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Medicaid Liens and *Gallardo*

Hannah Berkman, Horvitz & Levy LLP
H. Thomas Watson, Horvitz & Levy LLP
Peder K. Batalden, Horvitz & Levy LLP

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In February 2020, a trial court in Los Angeles ruled that federal law preempted a state Medicaid lien on a tort settlement. Medicaid beneficiary L.Q.—a child whose catastrophic birth injuries rendered her disabled—sued her health care providers for negligence and settled for $3 million. The California Department of Health Care Services (DHCS) asserted a lien on the settlement to recover medical expenses it had paid, a standard procedure under the state's Medicaid scheme. But the trial court denied the lien,[1] ruling that a state statute on which DHCS has long relied to assert such liens was preempted by the federal Medicaid Act's[2] anti-lien provision.

The court of appeal reversed in *L.Q. v. California Hospital Medical Center*[3] but noted that tension between certain Medicaid Act provisions had never been squarely addressed by the U.S. Supreme Court.[4] Relying on dicta from two Supreme Court decisions—*Arkansas Department of Health & Human Services v. Ahlborn*[5] and *Wos v. E.M.A. ex rel. Johnson*[6]—and on the language of the Act itself, the *L.Q.* court held DHCS could recoup its Medicaid costs from liable third parties by asserting a lien on the portion of a beneficiary's tort recovery allocated to past medical expense damages because the Medicaid beneficiary had already assigned those funds to the state by operation of law.[7]

This Term, the Supreme Court considered a related issue in *Gallardo ex rel. Vassallo v. Marstiller*[8]: may states recover Medicaid costs from liable third parties by dipping into the portion of a beneficiary's settlement allocated toward *future* medical expenses, as well as the portion allocated to *past* medical expenses? The Court answered "yes" by acknowledging competing interests—those of states administering Medicaid and seeking to keep their programs solvent and those of beneficiaries seeking to maximize their recoveries from liable tortfeasors—but tipping the balance toward the former.[9] The Court's decision confirms that states enjoy broad authority to recoup their Medicaid costs from beneficiaries' tort recoveries.[10] Whether this decision ultimately promotes Medicaid solvency will depend on whether it discourages Medicaid beneficiaries from pursuing tortfeasors, as Justice Sotomayor warned in dissent.[11]

Gallardo leaves other questions unanswered. Because the Court's decision failed to harmonize conflicting provisions of the Medicaid Act, states face continuing challenges to their statutory schemes, like California in the *L.Q.* litigation. As discussed during the *Gallardo* oral argument, most state Medicaid laws contain vague language that echoes federal law but overlooks thornier conflicts between reimbursement and protection of beneficiaries' property. This article examines the history of state Medicaid liens and offers suggestions for amending state laws to enhance the recovery—by both states and Medicaid beneficiaries—of medical expenses paid using Medicaid funds from liable third-party tortfeasors.

Statutory Background

To participate in Medicaid, states must develop and administer plans that conform to the Medicaid Act. The Act's anti-lien provision, part of the original 1965 statute, states that no "lien may be imposed against the property of any

individual" prior to their death "on account of medical assistance paid or to be paid on [their] behalf under a State plan."[12] The Act also includes several provisions requiring states to seek reimbursement from liable third parties, such as 42 U.S.C. § 1396a(a)(25)(A).[13] Under that statute, a state plan must require the administering agency to take "all reasonable measures to ascertain the legal liability of third parties" to "pay for care and services available under the plan."[14] Where third parties are liable, and the amount of reimbursement the state can "reasonably expect to recover exceeds the costs of such recovery," the agency must seek full reimbursement.[15]

In 1977, as part of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, Congress added an assignment provision, 42 U.S.C. § 1396k(a),[16] requiring beneficiaries to assign the state "any rights" "to payment for medical care from any third party," and to "cooperate" with the state in "identifying" any liable third party.[17] After it became clear that health insurers were evading the assignment provision,[18] Congress added an acquisition provision in 1993, 42 U.S.C. § 1396a(a)(25)(H),[19] requiring participating states to enact laws under which each state automatically acquires a beneficiary's right to payments from liable third parties for "health care items or services furnished" to the individual, "to the extent that [such] payment has been made under the State plan."

