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SUPERIOR COURT OF ARIZONA

MARICOPA COUNTY

AMBER WINTERS, et al., Plaintiffs, vs. BANNER HEALTH INC., et al., Defendants.	No. CV2012-007665 **DEFENDANTS' MOTION FOR NEW TRIAL** (Oral Argument Requested)

Defendants move for a new trial in this action pursuant to Rule 59(a)(8) because the Court's rulings on the Preemption Claim (the "Merits Ruling") and on Plaintiffs' Application for Attorneys' Fees (the "Fees Ruling") are contrary to law.

I. The Merits Ruling is contrary to law.

To keep repetition of previous arguments to a minimum, Defendants will focus on specific points in Merits Ruling.

A. There is no conflict between Arizona law and federal law.

1. Direct conflict—not implied conflict—is needed to overcome the presumption against preemption.

A.R.S. § 36-2903.01(G)(4) permits hospitals to enforce health care provider liens after accepting payment from AHCCCS. A hospital lien is collected from the tortfeasor,

not the patient. *E.g., Andrews v. Samaritan Health Sys.*, 36 P.3d 57, 61-62 (App. 2001). That is an undisputable point of Arizona law.

The presumption that a state statute is valid can be rebutted only if there is an actual, necessary, and material conflict between state and federal law. *Shroyer v. New Cingular Wireless Servs., Inc.*, 498 F.3d 976, 988 (9th Cir. 2007). A conflict exists when there is "clear evidence" that state law is "directly interfer[ing]" with a federal purpose that is evident from the statutory scheme at issue. *See English v. Gen. Elec. Co.*, 496 U.S. 72, 90 (1990). In other words, Arizona law is preempted only if a close examination of federal law reveals that Arizona law directly interferes with a federal purpose.

2. *Lizer* wrongly concluded that Arizona's lien statutes conflict with federal law.

The Merits Ruling concluded that Arizona law was preempted by 42 U.S.C. § 1396a(a)(25)(c) (the "TPL Statute") and 42 C.F.R. § 447.15. But instead of working through the text of those provisions, the Court relied on case law, primarily *Lizer v. Eagle Air Med. Corp.*, 308 F. Supp. 2d 1006 (D. Ariz. 2004). We will demonstrate the flaws in *Lizer* by quoting it and then discussing how it is erroneous:

> Eagle Air is correct that 42 U.S.C. § 1396a(a)(25)(c) only states that providers may not seek excesses from individuals-***it does not address seeking the balance from liable third parties***. However, when 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.[1]

Lizer begins with a telling acknowledgment, *i.e*, that the TPL Statute *does not even address* collection activity against third parties. *Lizer* thus found preemption on the basis of statutory silence.

[1] *Id.* at 1009 (emphasis added).

Lizer filled this gap with the "accompanying [payment-in-full] regulation." But there is a mismatch here: 42 C.F.R. § 447.15 does not and cannot implement the TPL Statute because it preceded the TPL Statute by over a decade—42 C.F.R. § 447.15 was adopted in the 1960s, and Congress enacted the TPL Statute in 1982. In any event, *Lizer* erred in describing the breadth of 42 C.F.R. § 447.15. *Lizer* put it this way:

> 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.[2]

In truth, 42 C.F.R. § 447.15 states as follows:

> 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.

In interpreting a regulation, the first question is whether its language has a "plain and unambiguous meaning with regard to the particular dispute in the case." *Robinson v. Shell Oil Co.*, 519 U.S. 337, 340 (1997). A regulation is ambiguous if it is susceptible to more than one reasonable interpretation. *Alaska Wilderness League v. E.P.A.*, 727 F.3d 934, 938 (9th Cir. 2013).

Lizer was wrong because there is more than one reasonable interpretation of 42 C.F.R. § 447.15. The Medicaid payment constitutes "payment in full"—but ***from whom***? The regulation answers that question as to the state agency (the Medicaid payment) and the beneficiary (cost-sharing)—but says *nothing* about third parties. It is not "plain" that the regulation bars providers from collecting from third parties after accepting payment from Medicaid. *See Salinas v. United States*, 522 U.S. 52, 60 (1997).

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[2] *Id.*

Faced with this sort of ambiguity, a court cannot ignore the views of the responsible agency and substitute its own notions of federal "policy" (which—discussed below—is what *Lizer* did). Rather, a court must look at the relevant agency's "subsequent interpretation of [the] regulation." *Coeur Alaska, Inc. v. Se. Alaska Conservation Council*, 557 U.S. 261, 278 (2009). And here, CMS clearly disagreed with *Lizer*: CMS has explained that 42 C.F.R. § 447.15 prohibits further collection only from *beneficiaries* and *the state agency*.[3] The regulation only applies "*after considering the third party's liability*."[4] In particular, CMS has opined that the regulation does not restrict providers "*from receiving amounts from third party resources* available to the recipient."[5] 42 C.F.R. § 447.15 does not restrict collection from third party payors, which includes tortfeasors. *See* 42 C.F.R. §§ 433.136 & 433.138(d).

In its 1997 policy statement, CMS explained that states could *permit* providers to enforce health care provider liens after receiving payment from Medicaid in certain circumstances. The agency thus rejected *Lizer*'s view that the Medicaid payment is payment in full from *all sources*, including third parties. The agency also rejected the view that lien enforcement is collection from the beneficiary, not from a third party.

The Merits Ruling declined to defer to CMS' policy statement because 42 C.F.R. § 447.15 was unambiguous. But the regulation does not even mention third parties. Moreover, the Court's ruling amounts to an assertion that the responsible federal agency failed to notice the unambiguous nature of its own regulation, even though the Court never worked through the regulation's text. CMS' interpretation of 42 C.F.R. § 447.15 is entitled to deference: the regulation does not prohibit providers from undertaking collection activities against third parties after accepting payment from Medicaid.

