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SUPERIOR COURT OF ARIZONA
MARICOPA COUNTY

CV 2012-007665 12/08/2016

HONORABLE DAWN M. BERGIN

CLERK OF THE COURT
L. Nelson
Deputy

AMBER WINTERS, et al. GEOFFREY M TRACHTENBERG

v.

BANNER HEALTH NETWORK, et al. CHRISTOPHER L HERING

L ERIC DOWELL

RULING

This minute entry addresses Plaintiffs' and Defendants' respective Motions for New Trial. The Court has considered the following:

Plaintiffs' Motion for New Trial Re Breach of Contract filed on December 29, 2014
- Defendants' Response filed on January 20, 2015
- Plaintiffs' Reply filed on January 22, 2015
- Defendants' Supplement to their Response to Plaintiffs' Motion for New Trial filed on October 3, 2016
- Plaintiffs' Response to Defendants' Supplement to Plaintiffs' Motion for New Trial Re Breach of Contract filed on October 7, 2016

Defendants' Motion for New Trial filed on November 26, 2014
- Plaintiffs' Response filed on December 24, 2014
- Defendants' Reply filed on January 14, 2015
- Defendants' Supplement to Motion for New Trial filed on October 3, 2016
- Plaintiffs' Response to Defendants' Supplement filed on October 7, 2016

Neither side has requested oral argument. The Court now makes the following findings and orders.

PROCEDURAL HISTORY

Plaintiffs in this case are AHCCCS[1] patients who received medical services from Defendant hospitals. After accepting payment from AHCCCS, the hospital Defendants asserted liens against proceeds from patients' settlements with third-party tortfeasors, in order to recover the difference between the AHCCCS reimbursement and the hospital's customary charge.

At the outset of this case, there were two categories of Plaintiffs:

1. Patients who had not yet paid the lien and were seeking declaratory and injunctive relief invalidating the liens (the "Open Lien Plaintiffs"); and

2. Patients who already settled with the hospital Defendants in exchange for a release of the liens and sought rescission of the settlement agreements and money damages (the "Closed Lien Plaintiffs").

A. Dismissal of All Closed Lien Plaintiffs' Claims

Defendants moved to dismiss the claims of the Closed Lien Plaintiffs based on accord and satisfaction. Plaintiffs argued that accord and satisfaction did not apply because federal law preempted A.R.S. § 36-2903.01(G)(4), which allows hospitals to collect any unpaid portion of their bills from third-party payers.[2] The trial court granted Defendants' Motion to Dismiss, and Plaintiffs appealed. On December 23, 2014, the Court of Appeals issued an opinion reversing the trial court, concluding that because federal law preempted A.R.S. § 36-2903.01(G)(4), the patients' settlement agreements with the Defendant hospitals were void. *Abbot v. Banner Health Network*, 236 Ariz. 436, 341 P.3d 478, (App. 2014).

The Arizona Supreme Court granted Defendants' Petition for Review, and on May 23, 2016, reversed the Court of Appeals and affirmed the judgment of the trial court, finding that because the law on the validity of the hospital Defendants' liens was not settled at the time of the settlement agreements between the patients and the hospitals, the doctrine of accord and satisfaction applied. *Abbott v. Banner Health Network*, 239 Ariz. 409, 372 P.3d 933 (2016). The Court did not address the preemption issue, but rather "assume[d], without deciding, that—as Plaintiffs argue—Arizona's lien statutes are preempted by federal law." *Id.* at 411, 372 P.3d at 935.

[1] AHCCCS is Arizona's Medicaid agency.
[2] A.R.S. §33-931(A) establishes a hospital's right to a lien, providing that a hospital "is entitled to a lien for the care and treatment ... of an injured person. A lien pursuant to this section extends to all claims of liability or indemnity... 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."

