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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 **RESPONSE TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT** (Assigned to the Hon. J. Richard Gama) (Oral Argument Requested)

In a series of opinions going back 15 years, Arizona's courts have held that healthcare-provider liens are not enforced "against" the patient; they are enforced only "against" the third-party tortfeasor. Plaintiffs argue that federal Medicaid law conflicts with, and thus preempts, Arizona law because federal law treats lien enforcement as "billing the patient."[1]

Plaintiffs are wrong. Similar to Arizona law, federal Medicaid law has repeatedly and unequivocally classified tortfeasors as *third party* sources of payment. Lien

[1] "Plaintiffs" refers to the Open Lien Plaintiffs, whose claims are at issue in this motion.

enforcement is therefore collection of "third-party liability," which is something that federal law encourages. The cases cited by the Plaintiffs misread the relevant federal statutes and regulations and erroneously presume that Congress created a federal interest in the size of Medicaid beneficiaries' personal-injury recoveries.

Plaintiffs also ignore the fact that the Court must defer to the federal government's administrative determination that Arizona law is consistent with federal law. In 2012, the U.S. Supreme Court held that, in considering claims that federal Medicaid statutes preempt state law, courts must defer to the Center for Medicaid Services' ("CMS") approval of State Medicaid Plans. Plaintiffs' preemption theory directly challenges the views of the public officials who administer the AHCCCS program at both the federal and state levels.

Defendants are entitled to judgment as a matter of law that Arizona's lien statutes are not preempted. The Court should deny Plaintiffs' motion for summary judgment and grant the Defendants' cross-motion for summary-judgment.

I. BACKGROUND: THE LONG HISTORY OF LIEN ENFORCEMENT ON AHCCCS ACCOUNTS

A. Arizona's hospitals have continually enforced liens on AHCCCS accounts, thousands of times, for 28 years.

Every lawyer who practices personal-injury law in Arizona eventually learns about a hospital's lien rights. Since 1985, the implementing statutes for AHCCCS have permitted the treating hospital to enforce a lien to collect "any unpaid portion" of its bill, subject to the senior lien held by AHCCCS.[2] This fact is very well-known. The Court of Appeals discussed the hospitals' right to enforce liens on AHCCCS accounts in opinions

[2] A.R.S. §§ 36-2903.01(G)(4) and § 36-2915(F).

published in 1998 and 2001.[3] The Arizona Supreme Court noted that fact in 2003.[4] The State Bar, the Trial Lawyers' Association, and other groups routinely present CLE programs to educate the bar about the treating hospital's lien rights.

The statute that the Plaintiffs challenge—A.R.S. § 36-2903.01(G)(4)—has been on the books, in plain view, since 1985.[5] If the statute itself did not provide enough publicity of the hospital's lien rights, AHCCCS regulations and the official "State Medicaid Plan" both permit the lien enforcement that the Plaintiffs are challenging.

On a common sense level, this long history of lien enforcement undercuts the plausibility of the Plaintiffs' case. Assume for the moment that the Plaintiffs are correct, *i.e.*, that lien enforcement on AHCCCS accounts necessarily violates federal law. Isn't someone in the federal government supposed to be paying attention to such matters? Isn't there a mechanism for reviewing whether the AHCCCS program complies with federal law? Why hasn't the federal government done anything to stop—or at least ask about—lien enforcement?

Plaintiffs' answer to these questions is that, for 28 years, state and federal officials have been asleep at the switch. That is not true, and it is not even plausible. The correct

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[3] *LaBombard v. Samaritan Health System*, 195 Ariz. 543, 991 P.2d 246 (App. 1998); *Andrews v. Samaritan Health System*, 201 Ariz. 379, 36 P.3d 57 (App. 2001). Plaintiffs contend that "much of the *Andrews* decision was subsequently disapproved" by *Blankenbaker v. Jonovich*. Mot. at 10 n.4. *Blankenbaker*, however, disapproved of *Andrews* only "to the extent that it holds that a health care provider may enforce its lien directly against the injured patient." 205 Ariz. 383, 387 n.7, 71 P.3d 910, 914 n.7 (2003).

[4] *Samsel v. Allstate Ins. Co.*, 204 Ariz. 1, 7, n.2, 59 P.3d 281, 287 n.2 (2002) (recognizing that *Andrews* gave the provider "a statutory lien against a claimant's tort recovery for the full charges made by a provider.").

[5] Plaintiffs contend that Arizona Administrative Code R9-22-702(b) "bans" lien enforcement. The regulation actually states that "[r]egistered providers must accept payment from the Administration or a contractor as payment in full." It says nothing about liens or third-party liability. And in any event, hospitals have a *statutory* right to enforce their liens, a right that cannot be abrogated by an administrative regulation.

answer is that the Plaintiffs' legal theory is wrong. This error may not be obvious to specialists in personal-injury law, but it is obvious to those—including the career experts who work for the federal government—who have deep expertise in this area. Just like Arizona law, federal Medicaid law treats lien enforcement as collection from the third-party tortfeasor, not collection from the patient.

B. Under Arizona law, lien enforcement does not constitute billing the patient.

In 1998, the Arizona Court of Appeals upheld a hospital's lien rights on an AHCCCS account even though the hospital had "no right to recover directly against [the patient] under the AHCCCS regulations."[6] In 2001, the Court of Appeals considered whether a hospital could enforce a lien with respect to a patient enrolled in an HMO, in light of a statute that expressly prohibited hospitals from billing patients enrolled in HMOs.[7] The Court held that the hospital could enforce its lien because, under Arizona law, lien collections come from the third-party tortfeasor, not the patient. In subsequent cases, our Supreme Court emphasized that healthcare-providers' liens "may not be enforced against patients."[8] Rather, "a healthcare provider lien can only be enforced against parties liable for damages as a result of a patient's injuries."[9]

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6 *LaBombard*, 195 Ariz. at 551, ¶ 31, 991 P.2d at 254.

7 A.R.S. § 20-1072.

8 *Maricopa Cnty. v. Barfield*, 206 Ariz. 109, 112, ¶ 9, 75 P.3d 714, 717 (App. 2003); *accord Blankenbaker*, 205 Ariz. at 387, 71 P.3d at 914 ("The legislature did not make the lien enforceable against an 'injured' person … but only against those 'liable for damages' on the patient's underlying damages claim.").

