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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 **REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR NEW TRIAL** (Oral Argument Requested)

Both the Merits Ruling and the Fees Ruling are contrary to law. The Court should grant the motion for new trial and enter judgment for Defendants as appropriate.[1]

I. The Merits Ruling is contrary to law.

Throughout this litigation, Plaintiffs have used a strategy of "dissuade and distract." They seek to dissuade the Court from considering the text of federal law by incessantly repeating their string citation of out-of-state cases. And they seek to distract

[1] Plaintiffs will certainly argue that the Court of Appeals' opinion in the closed lien prong of this litigation affects the disposition of this motion. To preserve a complete record for appeal, this reply will examine the issues as if no opinion had issued. Defendants have moved to stay this case until the Supreme Court rules on their Petition for Review.

from the preemption inquiry by trotting out meritless arguments, dumping irrelevant information on the Court,[2] and sniping at Defendants' counsel.

The Court should resist the temptation to add this case to the string citation. Federal law simply does not say what Plaintiffs claim it does—nothing *in the text of federal law* prohibits providers from pursuing third parties, including tortfeasors, after accepting payment from Medicaid. And in any event, CMS approved a provision in Arizona's plan that specifically allows hospitals to collect from third parties after being paid by AHCCCS. Plaintiffs' preemption claim necessarily fails.

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

If the Arizona lien statutes so clearly conflict with federal Medicaid law, Plaintiffs should be able to easily answer three questions. Where exactly did Congress or CMS explicitly prohibit providers from pursuing third parties after taking payment from Medicaid? Where exactly did Congress or CMS explicitly deem lien enforcement to be collection from the patient? And where exactly has Congress expressly articulated a federal interest in maximizing the tort recoveries of Medicaid beneficiaries?

Plaintiffs have never addressed these questions, content to repeat their string citation and their slogan that federal law prohibits providers from balance billing patients. Only Defendants have examined the key questions in any detail.

No federal statute or regulation expressly prohibits providers from collecting funds from a tortfeasor after accepting payment from Medicaid. Even *Lizer*—Plaintiffs' favorite case—concedes that 42 U.S.C. § 1396a(a)(25) *never addressed* collection activities against third parties. And 42 C.F.R. § 447.15 expressly prohibits collection activities against the state agency and the patient, but says nothing at all third parties. At best, the regulation is ambiguous, and nothing in its history ever discussed third parties.

[2] For example, Plaintiffs selectively quote the judges who heard the closed lien appeal and devote much discussion to statements at oral argument that have no legal effect.

CMS, however, filled in the gap by opining that providers *could collect from tortfeasors* after accepting payment from Medicaid, an opinion that is entitled to deference.

Nor has federal law ever deemed lien enforcement against a tortfeasor to be collection from the patient. In fact, the Treasury Department proclaimed the opposite in new regulations on a related issue. The Affordable Care Act prohibits nonprofit hospitals from engaging in an extraordinary collection action ("ECA") against a patient before making reasonable efforts to determine if the patient is eligible for financial assistance from the hospital. 26 U.S.C. § 501(r)(6). The proposed regulations defined ECA to include "[p]lacing a lien on an individual's property." Proposed 26 C.F.R. § 1.501(r)-6(b) (77 Fed. Reg. 38148, 38166 (Jun. 26, 2012)), attached as Exhibit A. Commenters questioned whether liens enforced against tortfeasors qualified as an ECA.

The final regulations specifically exempted health care provider liens from the definition of ECA. According to the Treasury Department:

> The proceeds of settlements, judgments, or compromises arising from a patient's suit against a third party who caused the patient's injuries ***come from the third party, not from the injured patient***, and thus hospital liens to obtain such proceeds should not be treated as collection actions against the patient.

79 Fed. Reg. 78954, 78984 (Dec. 31, 2014) (emphasis added), attached as Exhibit B. The Treasury Department precluded crafty personal-injury lawyers from arguing what Plaintiffs argue here: that lien enforcement against a tortfeasor is actually a collection activity against the patient.

Finally, the cases Plaintiffs so often cite are grounded in a falsehood: that a federal interest exists in maximizing the tort recoveries of Medicaid beneficiaries. Time and again—and as recently as 2013—Congress has enacted legislation that necessarily *reduces* those tort recoveries to finance Medicaid programs. Congress has *never once*

articulated a federal interest in maximizing the tort recoveries of Medicaid recipients.[3] This case shows exactly why preemption must be grounded in clear statutory text—otherwise, creative lawyers can and will invent federal interests that do not exist.

