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IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR MARICOPA COUNTY

AMBER WINTERS, *et al.*, on behalf of themselves and all others similarly situated, Plaintiffs, v. BANNER HEALTH NETWORK, *et al.*, Defendants.	Civil Case No. CV2012-007665 PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT ON BREACH OF CONTRACT CLAIM (The Honorable J. Richard Gama)

Plaintiffs, pursuant to Rule 56(a), A.R.C.P., move for summary judgment against all Defendants on Plaintiffs' breach of contract claim. Plaintiffs' motion is supported by the following memorandum of points and authorities, the record in this proceeding, as well as the contemporaneously filed Separate Statement of Facts ("SOF").

This motion is necessary because the Defendant hospitals have refused to stipulate that their conduct, which the Court declared unlawful in its Minute Entry (filed 1/21/14), constitutes a breach of contract, namely the Provider Participation Agreements ("PPAs"). *See* Minute Entry (filed 1/21/14) at n.7 ("Defendants have signed Provider Participation Agreements ('PPAs') with AHCCCS.").

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I. STANDARD OF REVIEW

Plaintiffs must demonstrate "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." *Orme School v. Reeves*, 802 P.2d 1000, 166 Ariz. 301, 305 (Ariz. 1990).

II. FACTS AND LAW

A. INTRODUCTION

In 1965, Congress established Medicaid by enacting Title XIX of the Social Security Act. See, 42 U.S.C. §§ 1396-1396w-5. Under Medicaid, the federal government agreed to provide financial assistance for participating states, so that those states could provide health care to the indigent. *Harris v. McRae*, 448 U.S. 297, 301-09 (U.S. 1980). Participation by states was voluntary, but if a state agreed to participate, they had to comply with the requirements of Title XIX. *Id.* Each state then created or designated a state agency to administer their Medicaid program. *Id.*

Participating states, such as Arizona through its AHCCCS Administration, were further required to enter into Medicaid Provider Participation Agreements ("PPAs") with participating healthcare providers, such as the Defendant hospitals, who receive a combination of state and federal Medicaid funds in exchange for providing medical care to the indigent. (SOF ¶1); *see also* Minute Entry (filed 1/21/14) at n.7. To be sure, a healthcare provider is prohibited from participating in Medicaid unless a PPA has been signed with the state Medicaid agency. 42 C.F.R. § 431.107.

B. THE CONTRACT

Defendants Banner Health Network (through hospitals such as Baywood Medical Center, Banner Boswell Medical Center, Banner Del E. Webb Medical Center, Banner Desert Medical Center, Banner Estrella, Banner Gateway Medical Center, Banner Good Samaritan Medical Center, Banner Heart Hospital, Banner Ironwood Medical Center, and Banner Thunderbird Medical Center), Dignity Health (through hospitals such as Chandler Regional Medical Center - Phoenix, St. Joseph's Hospital and Medical Center, and Mercy Gilbert Medical Center), Scottsdale Healthcare Corp (through hospitals such as Scottsdale Healthcare Thompson Peak), John C.

Lincoln Health Network (through hospitals such as John C. Lincoln Deer Valley and John C. Lincoln North Mountain), Carondelet Health Network (through hospitals such as Carondelet Heart and Vascular Institute and Carondelet St. Mary's Hospital), and Oro Valley Hospital LLC (through Oro Valley Hospital) all entered into a PPA contract with the AHCCCS Administration ("AHCCCSA") containing an identical Paragraph 15. (SOF ¶2).

Paragraph 15 of these PPAs all state:

> The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCSA that the person was ineligible for AHCCCS on the date of service or that services provided were not AHCCCS covered services. The Provider agrees to abide by Arizona Administrative Code R9-22-702 prohibiting the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person.

(SOF ¶3). The remaining Defendant hospitals have either entered into this same PPA agreement or an older agreement which states at Paragraph 4 that they will "comply with all applicable Federal and State laws and regulations." (SOF ¶4).

While these PPA contracts are entered into by the hospitals and the AHCCCS Administration, the general parameters of the contracts are set by the Department of Health and Human Services ("HHS"). (SOF ¶5); 42 C.F.R. §§ 434.1(b) and 434.6 (HHS sets the requirements for the content of the PPAs). HHS' policy in approving Paragraph 15 and other Paragraphs like it was primarily to benefit Medicaid patients consistent with the statutes passed by Congress. (SOF ¶6).

This is explained by the former General Counsel of HHS at the time most of the PPAs in this matter were executed:

> The intention to benefit Medicaid patients is fairly self evident. A prohibition on additional collection above what Medicaid pays does not affect the amount received by the state Medicaid agency. That same prohibition reduces the amount of money recovered by the Medicaid providers, The clear beneficiaries are the Medicaid patients, who are not subjected to additional collection once Medicaid has paid the provider.