B. The Second Amended Class Action Complaint and Summary Judgment Motions

On December 6, 2012, the Open Lien Plaintiffs filed a Second Amended Class Action Complaint, naming new Open Lien Plaintiffs. The claims included:

1. Declaratory and Injunctive Relief Pursuant to A.R.S. §12-1831 (the "Preemption Claim"); and
2. Breach of Contract (*i.e.*, breach of Defendants' Provider Participation Agreements)

Plaintiffs filed motions for summary judgment and Defendants cross-moved on both claims. On January 17, 2014, the trial court granted summary judgment in favor of Plaintiffs on the preemption claim, and on May 13, 2014, it granted summary judgment in favor of Defendants on the breach of contract claim.[3]

C. The Judgment

On November 12, 2014, the trial court entered judgment in favor of the Open Lien Plaintiffs on the preemption claim. The judgment contained the following findings and orders:

1. A.R.S. § 36-2903.01(G)(4) is preempted by 42 U.S.C. § 1396a(a)(25)(C) and/or 42 C.F.R. § 447.15;

2. The practice of asserting liens against personal injury recoveries after receiving *any* payment from AHCCCS is unlawful;

3. Any hospital lien or claim against a patient's personal injury recovery, whether pending at the time of or filed after one of the hospital Defendants received any payment from AHCCCS for the patient's care, is void and unenforceable;

4. Permanently enjoining the hospital Defendants from filing or asserting a lien or claim against a patient's personal injury recovery after having received any payment from AHCCCS for the patient's care;

5. Requiring the hospital Defendants to release and discharge all open liens on which the hospital has had contact with a patient, attorney, or insurance carrier adjuster (known liens) within 10 days of the judgment;

[3] After these rulings, the parties stipulated to dismiss Plaintiffs' remaining claims with prejudice.

6. Requiring the hospital Defendants to release and discharge all open liens within 5 days of this judgment after oral or written request;

7. Vacating the settlement procedures order entered on October 9, 2013 without prejudice to the validity of any settlement completed pursuant to the order;

8. Awarding attorneys' fees in the amount of $621,520 to the Entrekin Law Firm and $600,381.75 to Levenbaum Trachtenberg, PLC against the hospital Defendants jointly and severally;

9. Awarding taxable costs in the amount of $1,512.58 against the hospital Defendants jointly and severally; and

10. Dismissing all claims against KRMC (Kingman) as moot.

The Court denied Defendants' subsequent Motion to Alter or Amend the Judgment.

LEGAL ANALYSIS OF PENDING MOTIONS FOR NEW TRIAL

Defendants seek a new trial on the Court's rulings on preemption and attorneys' fees, and Plaintiffs seek a new trial on their breach of contract claim.

A. The Preemption Claim

As noted above, the trial court found in its January 17, 2014 ruling that A.R.S. §36-2903.01(G)(4) is preempted by 42 U.S.C. § 1396a(a)(25)(C) (the "Federal Statute") and 42 C.F.R. § 447.15 (the "Federal Rule") to the extent that §36-2903.01(G)(4) permits health care providers to assert liens against an AHCCCS patient's settlement proceeds when the provider has accepted payment from AHCCCS.

The Federal Statute precludes "balance billing," a practice in which a provider, after accepting Medicaid payments, attempts to collect from the patient the difference between that payment and the provider's customary charge.[4] The Federal Rule requires that a State Medicaid plan limit participation to "providers *who accept, as payment in full, the amounts paid by the*

[4] The language related to balance billing reads as follows: "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 …" 42 U.S.C. §1396a(a)(25)(C).

agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual." (Emphasis added).

A state law is preempted by federal law when it actually conflicts with federal law—that is, when "it is impossible for a private party to comply with both state and federal requirements . . . or where state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Olszewski v. Scripps Health*, 69 P.3d 927, 938-39 (Cal. 2003) (quoted citations omitted). "What is a sufficient obstacle is a matter of judgment, to be informed by examining the federal statute as a whole and identifying its purpose and intended effects." *Id.* (quoting *Crosby v. National Foreign Trade Council*, 530 U.S. 363, 373 (2000)).

The trial court, relying largely on *Lizer v. Eagle Air Med. Corp.*, 308 F. Supp. 2d 1006, 1009 (D. Ariz. 2004), found that Arizona's conferral of a lien in favor of a hospital, which the hospital then uses as a means of collecting the difference between the AHCCCS reimbursement and its customary charge from a patient's settlement proceeds, actually conflicts with the Federal Statute's prohibition against balance billing and the Federal Rule's limitation of participation in the State plan to providers who accept the AHCCCS reimbursement as "payment in full."