9 *Barfield*, 206 Ariz. at 112, ¶ 9, 75 P.3d at 717. Plaintiffs claim that the parties "stipulate that Defendants are balance billing Medicaid patients." Mot. at 13. Defendants made no such stipulation. The hospitals pursue third-party tortfeasors, not patients, in enforcing liens. Similarly, Defendants' counsel never conceded to the Arizona Legislature that hospitals cannot lawfully enforce liens after accepting payment from AHCCCS. DSOF ¶ 31 & Ex. P.

C. The Cases Plaintiffs Cite All Misstate the Nature of the Preemption Issue and Fail to Apply a Deferential Standard of Review.

A claim that federal law supersedes state law is always a serious and delicate matter, especially when the state law has been widely applied and relied upon for decades. There is a "strong presumption" that state statutes are valid.[10] The Court of Appeals has held that preemption cannot be found unless Congress "clearly manifest[s] its intent to supersede the state's exercise of its traditional police powers."[11]

A successful claim of preemption must show actual, necessary, material conflict between state and federal law.[12] Once the Court truly examines the text of the federal laws at issue—and the next section does—it is clear that there is no conflict at all between state and federal law.

Plaintiffs hardly even cite the state and federal statutes that supposedly conflict in this case. Their preemption "analysis" is entirely superficial. Instead of a side-by-side comparison of the supposedly-conflicting statutes, the Plaintiffs offer vague rhetorical assertions that "lien enforcement equals billing the patient."

To be sure, several courts have endorsed the theory that lien enforcement constitutes "collecting" from the patient.[13] Plaintiffs' motion does little more than quote from these cases and invite this Court to blindly follow. But the cases are not controlling

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[10] *North Dakota v. United States*, 495 U.S. 423, 433, 110 S. Ct. 1986, 1994 (1990); *State v. Turner*, 175 Ariz. 256, 258, 855 P.2d 442, 444 (App. 1993).

[11] *Turner*, 175 Ariz. at 258, 855 P.2d at 444.

[12] *Shroyer v. New Cingular Wireless Servs., Inc.*, 498 F.3d 976, 988 (9th Cir. 2007); *Ariz. Contractors Ass'n, Inc. v. Candelaria*, 534 F. Supp. 2d 1036, 1045 (D. Ariz. 2008).

[13] *Lizer v. Eagle Air Med Corp.*, 308 F. Supp. 2d 1006 (D. Ariz. 2004); *Olszewski v. Scripps Health*, 135 Cal. Rptr. 2d 1, 69 P.3d 927 (Cal. 2003).

authority—they are either unpublished or from out-of-state jurisdictions.[14] They are not even persuasive because they misstate and misread federal law.

More fundamentally, the cases cited by the Plaintiffs all pre-date the deferential standard of review mandated by the U.S. Supreme Court in 2012.[15] Given the complexity of the Medicaid statutes and the expertise of those who administer them, this Court must apply an "arbitrary and capricious" standard of review. In *Douglas*, the Supreme Court held that preemption is "the kind of legal question that ordinarily calls for APA review"—meaning deferential review of the decision of administrative agency; the federal agency's decision "carries weight" because "the agency is comparatively expert" in administering Medicaid.[16] This Court is bound by the decisions of the U.S. Supreme Court.[17]

As explained below, the federal Center for Medicaid Services ("CMS") ensures that the AHCCCS program is structured and administered in a manner that complies with federal law. The officials who administer Medicaid understand that lien enforcement is collection on third-party liability, not collection from the patient.

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14 *Lizer* is an unpublished decision, a fact conceded by Plaintiffs' counsel in the preceding District Court litigation. DSOF ¶¶ 28-29, Ex. M-N. The Court should therefore strike all references to *Lizer* as impermissible citations to an unpublished opinion.

15 *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1210 (2012); *accord Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1248 (9th Cir. 2013).

16 *Douglas*, 132 S. Ct. at 1210; *accord Managed Pharmacy Care*, 716 F.3d at 1248 (holding that CMS's approval of a state plan amendment is entitled to *Chevron* deference); *Pharm. Research & Mfrs. Am. v. Thompson*, 362 F.3d 817, 821 (D.C. Cir. 2004) (same).

17 *Weatherford v. State*, 206 Ariz. 529, 532, ¶ 8, 81 P.3d 620 (2003) ("[A] decision of the Supreme Court binds a state court on a substantive federal issue.").

II. NOTHING IN FEDERAL LAW EXPRESSLY PROHIBITS LIEN ENFORCEMENT OR TREATS LIEN ENFORCEMENT AS UNLAWFUL COLLECTION FROM THE PATIENT.

This section of the brief discusses the preemption issue from a "pre-*Douglas*" point of view. That is, it shows why the Plaintiffs' position is erroneous even if the Court did not have to defer to the determination of the federal government. This section examines the text of the statutes—an essential task that is wholly absent from the Plaintiffs' brief. Federal statutes and regulations do not conflict with Arizona law because Congress never said that providers may not enforce liens against third-party tortfeasors, and no federal statute or regulation says that lien enforcement is collection from the patient. In fact, federal law says the exact opposite.

Plaintiffs' preemption theory is that A.R.S. § 36-2903.01(G)(4)—which allows the treating hospital to enforce a lien for "any unpaid portion" of its bill—is preempted by one federal regulation and one federal statute. The regulation is 42 C.F.R. § 447.15, which will be called the "payment in full" regulation. The statute is 42 U.S.C. § 1396a(a)(25)(C), which will be called the "Third-Party Liability" or "TPL" statute. We discuss each in turn.

A. The "payment in full" regulation does not limit the pursuit of third party liability—and the regulation would conflict with federal law if it attempted to do so.

The payment-in-full regulation, 42 C.F.R. § 447.15, provides, in relevant part:

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

The text addresses the extent of the state agency's liability (the Medicaid payment) and the extent of the patient's liability (cost-sharing). The regulation does *not* say that

payment from Medicaid constitutes payment-in-full *as to third parties*. If CMS intended any Medicaid agency payment to exonerate third parties from all potential liability, it could have said so. Nothing in 42 C.F.R. § 447.15 requires providers to accept the Medicaid payment as payment in full *from all sources*, as is arguably true with the analogous statute governing Medicare.[18]

At day's end, the Plaintiffs are relying not on the text of the payment in full regulation, but on an *implication* that the provider may not seek payment from other sources. In the abstract, that implication may be plausible. But every tool of interpretation and bit of evidence shows that such an implication is mistaken. CMS has never adopted the "implied" reading suggested by the Plaintiffs—and has in fact rejected that reading.

