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IN THE SUPERIOR COURT OF THE STATE OF ARIZONA

IN AND FOR MARICOPA COUNTY

AMBER WINTERS, et al.,
on behalf of themselves and all others
similarly situated,

Plaintiffs,

v.

BANNER HEALTH NETWORK, et al.,

Defendants.

Civil Case No. CV2012-007665

PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

(Assigned to the Hon. Judge Gama)

(Oral Argument Requested)

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

I. STANDARD OF REVIEW

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

II. FACTS

A. INTRODUCTION

In 1965, Congress established Medicaid by enacting Title XIX of the Social Security Act. *See* 42 U.S.C. §§ 1396-1396w-5. Under Medicaid, the federal government agreed to provide financial assistance for participating states so that those states could provide health care to the

indigent. *Harris v. McRae*, 448 U.S. 297, 301-09 (1980). Participation by the states was voluntary, but if a state agreed to participate, it had to comply with the requirements of Title XIX and other applicable federal law. *Id.* Each state created or designated a state agency to administer their Medicaid program. *Id.*

Participating states were required to submit a specific plan to the Department of Health and Human Services ("HHS"), certifying that the state would comply with Medicaid statutes and regulations. *See* 42 C.F.R. § 430.10. These states could also submit separate documents in which the Secretary of HHS authorized waivers to particular Medicaid requirements and/or authorized pilot programs. *See e.g.*, 42 U.S.C. § 1315.

Participating states then sign Medicaid provider contracts with health care providers, called Program Participation Agreements ("PPAs"), who receive Medicaid funds from the state in exchange for providing medical care to indigent patients. (SOF ¶1).

B. 1965-69: COLLECTING ADDITIONAL MONIES FROM MEDICAID PATIENTS

During the first four years of Medicaid's existence (1965-69), the Secretary of Health Education and Welfare[1] ("HEW") approved some state Medicaid plans which allowed Medicaid providers to engage in "supplementation." This meant that providers could collect from Medicaid and then bill the patient or a responsible party for an additional sum. See discussion in *Johnson's Prof. Nurs. v. Weinberger*, 490 F.2d 841, 843 (5th Cir. 1974).

In 1967, Congress stated that it wanted to stop the practice of providers collecting from Medicaid and then billing an additional sum to a Medicaid patient or a responsible party. Congress stated in the record that "[a]s a matter of public policy, it would be best for all concerned . . . if the reimbursement made by the State" constituted the compensation received by Medicaid providers. Senate Report No. 744, 90th Cong., 1st Sess., at pp. 187-188 (1967).

Congress stated that it would pass legislation to this effect unless it received "assurance of the Department of Health, Education, and Welfare that existing supplementation programs will be

[1] The Department of Health, Education and Welfare was renamed the Department of Health and Human Services in 1980.

permitted to continue until January 1, 1971" in most states and that the few states with the greatest difficulty in reimbursing providers would submit plans "phasing out such supplementation during a reasonable period of time subsequent to January 1, 1971." *Id.*

In 1968, the Secretary of HEW promulgated 45 C.F.R. § 249.31, which read, in relevant part: "[P]articipation in the [Medicaid] program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure . . . " 33 Fed.Reg. 14894 (1968). This regulation became effective in 1969. *Id.*

C. 1970-79: THE RISE OF BALANCE BILLING AND SUBSTITUTE BILLING

1. Evolution of the Law Prohibiting Collections From Medicaid Patients

Throughout the 1970's, 42 C.F.R. § 249.31 was repeatedly renumbered, but its substance remained the same. It was moved to 42 C.F.R. § 250.30(a)(6) in 1972 (*Johnson's Prof., supra* at p. 843 fn.6), made a brief stop at 42 C.F.R. § 450.30(a)(8), and ultimately settled in at 42 C.F.R. § 447.15 in 1978. *See* 43 Fed.Reg. 45185 (1978).

Section 447.15 remains in effect today and reads, in relevant part:

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

42 C.F.R. § 447.15.[2] In addition, Congress ultimately passed a companion statute to the regulation at 42 U.S.C. § 1396a(a)(25)(C). The regulation and the statute are discussed interchangeably in the case law, so Plaintiffs will generally refer to § 447.15.