(SOF ¶7). Consistent with this, courts have recognized that the intent of PPAs with similar prohibitions is to benefit Medicaid patients and protect them from the type of balance billing at issue here. *E.g.*, *Smallwood v. Central Peninsula General*, 151 P.3d 319, 324-26 (Alaska 2006)

("The language of the provider agreement and the applicable state and federal Medicaid laws indicate that the state intended that Medicaid recipients like Smallwood benefit from providers' promises not to balance bill."); *Mallo v. Public Health Trust of Dade County*, 88 F.Supp.2d 1376 (S.D. Fl. 2000) (holding that a PPA "creates a third-party beneficiary contractual obligation on the part of the health care provider to collect from the Medicaid patient no more than the amount of the Medicaid payment" and that "Medicaid patients are the intended beneficiaries").

C. BREACH OF THE CONTRACT

On January 17, 2014, this Court concluded that, by asserting Healthcare Provider Liens against the recoveries of AHCCCS patients, the Defendant hospitals were charging, billing or collecting from AHCCCS patients in violation of federal law. *See* Minute Entry (filed 1/21/14). With respect to the present motion, the Court observed that "*Mallo* held that plaintiffs were third-party beneficiaries of PPAs between the providers and Medicaid." *Id.* at n.22. In light of this ruling and the Court's observations, Plaintiffs invited Defendants to avoid this motion by stipulating to a judgment that their assertion of unlawful Healthcare Provider Liens constituted a breach of the PPAs. Defendants refused.

As a result, Plaintiffs request the Court now find that, as a matter of law, by asserting Healthcare Provider Liens against the recoveries of AHCCCS patients, the Defendant hospitals are breaching the PPAs, which says they will not charge, bill, collect or attempt to collect from AHCCCS patients or violate federal law. (SOF ¶¶3-4). This relief is appropriate since, in the operative complaint, Plaintiffs asked the Court for a declaratory judgment that Defendants are in breach of the PPA contracts and an order, pursuant to A.R.S. § 12-1833, enjoining Defendants from continued breach. *See,* Second Amended Complaint at ¶133.

A plaintiff may properly sue on a contract to which they were not a party if they are a "third party beneficiary" to that contract. *Nahom v. Blue Cross/Blue Shield*, 885 P.2d 1113, 180 Ariz. 548, 552-53 (App. 1994). In order to be a "third party beneficiary," there must be: 1) a clear intent to benefit the party or a class to which the party belongs; 2) the benefit must be intentional and direct; and 3) the parties to the contract must have intended to recognize the third party as the primary party in interest regarding the benefit conferred. *E.g., id. Nahom* addressed a contractual

clause nearly identical to Paragraph 15 of the PPAs and the Court held that a Blue Cross insured patient had standing to enforce a contractual provision between Blue Cross and the hospital which prohibited balance billing by the hospital. *Id.*

The same is true here. As this Court already recognized, "*Mallo* held that plaintiffs were third-party beneficiaries of PPAs between the providers and Medicaid." *See* Minute Entry (filed 1/21/14) at n.22. This was also the holding in *Smallwood v. Central Peninsula General*, 151 P.3d 319, 324-26 (Alaska 2006), where the Alaska Supreme Court concluded that a Medicaid patient was a third party beneficiary and had standing to enforce the balance billing prohibition in a PPA.

The reasoning underlying these holdings is straightforward. Congress clearly intended with the balance billing prohibition to confer a direct, intentional benefit upon Medicaid recipients, not on either party to the PPA. *See, e.g., Lizer v. Eagle Air Med. Corp.*, 308 F.Supp.2d 1006, 1009 (D.Ariz. 2004) ("Congress passed the balance billing prohibition in order to protect eligible patients from having to pay additional sums for services already compensated by Medicaid."); *Mallo v. Public Health Trust of Dade County*, 88 F.Supp.2d 1376 (S.D. Fl. 2000) ("Since Medicaid patients are the intended beneficiaries of such a windfall, health care providers are not entitled to prey on an otherwise poor patient's change in economic status."); *Evanston Hosp. v. Hauck*, 1 F.3d 540, 544 (7th Cir. 1993) ("[S]omeone was bound to receive a windfall in these circumstances and Congress decided it should be the recipient of medical care, not the hospital."); *see also* Senate Report No. 744, 90th Cong., 1st Sess., at pp. 187-188 (1967) ("As a matter of public policy, it would be best for all concerned...if the reimbursement made by the State" constituted the full compensation received by Medicaid providers). Furthermore, as described hereinabove, the content of the PPAs are largely determined by HHS. (SOF ¶5); 42 C.F.R. §§ 434.1(b) and 434.6. The unrebutted testimony of the former General Counsel of HHS at the time many of these PPAs were signed has testified that HHS' primary intent of "Paragraph 15 and other Paragraphs like it" was to benefit Medicaid recipients. (SOF ¶6).

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III. CONCLUSION

Plaintiffs respectfully move for summary judgment against all remaining Defendants on Plaintiffs' breach of contract claim. Specifically, Plaintiffs request summary judgment that Defendants are in breach of the PPA contracts through their assertion of Healthcare Provider Liens against AHCCCS patient recoveries and an order, pursuant to A.R.S. § 12-1833, enjoining Defendants from continued breach.

RESPECTFULLY SUBMITTED this 30th day of January, 2014.

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