The first clue lies in the regulation's origin. Medicaid providers were collecting additional amounts directly from patients to supplement their Medicaid reimbursement.[19] In 1968, HEW adopted the payment-in-full regulation to stop providers from directly billing patients.[20] In an interpretive letter, HEW explained that the regulation was aimed at preventing "payments by *patients or relatives* for services not included in a State's definition of purchased services."[21]

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18 42 U.S.C. § 1395cc(a)(1)(A)(i) (subject to certain exceptions, Medicare provider may not bill "any individual *or any other person* for items or services for which such individual is entitled to have payment made" by Medicare (emphasis added)).

19 *See generally Johnson's Prof'l Nursing Home v. Weinberger*, 490 F.2d 841, 843 (5th Cir. 1974) and DSOF ¶ 1.

20 "HEW" is the Department of Health, Education, and Welfare, the predecessor to the Department of Health and Human Services ("HHS").

21 DSOF ¶ 2 (emphasis added).

The next clue comes from a 1997 policy statement issued by HCFA to "clarif[y] [its] policies on tort claims."[22] HCFA expressly disagreed with the Plaintiffs' theory that providers can *never* enforce a lien against a third-party tortfeasor after accepting payment from the Medicaid agency. To the contrary, the agency opined that states could indeed "permit providers to pursue payment in excess of Medicaid's reimbursement in tort situations."[23] According to the agency, "federal law [does] not preclude the practice of providers pursuing payment in tort situations in excess of Medicaid's reimbursement," as long as states preserve "certain principles."[24] Those principles include ensuring that the Medicaid agency is "made whole" for its payment and that the "provider lien [is] against the tortfeasor and not the general assets of the beneficiary."[25]

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[22] DSOF ¶ 16 & Ex. G. "HCFA" is the Health Care Financing Administration, CMS's predecessor.

[23] DSOF ¶ 16 & Ex. G.

[24] In another setting, the Plaintiffs might contend that current Arizona law does not meet the conditions set forth in HCFA's letter. But that is not what this case is about. A court cannot assess the correctness of the federal "principles," or whether Arizona meets them, without evidentiary development and testimony from agency officials in an administrative hearing. For present purposes, HCFA's letter demonstrates that the Plaintiffs' theory in this case—that federal law *always* prohibits lien enforcement—is plainly wrong.

[25] HCFA's policy letter addresses lien enforcement in the context of a "cost avoidance" regime, meaning a system in which the Medicaid agency withholds payment on a claim until all third-party liability is exhausted. AHCCCS does not cost-avoid claims; instead, AHCCCS uses the equally-permissible "pay and chase" method for handling third-party liability. In other words, AHCCCS pays the provider's claim and then pursues recovery from a tortfeasor using its lien and subrogation rights. *See* State Plan, Attachment 4.22-A at 4 (DSOF ¶ 27). The difference between "cost avoidance" and "pay and chase" has nothing to do with the present point, i.e., the error in the Plaintiffs' preemption theory. The basic logic of HCFA's letter applies with equal force in a "pay and chase" regime, except that the hospital need not return its payment to make the agency whole—AHCCCS is "made whole" when it enforces its own, senior lien.

In regulatory guidance published in the Federal Register, CMS has repeatedly affirmed its view that 42 C.F.R. § 447.15 only prohibits the provider from "collect[ing] additional payment *from the State*."[26] Restrictions on a provider's ability to collect directly from a Medicaid patient only apply "*after considering the third party's liability*."[27] CMS confirmed that "[t]he provider is *not restricted from receiving amounts from third party resources* available to the recipient."[28]

Moreover, if it were correct, the Plaintiffs' interpretation of 42 C.F.R. § 447.15 would bring that regulation into a rather obvious conflict with federal law. Congress made Medicaid "the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program."[29] CMS has repeatedly and unequivocally designated tortfeasors as *third party* sources of payment.[30] If the payment-in-full regulation's command was that "providers can't chase third-party tortfeasors," the regulation would violate this bedrock principle of Medicaid law.

In short, the policy of the payment in full regulation ("don't bill the patient") does not conflict with the policy of maximizing third-party liability ("do chase tortfeasors").

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26 DSOF ¶ 12 & Ex. F (55 Fed. Reg. 1423-02, 1428 (Jan. 16, 1990)).

27 DSOF ¶ 11 & Ex. F (55 Fed. Reg. 1423-02, 1428 (Jan. 16, 1990)).

28 *Id*.

29 DSOF ¶ 3 & Ex. C (Senate Report No. 99-146 at 279 (1985), reprinted in 1986 U.S.C.C.A.N. 42, 312); DSOF ¶ 10; *e.g.*, *Rehabilitation Association of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994).

30 *See* 42 C.F.R. §§ 433.136 (defining third party 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"), 433.138(d)(4)(ii) (obligating state Medicaid agencies to obtain information from accident report files that "identifies those Medicaid recipients injured in motor vehicle accidents").

These two policies happily coexist because federal law is the same as Arizona law: lien enforcement is collection of third-party liability, not collection from the patient.

B. The TPL statute merely addresses the patient's liability for co-payments in situations where third-party liability exists.

Plaintiffs' case also hinges on the TPL statute, 42 U.S.C. § 1396a(a)(25)(C). Though this is the *only* federal statute that the Plaintiffs invoke in support of their claim, their legal memorandum cites it only once. Plaintiffs do not analyze the TPL statute or even bother to quote it. Instead, they describe the TPL statute as merely a "companion" to the payment-in-full regulation and suggest they can be discussed "interchangeably."[31]

Although the Plaintiffs' motion barely mentions the TPL statute, the cases on which the Plaintiffs rely all turn on this statute to some extent. And for the most part, the cases fail to analyze the statute carefully. This section thus examines the text of the TPL statute very closely.

As originally enacted in 1965, the Medicaid statutes prohibited states from requiring Medicaid beneficiaries from paying anything—even a nominal amount—for their health care. In 1982, Congress allowed states to require Medicaid beneficiaries to pay nominal amounts in the form of "deductibles, co-insurance, co-payments or similar cost-sharing charges."[32]

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[31] Strictly speaking, the Plaintiffs are incorrect—the payment-in-full regulation was enacted well before the TPL statute. The TPL statute is paraphrased by an entirely separate regulation, 42 C.F.R. § 447.20; *see also* DSOF ¶¶ 5, 9. Because that regulation merely paraphrases the TPL statute, and because the Plaintiffs never mention it, it will not be separately analyzed except in one specific context.