2. Balance Billing and Substitute Billing Defined

Despite 42 C.F.R. § 447.15, Medicaid providers used various justifications to first bill Medicaid and then try to collect more money from the Medicaid patient. These collection efforts generally took the form of "balance billing" and "substitute billing."

"Balance billing" as used herein occurs when a Medicaid provider's bill exceeds the Medicaid reimbursement amount. The provider bills Medicaid, collects the full Medicaid

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[2] Deductibles, coinsurance and copayments are not at issue in this case. *See* Defendants' Answer to Second Amended Complaint (filed 12/26/2012).

payment and then asserts a lien against the patient's personal injury recovery, for the balance of unpaid charges, in addition to what the provider has already collected from Medicaid.

"Substitute billing" as used herein also occurs when a Medicaid provider's bill exceeds the Medicaid reimbursement amount. The provider bills Medicaid, collects the full Medicaid payment and then asserts a lien against the patient's personal injury recovery. When the personal injury case is settled, if the amount recovered by the patient is larger than the amount paid to the provider by Medicaid, the provider fully refunds the payment to Medicaid and seeks to collect all charges against the patient's personal injury recovery.

3. Balance Billing and Substitute Billing

At least as early as 1977, we have record of health care providers in California engaging in balance billing. That year, a Dr. Frank Palumbo billed Medicaid and collected $2,172 for treatment provided to a woman named Mary Kimble, then sought to recover an additional $1,567 for his services from Ms. Kimble's personal injury recovery. *Palumbo v. Myers*, 197 Cal.Rptr. 214, 149 Cal.App.3d 1020, 1022-23 (Cal. App. 1983).

D. 1980-89: THE FIGHT BEGINS OVER WHETHER BALANCE BILLING AND/OR SUBSTITUTE BILLING VIOLATES 42 C.F.R. § 447.15

1. THE *PALUMBO* CASE SETS THE PRECEDENT

In about 1980, Medicaid patients began to argue that balance billing violated the plain language of 42 C.F.R. § 447.15. Their argument was that when a health care provider billed Medicaid in full, then asserted and collected a lien against the patient's personal injury recovery, this was clearly inconsistent with providers accepting "as payment in full, the amounts paid by the agency . . ."

In 1983, the issue came before the California Court of Appeals in *Palumbo, supra*. Dr. Palumbo pointed out that there were many statutes stating that Medicaid providers should ease the financial burden on Medicaid by collecting from "third parties" so that Medicaid would be the "payor of last resort." *Id.* at pp. 1021-1030. Dr. Palumbo reasoned that these statutes therefore sanctioned the practice of balance billing. *Id.*

1 The Court rejected this argument out of hand and made the obvious point that balance
2 billing did not ease the financial burden on Medicaid and these were not collections from third
3 parties. *Id.* Dr. Palumbo was collecting the full payment from Medicaid first and then collecting
4 additional monies over-and-above that payment for himself, which did not ease the financial
5 burden on Medicaid and was expressly prohibited by 42 C.F.R. § 447.15. *Id.* The Court further
6 noted that Dr. Palumbo was collecting money from the Medicaid patient, not from third parties.
7 *Id.*

8 **2. HHS DISALLOWS BALANCE BILLING**

9 Shortly after *Palumbo*, California health care providers pushed a bill through the California
10 legislature that would allow balance billing in California. Recognizing that this bill was
11 inconsistent with prior pronouncements of HHS on the topic, the California legislature conditioned
12 enactment of the bill into law upon California obtaining a waiver of 42 C.F.R. § 447.15 from HHS.
13 *Olszewski v. Scripps Health*, 135 Cal.Rptr.2d 1, 7, 69 P.3d 927 (Cal. 2003). HHS refused to grant
14 the waiver and so the bill never became law. *Id.*

15 Plaintiffs herein have retained the former General Counsel of HHS and he has offered a
16 sworn statement indicating that from the beginning and up to the present time, HHS considers
17 balance billing to be a violation of 42 C.F.R. § 447.15 and that Arizona has ***never*** applied for nor
18 received a waiver from HHS authorizing Arizona health care providers to engage in balance
19 billing. (SOF ¶2). This is also supported by Arizona's list of obtained waivers, which says nothing
20 about balance billing liens. (*Id.*).