States responded by enacting a variety of statutory schemes to obtain reimbursement from liable third parties. These measures included intervention in beneficiaries' suits against tortfeasors and, despite the anti-lien provision, the assertion of liens on settlements and judgments.[20] Indeed, prior to 2006, many states interpreted the Medicaid Act to allow reimbursement from any component of a beneficiary's tort recovery.[21]

SCOTUS Cases: *Ahlborn* and *Wos*

The states' zealous efforts to recoup Medicaid payments from liable third parties produced extensive litigation, leading to the Supreme Court's *Ahlborn* decision in 2006.[22] Medicaid recipient Heidi Ahlborn challenged an Arkansas law that allowed the state's health department to recoup all of its Medicaid costs from beneficiaries' tort recoveries.[23] If state expenses exceeded a recovery's allocated medical expenses, the state's lien could attach to other damages, like those for pain and suffering, and a beneficiary could end up with nothing.[24] The Supreme Court held that the Arkansas scheme went too far: by allowing the state to lien recoveries of nonmedical expenses, it "squarely conflict[ed]" with the Medicaid Act's anti-lien provision.[25] The Court explained that, while the assignment and third-party liability provisions (§§ 1396k(a) and 1396a(a)(25)) "carved out" an implied "exception" to the anti-lien provision limited to payments for medical care, "[b]eyond that, the anti-lien provision applies."[26]

The Court acknowledged that beneficiaries may coordinate with tortfeasors to allocate an artificially small portion of their settlement to medical expenses to depress the potential lien amount but noted the risk could be avoided through a state's advance agreement to an allocation or by requiring court approval of the allocation.[27] The Court assumed without deciding that a state could recoup Medicaid expenses from third-party tortfeasors by placing a lien on settlements; Ahlborn did not ask the Court to hold the anti-lien provision prohibited the practice, which, the Court acknowledged, it "would appear" to do if "[r]ead literally and in isolation."[28]

The Court again addressed the interplay between these provisions in *Wos* in 2013.[29] In response to *Ahlborn*, North Carolina construed its Medicaid lien statute to define the portion of a tort recovery representing payment for medical expenses as "the lesser of the State's past medical expenditures or one-third of the plaintiff's total recovery."[30] A disabled minor plaintiff challenged the state's claim to one-third of her medical malpractice settlement, which was undifferentiated.[31]

The Supreme Court held that the Medicaid Act preempted North Carolina's law, underscoring that its main "defect" was the absence of a process to determine the portion of a tort recovery attributable to medical expenses.[32] The Court faulted the scheme for "pick[ing] an arbitrary number" and "by statutory command label[ing] that portion" as representing medical care payment.[33] That "irrebuttable, one-size-fits-all statutory

presumption" violated the anti-lien provision, which, as established by *Ahlborn*, prohibits a state from recouping its costs from any portion of a beneficiary's tort recovery not designated as payment for medical care.[34] Once more, the Court avoided the underlying question at the heart of ongoing litigation: are such liens allowed at all?

In response to these High Court decisions, Congress amended the Medicaid Act in 2013, overruling *Ahlborn* and allowing states to place liens on beneficiaries' entire tort recoveries.[35] The implementation of these amendments was delayed, however. Adding to the confusion, the amendments were retroactively repealed, restoring the "post-*Ahlborn* status quo."[36] This status quo continues to be challenged in court.

Lower Court Decisions

In the wake of *Ahlborn*, state and federal trial courts generally assumed that liens on payments for medical care were valid. That assumption was first squarely tested in *Tristani ex rel. Karnes v. Richman*.[37] There, a federal judge in Pennsylvania ruled that the Medicaid Act preempted all liens on tort recoveries and that the state must instead take an active role in recovering its past expenses—either by intervening in lawsuits or directly suing third-party tortfeasors.[38] But the Third Circuit disagreed, explaining that, based on the Medicaid Act as a whole, Pennsylvania's practice of asserting liens "must be viewed as an exception to the anti-lien and anti-recovery provisions."[39] The court noted that "practical considerations weigh[ed] in favor of [this] holding," as over 30 states used liens to recoup Medicaid expenses at the time.[40]

Similar challenges to state Medicaid lien laws continued. For example, the trial court in *L.Q.* denied the California DHCS' lien based on a perceived "conflict between the right of DHCS to be paid from a beneficiary's settlement proceeds and federal statutory law which prohibits a lien from being imposed against a settlement of an individual."[41] The court of appeal reversed, however, holding that allowance of such liens is "compelled by the plain language of the [Medicaid] Act," whose reimbursement provisions create "implied exceptions" to the anti-lien provision.[42]