[32] Section 131, Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248. This cost-sharing is the subject of 42 U.S.C. § 1396o, which "permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, co-insurance, co-payments or similar cost-sharing charges." 42 C.F.R. §§ 447.50 & 447.53(a) (A state "may impose a nominal deductible, co-insurance, co-payment or similar charge.").

The TPL statute was adopted at that time. It prescribes the effect of third-party liability on the Medicaid recipient's personal liability for the nominal co-payment. To quote, a state Medicaid plan must provide:

> that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1396o of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1396o of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1396o of this title), exceeds the total of the amount of the liabilities of third parties for that service.[33]

It should not be surprising that courts have misinterpreted this statute—it is badly drafted and very hard to understand. Just when the reader's mind is starting to lose track of the statute's meaning, there appears language that appears to limit the "payment" that a provider can "collect" from a Medicaid beneficiary. A lazy reader (or one who is looking to confirm a predetermined outcome) can spot those words and conclude—aha!—"here is the language that limits lien enforcement." But when the statute is actually understood—which requires reading the entire text—it becomes clear that the statute does nothing to limit lien enforcement. Both Congress itself and CMS have stated that the statute had a single, modest goal: to ensure that the third-party liability reduces or eliminates the patient's nominal co-payment.[34]

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33 42 U.S.C. § 1396a(a)(25)(C).

34 DSOF ¶¶ 6-7, 11-14.

The statute begins by saying that a provider "may not seek to collect from the individual … payment of an amount" for services provided to that individual. This language ***is*** referring to a provider's attempt to collect from the patient. To specify the extent to which this command applies, the statute uses two alternative subclauses, numbered (i) and (ii), separated by an "or." Subclause (i) says the provider may not collect ***any*** payment from the patient ***if*** the third-party liability is equal to or greater than the amount the state Medicaid plan would pay the provider. Because third-party liability is primary to both the Medicaid agency's liability and the patient's liability for the co-payment, the patient owes no co-payment if the third-party liability is sufficient to pay for everything.

Instead of an "if," subclause (ii) begins with "in an amount." Subclause (ii) thus backtracks on the first part of the statute, because it authorizes *some* collection from the Medicaid beneficiary. Subclause (ii) applies only in the extremely rare situation where the third party's liability covers some, but less than all, of the co-payment. If the amount payable by the Medicaid plan exceeds the third party liability by less than the amount of the co-payment, the provider can only seek to collect that gap rather than the higher co-payment amount.

When it adopted implementing regulations 30 years ago, CMS offered examples to show how the TPL statute works. This table reveals that the arithmetic mandated by the statute is much simpler than the dense language suggests. The hospital renders a service for which the prescribed reimbursement is $100.[35]

[35] This table is similar to the hypothetical example written by CMS to explain the intent and purpose of the statute. DSOF ¶ 8, Ex. E (52 Fed. Reg. 6350, 6355 (Mar. 3, 1987)). The table assumes a co-payment of $5.

Third Party Liability	Medicaid Agency Pays Provider	Medicaid patient owes provider
$0	$95	$5
$75	$20	$5
$95	$0	$5
$97	$0	$3
$100	$0	$0

As the table shows, the TPL statute directly undercuts the Plaintiffs' theory. The only "payment" the statute attempts to restrict is collection of the cost-sharing amounts from the patient. Third-party payments are not "payment . . . from the individual" but rather the "liability" of third parties. Construing the TPL statute as limiting lien collections would turn the statute upside down—the statute is aimed at *maximizing* the collection of third-party liability.

Far from equating lien enforcement with billing the patient, the TPL statute creates an *inverse* relationship between third-party liability and the patient's personal liability. That is, the amount the provider can collect from the Medicaid patient *rises* as the third party liability *falls*, and vice versa. When two things are inversely related, they cannot be the same thing. The TPL statute thus forecloses the Plaintiffs' theory that lien enforcement "equals" collection from the patient.

While promulgating the regulation that parallels the TPL statute, 42 C.F.R. § 447.20, CMS explained that the reading just offered is correct and that the reading offered by the Plaintiffs is wrong. CMS confirmed that the TPL statute's purpose is to protect "Medicaid recipients . . . from paying *cost-sharing amounts* when the amount of the cost-sharing plus the third party payment exceeds the Medicaid payment amount."[36] All the TPL statute does is "protect the amount of *cost-sharing liability* of Medicaid

[36] DSOF ¶ 14, Ex. F (55 Fed. Reg. 1423, 1429 (Jan. 16, 1990) (emphasis added)).

recipients."[37] The statute neither treats lien enforcement as collection from the patient nor does it restrict providers from collecting on third-party liability. To the contrary, the TPL statute only comes into play "*after* considering the third party's liability."[38]

For that reason, limitations that the TPL statute imposes on the amounts providers can collect from the patient "*apply only in those States that have included recipient cost-sharing in their State plan*."[39] This simple statement actually reveals a lot: the mandate of the TPL statute does not even "apply" in a state that does not require Medicaid recipients to make co-payments. If the TPL statute broadly prohibited lien enforcement, as the Plaintiffs and their cases contend, the statute would apply nationwide, not to just those states that require cost-sharing.

C. Maximizing the size of personal injury recoveries is not a goal of Medicaid; if anything, the opposite is true.

The foregoing shows that federal law does not clearly prohibit providers from undertaking third-party collections after billing Medicaid, nor does it clearly treat collection from third-party tortfeasors as collection from the patient. For that reason alone, Plaintiffs' preemption claim must fail.

But the Plaintiffs' preemption theory is fatally flawed in another way—it rests on the vindication of an imaginary "federal interest." A court may not "seek[] out a conflict[] between state and federal regulation where none clearly exists."[40] In assessing claims of preemption, courts must hew closely to the statutory language because "a freewheeling judicial inquiry into whether a state statute interferes with federal objectives would undercut the principle that it is Congress, rather than the courts, that preempts state

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37 DSOF ¶ 13, Ex. F (55 Fed. Reg. 1423, 1429 (Jan. 16, 1990) (emphasis added)).
38 DSOF ¶ 11, Ex. F (55 Fed. Reg. 1423, 1428 (Jan. 16, 1990) (emphasis added)).
39 DSOF ¶ 15, Ex. F (55 Fed. Reg. 1423, 1428 (Jan. 16, 1990) (emphasis added)).
40 *English v. Gen. Elec. Co.*, 496 U.S. 72, 90, 110 S. Ct. 2270, 2281 (1990).

law."[41] If a court could "discover" federal interests that lacked clear textual support, judges could invent any almost any "federal interest" they desired for purposes of invalidating any state statute they did not like.