Defendants contend that the trial court erred in finding an actual conflict between Arizona and federal law. They start with the proposition that an ambiguity exists in the Federal Rule because the Rule does not state whether "payment in full" includes only AHCCCS payments or also payments from third-party tortfeasors. In other words, according to Defendants, the lack of any mention of third-party tortfeasors with respect to the term "payment in full" creates an ambiguity. And, because of that ambiguity, the Court must defer to the views of the Centers for Medicare and Medicaid Services ("CMS"), the agency responsible for administering Medicaid.

Defendants' argument fails at the outset, however, because "payment in full" is not an ambiguous term. The Federal Rule clearly states that "payment in full" occurs when the hospital accepts payment from Medicaid. And, as Plaintiffs point out, myriad courts across the country have made the same finding. *See* Pls.' Resp. at 5-6, enumerating cases. Additionally, Defendants have cited no case supporting their position. Thus, given that there is no ambiguity in either the Federal Rule or Federal Statute, Defendants are asking this Court to re-define the term "payment in full" in the Federal Rule. This, of course, the Court will not do.

Defendants also argue that the *Lizer* Court "imagined that there is a federal policy goal of maximizing the personal injury recoveries of Medicaid beneficiaries," pointing to the fact that Congress never explicitly expressed such a policy and the application of other federal statutes have resulted in lower recoveries. Defs.' Mtn. at 5. In making this argument, however,

Defendants ignore, as they did with respect to their conflict argument, a multitude of cases adopting the exact opposite position.

In *Olszewski*, for example, the court reviewed the history of the relevant Medicaid statutes and rules and concluded that the Secretary of the Department of Health and Human Services (the "Secretary") "clearly intended to bar a health care provider from recovering from a Medicaid beneficiary any amount exceeding the cost-sharing charges allowed under the state plan," and that "[t]he Secretary found it necessary to impose this limitation on provider recovery in order to effectuate Congress's intent and to insure medical care for the needy." 69 P.3d at 941-42. Based on this analysis, the *Olszewski* Court invalidated a state statute that authorized a provider to recover its customary fee through a lien against settlement funds obtained by a Medicaid beneficiary from a third-party tortfeasor.

Similarly, in *Evanston Hospital v. Hauck*, 1 F.3d 540, 544 (7th Cir. 1993), the Court commented as follows on a hospital's attempt to recover the shortfall between its customary charge and the Medicaid reimbursement:

> What [the hospital] seeks, then is to turn Medicaid upside down by converting the system into an insurance program for hospitals, rather than for indigent patients. It wants to be reimbursed when the patient is indigent and still retain the right to sue patients who later become solvent-a classic example of wanting to both have and eat cake. The Medicaid system would go bankrupt in short order under this scenario because hospitals would have every incentive to capture as much government money as they could without regard for the probabilities of collecting reimbursement from the private party.

See also Spectrum Health Continuing Care Group v. Ana Marie Bowling Irrevocable Trust Dated June 27, 2002, 410 F.3d 304, 314-15 (6th Cir. 2005); *Mallo v. Public Health Trust of Dade County*, 88 F.Supp.2d 1376, 1387 (S.D.Fla.2000) (stating that "since Medicaid patients are the intended beneficiaries of such a windfall [from a settlement], health care providers are not entitled to prey on an otherwise poor patient's change in economic status. Plaintiff, a Medicaid recipient, is therefore the intended beneficiary of § 1396a(a)(25)(C) . . .").

B. Private Right of Action

In the Supplement to their Motion for New Trial, Defendants contend that the U.S. Supreme Court's decision in *Armstrong v. Exceptional Child Care Center, Inc.*, 135 S. Ct. 1378 (2015), deprives Plaintiffs of a private right of action to enforce the Federal Statute and Federal Rule, thereby requiring the Court to vacate its judgment in favor of Plaintiffs and enter judgment in Defendants' favor.