The *L.Q.* court explained that certain Medicaid Act provisions are in tension. On the one hand, the Act's acquisition of rights provision deems states to have acquired the right to third-party payments for medical care, and the reimbursement provision requires states to seek reimbursement for those third-party payments. On the other hand, the anti-lien provision forbids states from asserting liens against the property of Medicaid beneficiaries (presumptively including judgments and settlements in their favor—at least to the extent the right to those funds has not previously been assigned), and the anti-recovery provision prohibits states from seeking to recover benefits that were correctly paid on behalf of Medicaid beneficiaries.[43] Relying on dicta in *Ahlborn* and *Wos*, the *L.Q.* court resolved this tension by holding that state liens on Medicaid beneficiary recoveries are valid if limited to *past* medical costs. The court reasoned that, under the assignment clause, a Medicaid beneficiary's recovery of damages for past medical expenses belongs to the state, not to the beneficiary. Thus, the portion of L.Q.'s settlement on which DHCS asserted a lien was never L.Q.'s "property" within the meaning of the anti-lien provision.[44] The court also noted that states have "long imposed Medicaid liens limited to medical costs, . . . courts routinely have found such liens to be valid," and Congress has not prohibited such liens despite repeatedly having the opportunity to do so.[45]

Another California plaintiff, Daniel C., recently asserted a similar objection to a DHCS lien, contending that the agency was not entitled to any portion of his settlement under the Medicaid Act. After he appealed from the trial court order granting the lien, the same appellate court that decided *L.Q.* once again held that such liens were allowed under the Medicaid Act but that the trial court had erred by failing to equitably allocate the settlement proceeds between past medical expenses (to which the lien may attach) and other damages (to which the lien may not attach).[46] *Ahlborn* and state statutes require courts to make such allocations, the court noted, even though

"neither describes how" to do so.[47] Relying on California case law, the court said only that the trial court must make the allocation "on the basis of a rational approach."[48]

These ongoing challenges reflect that neither Congress nor the Supreme Court has struck a clear balance between allowing states to recover medical expenses and protecting beneficiaries' property. State agencies are often placed in a bind: they are required to seek reimbursement from liable third parties but their tools for doing so may run afoul of beneficiaries' property rights. And as evidenced by recent litigation in California and Pennsylvania, the lack of express guidance on the permissibility of liens opens the door to suits that challenge states' statutory schemes outright. While *L.Q.* suggested that its decision was compelled by the "plain language of the [Medicaid] Act,"[49] the "plain language" of the anti-lien and reimbursement provisions seem to compel contradictory results, as *Ahlborn* acknowledged nearly 15 years ago.[50]

The SCOTUS Decision in *Gallardo*

The Supreme Court stepped into this legal thicket in its June 6, 2022 decision in *Gallardo*. There, the majority upheld a Florida statutory scheme that entitles the state's Medicaid agency to 37.5% of a beneficiary's recovery, which presumptively represents past and *future* medical expenses.[51] The Court applied the "plain text of § 1396k(a)(1)(A)," the Act's assignment provision, which requires states to acquire from the beneficiary an assignment of "any rights" "to payment for medical care," distinguishing only between medical and nonmedical expenses rather than between past and future expenses.[52] The Court contrasted this language with § 1396a(a)(25)(H), the Act's acquisition provision that applies when "payment has been made" under the 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."[53] The more expansive language used in § 1396k(a)(1)(A), the majority reasoned, plainly allows states to seek reimbursement from future medical expense allocations.[54]

The Court thus rejected Gallardo's argument that the two provisions (§§ 1396k(a)(1)(A) and 1396a(a)(25)(H)) must be read in concert, instead holding that they differed in meaningful ways, with one providing a broad contractual right to third-party payments for medical care and the other providing a "more targeted statutory right for when the assignment might fail."[55] The Court also rejected Gallardo's policy arguments, including her assertion that the Court's reading of the assignment provision authorized a "lifetime assignment" covering any rights acquired in the future, since the statute applied only as long as Gallardo remained a Medicaid beneficiary.[56]

Justices Sotomayor and Breyer dissented, stating that the Court had improperly read the assignment provision in isolation, displacing the "general, asset-protective rule established by the anti-lien and anti-recovery provisions."[57] Acceptance of Medicaid, they noted, "does not render a beneficiary indebted to the State," as the program "is not a loan."[58] Rather, *Ahlborn* established only a "narrow exception" to the anti-lien provision and explicitly noted that it would be "unfair" to the recipient and "absurd" for the state to "share in damages for which it ha[d] provided no compensation."[59]

The dissenting Justices pointed out the irony that the majority's "alteration of the balance Congress struck between preserving Medicaid's status as a payer of last resort and protecting Medicaid beneficiaries' property might frustrate both aims."[60] As the decision tips the balance toward states' interest in keeping Medicaid solvent, it undermines beneficiaries' incentive to seek tort payouts in the first place. Of course, states may pursue tortfeasors directly, but Florida's counsel pointed out during oral argument that it is "more cost-effective" for beneficiaries to do so.[61] *Gallardo* could thwart state reimbursement efforts by disincentivizing beneficiaries to pursue tortfeasors.