Specifically, Plaintiffs' preemption theory presumes that Congress sought to protect the size of personal-injury recoveries of Medicaid beneficiaries. This is counter-intuitive to say the least—a program aimed at giving medical care to the poor does not naturally encompass a concern about state law personal-injury recoveries. In the nearly 50 years of Medicaid's existence, Congress has never articulated any concern about the size of a Medicaid beneficiary's personal-injury recovery.

In fact, Congress has repeatedly indicated that the federal interest is exactly the opposite. Congress has jumped at any opportunity to offload health care costs onto the tort system, showing not even the slightest compunction about reducing the amount a Medicaid patient will recover in a personal-injury case. Toward that end, federal law requires every state to implement laws that subrogate the Medicaid agency to the recipient's rights to receive payment from a third party.[42] Medicaid recipients must assign to the state Medicaid agency all rights to payment from any third party.[43] Any amounts collected by the state agency under that assignment "shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of" the recipient.[44] All of these steps necessarily reduce personal-injury recoveries.

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41 *Chamber of Commerce of U.S. v. Whiting*, 131 S. Ct. 1968, 1985 (2011) (quoting *Gade v. National Solid Wastes Management Assn.*, 505 U.S. 88, 111, 112 S.Ct. 2374 (1992) (Kennedy, J., concurring in part and concurring in judgment)).

42 42 U.S.C. § 1396a(a)(25)(H).

43 42 U.S.C. §§ 1396a(a)(45) & 1396k; 42 C.F.R. § 433.145(a).

44 42 U.S.C. § 1396k(b).

The AHCCCS program is in accord with federal law. AHCCCS holds a lien on the patient's personal-injury claim that is senior to all provider liens.[45] This lien gives AHCCCS a seat at the table in the patient's personal-injury case. That lien also necessarily reduces a patient's personal-injury recovery.

Plaintiffs cannot show that federal law preempts Arizona's lien statutes unless they demonstrate that Congress intended to protect the size of a Medicaid beneficiary's personal-injury recovery. They cannot possibly do so. Nothing even remotely suggests that Congress intended to protect the size of a Medicaid beneficiary's personal-injury recovery. Plaintiffs' preemption claim seeks to vindicate an interest that does not exist.

III. THE COURT MUST DEFER TO THE JUDGMENTS OF THE FEDERAL AND STATE OFFICIALS WHO HAVE CONCLUDED THAT ARIZONA LAW COMPLIES WITH FEDERAL LAW.

The Social Security Act, which includes Medicaid, is notoriously dense and obscure. For that reason, Congress charged a large bureaucracy with interpreting and applying the Medicaid statutes. This bureaucracy, particularly CMS, has developed special expertise and competence in administering the Medicaid program.

Applying that expertise, CMS approved Arizona's State Medicaid Plan, which specifically permits hospitals to pursue third-party liability after accepting payment from AHCCCS. The agency concluded that no conflict exists between federal law and Arizona's lien statutes. The Court must defer to that judgment.

A. Congress gave CMS the ongoing responsibility to ensure that Medicaid programs comply with federal law.

The Medicaid statute operates around the concept of the "state plan." Physically, the state plan is a three-ring binder with pages that are updated periodically.[46] Legally, the plan is the official, authoritative embodiment of the state's Medicaid program. A

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45 A.R.S. § 36-2915(A).

46 Arizona's state plan is available on the AHCCCS web site. DSOF ¶ 17.

state cannot participate in Medicaid unless CMS affirmatively approves its state plan.[47] Among many other requirements, all state plans must include the lengthy list of provisions that appear in the principal statute governing Medicaid, 42 U.S.C. § 1396a.

Congress requires HHS to review each state plan for compliance with federal law. HHS, in turn, delegated that duty to CMS.[48] CMS approves or disapproves each state plan "based on relevant federal statutes and regulations."[49] After every material change in state law, CMS reviews the state plan and any amendments.[50] CMS also reviews a plan's administration "to determine whether the state is complying with the federal requirements and the provisions of its plan."[51]

CMS's approval of a state plan has the force of law.[52] In other words, Congress made CMS "the primary check on [Medicaid] plans."[53] CMS cannot approve a state plan that violates federal law. Thus, CMS's approval is necessarily a determination that the plan and state law meet the requirements of federal law.[54]

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47 *Alaska Dept. of Health & Soc. Services v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 935 (9th Cir. 2005).

48 42 C.F.R. § 430.15(b).

49 42 C.F.R. § 430.15(a).

50 42 C.F.R. § 430.14.

51 42 C.F.R. § 430.32. HHS and the Office of the Inspector General enforce a state's continuing compliance with federal laws. Both agencies can deny all or part of federal Medicaid funds as a result of a state's noncompliance. 42 C.F.R. § 430.32(a) (HCFA review of plan and operation); § 430.35 (OIG audits).

52 *Managed Pharmacy Care*, 716 F.3d at 1249; *Pharm. Research*, 362 F.3d at 822.

53 *DeSario v. Thomas*, 139 F.3d 80, 96-97 (2d Cir. 1998).

54 *E.g.*, *Managed Pharmacy Care*, 716 F.3d at 1249; *Harris v. Olszewski*, 442 F.3d 456, 467-68 (6th Cir. 2006); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 595-96 (5th Cir. 2004); *RCJ Med. Services, Inc. v. Bonta*, 111 Cal. Rptr. 2d 223, 230-31 (Ct. App. 2001) ("Determinations as to whether State plans (including plan amendments and

B. Arizona's Medicaid Plan permits hospitals to pursue third-party liability after accepting payment from AHCCCS.

The payment-in-full regulation does not mention third-party payments. Arizona's State Plan, however, explicitly addresses what that regulation leaves unanswered. AHCCCS' payment to a hospital constitutes "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."[55] Arizona's State Plan thus allows hospitals to collect from third parties—including tortfeasors—after accepting payment from AHCCCS.