No actual conflict exists between Arizona's lien statutes and federal Medicaid law. The Merits Ruling wrongly concluded to the contrary. The Court should grant a new trial and enter judgment for Defendants.

B. The Court must defer to CMS' approval of Arizona's Medicaid plan, which expressly allows hospitals to collect from third parties after accepting payment from AHCCCS.

Attachment 4.19-A of Arizona's Medicaid Plan clarifies the point left open by 42 C.F.R. § 447.15—the AHCCCS payment 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." By approving this provision, CMS implicitly interpreted federal law to permit providers to collect from third parties after accepting the Medicaid payment. The agency's view of the law is entitled to *Chevron* and *Auer* deference, compelling judgment for Defendants.

Rather than offer a rebuttal, Plaintiffs misrepresent the scope of Attachment 4.19-A in the same manner as in the prior briefing. Resp. at 11. The Merits Ruling did not rely upon Plaintiffs' misstatements, so they will not be debunked again here.

The Merits Ruling instead held that "third party" meant "third party *insurers*," relying exclusively upon one snippet from an out-of-date version of the AHCCCS Fee-For-Service Manual. The current manual, however, unequivocally includes tortfeasors

[3] Plaintiffs wrongly claim that the hospitals are trying to "co-opt" the state agency's right to payment. Resp. at 11. Defendants cite these statutes only to show that no federal interest exists in maximizing the tort recoveries of Medicaid beneficiaries.

within the definition of "third party." *See* Ex. B to Mot. for New Trial at 9-2. Plaintiffs offer no counterargument.[4]

Tortfeasors are clearly third parties, even under the very authority the Court used to construe Attachment 4.19-A. Accordingly, Attachment 4.19-A expressly permits hospitals to pursue tortfeasors after accepting payment from AHCCCS. The Court should defer to CMS's approval of that provision and enter judgment for Defendants.

C. Remaining Arguments.

Plaintiffs include a grab bag of meritless arguments to distract the Court, all of which can be quickly rejected.

First, Plaintiffs contend that health care provider liens are filed "against patients." Resp. at 4-5. This is wrong. A health care provider lien extends to "claims of liability or indemnity . . . for damages accruing to the person to whom the services are rendered." A.R.S. § 33-931(A). The lien is not a personal debt of the patient, and thus cannot be enforced against the patient. *Maricopa Cnty. v. Barfield*, 206 Ariz. 109, 111-12, ¶ 9, 75 P.3d 714, 716-17 (App. 2003). The only "action" a hospital can take to enforce a health care provider lien is to sue the tortfeasor or its insurer. A.R.S. § 33-934(A). A lien cannot be against the patient if it can never be enforced against the patient.

Second, Plaintiffs invite the Court to ignore *Andrews v. Samaritan Health* because the case did not address federal Medicaid law. Resp. at 6-7. Defendants never cited *Andrews* for any proposition relating to federal law. Rather, *Andrews* sets forth the bedrock principles that govern *health care provider liens*. *Andrews* is controlling authority on those principles, and it is silly for Plaintiffs to suggest otherwise.

Next, Plaintiffs wrongly contend that the hospitals conceded that lien enforcement is collection against the patient by arguing that the patients voluntarily settled the liens.

[4] Plaintiffs instead try to distract the Court by citing Chapter 4 of the manual, which prohibits providers from collecting from AHCCCS recipients. Resp. at 11. Of course, that provision has no bearing on the meaning of the term "third party."

Resp. at 7-8. But who negotiates with whom is irrelevant to the preemption inquiry. What is relevant is whether Arizona law conflicts with federal law—in other words, whether the statutory rights granted to hospitals by Arizona law violate the restrictions imposed by federal Medicaid law. The answer to that question *cannot* turn on the hospitals' counterparty in settlement negotiations—otherwise, the hospitals could neutralize the preemption claim by negotiating with the tortfeasor. Unless Plaintiffs are prepared to concede that point, their argument is meritless.[5]

Finally, Plaintiffs twist the consent judgment in *Aycock v. Scottsdale Healthcare* into an admission that lien enforcement is collection from the patient. Resp. at 8-9. The judgment prohibits Dignity Health from enforcing liens after accepting payment from a Medicare Advantage plan ("MA plan"), except for outstanding cost-sharing. This carveout is consistent with the federal laws that the plaintiffs themselves cited, not an admission that lien enforcement is against the patient.[6] Liens permit hospitals to collect their customary charges from the tortfeasor irrespective of the patient's personal liability on the account. *See Andrews v. Samaritan Health Sys.*, 201 Ariz. 379, 383, 36 P.3d 57, 61 (App. 2001). The fact that the patient is responsible for cost-sharing does not make lien enforcement collection against the patient.