21 **3. MEDICAID PROVIDERS TURN TO STATE GOVERNMENT**

22 Having lost in court and at HHS, Medicaid providers turned to the more flexible members
23 of the state legislatures and state bureaucracies.

24 Florida enacted a balance billing regulation. Florida State Regulation 59G-7.055(6) states
25 that funds from a patient's personal injury settlement "collected by a provider are permitted to be
26 applied to provider charges that exceed Medicaid payment . . . ."

27 Tennessee Medicaid providers recognized that a state regulation authorizing balance billing
28 had no chance of being upheld, so they pushed through a substitute billing regulation. Tenn. R.

& Reg. 1200-13-1-.04(17)(d) stated: "The provider may void a claim previously paid by Medicaid at any time in an attempt to recover a larger payment from a potentially liable third party."

California followed Tennessee's lead in 1992, enacting Welf. & Inst. Code, §14124.74, a substitute billing statute which purported to allow a Medicaid provider to recover on a lien "against any judgment, award, or settlement obtained by the [Medicaid] beneficiary" after fully refunding the Medicaid payments received. *Olszewski, supra* at p. 7. This time, California did not seek input from HHS. *Id.*

Arizona also passed a statute which purported to allow hospitals to balance bill Medicaid patients. (See below). Every one of these state laws was subsequently held to be preempted by 42 C.F.R. § 447.15. (See below).

4. ARIZONA JOINS MEDICAID IN 1982

Arizona joined the Medicaid program in 1982 and established a state agency to administer Arizona Medicaid, known as the Arizona Health Care Cost Containment System ("AHCCCS"). (SOF ¶3).

a. Arizona Health Provider Lien Statute

Arizona has health care provider lien statutes at A.R.S. § 33-931 through 936. They state that a hospital or other health care provider has a lien for its customary charges and that a hospital's lien has priority over other health care providers' liens. These lien statutes are not in violation of federal law on their face because they do not make any statement or give any indication that the lien can be applied to a Medicaid patient. They are only preempted by 42 C.F.R. § 447.15 if the lien is applied to a Medicaid patient.

b. Arizona General Ban on Balance Billing a Medicaid Patient

Arizona has a state regulation, which is consistent with 42 C.F.R. § 447.15, that bans the practice of using the health care provider lien statutes set forth above to balance bill a Medicaid patient: Ariz. Admin. Code § R-9-22-702(b).

c. Arizona Hospital Balance Billing Statute

Where Arizona clearly violates federal law is in its enactment of a statute, for hospitals only, that creates an exception to the federal ban on balance billing a Medicaid patient. The statute

has gone through many iterations, but presently, A.R.S. § 36-2903.01(G)(4) states that a hospital may collect full payment from Medicaid and thereafter, use the health care provider lien statutes at A.R.S. § 33-931 through 936 to collect the balance of the hospital's bill from the Medicaid patient. This statute violates, and is preempted by, federal law.

d. AHCCCS

Plaintiffs have obtained a sworn statement from the former Inspector General of AHCCCS stating that AHCCCS considers balance billing to be a violation of 42 C.F.R. § 447.15, without an express waiver of 42 C.F.R. § 447.15 from HHS. He testified that the hospitals did ***not*** have such a waiver and he was not aware that the hospitals were engaging in this practice until his involvement in this lawsuit. (SOF ¶4).

E. 1990-99: BALANCE BILLING AND SUBSTITUTE BILLING ARE REPEATEDLY HELD PREEMPTED BY 42 C.F.R. § 447.15

1. *Evanston Hospital*

In 1993, the 7th Circuit considered whether balance billing and substitute billing violated 42 C.F.R. § 447.15 in *Evanston Hosp. v. Hauck*, 1 F.3d 540 (7th Cir. 1993). As in *Palumbo*, the hospital in *Evanston Hospital* argued that substitute billing was supported by the "payor of last resort" statutes, which required hospitals to bill other insurers before billing Medicaid. The hospital argued that under substitute billing, the hospital would refund all of Medicaid's money and sue the patient for the whole bill, easing Medicaid's financial burden. *Id.* at pp. 542-43.

