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SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2012-007665 01/17/2014

HONORABLE J. RICHARD GAMA

CLERK OF THE COURT
J. Polanco
Deputy

AMBER WINTERS, et al. GEOFFREY M TRACHTENBERG
B LANCE ENTREKIN

v.

BANNER HEALTH NETWORK, et al. CHRISTOPHER L HERING

L ERIC DOWELL

UNDER ADVISEMENT RULING

The Court has had under advisement Plaintiffs' Motion for Summary Judgment and Defendants' Cross-Motion for Summary Judgment. Having read and considered the briefing and having heard oral argument, the Court issues the following rulings.

I.

Congress created the Medicaid program in 1965 by adding Title XIX to the Social Security Act. The purpose of the Medicaid program was to provide federal financial assistance to participating states so those states could provide health care to the indigent. *See Harris v. McRae,* 448 U.S. 297, 301 (1980). Participation in the Medicaid program was voluntary; to participate, a state was required to submit a specific plan to the Department of Health, Education, and Welfare ("HEW") certifying that the state would comply with federal Medicaid law.[1] *See generally* 42 C.F.R. § 430.10.[2] Arizona joined the Medicaid program in 1982 and established the Arizona Health Care Cost Containment System ("AHCCCS") to administer the program. *See Ariz. Ass'n of Providers for Persons with Disabilities v. State,* 223 Ariz. 6, 10-11 (App. 2009); A.R.S. § 36-2901 *et seq.*

[1] In 1980, HEW was renamed the Department of Health and Human Services ("HHS").
[2] A participating state can obtain a waiver of a particular Medicaid requirement. *See, e.g.,* 42 U.S.C. § 1315.

In response to Congress' concern about nursing homes that were collecting from Medicaid and then pursuing patients and their relatives for supplemental payment,[3] HEW promulgated 45 C.F.R. § 249.31, which provided, in relevant part: "[P]articipation in the [Medicaid] program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure…." Although it has been renumbered several times, § 249.31 remained substantively unchanged; it is now numbered as 42 C.F.R. § 447.15 and provides, in relevant part:

> A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual.

To this same end, Congress passed what is now numbered as 42 U.S.C. § 1396a(a)(25)(C), which provides:

> …that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan….

At issue here is the interplay between A.R.S. § 36-2903.01(G)(4) and the federal proscription on "balance billing."[4] In Arizona, a health care provider has a lien on a patient's personal injury claim in order to secure payment of the customary charges incurred by the provider for the care, treatment, or transportation of the patient. A.R.S. § 33-931.[5] Section 36-2903.01(G)(4) provides that a hospital may collect full payment from Medicaid and thereafter "collect any unpaid portion of its bill from other third-party payors or in situations covered by

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[3] *See* S. Rept. No. 744, 90th Cong., 1st Sess., at 187-88 (1967), U.S. Code Cong. & Admin. News, at 3026, *as quoted in Johnson's Prof'l Nursing Home v. Weinberger,* 490 F.2d 841, 845 (5th Cir. 1974).

[4] "Balance billing occurs when a provider accepts payment from Medicaid and then seeks to recover from the patient the balance between that payment and its customary fee." *Miller v. Gorski Wladyslaw Estate,* 547 F.3d 273, 283 (5th Cir. 2008).

[5] A.R.S. § 33-931(A) provides, in relevant part:

> ...The lien shall be for the claimant's customary charges for care and treatment or transportation of an injured person. A lien pursuant to this section extends to all claims of liability or indemnity, except health insurance and underinsured and uninsured motorist coverage as defined in § 20-259.01, for damages accruing to the person to whom the services are rendered, or to that person's legal representative, on account of the injuries that gave rise to the claims and that required the services.

[A.R.S. § 33-931 *et seq*.].” Plaintiffs argue that § 36-2903.01(G)(4) is preempted because it permits a hospital to balance bill in violation of federal Medicaid law.[6] The Defendant hospitals (collectively, "Defendants") argue to the contrary.[7]

II.