II. The Fees Ruling is contrary to law.

A. The Court erred by awarding fees under Arizona's private attorney general doctrine to parties that prevailed on a federal claim.

Plaintiffs do not argue that federal law recognizes the private attorney general doctrine. They also do not contest that the Court adjudicated a federal claim—a party

[5] There is nothing inconsistent about arguing that lien enforcement is collection from the tortfeasor while claiming that the Closed Lien Plaintiffs cannot undo voluntary settlements after the fact. Nobody—be it the hospital, the tortfeasor, the insurer, or the patient—can undo a settlement by arguing that the settled claim was invalid.

[6] Indeed, it was *Plaintiffs' counsel* who initially proposed the carveout. *See* Exhibit C (Email from G. Trachtenberg, Aug. 6, 2014).

seeking a declaration that federal law preempts state law states a claim under the Supremacy Clause. *E.g.*, *Qwest Corp. v. City of Santa Fe*, 380 F.3d 1258, 1266 (10th Cir. 2004); *W. Air Lines Inc.* v. *Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225 (2d Cir. 1987). Instead, Plaintiffs want to pick and choose when federal law applies: they want federal law to apply to the merits and Arizona law to apply to attorneys' fees.

The Supremacy Clause does not allow this. If a state court is adjudicating a federal claim, federal law applies on *all substantive issues*, including whether a party is entitled to attorneys' fees. *Cnty. Executive*, 479 A.2d at 357 ("[T]he *entire* federal substantive law is applicable."). For decades, courts have disallowed litigants from picking which substantive federal laws apply when state courts hear federal claims. *See* authorities cited in Mot. for New Trial at 11-12. The Fees Ruling erred by applying Arizona law rather than federal law to decide whether Plaintiffs are entitled to fees.

Consistent with their strategy on the merits, Plaintiffs try to distract the Court in three ways. First, Plaintiffs contend that "Arizona law governs the Arizona private attorney general doctrine." Resp. at 12. That's true—if the Arizona private attorney general doctrine applies. The Arizona private attorney general doctrine applies only when the litigants are adjudicating a claim under Arizona law. Here, Plaintiffs litigated a claim under *federal law*, not Arizona law.[7] Thus, federal law, not Arizona law, applies when determining whether Plaintiffs are entitled to fees.

Second, Plaintiffs include an extended discussion of admiralty law, wrongly claiming that reverse *Erie* principles apply only in maritime cases. Resp. at 12-13. They

[7] Plaintiffs sought a declaratory judgment under A.R.S. § 12-1831, but a declaratory judgment action is a remedy for an underlying claim, not a claim unto itself. *Snyder v. HSBC Bank, USA, N.A.*, 913 F. Supp. 2d 755, 770 (D. Ariz. 2012).

simply made up that rule, citing one admiralty case that used the term "reverse *Erie*" in passing while describing a maritime statute.[8]

Defendants cited multiple cases, none of which involved admiralty or maritime law. Each and every case required a state court to apply federal law when deciding whether the prevailing party on a federal claim was entitled to attorneys' fees. That is exactly what reverse *Erie* is, and the principle applies here with equal force.

Finally, Plaintiffs cite four inapposite Arizona cases. In *Chaurasia v. Gen. Motors Corp.*, the claim arose out of contract, not the Supremacy Clause. 212 Ariz. 18, 26-27, 126 P.3d 165, 173-74 (App. 2006). *Kerr v. Killian* did not involve federal preemption at all—that case addressed whether *Arizona law* preempted the common fund doctrine. 197 Ariz. 213, 218, 3 P.3d 1133, 1138 (App. 2000). Similarly, the plaintiff in *Defenders of Wildlife v. Hull* sought a declaration that a state statute violated the *Arizona Constitution*. 199 Ariz. 411, 416, 18 P.3d 722, 727 (App. 2001). Finally, the plaintiff in *Am. Cable Television, Inc. v. Ariz. Pub. Serv. Co.* filed an action under A.R.S. § 40-254 to set aside an order of the Arizona Corporation Commission. 143 Ariz. 273, 275, 693 P.2d 928, 930 (App. 1983). None of these cases involved a *federal* claim, such as 42 U.S.C. § 1983 or, as here, the Supremacy Clause.

B. Plaintiffs failed to establish that private enforcement was necessary, disentitling them to fees under the private attorney general doctrine.