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[3] *See* DSOF ¶¶ 11-15 & Ex. F (Aug. 19, 2013).
[4] DSOF ¶ 11 & Ex. F.
[5] *Id.*

Instead of consulting the agency's views, *Lizer* invented—and then labored to effectuate—a "spirit" within the Medicaid statutes that, in fact, does not exist:

> 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.[6]

Lizer imagined that there is a federal policy goal of maximizing the personal-injury recoveries of Medicaid beneficiaries. But the opposite is true: across 50 years of Medicaid laws, Congress has *never* said that it cared about the tort recoveries of Medicaid beneficiaries. To the absolute contrary, federal laws require the Medicaid agency to subrogate to the beneficiary's tort claims and require beneficiaries to assign their rights to payment from any third party to the state agency. 42 U.S.C. §§ 1396a(a)(25)(H), 1396a(a)(45) & 1396k. This necessarily reduces a tort recovery.

Last year, in the Bipartisan Balanced Budget Act of 2013, Congress again showed its willingness to use tort recoveries to finance Medicaid programs. Previously, the U.S. Supreme Court limited the state agency's right of recovery to the portion of a tort recovery that was for "health care items and services." *Wos v. E.M.A. ex rel. Johnson*, 133 S. Ct. 1391, 1393 (2013); *Ahlborn v. Ark. Dep't of Health Servs.*, 547 U.S. 268 (2006). Section 202(b) of the 2013 Act overturned those rulings, giving the Medicaid agency a right to recover from "any payments [made] by [a] third party"—that is, the entirety of the tort recovery. *See* Exhibit A. That *increases* the state agency's rights against the tort recoveries of Medicaid beneficiaries.

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[6] *Lizer*, 308 F. Supp 2d at 1010.

There is ***no such thing*** as a federal interest in maximizing the tort recoveries of Medicaid beneficiaries. A non-existent federal interest cannot serve as the basis for preempting state law.

3. Defendants did not concede that lien enforcement is collection from the patient.

The Merits Ruling cited Defendants' motion to dismiss the Closed Lien Plaintiffs, which stated that those plaintiffs "negotiated settlements." According to the Court, Defendants acknowledged "backhandedly that they collected their customary fees from [the Closed Lien Plaintiffs], not from third-party tortfeasors." Merits Ruling at 5.

Respectfully, this is not so. Under Arizona law, the *tortfeasor* must obtain a release of all provider liens before paying a judgment or settlement. A.R.S. § 33-934. For practical reasons, the tortfeasor typically delegates that task to the patient—because the patient's desire to complete the settlement creates the pecuniary incentive to move the settlement along. These negotiations are at the tortfeasor's behest and on the tortfeasor's behalf. Of course, all settlement proceeds come from the tortfeasor (or his carrier), not the patient.

Preemption turns on federal statutes and policies, not on who calls whom or who acts as whose agent as a matter of state law or practicalities.

B. The Court failed to defer to CMS' approval of Arizona's Medicaid Plan, which permits providers to collect from third parties after receiving payment from AHCCCS.

Each state's Medicaid program revolves around the state plan. The "primary check" on the legality of the operation of state Medicaid plans is CMS, *e.g., Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1249 (9th Cir. 2013), because it must approve or reject a state plan "based on relevant federal statutes and regulations," 42 C.F.R. § 430.15(a). For that reason, CMS's approval of a state plan has the force of federal law. *DeSario v. Thomas*, 139 F.3d 80, 96-97 (2d Cir. 1998).

1. Courts must defer to CMS' approval of a Medicaid plan provision and the agency's implicit interpretation of federal law rendered in making that approval.

CMS cannot approve a state plan that violates federal law. Thus, its approval necessarily means that the state plan is consistent with federal law. *Managed Pharmacy Care*, 716 F.3d at 1249. Under well-settled principles of administrative law, that approval, and the implicit interpretations of federal law made by CMS in granting that approval, are entitled to deference. *E.g., Douglas v. Indep. Living Center of S. Cal.*, 132 S. Ct. 1204, 1210 (2012); *Managed Pharmacy Care*, 716 F.3d at 1248. Last month, the Second Circuit became the sixth federal appellate court to so hold. *Cmty. Health Care Ass'n of N.Y. v. Shah*, --- F.3d ----, 2014 WL 4977280, at *13 (2d Cir. Oct. 7, 2014).

A litigant cannot extinguish that deference, or end-run the agency's role, by asserting a preemption claim. *Douglas*, 132 S. Ct. at 1211. Permitting litigants to assert preemption actions outside the construct of deference would "defeat the uniformity that Congress intended by centralizing administration of [Medicaid] in the agency." *Id*.

2. The Court must defer to CMS' approval of Attachment 4.19-A, which permits hospitals to collect from third parties after accepting payment from AHCCCS.

Arizona's State Plan supplies the clarification that the federal regulation requires. While 42 C.F.R. § 447.15 does not mention third-party payments, Attachment 4.19-A of Arizona's plan states that AHCCCS reimbursement is "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." That can only mean one thing: AHCCCS' payment is payment-in-full on the account, *except for payments from third parties*. In other words, Attachment 4.19-A *expressly permits* the hospital to collect additional monies from third parties.

By approving that provision, CMS necessarily concluded that Attachment 4.19-A complied with federal law, meaning that the TPL Statute and 42 C.F.R. § 447.15 do *not*

prohibit providers from seeking third-party payments after accepting payment from Medicaid. For the reasons set forth in the prior briefing, CMS' implicit interpretations of federal law in approving Attachment 4.19-A are entitled to *Chevron* and *Auer* deference.

3. Attachment 4.19-A squarely permits hospitals to enforce health care provider liens.

To explain away Attachment 4.19-A, the Merits Ruling construed the term "third party payments" as merely encompassing payments from "Medicare and all private insurance carriers, including HMOs." Merits Ruling at 7. This is error. The state plan does not define "third party payments" as *third party insurers*. Nor does CMS. Rather, "third party" is defined 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." 42 C.F.R. § 433.136.