Defendants contend that enforcement of a health care provider lien is not balance billing because it is collection from the third-party tortfeasor, not from the Medicaid patient. This contention was rejected in *Lizer v. Eagle Air Med Corp.,* 308 F. Supp. 2d 1006 (D. Ariz. 2004). In *Lizer*, the health care provider (Eagle Air, an air ambulance company) received payment from AHCCCS for its service and then asserted a health care provider lien against the insurance proceeds payable to the plaintiffs. *See* A.R.S. § 33-931. Eagle Air argued this was not prohibited by federal law because it was not actually billing the balance to the Medicaid patient. *Id.* at 1009. Judge Broomfield disagreed:

> [W]hen read in connection with the accompanying regulation and considered in light of practical considerations it is clear that Congress did not intend the narrow and formalistic interpretation posited by Eagle Air. First, the pertinent regulation clearly mandates that states must require providers to accept Medicaid payments as payment in full. See 42 C.F.R. § 447.15. This language prevents providers from billing *any* entity for the difference between their customary charge and the amount paid by Medicaid. Providers are not merely prevented from balance billing patients themselves. Furthermore, this case demonstrates the necessity of the payment in full provision in order to carry out the full spirit of 42 U.S.C. § 1396a(a)(25)(c). Permitting providers to charge the balance of their bill to entities which are liable to the patient ultimately results in the patient recovering less from the liable entity. Congress passed the balance billing prohibition in order to protect eligible patients from having to pay additional sums for services already compensated by Medicaid. The accompanying regulation was passed in order to ensure that this purpose was carried out by preventing providers from intercepting funds on the way to a patient.

Id. (emphasis in original).

Lizer did not address A.R.S. § 36-2903.01(G)(4), presumably because Eagle Air was not a hospital, but the Court agrees with Plaintiffs that this is a distinction without a difference.[8] An

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[6] *See generally* May 21, 2013 Minute Entry (granting Plaintiffs' Motion to Certify a class of Open Lien Plaintiffs).
[7] Defendants have signed Provider Participation Agreements ("PPAs") with AHCCCS.

air ambulance and a hospital are both providers under federal Medicaid law. *See* 42 C.F.R. 400.203. If a health care provider lien asserted by an air ambulance on insurance proceeds payable to a Medicaid patient "stands as an obstacle to…the ultimate purpose and objective of the federal Medicaid provisions regarding balance billing," *see* 308 F. Supp. 2d at 1010 (citation omitted), it stands as no less an obstacle when asserted by a hospital, regardless that hospitals were specially blessed by § 36-2903.01(G)(4).

As Judge Broomfield noted, his decision was consistent with decisions in other jurisdictions. *Lizer,* 308 F. Supp. 2d. at 1010 (citing cases). Similarly, in holding that California's "substitute billing" statute was preempted by 42 C.F.R. § 447.15,[9] the California Supreme Court stated:

> These cases establish that a provider that treats a Medicaid beneficiary may not recover from that beneficiary an amount exceeding the Medicaid payment by asserting a lien against the beneficiary's entire recovery from a third party tortfeasor. *Defendant does not cite, and we could not find, any case law to the contrary*. In fact, virtually every case addressing the federal Medicaid statutes and regulations governing provider reimbursement holds that "[u]nder federal law, medical service providers must accept the state-approved Medicaid payment as payment-in-full, and may not require that patients pay anything beyond that amount." By finding that federal law preempts sections 14124.791 and 14124.74 and, in doing so, renders defendant's lien invalid, *we merely join this chorus*.

Olszewski v. Scripps Health, 69 P.3d 927, 945 (Cal. 2003) (emphasis added; citation and footnote omitted).[10] Decisions in other jurisdictions post-*Lizer* continue to be in accord. *See Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust Dated June 27, 2002,* 410 F.3d 304 (6th Cir. 2005); *West v. Shelby Cnty. Healthcare Corp.,* 2013 WL 500777 (Tenn. App. Feb. 11, 2013) (appeal granted Aug. 15, 2013);[11] *cf. Miller,* 547 F.3d at 282-84.

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[8] Defendants contend that *Lizer* is, in fact, an unpublished decision. The Court's review of Westlaw as of January 15, 2014 indicates *Lizer* is published at 308 F. Supp. 2d 1006; it has 32 Citing References, including two in Secondary Sources published and/or updated in 2011.

[9] "Substitute billing occurs when a provider accepts payment from Medicaid and then tries to return the payment in order to recover its entire customary fee from the patient." *Miller,* 547 F.3d at 283.

[10] "We acknowledge that liens filed pursuant to section 14124.791 are not strictly a form of balance billing because the lien holder must refund the Medi–Cal payment before recovering on them. But nothing in the language or history of the federal statutes and regulations restricting provider recovery from Medicaid beneficiaries limits their restrictions to balance billing." *Olszewski, id.* at 945-46.

[11] *See* Tenn. Ct. App. Rules 11, 12.