The private attorney general does not apply unless "a state agency that is charged with carrying out state law [was not] in a position to challenge the validity of a duly enacted statute." *Kadish II*, 177 Ariz. at 330, 868 P.2d at 343. In other words, the prevailing party must show that private enforcement was necessary to obtain the result in the litigation. The Fees Ruling wrongly concluded that Plaintiffs had to file this suit to enforce federal Medicaid law. This is so because of Plaintiffs' own rhetoric.

[8] *Offshore Logistics, Inc. v. Tallentire*, 477 U.S. 207, 222-23, 106 S. Ct. 2485, 2494 (1986). The Court never purported to *limit* reverse *Erie* principles to admiralty cases.

During the merits briefing, Plaintiffs accused the hospitals of committing fraud, arguing that the AHCCCS Administration viewed lien enforcement as fraudulent. Now, Plaintiffs claim that AHCCCS was actually powerless to stop lien enforcement because the liens were legal under Arizona law.

Notably, Plaintiffs have never tried to reconcile these two positions. So which one is it? If Plaintiffs' position on the merits is correct, Plaintiffs could have filed a grievance with the AHCCCS Administration to stop lien enforcement, making this action unnecessary. If the position Plaintiffs take now is correct, they poisoned the well during the merits briefing and should not be allowed to change their position now. Either way, they have not shown that private enforcement was necessary.

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

The Fees Ruling wrongly analogized this case to *Arnold v. Ariz. Dept. of Health Services*. This case did not concern whether AHCCCS members will receive medically necessary care. Instead, this case presented an economic question—whether hospitals can pay for that care by enforcing health care provider liens. Unlike *Arnold*, this case is about money, not lives.

Plaintiffs cite three private-attorney-general cases involving the Arizona State Land Department ("ASLD"), claiming that they were also about money. Resp. at 16. But unlike Plaintiffs here, the plaintiffs in the ASLD cases did not file suit to vindicate their personal economic interests. Rather, they filed suit to confer substantial benefits on the entire state, by forcing ASLD to comply with its constitutional and fiduciary duties to the public school system.

The ASLD cases were about money, but not about the plaintiffs' own economic interests—the money at issue benefitted the public, not the plaintiffs. This case, in contrast, is about *both* money *and* Plaintiffs' own economic interests. In that way, the ASLD cases actually show how the Fees Ruling diverges from the governing case law.

Plaintiffs then make a truly incredible argument: that this case will *save lives* in the way *Arnold* did. Resp. at 16-17. This is nonsense. Plaintiffs received the medical care they needed after being injured in their auto accidents. Defendants will continue providing that care no matter how the Court rules in this case. This case is not comparable to *Arnold*, a case where a group of lawyers toiled for decades to bring life-saving mental health care to the indigent.

D. The Court must exclude time entries for work performed for the Closed Lien Plaintiffs.

Finally, the Court abused its discretion by ordering Defendants to compensate the *Open Lien Plaintiffs* for time that was attributable to *only* the *Closed Lien Plaintiffs*.

These objectionable time entries do *not* involve services that could have benefitted both groups of Plaintiffs, such as "a nationwide search of all cases that applied 42 C.F.R. § 447.15," Resp. at 17.[9] They were for services that clearly benefitted only the Closed Lien Plaintiffs—by referring specifically to accord and satisfaction, Defendants' motion to dismiss, communications with the Closed Lien Plaintiffs, etc.[10]

Plaintiffs argue that the claims asserted by both sets of plaintiffs turned on a common core of facts. But that is not the point: the Closed Lien Plaintiffs are *different parties* that *did not prevail*. It is extraordinarily unfair to make Defendants pay for the *unsuccessful prosecution* of the Closed Lien Plaintiffs' case simply because some of their legal arguments overlapped with those of the Open Lien Plaintiffs.

III. Conclusion.

The Court should grant Defendants' motion for new trial and enter judgment for Defendants on the merits. At the very least, the Court should vacate the Fees Ruling and enter an order denying Plaintiffs' request for attorneys' fees.

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[9] These time entries were the subject of a separate objection, in which Defendants argued for a percentage discount to account for time that did not benefit the Open Lien Plaintiffs.

[10] *See* Exhibits 3a & 3b to Objection to Pl.'s App. for Attorneys' Fees.

RESPECTFULLY SUBMITTED this 14th day of January, 2015.

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EXHIBIT A

FEDERAL REGISTER

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Part II

Department of the Treasury

Internal Revenue Service

26 CFR Part 1

Additional Requirements for Charitable Hospitals; Proposed Rule

medical care provided by a hospital facility may state the gross charges for such care as the starting point to which various contractual allowances, discounts, or deductions are applied, as long as the actual amount the individual is expected to pay is less than the gross charges for such care.