The Merits Ruling relied upon the October 2003 AHCCCS Fee-For-Service Provider Manual (the "Provider Manual"): "Providers must determine the extent of the third party coverage and bill Medicare and all private insurance carriers, including HMOs, prior to billing AHCCCS." Merits Ruling at 7. But the Provider Manual did not purport to *define* third party for all purposes as "Medicare and all private insurance carriers"—and nor could it do so without violating 42 C.F.R. § 433.136.

More important, AHCCCS revised its Provider Manual in March 2014 and has now removed all doubt as to the definition of "third party." *See* Exhibit B. The sentence cited by the Court now reads: "Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS." *Id.* at 9-1. A "third party" is "a person, entity or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability

of an applicant or member."[7] *Id.* And "third-party liability" tracks federal law almost exactly: the term means "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a State plan." *Id.* at 9-2. The Provider Manual then lists examples of third parties—and one such example is "***a tortfeasor***." *Id.* at 9-2.

Similarly, AHCCCS' Program Integrity Guide gives examples of "third party liability," one of which is an "automobile . . . accident[] for which another person or entity is liable for causing some or all of the accident." *See* Exhibit C. Chapter 434 of the AHCCCS Contractor Operations Manual defines "third party liability" as "[a] person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member." *See* Exhibit D.

No authority supports the Merits Ruling's conclusion that "third party payments," as used in Attachment 4.19-A, only means payments made by insurers. Attachment 4.19-A deems the AHCCCS payment as payment in full, *except* for payments made by *any* third party. Attachment 4.19-A thus squarely permits hospitals to enforce health care provider liens after accepting payment from AHCCCS. The Court must defer to CMS' approval of Attachment 4.19-A and the agency's implicit interpretations of federal law.

4. The payer-of-last-resort principle regulates the AHCCCS Administration, not providers.

In construing Attachment 4.19-A, the Court noted that Medicaid is the payer of last resort. That principle is derived from federal law requiring "the agency" to reject a provider's claim if "the agency" has established the "probable existence of third party liability." 42 C.F.R. § 433.139(b)(1); *accord* 42 U.S.C. § 1396a(a)(25).

Respectfully, the Court has misapprehended this principle. The payer-of-last-resort rule regulates state Medicaid agencies, not providers. The state agency must gather

[7] "First-party liability" means "the obligation of any insurance plan or other coverage obtained directly or indirectly by a member." Ex. B at 9-1.

information about potentially-responsible third parties and determine the probable existence of third-party liability. 42 C.F.R. § 433.139. The state agency must coordinate with all potential payers to ensure that Medicaid funds are paid last, to conserve Medicaid funds. *Id.* § 433.139. To that same end, a provider must seek payment from all potential third party payers before seeking payment from AHCCCS. *See* Ex. B at 9-1 & 9-2.

If the third-party is an insurer, things are simple: the insurer pays the hospital in lieu of AHCCCS, conserving Medicaid funds. See Ex. B at 9-3. But because tort claims are uncertain and take time to litigate, things are more complicated with respect to tortfeasors. Hospitals only have 6 months from the date of discharge to submit timely claims to AHCCCS, A.A.C. § R9-22-703(B)(2), and AHCCCS must pay claims within 60 days after their receipt or incur a late penalty, *id.* § R9-22-703(C)(2). These deadlines often pass before a tortfeasor's liability is established. Yet AHCCCS must still refrain from paying a claim until the tortfeasor's potential liability is exhausted. And the provider must seek payment from the tortfeasor—which takes the form of a health care provider lien—before billing AHCCCS.

Federal law prescribes how to work through this. AHCCCS may pay a provider before the tortfeasor's liability is established, but must recover that payment from the tortfeasor—by asserting a lien on the judgment or settlement proceeds. 42 C.F.R. § 433.139(d). This is known as "pay and chase." "Pay and chase" functions as an "undo" button—the provider receives payment from the tortfeasor through its health care provider lien, and AHCCCS is reimbursed for its payment to the provider. The parties return to the same position as if the tortfeasor's liability had been clearly established before the provider's deadline to submit a claim to AHCCCS.

The payer-of-last-resort principle does not force providers to waive their claims against third parties by accepting payment from AHCCCS. Rather, this principle ensures that AHCCCS conserves public funds by coordinating among all potential payers.

II. The Fees Ruling is contrary to law.

A. The Court Erred by Applying Arizona Law to Award Fees Incurred in Vindicating a Claim Based on Federal law.

1. The Court must apply federal law in deciding whether Plaintiffs are eligible for attorneys' fees.

Because the doctrine of preemption is rooted in the Supremacy Clause. Plaintiffs have vindicated a *federal* interest. Under the "reverse *Erie*" doctrine, state courts must apply federal law when they are adjudicating a federal question. *Dice v. Akron, C. & Y. R. Co.*, 342 U.S. 359, 361-62 (1952); Kevin M. Clermont, *Reverse Erie*, 82 Notre Dame L. Rev. 1 (2006). This rule is also derived from Supremacy Clause. *Cnty. Executive of Prince George's Cnty. v. Doe*, 479 A.2d 352, 357 (Md. 1984); *Sweeney v. Tucker*, 375 A.2d 698, 711 (Pa. 1977); *Reverse Erie* at 32 ("[R]everse-*Erie* is telling the state court when to apply existing federal law so as to displace state law under the command of the Supremacy Clause.").

In resolving a federal question, a state court may not mix-and-match between federal and state law. Rather, "the *entire* federal substantive law is applicable." *Cnty. Executive*, 479 A.2d at 357; *see Reverse Erie* at 32 (a state court must "follow what the U.S. Supreme Court has decided or would rule"). The state court must apply federal law in full, *Garrett v. Moore-McCormack Co.*, 317 U.S. 239, 243 (1942), and "may not refuse to apply federal law in one particular respect." *Cnty. Executive*, 479 A.2d at 357.