CMS approved this section of Arizona's State Plan in 2007.[56] At that time, CMS specifically certified that AHCCCS is operating in compliance with the payment-in-full regulation[57] and the regulation that implements the TPL statute, 42 C.F.R. § 447.20.[58] AHCCCS is aware that the hospitals enforce liens after accepting the Medicaid payment—and regularly participates in the negotiation of lien settlements.[59] Against that backdrop, CMS and AHCCCS certified that all hospitals that participate in AHCCCS are in compliance with 42 C.F.R. § 447.15.[60]

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administrative practice under plans) originally meet or continue to meet the requirements for approval are based on relevant Federal statutes and regulations.").

[55] DSOF ¶¶ 20-21 & Ex. I (emphasis added).

[56] DSOF ¶ 22 & Ex. I. Plaintiffs make much of the fact that HHS has not granted Arizona a Section 1115 waiver that authorizes lien enforcement. Mot. at 5. But a Section 1115 waiver is necessary only if a state seeks to deviate from federal law to perform an "experimental, pilot, or demonstration project." 42 U.S.C. § 1315. Arizona's Plan specifically permits hospitals to enforce liens after accepting payment from AHCCCS. CMS approved the Plan, making a Section 1115 waiver unnecessary.

[57] DSOF ¶¶ 18-19 & Ex. H.

[58] DSOF ¶¶ 25-26 & Ex. K.

[59] DSOF ¶ 30 & Ex. O.

[60] DSOF ¶¶ 23-24 & Ex. J.

C. The Court must apply a deferential standard of review to CMS's approval of Arizona's Plan.

In the past decade, federal courts have recognized that the views of the professional bureaucrats who administer Medicaid must mean something. Federal courts have tried to respect, and find a way to draw upon, CMS's expertise.[61] This tracks the administrative law doctrines known as "exhaustion-of-administrative-remedies" and "primary jurisdiction."

Although judges are certainly capable of legal analysis, generalist judges lack the specialized knowledge that CMS has acquired. That is why, under both Arizona law and federal law, courts apply significant deference to the considered views of administrative officials. In the particular context of this case, "[c]ourt review of CMS approval or rejection of state Medicaid plans and amendments is particularly deferential, given that the federal Medicaid statute is the prototypical 'complex and highly technical regulatory program.'"[62]

Until 2012, those principles were confined to the decisions of lower federal courts, which are not binding upon this Court. But in 2012, the U.S. Supreme Court issued a decision mandating a deferential standard of review, *Douglas v. Independent Living Center of Southern California*.[63]

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61 *E.g., Md. Dep't of Health & Mental Hygiene v. Ctrs. for Medicare & Medicaid Servs*., 542 F.3d 424, 428 (4th Cir. 2008) ("[W]e take care not lightly to disrupt the informed judgments of those who must labor daily in the minefield of often arcane policy, especially given the substantive complexities of the Medicaid statute.").

62 C. Sharkey, *Preemption as a Judicial End Run Around the Administrative Process*, 122 Yale L.J. Online 1, 8 (2013) (citing *Thomas Jefferson University v. Shalala*, 512 U.S. 504, 512 (1994)).

63 132 S. Ct. 1204 (2012).

In *Douglas*, the plaintiffs alleged that federal Medicaid law preempted California statutes that reduced payment to providers.[64] They urged the Court to address the preemption issue in the first instance. The U.S. Supreme Court rejected that approach because CMS approved a state plan amendment that implemented the rate reductions.[65] The Court explained that the outcome of the case could depend on CMS's views:

> The federal agency charged with administering the Medicaid program has determined that the challenged rate reductions comply with federal law. That agency decision does not change the underlying substantive question, namely whether California's statutes are consistent with a specific federal statutory provision (requiring that reimbursement rates be "sufficient to enlist enough providers"). But it may change the answer.[66]

Because CMS approved California's state plan, the preemption question becomes "the kind of legal question that ordinarily calls for [Administrative Procedure Act] review."[67] By this, the Court meant the deferential "arbitrary and capricious" standard of review for agency action. CMS's decision to approve the plan "carries weight" because "the agency is comparatively expert" in administering Medicaid.[68]

Review of agency decisionmaking also "requires courts to apply certain standards of deference," such as *Chevron* deference.[69] A litigant cannot use a preemption challenge to circumvent these deferential standards of review.[70] It is important to defer

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64 *Id.* at 1209.
65 *Id.* at 1210.
66 *Id.*
67 *Id.*
68 *Id.*
69 *Id.*
70 *Id.* at 1211 (noting that permitting a preemption action "would subject the States to conflicting interpretations of federal law by several different courts (and the agency),

to the views of officials who had approved the state Medicaid plan, given the complexity of Medicaid statutes and the expertise of those who administer them.

Since *Douglas*, the lower courts have been careful to solicit, and defer to, the views of CMS whenever there is an allegation that federal Medicaid laws preempt a state statute. The academic literature has concluded that, after *Douglas*, "CMS's approval of the plan should be accorded the same heightened deference in a preemption challenge."[71] Following *Douglas* in 2012, Arizona's district court has deferred to CMS's approval of Arizona's state Medicaid plan in at least two published opinions.[72]

D. The Court must defer to CMS's implementation of federal law.

This case is in the same posture as *Douglas*. A.R.S. § 36-2903.01(G)(4) permits hospitals to enforce liens after accepting payment from AHCCCS. Arizona's Plan implements that statute by providing that hospitals may pursue third-party payments after accepting payment from AHCCCS. CMS approved the Plan.

In doing so, CMS has determined that the "conflict with federal law" perceived by the Plaintiffs simply does not exist.[73] The court must defer to that determination—

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thereby threatening to defeat the uniformity that Congress intended by centralizing administration of the federal program in the agency").

[71] Sharkey, *Preemption as a Judicial End Run Around the Administrative Process*, 122 Yale L.J. Online 1, 8 (2013)

[72] *Planned Parenthood Ariz. v. Betlach*, 899 F. Supp. 2d 868, 885-86 (D. Ariz. 2012) (holding that giving deference to CMS's approval of Arizona's Medicaid plan is "squarely in line with a thorough body of case law"); *Ariz. Hosp. & Healthcare Ass'n. v. Betlach*, 865 F.Supp.2d 984, 992-93 (D. Ariz. 2012) (granting *Chevron* deference to CMS's approval of amendments to Arizona's State Medicaid Plan); *see also Arc of Cal. v. Douglas*, ___ F. Supp. 2d ___, 2013 WL 3331145 at *5 (E.D. Cal. July 1, 2013) (applying deference to federal approval of a State Medicaid Plan waiver based on the "agency expertise" cited in *Douglas*).