(d) *Safe harbor for certain charges in excess of AGB.* A hospital facility will be deemed to meet the requirements of paragraph (a) of this section, even if it charges more than AGB for emergency or other medically necessary care (or gross charges for any medical care) provided to a FAP-eligible individual if—

(1) The FAP-eligible individual has not submitted a complete FAP application to the hospital facility as of the time of the charge; and

(2) The hospital facility has made and continues to make reasonable efforts to determine whether the individual is FAP-eligible, as described in § 1.501(r)–6(c), during the applicable time periods described in that section (including by correcting the amount charged if the individual is subsequently found to be FAP-eligible).

§ 1.501(r)–6 Billing and collection.

(a) *In general.* A hospital organization meets the requirements of section 501(r)(6) with respect to a hospital facility it operates if the hospital facility does not engage in extraordinary collection actions (ECAs), as defined in paragraph (b) of this section, against an individual before the hospital facility has, consistent with paragraph (c) of this section, made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy (FAP). For purposes of this section, with respect to any debt owed by an individual for care provided by a hospital facility—

(1) ECAs against the individual include ECAs against any other individual who has accepted or is required to accept responsibility for the individual's hospital bills; and

(2) The hospital facility will be deemed to have engaged in an ECA against the individual if any purchaser of the individual's debt or any debt collection agency or other party to which the hospital facility has referred the individual's debt has engaged in an ECA against the individual.

(b) *Extraordinary collection actions.* ECAs are actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require a legal or judicial process or involve selling an individuals' debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. For purposes of this paragraph (b), actions that require a legal or judicial process include, but are not limited to, actions to—

(1) Place a lien on an individual's property;

(2) Foreclose on an individual's real property;

(3) Attach or seize an individual's bank account or any other personal property;

(4) Commence a civil action against an individual;

(5) Cause an individual's arrest;

(6) Cause an individual to be subject to a writ of body attachment; and

(7) Garnish an individual's wages.

(c) *Reasonable efforts*—(1) *In general.* With respect to any care provided by a hospital facility to an individual, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible only if the hospital facility—

(i) Notifies the individual about its FAP during the notification period (as defined in § 1.501(r)–1(b)(18)), as described in paragraph (c)(2) of this section;

(ii) In the case of an individual who submits an incomplete FAP application during the application period (as defined in § 1.501(r)–1(b)(3)), meets the requirements described in paragraph (c)(3) of this section; and

(iii) In the case of an individual who submits a complete FAP application during the application period, meets the requirements described in paragraph (c)(4) of this section.

(2) *Notification*—(i) *In general.* Except as provided in paragraph (c)(2)(ii) of this section, with respect to any care provided by a hospital facility to an individual, a hospital facility will have notified the individual about its FAP for purposes of paragraph (c)(1)(i) of this section only if the hospital facility—

(A) Distributes a plain language summary of the FAP (as defined in § 1.501(r)–1(b)(19)) and offers a FAP application form to the individual before discharge from the hospital facility;

(B) Includes a plain language summary of the FAP with all (and at least three) billing statements for the care and all other written communications regarding the bill provided to the individual during the notification period;

(C) Informs the individual about the FAP in all oral communications with the individual regarding the amount due for the care that occur during the notification period; and

(D) Provides the individual with at least one written notice that—

(*1*) Informs the individual about the ECAs the hospital facility or other authorized party may take if the individual does not submit a FAP application or pay the amount due by a deadline (specified in the notice) that is no earlier than the last day of the notification period; and

(*2*) Is provided to the individual at least 30 days before the deadline specified in the written notice.

(ii) *Notification when FAP application is submitted.* If an individual submits a complete or incomplete FAP application to a hospital facility during the application period, the hospital facility will be deemed to have notified the individual about its FAP for purposes of paragraph (c)(1)(i) of this section as of the day the application is submitted. However, to have made reasonable efforts to determine whether such an individual is FAP-eligible, the hospital facility must meet the requirements of paragraphs (c)(3) and (c)(4) of this section, as applicable.

(iii) *When no FAP application is submitted.* If an individual fails to submit a FAP application during the notification period (or, if later, by the deadline specified in the written notice described in paragraph (c)(2)(i)(D) of this section) and the hospital facility has notified (and documented that it has notified) the individual as described in paragraph (c)(2)(i) of this section, the hospital facility will have satisfied paragraph (c)(1)(i) of this section. Until and unless the individual subsequently submits a FAP application during the remainder of the application period, paragraphs (c)(1)(ii) and (c)(1)(iii) do not apply. As a result, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible and may engage in one or more ECAs against the individual.