Because a party's entitlement to attorneys' fees is a question of substantive law, state courts that decide a federal question must apply the federal law governing attorneys' fees. This is most often seen in claims under 42 U.S.C. § 1983. *See Verdugo v. Pima Cnty.*, 135 Ariz. 401, 402, 661 P.2d 665, 666 (App. 1983) (applying 42 U.S.C. § 1988 in adjudicating claim for attorneys' fees under § 1983); *accord Maine v. Thiboutot*, 448 U.S. 1, 10-11 (1980) (state court must apply § 1988 to decide whether a successful § 1983 litigant is entitled to attorneys' fees); *Brown v. Ely*, 14 P.3d 257, 264 (Alaska 2000)

(state rule of civil procedure may not supplement § 1988); 2 *Section 1983 Litigation in State Courts* § 22:14 (state courts may not apply state-law "fee-shifting policies" to § 1983 claims because "§ 1988 is the governing standard").

For example, in *Challenge, Inc. v. State ex rel. Corbin* the Court of Appeals reviewed an award of fees against a § 1983 plaintiff made under 42 U.S.C. § 1988 and A.R.S. § 12-341.01. 138 Ariz. 200, 206, 673 P.2d 944, 950 (App. 1983). The Court reversed the award after applying the federal standard for awarding fees under § 1988 and did not attempt to uphold the fee award on state law grounds. *Id.* Because this case turns upon federal law, the Supremacy Clause compels the Court to apply federal law in evaluating Plaintiffs' entitlement to attorneys' fees.

2. Plaintiffs are not entitled to an award of fees because the private attorney general doctrine is inapplicable in federal litigation.

Under federal law, the U.S. Supreme Court has rejected the private attorney general doctrine. *Alyeska Pipeline Serv. Co. v. Wilderness Soc'y*, 421 U.S. 240 (1975). Congress has made "specific and explicit provisions" permitting attorneys' fees awards in particular circumstances, reserving the "the power and judgment" to permit fee awards in some circumstances, but not others. *Id.* at 260, 263. The private attorney general doctrine would override Congress' decisions, permitting the court to "fashion drastic new rules with respect to the allowance of attorneys' fees to the prevailing party in federal litigation." *Id.* at 269.

Congress did not authorize courts to award attorneys' fees in litigation arising out of the Supreme Clause or the Social Security Act. Plaintiffs cannot evade that result by using Arizona's private attorney general doctrine. A state court may not apply state law to an action posing a federal question, even if state law would merely supplement federal law. See *Franklin Cnty. Sch. Bd. v. Page*, 540 So. 2d 891(Fla. Dist. Ct. App. 1989) (holding that Florida law governing contingency multipliers was inapplicable to an award

of attorneys' fees to a § 1983 plaintiff). The Court erred by applying Arizona law to Plaintiffs' claim for attorneys' fees—federal law governs whether Plaintiffs are entitled to attorneys' fees. Under federal law, Plaintiffs are not entitled to an award of fees.

B. The Court clearly erred by finding that private enforcement was necessary.

The Fees Ruling concluded that "the right of indigent Arizonans to the protections accorded by federal Medicaid law" could "only be enforced privately because vindication required a direct challenge to a duly enacted statute." Fees Ruling at 2.

Respectfully, that is incorrect. The AHCCCS Administration operates a grievance system to address legal disputes that arise in connection with the AHCCCS program. *See generally* A.R.S. § 36-2903.01(B)(4) and A.A.C. R9-34-101, *et seq.* Plaintiffs, of course, filed no grievance.[8] According to Plaintiffs, a grievance would have been futile because the state *could not* have compelled the hospitals to cease lien enforcement. *Pl.'s Reply in Supp. Of Pl.'s App. For Atty's Fees* ("*Reply*") at 4-5 (Jul. 1, 2014). Yet on the merits, Plaintiffs repeatedly argued that AHCCCS views lien enforcement as a fraudulent activity. *Pl.'s Reply in Supp. of Pl.'s Mot. For Summ. J.* at 4-6 (Sept. 6, 2013).

Those positions are irreconcilable. If AHCCCS considered health care provider lien enforcement to be fraudulent, Plaintiffs certainly could have filed a grievance to that effect with AHCCCS. If the position taken by Plaintiffs in their fee application is correct, Plaintiffs misled the Court during the merits briefing.

Plaintiffs cannot have it both ways. They have not demonstrated that private enforcement was necessary to obtain the result here. Rather, Plaintiffs chose to file this

[8] Plaintiffs point to a letter their lawyers sent to the AHCCCS Administration in June 2011. *Reply* at Ex. 2. An grievance is an administrative proceeding, not a letter addressed to the AHCCCS Administration. The AHCCCS Administration's website describes how to file a grievance. *See* http://www.azahcccs.gov/grievancesappeals/.

action, rather than pursue a grievance with AHCCCS. That choice has consequences: Plaintiffs are not entitled to an award of fees under the private attorney general doctrine.

C. The Fees Ruling vastly expands the private attorney general doctrine.

The Fees Ruling errantly compared this case to *Arnold v. Ariz. Dep't of Health Servs.* *Arnold* involved the government's duties to *provide* health care to the severely mentally ill. By prevailing, plaintiffs' counsel in *Arnold* secured mental health care for a truly desperate population. *Arnold* was about the government's moral duties to the most vulnerable members of our society, not about economics or money.

This case is not even remotely comparable to *Arnold*. Plaintiffs misled the Court when they stated that this case concerned whether AHCCCS members would receive health care. *Reply* at 4:17-20. Plaintiffs, in fact, received the medical care they needed, and the hospitals will continue treating AHCCCS members, regardless of this litigation.