In *Armstrong*, providers of habilitation services under Idaho's Medicaid plan sued the Idaho Health and Welfare Department (the "Department"), arguing that Idaho's reimbursement rates were lower than those permitted by 42 U.S.C. §1396a(a)(30)(A) ("Section 30(A)"). *Id.* at 1380. They sought to enjoin the Department to increase its rates to comply with Section 30(A). The Supreme Court reversed the Ninth Circuit's entry of summary judgment in favor of Plaintiffs, with a majority joining in three sections of the opinion and only a plurality in the last section.

A five-member majority found that the Supremacy Clause does not provide for a private right of action. However, a court may use its equitable powers to enjoin unlawful state or federal action in certain circumstances. The majority ultimately determined that private enforcement of §30(A) was implicitly precluded, pointing to two particular aspects of Section 30(A). *Id.* at 1385. First, Congress provided for only one remedy for a State's failure to comply with Section 30(A)—the withholding of Medicaid funds. Second, the broad mandate of Section 30(A) regarding rate setting, along with the complex process involved, is properly left to the Secretary of HHS. In short, "[t]he sheer complexity associated with enforcing §30(A), coupled with the express provision of an administrative remedy, §1396c, shows that the Medicaid Act precludes private enforcement of *§ 30(A)* in the courts." *Id.* (emphasis added).

It is clear that the majority's holding related exclusively to Section 30(A) of the Medicaid Act, yet Defendants disingenuously suggest that it applied to the entirety of 42 U.S.C. §1396a. In a footnote at page 5 of their Supplement, Defendants state in conclusory fashion that "*Armstrong* involved a different subsection of 42 U.S.C. § 1396a, referred to as Section 30(A), but the Supreme Court's analysis is phrased in terms of the entire statute and thus applies with full force to Section (25)(C)." This is <u>not</u> true of the majority opinion.

Further, Defendants rely on Section IV of the opinion, *which drew only a plurality,* for the proposition that the Medicaid Act provides no private cause of action because it lacks "rights-creating language."[5] Because less than a majority concurred in this determination, any

[5] Interestingly, Defendants argue that the plurality found that *the statute* lacked rights-creating language, but the opinion actually states that "Section 30(A)" lacks such language. *Id.* at 1387.

argument that *Armstrong* precludes a beneficiary of Medicaid from suing to enforce federal law because the Medicaid statute lacks "rights-creating language" fails.

Plaintiffs argue that *Armstrong* does not preclude this action because the action is authorized by Arizona's Declaratory Judgment Act, A.R.S. § 12-1832, and Plaintiffs need not establish a federal cause of action or federal subject matter jurisdiction. The Court agrees.

Plaintiffs additionally argue that the factors that weighed against the court exercising its equitable powers to allow *Armstrong* to go forward weigh in the opposite direction here. This is clearly the case because preemption of A.R.S. § 36-2903.01(G)(4) would simply ban the practice of hospitals asserting liens against an AHCCCS patient's settlement proceeds as a means of recovering the shortfall between the hospital's customary charge and the AHCCCS payment. It will not endanger any federal administrative process, nor does it raise the specter of inconsistent judicial findings or interpretations.

C. Attorneys' Fees

The trial court issued a minute entry on October 10, 2014 finding that Plaintiffs were entitled to attorneys' fees under the private attorney general doctrine as articulated in *Arnold v. Ariz. Dep't of Health Servs.*, 160 Ariz. 593, 609, 775 P.2d 521, 537 (1989). Under this equitable doctrine, fees are available to a private party who vindicates a right that: "(1) benefits a large number of people; (2) requires private enforcement; and (3) is of societal importance." *Id.*

Defendants argue that: (1) Plaintiffs vindicated a federal interest because "the doctrine of preemption is rooted in the Supremacy Clause;" therefore, the Court must apply federal law, which does not recognize the private attorney general doctrine; (2) private enforcement was not necessary; (3) the ruling "vastly expands the private attorney general doctrine;" and (4) the trial court erred in awarding Plaintiffs fees for work related to the Closed Lien Plaintiffs.