(iv) *Example.* The following example illustrates this paragraph (c)(2):

Example. Individual A receives care from hospital facility T on February 1 and February 2. When A is discharged from T on February 2, T gives A its FAP application form and a plain language summary of its FAP. On March 1, April 15, and May 30, T sends A billing statements that include a one-page insert that provides a plain language summary of the FAP. With the May 30 billing statement, T also includes a letter that informs A that if she does not pay the amount owed or submit a FAP application form by June 29 (120 days after the first billing statement was provided on March 1), T may report A's delinquency to credit reporting agencies, seek to obtain a judgment against A, and, if such a judgment is obtained, seek to attach and seize A's bank account or other personal property, which

EXHIBIT B

FEDERAL REGISTER

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Part II

Department of the Treasury

Internal Revenue Service

26 CFR Parts 1, 53, and 602
Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule

corrects and discloses the failure in accordance with published guidance. Under this provision, if a hospital facility acts reasonably and in good faith to supervise and enforce the section 501(r)(6) obligations of its contractual agreements with debt collectors or purchasers and corrects any contractual violations it discovers, then an error on the part of the debt collectors or purchasers should not be willful and, provided that it is not egregious, could be excused if the hospital facility corrects and discloses the failure in accordance with the procedures outlined in the revenue procedure described in § 1.501(r)–2(c). Accordingly, the final regulations retain the provision holding a hospital facility accountable for the ECAs of the third parties collecting debt on its behalf or to which it sells debt.

One commenter interpreted the 2012 proposed regulations as suggesting that a hospital facility must meet the section 501(r)(6) requirements with respect to all care provided by the hospital facility, even if that care is elective and not medically necessary. Section § 1.501(r)–6(b) of these final regulations and the 2012 proposed regulations define ECAs as actions related to obtaining payment of bills "for care covered under the hospital facility's FAP." Both the proposed and final regulations under section 501(r)(4) only require a FAP to cover emergency and other medically necessary care. Because a hospital facility has discretion over whether its FAP covers elective procedures that are not medically necessary, it has discretion over whether or not it must meet the section 501(r)(6) requirements with respect to such elective care.

a. Extraordinary Collection Actions

The 2012 proposed regulations defined ECAs as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that require a legal or judicial process, involve selling an individual's debt to another party, or involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies").

Some commenters asked that the final regulations clarify that certain additional actions, such as writing off an account to bad debt, sending a patient a bill, or calling a patient by telephone to make reasonable inquiries, are not ECAs. These actions do not require a legal or judicial process or involve reporting adverse information to a credit agency or the selling of an individual's debt and would not come within the definition of ECAs under either the 2012 proposed regulations or the final regulations. However, because there are many possible actions that would not be ECAs and such actions cannot be exhaustively listed in the regulations, the final regulations do not respond to these comments by enumerating actions that are not ECAs (although they do provide for some exceptions with respect to the ECAs that are enumerated, as described in sections 6.a.ii and 6.a.iii of the preamble).

i. Reports to Credit Agencies

Many commenters argued that reporting adverse information to a credit agency should not be considered an ECA because such reporting is not a collection action and is a common practice of hospital facilities. One commenter argued that Congress could not have intended credit agency reporting to be an ECA because section 501(r)(4)(A)(iv) provides that a tax-exempt hospital facility's FAP or separate billing and collection policy must include, among other items, "the actions the organization may take in the event of non-payment, including collections action[s] and reporting to credit agencies." Other commenters supported defining ECAs to include reporting an individual's non-payment of a debt to a credit agency, noting that such an action is a tool in collecting debt and can have extraordinarily detrimental consequences for individuals by resulting in bad credit records for many years.

The Treasury Department and the IRS view reporting to credit agencies as a collection action because it is a tool to collect delinquent debts, and bad credit reports can have extraordinarily detrimental consequences for the affected individuals. Moreover, the requirement under section 501(r)(4)(A)(iv) that a hospital facility describe reporting to credit agencies in its FAP or billing and collections policy evidences Congress's concern regarding such reporting. In addition, the JCT's Technical Explanation states that " 'reasonable efforts' includes notification . . . before collection action or reporting to credit agencies is initiated." Technical Explanation, at 82. Because section 501(r)(6) only requires a hospital facility to make reasonable efforts before initiating an ECA, this statement supports the conclusion that reporting to credit agencies is an ECA. Accordingly, the final regulations continue to include the reporting of adverse information to credit agencies as an ECA.

ii. Certain Liens

The 2012 proposed regulations provided a non-exclusive list of examples of actions that require a legal or judicial process, which included the placement of a lien on an individual's property. Numerous commenters noted that, when a patient has sued a third party due to an auto accident or other type of accident and, as a part of the settlement, is entitled to receive reimbursement for medical bills, state laws commonly allow hospitals to place a lien on that portion of potential settlement proceeds. Commenters stated that they often need to move quickly if they will ever be able to take possession of such funds and asked that the final rule confirm that this common practice will not be treated as an ECA against the patient.