The Court rejected this, stating "[w]hat *Evanston Hospital* seeks, then, is to turn Medicaid upside down by converting the system into an insurance program for hospitals rather than for indigent patients. It wants to be reimbursed when the patient is indigent and still retain the right to sue patients who later become solvent—a classic example of wanting to both have and eat cake." *Id.* at p. 544. The Court then held that balance billing and substitute billing were violations of 42 C.F.R. § 447.15. *Id.*

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2. *Public Health Trust*

Three years later, a Florida hospital argued that Florida State Regulation 59G-7.055(6), which is almost identical to A.R.S. § 36-2903.01(G)(4), authorized the hospital to engage in balance billing.

The Florida Court of Appeals held that the regulation was preempted by 42 C.F.R. § 447.15: "[c]learly, this state administrative regulation is in direct conflict with federal Medicaid laws and the state statute which provide that when a medical provider accepts payment from Medicaid, such payment constitutes 'payment in full.' Because this state administrative regulation is in direct conflict with federal law, the state administrative provision is invalid under the Supremacy Clause." *Public Health Trust v. Dade County School*, 693 So.2d 562, 566 (Fla.App. 1996).[3]

F. 2000-09: BALANCE BILLING AND SUBSTITUTE BILLING ARE REPEATEDLY HELD PREEMPTED AND ALSO HELD A VIOLATION OF MEDICAID PROVIDER CONTRACTS

1. *Mallo* - Third Party Beneficiaries

During 2000, in *Mallo v. Public Health Trust of Dade County*, 88 F.Supp.2d 1376 (S.D. Fl. 2000), a Medicaid patient of a Florida hospital brought a class action to recover monies collected from him and others similarly situated by means of balance billing. The class was certified and the case later settled. The Court held: "[o]nce a health care provider commits to Medicaid assistance for a patient, the provider is barred from billing the patient for an amount in excess of the State's Medicaid disbursement." *Id.* at p. 1387.

What makes the case notable is that for the first time, a Court held that plaintiffs were third party beneficiaries of agreements—the PPAs—between the provider and Medicaid prohibiting the provider from balance billing Medicaid patients. *Id.* at 1383-86.

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[3] Two years later, Michael Beard wrote in The American Journal of Trial Advocacy: "[A] number of courts have considered whether a physician accepting a Medicaid payment could seek to recover additional sums after the patient had received a settlement of a personal injury lawsuit. Because of the balance billing prohibition, all courts considering the issue have denied such recovery." Beard, *Changes in Healthcare Provider Reimbursement Systems on the Recovery of Damages for Medical Expenses*, 21 Am. J. Trial Adv. 453, 470 n.98 (1998).

This "third party beneficiary" holding was later greatly expanded. In *Smallwood v. Central Peninsula Gen.*, 151 P.3d 319, 320-21 (Alaska 2006), the Alaska Supreme Court held that when a Medicaid provider contract prohibited balance billing, a Medicaid patient could sue a hospital that tried to balance bill the patient, because the patient was a third party beneficiary of the provider contract. *Id.* ("We conclude that Smallwood is a third-party beneficiary of the provider agreement between the hospital and the state; he can therefore sue to enforce the balance billing prohibition.").

Arizona has never had a directly on point case, but in *Nahom v. Blue Cross*, 180 Ariz. 548, 552, 885 P.2d 1113, 1117-18 (App. 1994), a Blue Cross patient was sued as a third party beneficiary to enforce a balance billing provision in a contract between a provider and Blue Cross. The Arizona Court of Appeals held that the patient was a third party beneficiary of the provider contract and could enforce the balance billing provision. *Id.*

Between 2005-10, Defendant hospitals herein signed PPAs with AHCCCS. (SOF ¶5). Those contracts contain a provision (Par. 15) which explicitly prohibits balance billing of Medicaid patients. (*Id.*). Plaintiffs herein are third party beneficiaries of that provision and entitled to sue for its breach. *Mallo, supra; Smallwood, supra; Nahom, supra.* Indeed, the former General Counsel of HHS has offered sworn testimony that the intent of these PPAs was to prevent balance billing. (SOF ¶6).

2. *Olszewski*

In 2003, the California Supreme Court decided *Olszewski, supra.* The Court held that the substitute billing statute passed in 1992, Welf. & Inst. Code, §14124.74, was preempted by 42 C.F.R. § 447.15. ("[W]e hold that federal law preempts sections 14124.791 and 14124.74 and invalidates defendant's liens . . . .") *Id.* at 28.