[73] Plaintiffs introduce an affidavit from Thomas Barker, a former attorney at CMS, who opines that lien enforcement is not permitted by federal law, Arizona's Plan, or the provider agreements. *See* PSOF ¶ 2 & Ex. 2 at ¶¶ 6-24. The Court should strike Barker's

CMS's interpretation of the relevant Medicaid statutes and regulations is a "necessary presupposition" of the agency's approval of Arizona's plan.[74]

In sum, the Plaintiffs' motion skips over a key step and asks a fundamentally wrong question. The question presented here is not one of preemption. Rather, it is whether CMS's approval of Arizona's Plan was arbitrary and capricious.

1. The Court must defer to CMS's view that 42 C.F.R. § 447.15 does not prohibit providers from collecting payments from third parties after receiving payment from AHCCCS.

By approving Arizona's Plan, CMS necessarily concluded that the Plan complied with federal law. CMS could not have reached that conclusion without agreeing with the interpretation that 42 C.F.R. § 447.15 is inapplicable to third-party payments. The agency revealed its view that the payment-in-full regulation does not bar hospitals from pursuing payments from third parties after accepting payment from Medicaid.

An agency's interpretation of an ambiguous regulation is "controlling" unless it is "plainly erroneous or inconsistent with the regulation."[75] CMS's interpretation of 42 C.F.R. § 447.15 easily merits deference under this standard.

A regulation is unambiguous "when it admits of only one meaning."[76] Here, the payment in full regulation directly speaks to liability of the state agency and the patient.

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affidavit. Courts do not decide legal issues based on witness testimony. *Baker v. Leight*, 91 Ariz. 112, 119, 370 P.2d 268, 273 (1962) (opinions on legal issues are inadmissible). A court therefore does not consider legal opinions or conclusions in affidavits. *Williams v. Campbell*, 20 Ariz. App. 136, 137, 510 P.2d 766, 767 (App. 1973).

[74] *Nat'l R.R. Passenger Corp. v. Boston & Maine Corp.*, 503 U.S. 407, 419-20, 112 S. Ct. 1394, 1403 (1992); *accord Hood*, 391 F.3d at 596 ("More importantly, CMS has approved state Medicaid plans that expressly provide incontinence supplies under the home health care category of medical assistance. This demonstrates that CMS interprets the § 1396d(a)(7) 'home health care services' category as appropriately covering incontinence supplies under its construction of the statute.").

[75] *Auer v. Robbins*, 519 U.S. 452, 461, 117 S. Ct. 905, 911 (1997).

But that regulation neither permits nor prohibits providers from pursuing third parties after accepting payment from Medicaid—there is simply no clear answer.

CMS's view that 42 C.F.R. § 447.15 does not apply to third-party payments is not plainly erroneous. The regulation is silent as to whether accepting payment from Medicaid satisfies the obligations of third parties. One can easily infer from that silence that CMS intended the Medicaid payment to satisfy the state's obligation and the patient's obligation, but *not* the obligations of third parties. CMS could have expressly stated that the Medicaid payment satisfies all third-party liability, but it did not do so. And as shown above, nothing suggests that the agency intended 42 C.F.R. § 447.15 to apply to third-party liability.

CMS has spoken: the payment-in-full regulation limits the obligations of the state agency and the patient, but not third parties. The Court must defer to the agency's application of the regulation.

2. The Court must defer to CMS's view that the TPL statute does not prohibit third-party collections, including lien enforcement.

Similarly, CMS could not have approved Arizona's State Plan without concluding that the Plan complied with the TPL statute. By approving Arizona's State Plan—including Attachment 4.19-A—CMS necessarily concluded that lien enforcement, a species of third-party liability, is not unlawful collection from the patient.

Under the familiar *Chevron* test, a court must defer to an agency's interpretation of a federal statute if (1) Congress has not "directly spoken to the precise question at issue" and (2) the agency's interpretation is not "arbitrary, capricious, or manifestly contrary to

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76 *Parrot v. DaimlerChrysler Corp.*, 212 Ariz. 255, 257, 130 P.3d 530, 532 (2006) (citing *Millett v. Frohmiller*, 66 Ariz. 339, 345, 188 P.2d 457, 461 (1948)).

the statute."[77] *Chevron* deference is "particularly warranted" with respect to Medicaid because it is a "'complex and highly technical regulatory program' [that] benefit[s] from expert administration" by CMS.[78]

Here, the precise question at issue could be formulated in two ways: (1) whether providers may enforce liens on personal-injury recoveries after receiving payment from Medicaid or (2) whether such lien enforcement constitutes "collect[ing] from the patient. Nothing in the TPL statute speaks to either question; indeed, the statute does not address providers' liens at all. Congress therefore did not speak to either possible formulation of the question at issue here.

The question becomes whether CMS's interpretation of the TPL statute is permissible. As shown above, Congress intended to maximize, not preclude, third-party collections. The implementing regulations specifically classify tortfeasors as one source of third-party payment. Nothing in the text or history of the TPL statute even remotely supports the notion that lien enforcement against a third-party tortfeasor is collection from the patient. CMS's view that the TPL statute does not prohibit lien enforcement is certainly not arbitrary and capricious. The Court must defer to the agency's application of the statute.

E. Plaintiffs' preemption claim necessarily fails.

CMS has amply demonstrated that it does not agree with the Plaintiffs' preemption theory. The agency approved Arizona's Medicaid plan, which permits hospitals to pursue

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77 *Va. Dep't of Med. Assistance Servs. v. U.S. Dep't of Health & Human Servs.*, 678 F.3d 918, 921-22 (D.C. Cir. 2012); *The Wilderness Soc'y v. U.S. Fish & Wildlife Serv.*, 353 F.3d 1051, 1060 (9th Cir. 2003).

78 *W. Va. v. Thompson*, 475 F.3d 204, 212 (4th Cir. 2007) (quoting *Thomas Jefferson Univ.*, 512 U.S. at 512, 114 S.Ct. 2381 (1994)); *accord Perry v. Dowling*, 95 F.3d 231, 236 (2d Cir. 1996) ("Such deference is particularly warranted with respect to interpretations of the Social Security Act, because of the Act's intricate nature."); *Ariz. Hosp. & Healthcare Ass'n*, 865 F. Supp. 2d at 992.

payments from third parties after accepting payment from AHCCCS. In doing so, CMS paved the way for hospitals to enforce liens against third-party tortfeasors.