Looking Forward

As noted during the *Gallardo* oral argument, many states' Medicaid lien statutes are ambiguous regarding recovery scope and procedure.[62] Many states haven't updated their laws since *Ahlborn*, and some allow liens against *all* recoveries by beneficiaries—including nonmedical damages.[63] States now have a substantial incentive to legislate in this area. In doing so, they should keep in mind several competing concerns.

States can adopt measures establishing a (rebuttable) presumptive recovery from beneficiaries' tort settlements, like the Florida scheme upheld in *Gallardo*. But this strategy may inhibit beneficiaries from pursuing tort claims altogether. To avoid such a result, states should consider allowing beneficiaries to keep a portion of the medical expense damages they recover, similar to the 15% to 25% bounty that relators may recover in qui tam actions under the federal False Claims Act.[64] Bounties encourage beneficiaries to bring potentially meritorious tort claims that may produce recoveries for them to share with the state.

States also should address the problem *Ahlborn* flagged: beneficiaries' incentive to structure settlements in ways that avoid allocating funds to medical expenses in order to circumvent states' recovery rights.[65] Requiring that a court decide settlement allocation may reduce this risk. For example, *Daniel C.* rejected an argument that a Medicaid "beneficiary's settlement of a tort claim includes damages for past medical expenses *only* if the beneficiary so intends—or, in other words, that the beneficiary's intended allocation of the settlement is dispositive."[66] The court relied on a state statute affording DHCS "'a right to recover . . . the reasonable value of benefits' provided" to the beneficiary and further providing "that *the court*, not the Medi-Cal beneficiary, determines what portion of a settlement is fairly allocated to satisfy DHCS's lien."[67] States should consider adopting similar provisions requiring court approval or determination of settlement allocations.

States would be well-advised to craft detailed schemes, rather than merely "parrot[ing] the federal provisions," to limit interpretive disputes down the road.[68] California's lien statute, for example, was amended in 2007 to reflect *Ahlborn*.[69] It furnishes specific procedures for seeking reimbursement of past medical expenses from tort recoveries.[70] The scheme is well-crafted, but *Gallardo* calls it into question. If states must seek reimbursement to the extent of third parties' legal liability, are statutory schemes that limit reimbursement to *past* medical expenses violating this requirement? The federal government's amicus brief in support of Gallardo argued just this point: "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," and under such a reading, "laws such as California's, which do not go that far, would be preempted."[71]

After rehearing was granted in *Daniel C.* (to address *Gallardo's* impact), the settlement beneficiary argued that *Gallardo* does not require states to obtain reimbursement from portions of tort settlements allocated for future care, and the case was therefore inapplicable to California's statute and the pending appeal.[72] In its supplemental brief, the DHCS agreed: while federal law "*permits* [S]tates to recover from any portion of a settlement allocated towards past or future medical damages, California has opted to limit its recovery to the portions of a settlement which represent payment for past medical expenses."[73] California's statute is narrower and more restrictive than Florida's. This divide reflects states' "'considerable latitude to design administrative and judicial procedures' to adjudicate Medi-Cal lien recovery matters."[74] But the issue remains unresolved, and the *Daniel C.* court may determine that the DHCS' position neglects to pursue "all reasonable measures" against liable third parties as required by § 1396a(a)(25)(A)–(B). *Daniel C.,* as well as *L.Q.,* demonstrates that without clear federal guidance, challenges to states' statutory schemes will persist.

Meanwhile, health care and personal injury attorneys must confront confounding issues regarding settlement allocation and trusts for disabled clients. After receiving a tort recovery, beneficiaries will often become ineligible for Medicaid unless they transfer settlement money into a statutorily exempt special needs trust, which will allow them to pay for expenses that Medicaid does not cover while remaining eligible for the program.[75] Medicaid coverage is limited, and future medical expenses obtained in litigation could previously be placed in such a trust to

pay for live-in care, dental care, and other ongoing costs. *Gallardo* may reduce the amounts beneficiaries have to place in such trusts, as Medicaid liens must be satisfied before the trust can be funded.