The question here was whether hospitals may use health care provider liens to pay for care given to AHCCCS members who were injured in car accidents. Put differently, this action is about how to divide tort recoveries. That is a purely economic question, a fact that does not—and cannot—change because Plaintiffs are needy or because a public health insurance program is involved. At bottom, this case is about money, not lives.

In reality, the Court has greatly expanded the private attorney general doctrine. The Court concluded that this case was about how the government "treats the sick [or] needy." Fees Ruling at 2. But the entire Social Security Act concerns how the government "treats the sick [or] needy." Under the Court's rationale, any litigation involving the Social Security Act is a private attorney general doctrine case. Essentially, the Court has created a new fee-shifting principle out of whole cloth for cases involving public programs. In doing so, the Court fell victim to "doctrine creep," which threatens to further undermine the American Rule that litigants must bear their own fees.

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D. The Court abused its discretion by awarding fees for work performed on the Closed Lien Plaintiffs.

The Closed Lien Plaintiffs *lost* on their claims. Yet the Court awarded the *Open Lien Plaintiffs* fees expended in litigating the *Closed Lien Plaintiffs'* case.

The Court apparently accepted Plaintiffs' argument that the Closed Lien Plaintiffs' claims were simply an unsuccessful legal theory. But this is clearly incorrect. The Closed Lien Plaintiffs were *different plaintiffs* who sought *different relief* (a refund of money paid to satisfy health care provider liens), and whose claims turned on a *separate affirmative defense* (accord and satisfaction).

The rules governing fee awards all derive from one principle: a prevailing party may recover only those attorneys' fees that were necessary to achieving the result in the litigation. *Hensley v. Eckerhart*, 461 U.S. 424, 434 (1983). The Court awarded the Open Lien Plaintiffs attorneys' fees for, *inter alia*, (1) litigating whether accord and satisfaction barred the Closed Lien Plaintiffs' claims, (2) communications between Plaintiffs' counsel and the Closed Lien Plaintiffs, and (3) counsel's review of spreadsheets listing the members of a potential class of Closed Lien Plaintiffs. *See* Objection 6, Def.'s Oppo. to Pl.'s App. For Atty's Fees (Jun. 16, 2014).

Counsel did not render those services in pursuing an unsuccessful legal theory for the Open Lien Plaintiffs—those services were rendered for different parties. They did not contribute in any conceivable way to the judgment obtained by the Open Lien Plaintiffs. The Court abused its discretion by awarding fees for claims litigated on behalf of different parties who did not prevail on their claims.

III. Conclusion

The Merits Ruling and the Fees Ruling are both contrary to law. The Court should grant a new trial and either enter judgment in favor of Defendants on the merits or vacate the award of attorneys' fees in its entirety. At the very least, the Court should reverse its award of fees for the work performed on behalf of the Closed Lien Plaintiffs.

RESPECTFULLY SUBMITTED this 26th day of November, 2014.

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EXHIBIT A

SEC. 202. STRENGTHENING MEDICAID THIRD-PARTY LIABILITY.

(a) PAYMENT FOR PRENATAL AND PREVENTIVE PEDIATRIC CARE AND IN CASES INVOLVING MEDICAL SUPPORT.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(1) in subparagraph (E)(i), by inserting before the semicolon at the end the following: ", except that the State may, if the State determines doing so is cost-effective and will not adversely affect access to care, only make such payment if a third party so liable has not made payment within 90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services"; and

(2) in subparagraph (F)(i), by striking "30 days after such services are furnished" and inserting "90 days after the date the provider of such services has initially submitted a claim to such third party for payment for such services, except that the State may make such payment within 30 days after such date if the State determines doing so is cost-effective and necessary to ensure access to care.".

(b) RECOVERY OF MEDICAID EXPENDITURES FROM BENEFICIARY LIABILITY SETTLEMENTS.—

(1) STATE PLAN REQUIREMENTS.—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(A) in subparagraph (B), by striking "to the extent of such legal liability"; and

(B) in subparagraph (H), by striking "payment by any other party for such health care items or services" and inserting "any payments by such third party".

(2) ASSIGNMENT OF RIGHTS OF PAYMENT.—Section 1912(a)(1)(A) of such Act (42 U.S.C. 1396k(a)(1)(A)) is amended by striking "payment for medical care from any third party" and inserting "any payment from a third party that has a legal liability to pay for care and services available under the plan".

(3) LIENS.—Section 1917(a)(1)(A) of such Act (42 U.S.C. 1396p(a)(1)(A)) is amended to read as follows:

"(A) pursuant to—

"(i) the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

"(ii) rights acquired by or assigned to the State in accordance with section 1902(a)(25)(H) or section 1912(a)(1)(A), or".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2014.

SEC. 203. RESTRICTION ON ACCESS TO THE DEATH MASTER FILE.

(a) IN GENERAL.—The Secretary of Commerce shall not disclose to any person information contained on the Death Master File with respect to any deceased individual at any time during the 3-calendar-year period beginning on the date of the individual's death, unless such person is certified under the program established under subsection (b).

(b) CERTIFICATION PROGRAM.—

(1) IN GENERAL.—The Secretary of Commerce shall establish a program—

EXHIBIT B

GENERAL INFORMATION

AHCCCS has liability for payment of benefits after Medicare and all other first- and third-party payer benefits have been paid. Providers must determine the extent of the first- and third-party coverage and bill Medicare and all other coverage plans, including HMOs, prior to billing AHCCCS.

Providers who qualify for Medicare payment but have not applied to Medicare must register their National Provider Identifier (NPI) with Medicare and must bill Medicare before billing Medicaid for all Medicare covered services.

AHCCCS maintains a record of each recipient's coverage by Medicare and Other coverages. If a recipient's record indicates first- third-party coverage but no Medicare and/or insurance payment is indicated on the claim, the claim will be denied.