Defendants urge these cases were wrongly decided and caution the Court against "blindly" following them.[12]

Defendants argue that, under Arizona law, lien enforcement does not constitute balance billing the Medicaid patient. *See LaBombard v. Samaritan Health Sys.,* 195 Ariz. 543, 551 (App. 1998); *Andrews v. Samaritan Health Sys.,* 201 Ariz. 379 (App. 2001).[13] Judge Broomfield acknowledged, however, that Arizona law permitted Eagle Air to do precisely what it did—"place a lien on a lawsuit or settlement pursuant to A.R.S. § 33-931 and thus recover some or all of the difference between [its] customary charge and the amount [AHCCCS] paid [it]." *Lizer,* 308 F. Supp. 2d at 1009 (citing *LaBombard* and *Andrews*). The issue was whether Arizona law was preempted by federal Medicaid law, which was an issue of first impression in the Ninth Circuit at the time, s*ee Lizer, id.,* and which is the issue here.

In moving to dismiss 15 plaintiffs who settled liens early in this case by voluntarily paying a compromise amount, Defendants stated that "those 15 plaintiffs…negotiated settlements and performed by tendering the reduced payments."[14] Clearly, Defendants acknowledged, albeit backhandedly, that they collected their customary fees *from those 15 plaintiffs*, not from third-party tortfeasors.[15] The Court agrees with the Sixth Circuit, which stated:

> [O]nce the settlement has been approved, the settlement proceeds are no longer the property of the tortfeasor…Instead, the entirety of the settlement, regardless of how it is allocated, belongs to [the Medicaid patient]; [the health care provider's] lien is merely an encumbrance upon that property.

Spectrum Health, 410 F.3d at 317.

Defendants point to Attachment 4.19-A to Arizona's State Medicaid Plan ("the Plan"), which defines "prospective rates" as the "inpatient hospital rates defined in advance of a payment period and *represent payment in full* for covered services *excluding* any quick-pay discounts, slow pay penalties, *and third party payments* regardless of billed charges or individual hospital costs." (Emphasis added.) Defendants contend that "third party payments" expressly permits lien enforcement against tortfeasors, and further that, by approving the Plan, the Centers

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[12] Resp. to Pls.' Mot. for Summ. J. and Defs.' Cross-Mot. for Summ. J. at 5-6.
[13] *Disapproved of by Blankenbaker v. Jonovich,* 205 Ariz. 383 (2003).
[14] Mot. to Dismiss (filed July 13, 2012) at 5; *see also id.* at 2, 8.
[15] *See LaBombard,* 195 Ariz. at 546 (hospital argued that lien statute entitled it to be paid its customary charges "from the patient's recovery from third parties"); *Samsel v. Allstate Ins. Co.,* 204 Ariz. 1, 7 n.2 (2002) (statutory lien exists "against a claimant's tort recovery for the full charges made by a provider").

for Medicare and Medicaid Services ("CMS") necessarily concluded the Plan complied with 42 U.S.C. § 1396a(a)(25)(C) and 42 C.F.R. § 447.15.[16]

"Third party" is defined by 42 C.F.R. § 433.136 as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan." However, § 433.136 defines "third party" in conjunction with "third-party liability programs." *See Miller,* 547 F.3d at 278. Congress intended that Medicaid be the "payer of last resort." *Ark. Dep't of Health & Human Servs. v. Ahlborn,* 547 U.S. 268, 291 (2006). "This means that all other available resources must be used before Medicaid pays for the medical care of an individual enrolled in a Medicaid program." *Miller,* 547 F.3d at 278, *citing Caremark, Inc. v. Goetz*, 480 F.3d 779, 783 (6th Cir. 2007). To ensure this, "[f]ederal law requires states to establish procedures by which state Medicaid plans may be reimbursed by third-party tortfeasors for payments the plans make on behalf of injured persons to whom tortfeasors are legally liable." *Sw. Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.,* 226 Ariz. 404, 406 (App. 2011), *citing* 42 U.S.C. § 1396a(a)(25)(B), (H) *and Ahlborn, id.* at 275-76; *see also* 42 U.S.C. § 1396k.[17] 42 C.F.R. § 433.136 does not state or imply that Defendants may disregard 42 C.F.R. § 447.15's "payment in full" mandate or that they may supplement AHCCCS payments through lien recoveries notwithstanding 42 U.S.C. § 1396a(a)(25)(C).