Ultimately, *Gallardo* did not settle the fundamental question: may liens on tort settlements ever be imposed? The plaintiff in *L.Q.* and dissent in *Tristani* argued that states should satisfy their obligation to recoup Medicaid expenses directly from liable third parties rather than beneficiaries who obtain judgments or secure settlements. That would seem to resolve the conflict between the anti-lien and reimbursement provisions. If the U.S. Supreme Court were to adopt that position, most state reimbursement schemes would be preempted. But until that issue is squarely decided by Congress or the Supreme Court, the argument will likely continue to be raised in litigation.

Hannah Berkman is a pre-law fellow at appellate firm Horvitz & Levy LLP in San Francisco. She prepares drafts of appellate updates for the California Society for Healthcare Attorneys and other legal associations, conducts legal research on a variety of issues, and cite checks appellate briefs prior to filing. Prior to joining Horvitz, Hannah worked at global immigration firm Fragomen, Del Rey, Bernsen & Loewy, LLP as the lead legal writer on her team. She earned a Master of Arts in Global Studies and a Bachelor of Arts in Media Studies and Psychology from UC Berkeley. She can be reached at hberkman@horvitzlevy.com.

H. Thomas Watson is a partner at the appellate firm Horvitz & Levy LLP, and a California State Bar Certified Appellate Specialist. He has extensive experience litigating before the California Supreme Court as appellate counsel for both parties and amici curiae, and has worked on numerous cases in the California Court of Appeal, the Ninth Circuit Court of Appeals, and appellate courts in other jurisdictions. Tom edits and updates the firm's MICRA Manual and its Evidence Code section 1157 Manual, and he publishes and presents extensively on numerous areas of the law, including appellate procedure, medical expense damages, health law, and insurance law. Tom also co-authors regular health law appellate updates for the California Society for Healthcare Attorneys and the California Lawyer's Association's Health Law Standing Committee. He can be reached at htwatson@horvitzlevy.com.

Peder Batalden is a partner at Horvitz & Levy LLP, an appellate boutique in Los Angeles. He specializes in federal practice and procedure and has argued and won numerous appeals in the Ninth and Tenth Circuits. Peder is a co-author of the leading treatise on civil appeals before the Ninth Circuit, the Rutter Group's Ninth Circuit Civil Appellate Practice. He enjoys an active health care practice as well. He handles appeals for major medical providers and co-authors appellate updates for the California Society for Healthcare Attorneys and the California Lawyer's Association's Health Law Standing Committee. He can be reached at pbatalden@horvitzlevy.com.

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1 *L.Q. v. Cal. Hosp. Med. Ctr.*, 285 Cal. Rptr. 3d 93, 96 (Ct. App. 2021).

2 Social Security Act §§ 1900–47, 42 U.S.C. §§ 1396–1396w-6.

3 285 Cal. Rptr. 3d 93.

4 *Id.* at 98.

5 547 U.S. 268 (2006).

6 568 U.S. 627 (2013).

7 *L.Q.*, 285 Cal. Rptr. 3d at 105–08.

8 142 S. Ct. 1751 (2022).

9 *Id*. at 1755–56.

10 *Id.* at 1758–59.

11 *Id*. at 1769 (Sotomayor, J., dissenting).

12 42 U.S.C. § 1396p(a)(1); *see* Social Security Amendments of 1965, Pub. L. No. 89-97, sec. 121, § 1902(a)(18), 79 Stat. 286, 347.

13 *See* Social Security Amendments of 1967, Pub. L. No. 90-248, § 229(a), 81 Stat. 821, 904 (1968).

14 42 U.S.C. § 1396a(a)(25)(A).

15 *Id.* § 1396a(a)(25)(B).

16 Pub. L. No. 95-142, sec. 11(b), § 1912(a), 91 Stat. 1175, 1196–97 (1977).

17 42 U.S.C. § 1396k(a)(1)(A), (C).

18 U.S. Gen. Acct. Off., GAO/HRD-91-25, Medicaid: Legislation Needed to Improve Collections from Private Insurers 5–7, 11–12 (1990).

19 Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, sec. 13622(c)(3), § 1902(a)(25), 107 Stat. 312, 632.