The initial claim *must* be submitted to AHCCCS within six months of the date of service, even if payment from Medicare or Other Insurance has not been received. The claim must be resubmitted with the primary coverage payment Remit/EOB within 12-months of the date of service (clean claim time frame). (Refer to Chapter 4 General Billing Rules for timely filing requirements.)

FIRST- AND THIRD-PARTY / OTHER COVERAGE

A.R.S. §36-2946 advises that "The Administration shall coordinate benefits provided under this article to a member so that any costs for services payable by the system are costs avoided or recovered from any available third party payor. ... The system shall act as a payor of last resort for members unless specifically prohibited by federal law."

A.A.C. R-9-22-1001 – Definitions
"In addition to the definitions in A.R.S. §36-2901, 36-2923 and 9 A.A.C. 22 Article 1, the following definitions apply to this Article:

"Cost avoid" means to deny a claim and return the claim to the provider for a determination of the amount of the first- or third-party liability.

"First-party liability" means the obligation of any insurance plan or other coverage obtained directly or indirectly by a member that provides benefits directly to the member to pay all or part of the expenses for medical services incurred by AHCCCS or a member.

"Third-party" means a person, entity or program that is, or may be, liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

"Third-party liability" means any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished to a member under a state plan."

A.A.C. R-22-1003 Cost Avoidance section A advises that the Administration's reimbursement responsibility is limited to no more than the difference between the Capped Fee-For-Service schedule and the amount of the third-party liability.

Section C advises that the requirement to "cost avoid" applies to all AHCCCS-covered services under Article 2 of this Chapter. The only exception provided by Rule is that the Administration shall pay the full amount of the claim according to the Capped Fee-For-Service schedule and then seek reimbursement when:

1. The claim is for labor and delivery and postpartum care; or
2. The liability is from an absent parent, and the claim is for prenatal care or EPSDT services.

Coordination of benefits with first- or third-parties includes, but is not limited to the following:

- Private health insurance
- Employment-related disability and health insurance
- Long-term care insurance
- Other federal programs not excluded by statute from recovery
- Court ordered or non-court ordered medical support from an absent parent
- State worker's compensation
- Automobile insurance, including underinsured and uninsured motorists insurance
- Court judgment or settlement from a liability insurer including settlement proceeds placed in a trust
- First-party probate estate recovery
- Adoption-related payment
- A tortfeasor

An AHCCCS registered provider agrees to accept the Capped Fee-For-Service schedule as payment in full.

If the first- or third-party coverage paid more than the Capped Fee-For-Service scheduled amount then no further reimbursement is made by AHCCCS.

For example, a provider bills $4,500.00 for a surgical procedure:

- the first-party plan allowed $1,388.23, paid $1,110.58 and shows a 20% coinsurance amount of $277.65;
- the AHCCCS Capped Fee-For-Service schedule allows $753.21 for the surgery

There will be no AHCCCS payment, as the provider has already been paid more than the Capped Fee-For-Service scheduled amount. The provider must accept the $1,110.58 as payment in full and cannot balance bill the recipient for any amount.

Should more than one coverage plan make payment and the total paid by the multiple coverage plans is more than the AHCCCS Capped Fee-For-Service schedule then there will be no AHCCCS payment and the provider cannot balance bill the recipient for any amount.

If the first- or third-party payor denies a covered service the provider must follow the plan's appeal process and exhaust all remedies before AHCCCS can consider the covered service. The provider must submit a copy of plan's final appeal decision to AHCCCS with the claim resubmission or the claim may be denied as incomplete.

MEDICARE

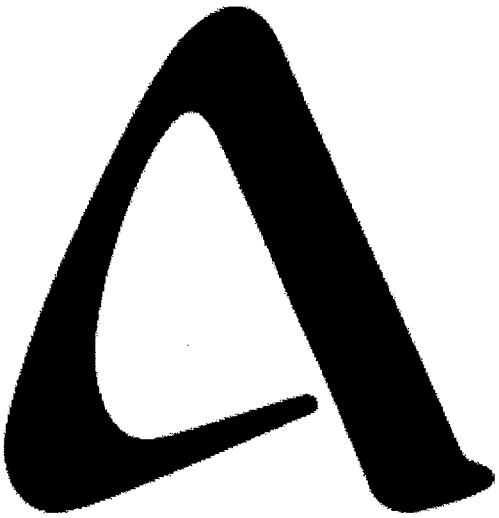
A. AHCCCS MEDICARE ELIGIBILITY DEFINITIONS

QMB Only – a **Q**ualified **M**edicare **B**eneficiary under the Federal QMB program. This individual has Medicare coverage but does not qualify for Medicaid. AHCCCS can *only* reimburse the provider for the Medicare deductible and coinsurance. If Medicare denies the service and upholds the denial upon the provider's appeal, then AHCCCS *makes no payment.* Refer to Arizona Administrative Code (A.A.C.) R9-29-301.

QMB Dual – this individual qualifies under the federal QMB program and has AHCCCS. Per A.A.C. R9-29-302, AHCCCS will pay the following costs for FFS recipients when the services are received from an AHCCCS registered provider *and* the service is covered:

1. a. By Medicare only, then AHCCCS pays only the Medicare deductible/coinsurance
   b. By Medicaid only, then AHCCCS pays the FFS rate
   c. By both Medicare and Medicaid, then AHCCCS pays the Medicare deductible/ coinsurance.
2. When services are received from a non-registered provider and the service is covered, then AHCCCS does not pay the Medicare deductible/coinsurance.

EXHIBIT C



AHCCCS

Program Integrity Reporting Guide

Definition of Terms:

Claim Edits: This is a cost avoidance tool whereby rules or filters in the AHCCCS Contractor's claims payment system identifies elements/codes of claims that are incorrectly billed or may be overbilled. The system may adjust or deny claims in this process.