The proceeds of settlements, judgments, or compromises arising from a patient's suit against a third party who caused the patient's injuries come from the third party, not from the injured patient, and thus hospital liens to obtain such proceeds should not be treated as collection actions against the patient. In addition, the portion of the proceeds of a judgment, settlement, or compromise attributable under state law to care that a hospital facility has provided may appropriately be viewed as compensation for that care. Accordingly, in response to comments, the final regulations expressly provide that these liens are not ECAs.

iii. Sale of an Individual's Debt to Another Party

A number of commenters argued that debt sales should not be considered ECAs because they are an important way for hospitals to avoid having to collect debt themselves. Some commenters noted that holding hospital facilities accountable for the actions of debt buyers should be sufficient to ensure that debt buyers do not themselves engage in ECAs before reasonable efforts are made. In addition, several commenters argued that certain debt sales are beneficial to the patient as well as to the hospital facility because, for example, the buyer may service the debt more efficiently or be able to offer extended payment plans at no or low interest that the hospital facility cannot. These commenters recommended that debt sales should not be considered ECAs if the purchaser of the debt is contractually obligated not to take any actions that are ECAs and/or the debt is returnable to or recallable by the hospital facility.

Other commenters stated that hospital facilities lose control of the debt once

is determined to be FAP-eligible for the care, the hospital facility refunds any amount the individual has paid for the care (whether to the hospital facility or any other party to whom the hospital facility has referred or sold the individual's debt for the care) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than $5 (or such other amount set by notice or other guidance published in the Internal Revenue Bulletin).

(e) *Medically necessary care.* For purposes of meeting the requirements of this section, a hospital facility may (but is not required to) use a definition of medically necessary care applicable under the laws of the state in which it is licensed, including the Medicaid definition, or a definition that refers to the generally accepted standards of medicine in the community or to an examining physician's determination.

§ 1.501(r)–6 Billing and collection.

(a) *In general.* A hospital organization meets the requirements of section 501(r)(6) with respect to a hospital facility it operates only if the hospital facility does not engage in extraordinary collection actions (ECAs), as defined in paragraph (b) of this section, against an individual to obtain payment for care before the hospital facility has made reasonable efforts to determine whether the individual is eligible for assistance for the care under its financial assistance policy (FAP), as described in paragraph (c) of this section. For purposes of this section, with respect to any debt owed by an individual for care provided by a hospital facility—

(1) ECAs against the individual include ECAs to obtain payment for the care against any other individual who has accepted or is required to accept responsibility for the individual's hospital bill for the care; and

(2) The hospital facility will be deemed to have engaged in an ECA against the individual to obtain payment for the care, or to have taken one or more of the steps necessary to have made reasonable efforts to determine whether the individual is FAP-eligible for the care, if any purchaser of the individual's debt, any debt collection agency or other party to which the hospital facility has referred the individual's debt, or any substantially-related entity (as defined in § 1.501(r)–1(b)(28)) has engaged in such an ECA or taken such steps (whichever is applicable).

(b) *Extraordinary collection actions*—(1) *In general.* Except as otherwise provided in this paragraph (b), the following actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP are ECAs:

(i) Selling an individual's debt to another party (other than debt sales described in paragraph (b)(2) of this section).

(ii) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

(iii) Deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under the hospital facility's FAP (which is considered an ECA to obtain payment for the previously provided care, not the care being potentially deferred or denied). If a hospital facility requires a payment before providing medically necessary care to an individual with one or more outstanding bills for previously provided care, such a requirement for payment will be presumed to be because of the individual's nonpayment of such bill(s) unless the hospital facility can demonstrate that it required the payment from the individual based on factors other than, and without regard to, the individual's nonpayment of past bills.

(iv) Actions that require a legal or judicial process, including but not limited to—

(A) Placing a lien on an individual's property (other than a lien described in paragraph (b)(3) of this section);

(B) Foreclosing on an individual's real property;

(C) Attaching or seizing an individual's bank account or any other personal property;

(D) Commencing a civil action against an individual;

(E) Causing an individual's arrest;

(F) Causing an individual to be subject to a writ of body attachment; and

(G) Garnishing an individual's wages.