Defendants posit that a June 1997 opinion letter from HCFA represents the agency's policy allowing providers to enforce liens against tortfeasors after accepting payment from Medicaid.[18] To the extent it does, the Court agrees with Plaintiffs that the letter is not entitled to deference. The language of 42 C.F.R. § 447.15 is unambiguous; the letter does not clarify anything about that language. *See Spectrum Health,* 410 F.3d at 319. "To defer to the agency's position would be to permit the agency, under the guise of interpreting a regulation, to create de facto a new regulation." *Id.* at 319-20 (footnote omitted), *citing Christensen v. Harris Cnty.,* 529 U.S. 576, 588 (2000).

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[16] CMS is an agency within HHS. Before July 2001, CMS was known as the Health Care Financing Administration ("HCFA"). *See Miller,* 547 F.3d at 278 n.2.

[17] In compliance with federal law, A.R.S. § 36-2915(A) provides, in relevant part:

> [AHCCCS] is entitled to a lien for the charges for hospital or medical care and treatment of an injured person for which [AHCCCS] or a contractor is responsible, on any and all claims of liability or indemnity for damages accruing to the person to whom hospital or medical service is rendered, or to the legal representative of such person, on account of injuries giving rise to such claims and which necessitated such hospital care and treatment.

See Ariz. Health Care Cost Containment Sys. v. Cochise Cnty., 186 Ariz. 201, 211 (App. 1996); *Sw. Fiduciary,* 226 Ariz. at 406-07; *see also* 42 C.F.R. § 433.138(d)(4)(ii) (obligating state Medicaid agencies to obtain "[f]rom State Motor Vehicle accident report files, information that identifies those Medicaid beneficiaries injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.").

[18] The letter states that HCFA was "re-examin[ing] our third party liability policy regarding tort claims" and broadening its policy interpretation "which will allow States to permit providers to pursue payment in excess of Medicaid's reimbursement in tort situations as long as certain conditions are met."

Defendants posit that CMS has reaffirmed 42 C.F.R. § 447.15 only prohibits a provider from collecting additional payment from the state, not from third-party tortfeasors, citing to two sections of the Federal Register. *See* 55 Fed. Reg. 1423-02, 1428-29 (Jan. 16, 1990); 52 Fed. Reg. 6350-01, 6355-56 (Mar. 3, 1987). As Plaintiffs note, however, these sections discuss payments from Medicaid patients in states that allow co-pays and deductibles, which the parties agree are not at issue here.

What else could Attachment 4.19-A mean, if "third party payments" does not allow hospitals to enforce liens against tortfeasors?[19] The Court agrees with Plaintiffs that Attachment 4.19-A means hospitals can bill Medicare and all private insurance carriers, including HMOs, to the extent of the third-party coverage, and these "third party payments" are excluded from the hospital rates that represent payment in full for the covered services.[20]

III.

Defendants contend that A.R.S. § 36-2903.01(G)(4) must not violate federal Medicaid law because, if it did, common sense dictates *something* would have been done about it before now.[21] The Court agrees with Plaintiffs that the length of time a statute has been on the books is not determinative of its legality. *See generally Olszewski, supra.*

The Court finds *Lizer* and the case law in other jurisdictions both pre and post-*Lizer* to be persuasive. Under federal Medicaid law, AHCCCS has authority to go after third-party tortfeasors "who might bear some legal responsibility for footing the bill"; AHCCCS providers who bill AHCCCS do not. *See Mallo v. Pub. Health Trust of Dade Cnty.,* 88 F. Supp. 2d 1376, 1387 (S.D. Fla. 2000),[22] *citing Evanston Hosp. v. Hauck,* 1 F.3d 540, 543 (7th Cir. 1993). There is bound to be a windfall under these circumstances, and Congress has decided it should fall on the Medicaid patient. *See Mallo, id., citing Hauck, id.* at 544.

The Court finds that A.R.S. § 36-2903.01(G)(4) is preempted because it violates federal Medicaid law that prohibits a health care provider from collecting the balance of its bill from the Medicaid patient. Accordingly, based on the foregoing,

IT IS ORDERED granting Plaintiffs' Motion for Summary Judgment and denying Defendants' Cross-Motion for Summary Judgment.

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[19] *See* Reply in Supp. of Defs.' Cross-Mot. for Summ. J. at 6.
[20] *See* Arizona Medicaid Provider Billing Handbook at 9-1 (*see* Second Am. Class Action Compl., Ex. 4).
[21] Resp. to Pls.' Mot. for Summ. J. and Defs.' Cross-Mot. for Summ. J. at 2-4.
[22] *Mallo* held that plaintiffs were third-party beneficiaries of PPAs between the providers and Medicaid. *Id.* at 1383-86.

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