In *Olszewski*, the hospitals argued for the first time that, because they were asserting their liens against a recovery from a third party tortfeasor, the lien was not an attempt to collect from the Medicaid patient, it was merely an attempt to collect from a "third party" and was therefore permissible under 42 C.F.R. § 447.15.

The Court rejected this and held: "[A] provider does not have a direct cause of action against a third party tortfeasor and may not independently recover any amount from that tortfeasor. Consequently, a lien filed under section 14124.791 does not attach until after the judgment, compromise, or settlement becomes the property of the Medicaid beneficiary." Therefore, the Court concluded, assertion of a balance billing or substitute billing lien was an attempt to collect from the patient, not from a third party. *Id.* at 22.

3. *Lizer*

In 2004, Arizona finally took up the issue of balance billing Medicaid patients.[4] The health care provider argued that, because the Arizona health care provider lien statutes at A.R.S. § 33-931 through 936 may only be employed against a recovery from a third party, this was not an impermissible attempt to collect from a Medicaid patient, it was only an attempt to collect from a third party tortfeasor.

The Court easily rejected this flawed reasoning: "[I]t is clear that Congress did not intend the narrow and formalistic interpretation posited by Eagle Air. First, the pertinent regulation clearly mandates that states must require providers to accept Medicaid payments as payment in full. *See* 42 C.F.R. § 447.15. This language prevents providers from billing any entity for the difference between their customary charge and the amount paid by Medicaid. Providers are not merely prevented from balance billing patients themselves." *Lizer v. Eagle Air Med. Corp.*, 308 F.Supp.2d 1006, 1009-10.

The Court concluded: "[T]he lien statute is preempted and cannot be used by Eagle Air to assert a lien against the insurance proceeds for the balance of plaintiffs' bill." *Id* at 1010.

a. Aftermath

Arizona hospitals have simply ignored *Lizer, supra.*

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[4] In *Andrews v. Samaritan*, 36 P.3d 57 (App. 2001), the Arizona Court of Appeals held that balance billing *privately insured* patients is legal, but because privately insured patients do not have the special protection against balance billing afforded by 42 C.F.R. § 447.15, the case is inapposite. Moreover, much of the *Andrews* decision was subsequently disapproved by the Supreme Court in *Blankenbaker v. Jonovich*, 71 P.3d 910 (Ariz. 2003).

When pressed on this, they argue *Lizer* is not good law because a motion not to publish the decision was granted at some later point in the case. This ignores the fact that the Court ultimately did authorize publication and it has since been cited in four jurisdictions as authority that balance billing violates federal law. *Lizer* was relied on by the 6th Circuit as precedent for the most well-known case in this area of law, *Spectrum Health v. Anne Marie Bowling*, 410 F.3d 304 (6th Cir. 2005). It is good law to this day, according to Shepards. The Federal District Court of Arizona has also had more than one opportunity to correct *Lizer* in the last ten years and has chosen not to do so, mainly because *Lizer* is wholly consistent with every other case ever decided in this area of law.

The hospitals have also argued that it is somehow significant that *Lizer* involved an air ambulance service, not a hospital. It is not significant. The air ambulance service was using the Arizona health care provider statutes to balance bill a Medicaid patient. The Court held that this was preempted by 42 C.F.R. § 447.15. *Id.* at 1010. The Defendant hospitals in this case are also using the Arizona health care provider statutes to balance bill Medicaid patients. The holding is perfectly on point.

4. *Spectrum Health*

In 2005, the 6th Circuit decided *Spectrum, supra. Spectrum* had a remarkable set of facts in that the Medicaid patient's guardians stipulated to the lien in advance of any settlement and then tried to get out of it. The *Spectrum* case cited *Lizer* (*Id.* at 315), discussed 42 C.F.R. § 447.15 and held: "[W]e conclude that the enforcement of Spectrum's lien on the proceeds of the malpractice settlement to recover the balance of its customary fee is prohibited by federal and state law." *Id.*

As in *Olszewski* and *Lizer*, defendants argued that their lien was only against a third party tortfeasor, not against the Medicaid patient. The 6th Circuit quickly disposed of this argument, stating: "[O]nce the settlement has been approved, the settlement proceeds are no longer the property of the tortfeasor either. Instead, the entirety of the settlement, regardless of how it is allocated, belongs to Bowling; Spectrum's lien is merely an encumbrance upon that property. . . . Therefore, by seeking to enforce its lien, Spectrum is attempting to recover its customary fee from the Medicaid patient herself in clear violation of both federal and state law." *Id.* at 317-18.