(2) *Certain debt sales that are not ECAs.* A hospital facility's sale of an individual's debt for care provided by the hospital facility will not be considered an ECA if, prior to the sale, the hospital facility has entered into a legally binding written agreement with the purchaser of the debt pursuant to which—

(i) The purchaser is prohibited from engaging in any ECAs to obtain payment for the care;

(ii) The purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);

(iii) The debt is returnable to or recallable by the hospital facility upon a determination by the hospital facility or the purchaser that the individual is FAP-eligible; and

(iv) If the individual is determined to be FAP-eligible and the debt is not returned to or recalled by the hospital facility, the purchaser is required to adhere to procedures specified in the agreement that ensure that the individual does not pay, and has no obligation to pay, the purchaser and the hospital facility together more than he or she is personally responsible for paying as a FAP-eligible individual.

(3) *Liens on certain judgments, settlements, or compromises.* Any lien that a hospital facility is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which the hospital facility provided care is not an ECA.

(4) *Bankruptcy claims.* The filing of a claim in any bankruptcy proceeding is not an ECA.

(c) *Reasonable efforts*—(1) *In general.* A hospital facility will have made reasonable efforts to determine whether an individual is FAP-eligible for care only if the hospital facility meets the requirements described in paragraph (c)(2) or (c)(3) of this section.

(2) *Presumptive FAP-eligibility determinations based on third-party information or prior FAP-eligibility determinations*—(i) *In general.* With respect to any care provided by a hospital facility to an individual, the hospital facility will have made reasonable efforts to determine whether the individual is FAP-eligible for the care if it determines that the individual is FAP-eligible for the care based on information other than that provided by the individual or based on a prior FAP-eligibility determination and, if the individual is presumptively determined to be eligible for less than the most generous assistance available under the FAP, the hospital facility—

(A) Notifies the individual regarding the basis for the presumptive FAP-eligibility determination and the way to apply for more generous assistance available under the FAP;

(B) Gives the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and

(C) If the individual submits a complete FAP application seeking more generous assistance during the

EXHIBIT C

Chris Hering

From: Geoffrey Trachtenberg <gt@ltinjurylaw.com>
Sent: Wednesday, August 06, 2014 12:27 PM
To: Richard B. Burnham
Cc: Lance Entrekin; Steve Evans; Paula J. Gill
Subject: Aycock V. Scottsdale Healthcare, et al.

Dick -

Thank you for your letter of today, which is quite a departure from your letter of May 1, 2014, stating that Dignity was asserting a "final lien balance" against Ms. DeMello's injury recovery for $55,431.71. It's also a departure from your letter of May 22, 2014, which advised us that "[t]he hospital will enforce its lien only to the extent of the [$900] deductible as it has every right to do."

Your new position is that the hospital is going to sue Ms. DeMello in federal court—"not pursuant to the lien," but under a contract theory—for $900, plus attorneys' fees and costs, unless she agrees to dismiss Dignity from the class action lawsuit seeking to protect the putative class from your client's assertion of unlawful liens.

Does that sound right? To us, it sounds like bullying and, if we were to succumb to it, legal malpractice.

Let me be clear: Ms. DeMello has no objection to voluntarily paying her $900 contractual deductible and, if you have not already done so, please send a bill for that amount and instructions on where your client wishes payment to be sent. I've spoken to Steve Evans, her primary injury attorney, and she happy to voluntarily pay her contractual deductible immediately.

This, of course, does not have any bearing on the hospital's practice of filing unlawful healthcare provider liens to collect money from injured Medicare Advantage patients. While we appreciate Dignity's willingness not to balance bill those patients, as required by law, we continue to have a problem with Dignity's conduct in filing liens which purport to seek amounts in excess of deductibles or co-payments.

The concerns we have for the putative class is that (a) your client's liens do not state on their face that the amount it is seeking is only for "deductibles," nor do they correct liens filed after learning that a patient is a Medicare Advantage patient; (b) your new solution to informally "notify attorneys" is not a legally appropriate solution to these false and misleading liens nor does it protect unrepresented people; and (c) it's not appropriate to use Healthcare Provider Liens to collect from patients amounts owed for deductibles since they do not constitute "customary charges" under the statute.

That said, my question is whether Dignity is willing to enter into a stipulated order that enjoins it from filing Healthcare Provider Liens, pursuant to ARS 33-931, eq seq., against the recoveries of Medicare Advantage patients for amounts in excess of deductibles or co-payments? While even that would potentially be improper (i.e., since deductibles and co-payments are not "customary charges" under the statute), it would be something that we would certainly be willing to take to the Court and, if approved by the Court, would end Dignity's involvement in this matter.

Geoff

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