20 *See* Hinshaw & Culbertson LLP, 50 State Primer on Medicaid Recovery Laws, 2–3 (2d ed. 2019), http://www.hinshawlaw.com/assets/htmldocuments/Booklets/50StatePrimeronMedicaidRecoveryLawsMrMedicare.pdf.

21 *See*, *e.g.*, *Richards v. Ga. Dep't of Cmty. Health*, 604 S.E.2d 815, 818 & n.2 (Ga. 2004); *Houghton v. Dep't of Health*, 57 P.3d 1067, 1069 (Utah 2002); *see also* Transcript of Oral Argument at 31–33, *Gallardo ex rel. Vassallo v. Marstiller*, 142 S. Ct. 1751 (2022) (No. 20-1263).

22 *Ahlborn*, 547 U.S. 268.

23 *Id*. at 272.

24 *Id*. at 272, 278.

25 *Id*. at 279–80.

26 *Id*. at 284–85.

27 *Id.* at 287–88.

28 *Id*. at 280 n.9, 284.

29 *Wos*, 568 U.S. 627.

30 *Id.* at 635 (citation omitted).

31 *Id.* at 630–32.

32 *Id.* at 636.

33 *Id.*

34 *Id.* at 639.

35 Bipartisan Budget Act of 2013, Pub. L. No. 113-67, sec. 202(b), §§ 1902(a)(25), 1912(a)(1)(A), 1917(a)(1)(A), 127 Stat. 1165, 1177.

36 *L.Q.*, 285 Cal. Rptr. 3d at 107.

37 652 F.3d 360, 369 n.10 (3d Cir. 2011).

38 *Id.* at 368–69.

39 *Id.* at 370.

40 *Id.* at 375.

41 *L.Q.*, 285 Cal. Rptr. 3d at 97 (citation omitted).

42 *Id.* at 98, 105.

43 *Id.* at 98–99; *see id.* at 106.

44 *Id.* at 105–06.

45 *Id.* at 108.

46 *Daniel C. v. White Mem'l Med. Ctr.*, 294 Cal. Rptr. 3d 537, 541–544, 547, 553 (Ct. App. 2022), *reh'g granted*, No. B308253 (Cal. Ct. App. June 7, 2022).

47 *Id.* at 550.

48 *Id.* at 553 (citation omitted).

49 *L.Q.*, 285 Cal. Rptr. 3d at 98.

50 *See Ahlborn*, 547 U.S. at 284.

51 *Gallardo*, 142 S. Ct. at 1755–56.

52 *Id.* at 1758 (citation omitted).

53 *Id.* at 1758–59.

54 *Id.* (citation omitted).

55 *Id.* at 1760–61.

56 *Id.* at 1761.

57 *Id.* at 1762, 1765 (Sotomayor, J., dissenting).

58 *Id.* at 1762.

59 *Id.* at 1763 (citation omitted).

60 *Id.* at 1769.

61 Transcript of Oral Argument, *supra* note 21, at 65.

62 *Id.* at 57–58.

63 *Id.*; *see, e.g.*, Ala. Code §§ 22-6-6 to -6.1 (2015); Del. Code Ann. tit. 31, § 522 (West 2015); N.J. Stat. Ann. § 30:4D-7.1 (West 2009).

64 31 U.S.C. §§ 3729–3733.

65 *See Ahlborn*, 547 U.S. at 288.

66 *Daniel C.*, 294 Cal. Rptr. 3d at 547.

67 *Id.* at 547–48 (citation omitted).

68 Transcript of Oral Argument, *supra* note 21, at 58.

69 Act of Aug. 24, 2007, ch. 188, § 71, 2007 Cal. Stat. 2427–28.

70 Cal. Welf. & Inst. Code § 14124.76 (West 2018).

71 Brief for the United States as Amicus Curiae Supporting Petitioner at 26–27, *Gallardo ex rel. Vassallo v. Marstiller*, 142 S. Ct. 1751 (2022) (No. 20-1263).

72 Appellant's Supplemental Brief at 16–17, *Daniel C. v. White Mem'l Med. Ctr.*, 294 Cal. Rptr. 3d 537 (Ct. App. 2022) (No. B308253).

73 Lien-Claimant and Respondent's Supplemental Brief at 10, *Daniel C. v. White Mem'l Med. Ctr.*, 294 Cal. Rptr. 3d 537 (Ct. App. 2022) (No. B308253).

74 *Id.* (quoting *Wos*, 568 U.S. at 641).

75 *See* 42 U.S.C. § 1396p(d)(4)(A).

