and anti-recovery provisions and recognized in *Ahlborn*, that demonstrates the Court's error.

The Court itself appears to recognize that its textual analysis leads to unfair and absurd results, leading it to suggest an unpersuasive workaround. The Court responds to the lifetime-assignment quandary, see *supra,* at 1766 - 1767, by reasoning that the assignment provision's use of the phrase " 'any rights ... *of the individual*' " is "most naturally read" to impose a temporal limitation to rights possessed while on Medicaid, *ante,* at 1760 - 1761. Neither party even suggests this reading of the statute.[4] That is because it is anything but natural, especially under the interpretive ***1769** approach the Court uses today. An "individual" continues to be an "individual" for the duration of his or her life, whether on or off Medicaid. Were there any ambiguity, the word " 'any,' " we are told, " 'has an expansive meaning' " that would counsel against the Court's implicit limitation. *Ante,* at 1758. Perhaps sensing that its claim to natural meaning lacks force, the Court, at last, acknowledges "background legal principles" that militate against allowing a lifetime assignment. *Ante,* at 1761. While background principles indisputably are relevant, the Court errs by discarding the more relevant background rule of insurance law that Congress embraced in the Act, see *supra,* at 1766, which could have avoided the Court's dilemma altogether.[5]

Over the long term, the Court's alteration of the balance Congress struck between preserving Medicaid's status as payer of last resort and protecting Medicaid beneficiaries' property might frustrate both aims. As a State's right of recovery from any damages payout expands, a Medicaid beneficiary's share shrinks, reducing the beneficiary's incentive to pursue a tort action in the first place. See Brief for American Justice Association et al. as *Amici Curiae* 16–20. Under the provisions of the Act at issue here, States may sue tortfeasors directly, but as Florida itself explains, it is "more cost-effective" for beneficiaries to sue. Tr. of Oral Arg. 65. By diminishing beneficiaries' interests in doing so, the Court's expansion of States' assignment rights could perversely cause States to recover fewer overall expenses, all while unsettling expectations in the States that have relied on a contrary reading of federal law.[6]

In the end, the Court's atomizing interpretation has little to commend it, particularly when contrasted with the consistent, administrable scheme Congress crafted. The Court's reading also undercuts Congress' choice to allow Medicaid beneficiaries to place their excess recovery funds in Special Needs Trusts, protecting their ability to pay for important expenses Medicaid will not cover. See n. 1, *supra*. Congress may wish to intercede to address any disruption that ensues from today's decision, but under a proper reading of the Act, such intervention would have been unnecessary.

* * *

"[T]he meaning of a statute is to be looked for, not in any single section, but in all the parts together and in their relation to the end in view." *Panama Refining Co. v. Ryan*, 293 U.S. 388, 439, 55 S.Ct. 241, 79 L.Ed. 446 (1935) (Cardozo, J., dissenting). Because the Court disserves this cardinal rule today, I respectfully dissent.

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Footnotes

* The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U.S. 321, 337, 26 S.Ct. 282, 50 L.Ed. 499.

1 For the sake of simplicity, we refer to the State, its Medicaid agency, or simply Medicaid interchangeably.

2 According to the dissent, our conclusion conflicts with the "background principl[e] of insurance law" that an insurer's third-party recovery is limited " 'to the same elements as those for which [the insurer] has made payment.' " *Post*, at 1766 (opinion of SOTOMAYOR, J.) (quoting 16 S. Plitt, D. Maldonado, J. Rogers, & J. Plitt, Couch on Insurance § 226:36 (3d ed. 2021)). But even assuming this principle is relevant as the dissent supposes, the dissent concedes that it gives way if a "contractual ter[m]"—an assignment provision, for example—permits a broader recovery. *Post*, at 1766; see also, *e.g.*, 16 Couch on Insurance § 222:63 (citing examples). Here, § 1396k(a)(1)(A) mandates an assignment provision that does just that.