5. Other Cases

During this decade, two other courts discussed the issue *in dicta* and both stated that balance billing a Medicaid patient was prohibited by 42 C.F.R. § 447.15. *See Bynum v. Magno*, 101 P.3d 1149, 1152 (Hi. 2004); *Wright v. Smith*, 641 F.Supp.2d 536, 541 (W.D.Va. 2009).

G. 2010-13: THE FINAL STATE LAW IS STRUCK DOWN

1. An Admission

Beginning in the Summer of 2011 and continuing through the Spring of 2012, a legal representative hired by Defendant hospitals herein met with members of the Arizona state legislature in order to lobby them on issues related to balance billing. A member of the legislature at the time has offered a sworn statement that Defendants' legal representative, speaking on Defendants' behalf, repeatedly conceded to a number of legislators that Defendants could not lawfully balance bill a Medicaid patient after billing Medicaid. (SOF ¶7). Defendants' legal representative never informed the legislature that his clients were balance billing Medicaid patients for millions of dollars annually. (*Id.*).

2. *West*

As set forth above, the state laws purporting to allow balance billing or substitute billing of Medicaid patients in Arizona, California and Florida had all been struck down as preempted by 2010. *Public Health Trust, supra; Olszewski, supra; Lizer, supra.*

On information and belief, the only state law left purporting to allow these practices was Tenn. R. & Reg. 1200-13-1-.04(17)(d), which authorized substitute billing of a Medicaid patient.

In February, 2013, the Tennessee Court of Appeals struck it down, holding that it was preempted by 42 C.F.R. § 447.15. *West v. Shelby County Healthcare Corp.*, No. W2012-00044-COA-R3-CV. ("Accordingly, to the extent that the Tennessee Rules and Regulations can be interpreted to allow a hospital to balance bill or to substitute bill, they are in direct conflict with the federal prohibition against these practices. Accordingly, federal law will govern.")

The Court then addressed the argument that the assertion of a lien against the Medicaid patient's recovery from a tortfeasor was not an attempt to collect from the patient, but only an attempt to collect from a third party, and held: "Both case law and logic indicate that the Med's

liens must be considered an effort 'to collect from' the patient . . . As the Sixth Circuit persuasively reasoned in *Spectrum*, the lien attaches only once the settlement is approved; and once the settlement is approved, the money belongs to the patient, not the tortfeasor (or his or her insurer)." *Id.*

3. Other Authority

At oral argument on the Motion to Certify in April, 2013, counsel for Defendants herein told this Court that Defendants had very strong authority authorizing balance billing of Medicaid patients from the Federal Register.[5] Having never received disclosure of this, Plaintiffs requested disclosure after the hearing. Defendants cited Plaintiffs to 52 Fed.Reg. 6350 (1987).

52 Fed.Reg. 6350 states that a provider is only entitled to "the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan." Id. at p. 13, ll. 16-18. Plaintiffs agree. This in no way supports Defendants' argument.

III. DISCUSSION

The parties stipulate that Defendants are balance billing Medicaid patients. The parties also stipulate that Defendants signed the Medicaid PPAs referred to herein. There is no genuine issue of material fact on these points. *Orme, supra.*

The intent of Congress, the plain language of a federal statute and its implementing regulation, the interpretation of those federal laws by HHS and AHCCCS, the interpretation of those federal laws by every case that has ever addressed the issue, and the plain language of the Medicaid provider contracts are all clear that balance billing a Medicaid patient is prohibited by federal law. It has been prohibited for 44 years. *See* prior regulation 45 C.F.R. § 249.31 (1969). Plaintiffs are entitled to judgment as a matter of law. *Id.*

IV. CONCLUSION

Plaintiffs respectfully move for summary judgment against all Defendants.

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[5] For purposes of this discussion, Plaintiffs will leave aside whether a statement in the Federal Register could trump Congressional intent, the plain language of a federal regulation and federal statute, the holdings in the dozen cases, the PPAs signed by Defendants, and the rules of both HHS and AHCCCS.

1 RESPECTFULLY SUBMITTED this 27th day of June, 2013.

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