Coordination of Benefits (COB): Those claims for which another health or disability carrier, workers' compensation carrier, or a government payer such as Medicare or Veterans Administration has primary responsibility for payment of the claim. The AHCCCS Contractor generally identifies the existence of another payer's responsibility prior to payment and denies the claim until an explanation of benefits (EOB) is submitted indicating payment by the primary payer. The AHCCCS Contractor pays only the amount that has not been paid by the primary payer up to the amount that would be payable by the Contractor. At times another payer is identified after payment of the claim by the Contractor and the claim payment is recouped.

The amount saved should be valued at what would have been paid in the absence of the other payer or a percent of billed or allowable charges generally between 27%-32% which is determined by the Contractor according to its analysis.

Note: For the purposes of this report - only claims that the Contractor did not pay any amounts and did not previously encounter (whether identified pre or post claim payment) should be included in this category. Partially paid claims should not be included. In addition, denied claims with **no** payment due to COB that have been submitted to AHCCCS should not be included.

Third Party Liability (TPL/Subrogation): Those claims resulting from care for conditions resulting from an accident or occurrence which another person or entity (other than a health insurer or government health care program) has liability.

For example: Court ordered restitution payments, automobile or slip and fall accidents for which another person or entity is liable for causing some or all of the accident and therefore responsible for costs of medical care for the injured person.

TPL is always pay and chase, i.e., claims identified as having TPL are paid by the AHCCCS Contractor which will coordinate reimbursement (chase) from the liable party (and/or its insurer).

General Instructions:

1. Each Program Integrity (PI) Report is dedicated to one line of business [ALTCS (EDPD or DD) or Acute]. The report(s), along with all attachments, should be sent to the Contractor's Financial Coordinator in the Division of Health Care Management (DHCM) via email on the 15th day of the second month following the quarter (approximately 45 days after the end of the quarter). If you should have any questions regarding the report or requirements, please contact your Financial Coordinator.

2. All reported amounts should be the actual amounts recovered/identified during the quarter being reported (not the quarter of the date of service etc.). Thus the quarter in which the claim is adjudicated (for COB, claim edits, and "other" category) or, in case of TPL, the date the monies are received, is the quarter in which the sums are included.

3. Dental is included in all categories.

4. Pharmacy COB should be included by those Contractors that have access to that data and this should be indicated on Line E of the report. For Contractors that don't include this data, please indicate a timeline for when that data may be included.

5. Reinsurance and joint TPL case payments from AHCCCS should **not** be included; however, some plans have indicated that it is not possible to exclude them. If reinsurance and/or other recoveries are included, this should be indicated on Line F and G of the report.

6. Full billed charges should not be used to value claims. The actual savings, avoidance of cost, or recovery should be reported.

Cost Avoidance / Savings / Recoveries Report Instructions:
(See template at the end of this guide)

Contractor's Name, Line of Business and Quarter End Date: This data is summarized and reported based on the calendar year quarters, so please ensure the quarter end date is reported as mm/dd/yyyy.

A. **TPL/Subrogation Dollars:** Identify claims where TPL was recovered or applied and calculate total dollar amount saved through application of TPL payments during the month (the difference between the total Contractor's allowable amount of claims and the total Contractor's payments made net or any recovery or reimbursement).

B. **COB Dollars:** Identify claims with COB that resulted in no payment by the plan and calculate the total dollar amount saved due to other payment coverage.

C. **Claim Edits Dollars**: The total amount of cost avoidance achieved on claims processed during the quarter, through system edits listed below:

1. Bundling (CCI)
2. Unbundling (CCI)
3. Medically unlikely edits (Cannot be billed together) (CCI)
4. Age/Gender Edit (e.g. Diagnosis conflict with gender)
5. Maximum Units (Exceeding Medical Necessity)
6. Multiple procedure ranking and reduction
7. Assistant Surgeon/Co-Surgeon; codes allowable and reduction
8. Service to diagnosis code mismatch
9. Invalid CPT, HCPCS, and modifier combination
10. Global days
11. Benefit limit

D. **Other Savings Dollars:** Total dollar amount recovered during the month for reasons and through mechanisms not previously discussed in the earlier sections of these instructions. Examples of situations or edits are:

1. AHCCCS cat/svc invalid
2. AHCCCS cert. termed
3. AHCCCS registration terminated
4. Membership inactive
5. No provider ID for location
6. Non contracted provider
7. Provider not registered with AHCCCS
8. W-9 needed for payment

E. **Pharmacy COB Included**: Indicate Yes or No

F. **Reinsurance Recoveries Included:** Indicate Yes or No

G. **Joint TPL Payments from AHCCCS:** Indicate Yes or No

Template for the Cost Avoidance / Savings / Recoveries Report

COST AVOIDANCE/SAVINGS/RECOVERIES REPORT

Name of Contractor:

Line of Business:

For the Quarter Ending (enter as mm/dd/yyyy):

Line	Item	Quarterly results
A	TPL/Subrogation Dollars	
B	COB Dollars	
C	Claim Edits Dollars	
D	Other Savings Dollars	
E	Pharmacy COB Included (Yes/No)	
F	Reinsurance Recoveries Included (Yes/No)	
G	Joint TPL Payments from AHCCCS Included (Yes/No)	

If Pharmacy COB is not included, estimated date when it can be included:

EXHIBIT D

434 - COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

Effective Date: 10/01/13
Revision Date: 07/22/13

Staff responsible for policy: DHCM Operations

I. Purpose

This policy applies to Acute Care, ADHS/DBHS, ALTCS/EPD, CRS, DES/CMDP (CMDP), and DES/DDD (DDD) Contractors. Contractors and establishes requirements to be followed for the coordination of benefit activities for members who have first or third party coverage other than Medicare.

II. Definitions

Cost Avoidance	The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the Contractor or before payment is made by the Contractor. This assumes that the Contractor can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party render the service so that the Contractor is only liable for coinsurance and/or deductibles.
Copayment	A monetary amount specified by the Director that the member pays directly to a Contractor or provider at the time covered services are rendered, as defined in R9-22 Article 7.
First Party Liability	The resources available from any insurance or other coverage obtained directly or indirectly by a member or eligible person that provides benefits directly to the member or the eligible person and is liable to pay all or part of the expenses for medical services incurred by AHCCCS, a Contractor, or member.
Fee for Service (FFS):	Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.
Non-Contracting Provider	A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.