3 The United States makes a similar argument when it relies on § 1396a(a)(25)(I)(ii), under which States must enact laws requiring health 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." We disagree that this provision "suggests that Congress understood the assignment of rights under Section 1396k to be limited to third-party payments for services covered by Medicaid." Brief for United States as *Amicus Curiae* 19. Like § 1396a(a)(25)(H), this provision targets specific attempts by health insurers to avoid making payments to state Medicaid programs. Its narrower focus on health insurers, who typically pay only once medical services are rendered, explains its application to a narrower category of third-party payments, and says little to nothing about the meaning of § 1396k(a)(1)(A)'s broader scope.

4 That Congress required States' compliance with § 1396k(a)(1)(A) via a separate paragraph—§ 1396a(a)(45)—rather than subordinating it under § 1396a(a)(25), supports our conclusion that they need not be interpreted in lockstep.

5 Florida also suggested at argument that § 1396k(a)(1)(A) includes a germaneness requirement such that the assignment extends only to payments for medical care germane—*i.e.*, related—to an injury or illness for which Medicaid covered treatment. See Tr. of Oral Arg. 69. However, we have no adversary briefing on this issue and no cause to resolve it. It is undisputed that the settlement from which Florida seeks recovery is germane to the injury for which Florida paid out Medicaid funds, and Florida law requires as much. See Fla. Stat. § 409.910(6)(c).

1 Petitioner Gianinna Gallardo has continued to receive Medicaid benefits, despite the proceeds from her tort settlement, because those proceeds were transferred into a congressionally authorized Special Needs Trust, a narrow exception to Medicaid's asset limits. See Reply Brief 22, n. 6. Such a trust exists to pay expenses not covered by Medicaid, which may include, for example, certain home nursing care or a home ramp for a wheelchair. Upon a beneficiary's death, all trust assets are transferred to the State until the State is fully reimbursed for all medical assistance it has furnished. See § 1396p(d)(4)(A); Brief for American Justice Association et al. as *Amici Curiae* 4–7.

2 The *Ahlborn* Court "assume[d]" without deciding "that a State can fulfill its obligations under the federal third-party liability provisions by ... placing a lien on ... the settlement that a Medicaid recipient procures on her own." *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 280, n. 9, 126 S.Ct. 1752, 164 L.Ed.2d 459 (2006); see also *id.*, at 281, 126 S.Ct. 1752 ("assuming" that one of these provisions, § 1396k(b), "applies in cases where the State does not actively participate in the litigation").

3 Much as an insurer might modify this default rule under contract, Congress could do so by statute. The parties agree that Congress did so as to Medicare, which, in the parties' view, permits a broader scope of recovery for services (both furnished and to be furnished) from a third party's liability in tort. See Brief for Respondent 41; Reply Brief 8–9. The difference, if any, between the two programs reflects Medicaid's focus on the needy, as well as the fact that individuals may lose and regain Medicaid eligibility over time based on changes in their circumstances, whereas most Medicare enrollees are seniors entitled to coverage for the rest of their lives.

4 In its briefing, Florida responded to the lifetime-assignment concern by stating only that its own law did not go so far. Brief for Respondent 45. Confronted anew with the concern at argument, Florida proposed an implicit "germaneness requirement," see Tr. of Oral Arg. 68–70, which the Court does not embrace, see *ante,* at 1761, n. 5.

5 The Court does not dispute the background principle that an insurer's third-party recovery is limited to the elements for which the insurer has made payment. See *supra,* at 1766. The Court responds, however, that Congress clearly displaced this principle in the assignment provision. See *ante,* at 1759, n. 2. That, of course, is the entire question. For the reasons explained, the Court's reading of the assignment provision is erroneous.

6 The vast majority of lower courts (including Florida's Supreme Court) read these provisions much as I do. See, *e.g., Latham v. Office of Recovery Servs.*, 2019 UT 51, 448 P.3d 1241; *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53 (Fla. 2018); *In re E. B.*, 229 W.Va. 435, 729 S.E.2d 270 (2012); *Doe v. Vermont Office of Health Access*, 2012 VT 15A, 191 Vt. 517, 54 A.3d 474; Pet. for Cert. 18–19 (collecting additional cases).