CMS did not act in an arbitrary or capricious manner. Plaintiffs cannot avoid that conclusion by asserting a preemption claim. The Court must therefore defer to CMS's approval of Arizona's plan and its accompanying interpretations of federal law.

IV. PLAINTIFFS CANNOT OVERCOME THE PRESUMPTION AGAINST PREEMPTION BY CITING UNPERSUASIVE OUT-OF-STATE CASES.

The out-of-state cases cited by the Plaintiffs are suspect for several additional reasons. First, none of the cases analyzes the issue in light of a state Medicaid plan that expressly permits hospitals to pursue third parties for payment after billing Medicaid. That distinction is critical because it changes the standard of review. Under *Douglas*, the Court must apply a deferential standard of review to CMS's approval of Arizona's Plan.

Second, the lien laws of other states frequently differ from Arizona's lien laws. Arizona's lien statutes are distinguishable in nuanced but important ways that often undercut the logic of the out-of-state case law. For example, some of the lien statutes that courts have struck as preempted give the provider a direct cause of action against the *patient*, not the tortfeasor as with Arizona law.[79]

In *Evanston Hospital v. Hauck*, Illinois law specifically barred providers "from obtaining, or attempting to obtain, additional payment . . . from the recipient *or any other person*" upon accepting payment from Medicaid.[80] Arizona's Plan is the exact reverse: providers may seek payment from third parties after accepting payment from AHCCCS.

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79 *Olszewski*, 69 P.3d at 944 ("[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."); *W. v. Shelby Cnty. Healthcare Corp.*, 2013 WL 500777 at *13 (Tenn. Ct. App. Feb. 11, 2013) ("The [provider's lien] statute does not give the hospital an independent cause of action against the third party tortfeasor.").

80 1 F.3d 540, 542 (7th Cir. 1993) (quoting 305 ILCS 5/11-13) (emphasis added).

Even *Lizer v. Eagle Air Med. Corp.* is inapposite. There, the lien was asserted by an air ambulance company, not a hospital. The District Court did not consider, much less strike down, A.R.S. § 36-2903.01(G)(4), which specifically gives lien rights to *hospitals*. More importantly, the District Court did not consider Arizona's Medicaid plan, which specifically permits *hospitals* to supplement AHCCCS payments with third-party payments, including lien enforcement. No similar provisions exist for air ambulance companies.

Finally, the cases fail to drill into the statutory and regulatory history undergirding the provisions they contend support a finding of preemption. The cases do not recognize that CMS classified tortfeasors as third parties, making lien enforcement a form of third-party liability, not tantamount to billing the patient. They do not consider how the entire body of federal Medicaid law works together.

Plaintiffs seem to believe that citing out-of-state cases ends the matter and conclusively establishes that federal law preempts Arizona's lien laws. But it does not. Plaintiffs must show that *Congress* intended to preempt state statutes permitting lien enforcement. Citing cases is not a substitute for detailed analysis of the federal statutes and regulations governing Medicaid.

V. DEFENDANTS HAVE NOT VIOLATED THEIR PROVIDER AGREEMENTS WITH AHCCCS.

Plaintiffs contend that the AHCCCS provider agreements "explicitly prohibit[] balance billing of Medicaid patients" and that lien enforcement violates those agreements. Mot. at 9.

As an initial matter, the Plaintiffs are not third-party beneficiaries of the provider agreements. A person cannot enforce a contract as a third-party beneficiary unless (1) the contract indicates "an intention to benefit that person," (2) the benefit is both intentional and direct, and (3) it "definitely appear[s] that the parties intend to recognize the third

party as the primary party in interest."[81] The provider agreements govern the relationship between the provider and the AHCCCS Administration. They do not intentionally and directly confer a specific benefit on AHCCCS members or recognize AHCCCS members as the primary party in interest.

Even if the Plaintiffs did have standing to enforce the provider agreements, they cannot establish a breach by the Defendants. The so-called "balance-billing" provision (Paragraph 15) states:

> The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCSA that the person was ineligible for AHCCCS on the date of service, or that services provided were not AHCCCS covered services. The Provider agrees to abide by Arizona Administrative Code R9-22-702 prohibiting the Provider from charging, collecting, or attempting to collect payment from an AHCCCS eligible person.

This paragraph is silent as to health care providers' liens, and for good reason. For all the reasons discussed above, lien enforcement is collection from a third party, not from the patient. As such, the Defendants do not violate the provider agreements by enforcing liens.[82]

Moreover, A.A.C. R9-22-702 removes any remaining doubt as to whether lien enforcement is unlawful collection from the patient. A provider *may* "recover from a member that portion of a payment made by a third party to the member for an AHCCCS covered service if the member has not transferred the payment to the Administration or

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81 *Nahom v. Blue Cross & Blue Shield of Arizona, Inc.*, 180 Ariz. 548, 552, 885 P.2d 1113, 1117 (App. 1994) (quotations omitted).

82 Indeed, interpreting the provider agreements as prohibiting lien enforcement would violate A.R.S. § 36-2903.01(G)(4), which specifically permits hospitals to assert liens after receiving payment from AHCCCS.

the contractor as required by the statutory assignment of rights to AHCCCS."[83] Thus, even if lien enforcement is somehow considered collection from the patient, the practice is specifically permitted by the Arizona Administrative Code.

Defendants are not breaching the provider agreements by enforcing liens against third-party tortfeasors.

VI. CONCLUSION

Arizona's lien statutes are presumptively valid. Defendants need not show that federal law affirmatively permits the hospitals to enforce liens against tortfeasors who injure AHCCCS members. Rather, the Plaintiffs must show that Congress intended to supersede state laws governing lien enforcement—that Arizona law frustrates some federal purpose. More than that, the plaintiffs must show that the federal bureaucrats who approved Arizona's Plan acted arbitrarily and capriciously when they made their decision.

Plaintiffs cannot do so. Federal law does not preempt Arizona's lien statutes. The Court should grant summary judgment in Defendants' favor on all of the Plaintiffs' claims.

DATED this 19th day of August, 2013.

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[83] A.A.C. R9-22-702(D)(2).

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