Provider	Any person or entity who submits a claim and receives payment for the provision of covered services to members pursuant to the provisions A.R.S. §36-2901 et seq. or any subcontractor of a Provider delivering such services. For the purposes of this policy, a Provider shall be further defined as all individuals associated by the same Tax Identification Number utilized for claiming purposes.
Retroactive Third Party Recovery	An action initiated by the Contractor to recover all or part of a previously paid claim resulting from the discovery of a liable party not known at the time of payment. Retroactive Third Party Recoveries only include overpayments identified by the Contractor where the Contractor seeks to actively recover funds from a liable party without the involvement of the provider.
Third Party Liability (Liable Party)	A person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by an AHCCCS applicant or member.

III. Policy

A. Providers CONTRACTED with a Contractor

The Contractor shall pay the lesser of the difference between:

a. The Primary Insurance Paid Amount and the Primary Insurance rate, i.e. the member's copayment required under the Primary Insurance, OR
b. The Primary Insurance Paid amount and the Contractor's Contracted Rate

The lesser of methodology applies unless the Contractor's contract with the provider requires a different payment scheme.

B. Providers NOT CONTRACTED with a Contractor

The Contractor shall pay the lesser of the difference between:

a. The Primary Insurance Paid amount and the Primary Insurance Rate, i.e., the member's copayment required under the Primary Insurance, OR
b. The Primary Insurance Paid Amount and the AHCCCS Fee for Service Rate

Examples:

Scenario 1	
AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $45 Primary Paid $30	
Contractor Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $45 - $30 vs. $55 - $30)
Contractor Payment to Non-Contracted Provider in this example	$15 (this is calculated from the lesser of: $45 - $30 vs. $50 - $30)
Scenario 2	
AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $60 Primary Paid $40	
Contractor Payment to Contracted Provider in this example	$15 (this is calculated from lesser of: $60 - $40 vs. $50 - $40)
Contractor Payment to Non-Contracted Provider in this example	$10 (this is calculated from the lesser of: $60 - $40 vs. $50 - $40)
Scenario 3	
AHCCCS FFS Rate $50 Contractor Rate $55 Primary Insurance Rate $70 Primary Paid $60	
Contractor Payment to Contracted Provider in this example	$0 (this is calculated from the lesser of: $70 - $60 vs. $55 - $60)
Contractor Payment to Non-Contracted Provider in this example	$0 (this is calculated from the lesser of: $70 - $60 vs. $50 - $60

If the Contractor refers the member for services to a third party insurer, other than Medicare, and the insurer requires payment in advance of all copayments, coinsurance and deductibles, the Contractor must make such payments in advance.

C. Members with a CRS Condition

A member with private insurance or Medicare coverage is not required to utilize CRS. This includes members with Medicare whether they are enrolled in Medicare FFS or a Medicare Managed Care Plan. If the member uses the private insurance network for a CRS-covered condition, the Contractor is responsible for all applicable deductibles and copayments. For members who have Medicare coverage, refer to ACOM Policy 201 for more information.

D. Retroactive Third Party Recovery

The Contractor shall engage in retroactive third party recovery efforts for members for which a claim was paid, for up to two years from the date of service except for tagged claims as described below, to determine if there are other payor sources that were not known at the time of payment. The Contractor is prohibited from recouping related payments from providers, requiring providers to take action, or requiring the involvement of providers in any way.

The Contractor has two years from the service date to recover payments for a particular claim, or to identify claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when the Contractor has affirmatively identified a third party payor source and has begun the process of recovering payment. The Contractor will "tag" claims that have a reasonable expectation of recovery using an automated process to be developed by AHCCCS. If AHCCCS determines that a Contractor is tagging claims that do not meet these requirements, AHCCCS may impose sanctions.

After two years from the service date, AHCCCS will direct recovery efforts for retroactive recovery of claims for any claims not tagged by the Contractor. Although Contractors are responsible for recovery efforts for tagged claims irrespective of the two year time period, AHCCCS may, on a case by case basis, elect to direct recovery efforts for claims which are tagged by the Contractor. Any recoveries obtained by AHCCCS through its recovery efforts will be retained exclusively by AHCCCS and will not be shared with the Contractor.

The timeframe for submission of claims for recovery is limited to three years from the date of service consistent with A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

Although all encounters related to the Contractor's recovery efforts must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the Contractor may not request adjustments from, nor adjust related payment to,

providers. Instead, the Contractor must submit an external replacement file (via an approved AHCCCS vendor with a prescribed AHCCCS file format) in order to directly update impacted encounters. This external replacement file must be submitted within 120 days from completion of the recovery project. The Contractor must contact the AHCCCS Encounter Unit at the completion of the recovery project for a list of approved AHCCCS vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.
Encounters will not be adjusted when recoveries occur as a result of AHCCCS' efforts. AHCCCS will instead flag all encounters that are impacted by retroactive recovery and will develop and maintain a database to store recovery payments.

Utilizing the data from the replacement file submitted by the Contractor, and the database used to store AHCCCS' recoveries, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments when appropriate.

The Contractor must submit quarterly updates regarding retroactive third party recoveries as outlined in the AHCCCS Program Integrity Reporting Guide (Cost Avoidance/Recovery Report) to DHCM Finance Manager.

IV. References

- R9-22 Article 7.
- R9-28 Article 7.
- Title XIX of the Social Security Act
- A.R.S. §36-2901, et. seq.
- A.R.S. §36-2923
- Deficit Reduction Act of 2005 (Public Law 109-171)
- AHCCCS Program Integrity Reporting Guide