With respect to Defendants' first argument regarding application of federal law, they did not cite a single on-point case to support their position. In contrast, *Defenders of Wildlife v. Hull*, 199 Ariz. 411, 18 P.3d 722 (App. 2001), a case cited by Plaintiffs, entirely undermines their argument. In *Defenders of Wildlife*, the court held that certain sections of an Arizona statute that conflicted with a federal standard were invalid "by operation of the preemption doctrine," *id.* at 426, 18 P.3d at 737, and proceeded to award the plaintiffs attorneys' fees under the private attorney general doctrine, *id.* at 428, 18 P.3d at 739. Defendants try to distinguish this case by pointing out that plaintiffs sought a declaration that a state statute violated the

Arizona Constitution. This, however, is completely irrelevant to the court's invalidation of portions of a state statute based on the Supremacy Clause and preemption doctrine.

The Court rejects Defendants' arguments that private enforcement was not necessary, and that the trial court's ruling somehow dangerously expands the private attorney general doctrine, for the reasons set forth in Plaintiffs' Response at pages 15-17.

The Court also rejects Defendants' complaint that the trial court abused its discretion by awarding fees related to work performed on the Closed Lien Plaintiffs' claims. This issue was thoroughly briefed and considered by the trial court, and the court indicated on page 2 of the minute entry that it "concur[red] with Plaintiffs' replies to Defendants' objections to categories of time entries 5 through 21."

Finally, at page 18 of their Response to Defendants' Motion for New Trial, Plaintiffs request additional fees in the amount of $15,130 for time related to responding to Defendants' Motion for New Trial and Motion to Amend or Alter the Judgment. The Court declines to award additional fees. The complaint in this case was filed on May 28, 2012, approximately four and a half years ago. At the last hearing, counsel indicated that the Court's rulings on the Motions for New Trial would be appealed. The Court declines to delay resolution at the trial court level any longer to allow another round of briefing on attorneys' fees. Furthermore, Plaintiffs have already been awarded approximately $1.2 million in fees. Fifteen thousand dollars pales in comparison.

D. The Breach of Contract Claim

Plaintiffs seek a new trial on their breach of contract claim based on the Court of Appeals' determination that the hospital Defendants breached their AHCCCS Provider Participation Agreements by enforcing liens under A.R.S. § 36-2903.01(G)(4). Plaintiffs point to the following language from the Court of Appeals' December 23, 2014 opinion:

> Equally important, even if there were a good faith dispute about the enforceability of the liens, the Hospitals cannot rely on such a theory because they expressly agreed in their Provider Participation Agreements that they would be bound by federal law, and they would "abide by Arizona Administrative Code R9–22–702 prohibiting the Provider from charging, collecting, or attempting to collect payment from an AHCCCS eligible person." Thus, the Hospitals effectively agreed that they would be bound by such a prohibition. Moreover, the Hospitals agreed that they would accept AHCCCS payments as payment in full for the services rendered. These Provider Participation Agreements trump any argument by the Hospitals that there was a good faith dispute about the legality of the liens such that an accord and satisfaction can be enforced.

Abbott v. Banner Health Network, 236 Ariz. at 446, 341 P.3d at 488.

Plaintiffs filed the Motion for New Trial on the breach of contract claim on December 29, 2014, forty-five days after the entry of judgment, and thirty days beyond the deadline fixed by Rule 59(d). Defendants urge the Court to summarily deny the Motion as untimely. Arizona law is clear that the Court may not extend the deadline for filing a motion for new trial except under the specific circumstances set forth in Rule 6(b). The Court agrees that Plaintiffs cannot meet those requirements.

Plaintiffs request that if the Court declines to extend the time for filing the Motion under Rule 6(b), it treat the motion as one for relief from judgment under Rule 60(c). Without citing any specific authority, Plaintiffs contend that subsections (1), (2), (4), and (6) of Rule 60(c) "provide grounds that *could* apply." Pls.' Reply at 2 (emphasis added). These conclusory few sentences are insufficient to support relief under Rule 60(c); therefore, the Court declines to treat the Motion for New Trial as a Motion for Relief from Judgment under Rule 60(c).

For these reasons,

IT IS ORDERED denying Plaintiffs' Motion for New Trial.

IT IS FURTHER ORDERED denying Defendants' Motion for New Trial.

IT IS FURTHER ORDERED denying Plaintiffs' request for additional attorneys' fees.

/ s / HONORABLE DAWN M. BERGIN

JUDICIAL OFFICER OF THE SUPERIOR COURT