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# CLIENT ALERT

## Managed Care Lawsuit Watch - June 2015

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*This summary of key lawsuits affecting managed care is provided by the Health Care Group of Crowell & Moring. If you have questions or need assistance on managed care law matters, please contact Chris Flynn, Peter Roan, or any member of the Health Care Group.*

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- *U.S. ex rel. Oughatiyan v. IPC The Hospitalist Co., Inc.*
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- *Commonwealth of Massachusetts v. Partners Healthcare System, Inc. et. al.*


***Armstrong v. Exceptional Child Ctr, Inc.***
**135 S. Ct. 1378 (2015)**

The U.S. Supreme Court of America held that Medicaid providers do not have a cause of action to challenge a state's provider reimbursement rates.

The plaintiffs, habilitative services providers who received payment under Idaho's Medicaid plan, sued several Idaho Health and Welfare Department officials claiming that the state reimbursed the providers at rates lower than federal law allows. The providers asked the court to enjoin these officials to increase their payment rates. The Medicaid system requires that each state adopt a Medicaid "plan" and obtain federal approval for this plan. The applicable statute, Section 30(A) of the federal Medicaid Act, requires that each state's Medicaid plan "assure that payments are consistent with efficiency, economy, and quality of care" and "safeguard against unnecessary utilization of . . . care and services." 42 U.S.C. § 1396a(a)(30(A).

The District Court granted summary judgment for the providers, and the Ninth Circuit affirmed, holding that the Supremacy Clause gave the providers an implied right of action, allowing them to sue to seek an injunction and require compliance with 30(a). The Supreme Court reversed in a 5-4 decision.

The Court explained that in interpreting the Supremacy Clause, it must be read in the context of the Constitution as a whole. In doing that, the majority concluded that reading an implied private right of action into the Supremacy Clause would mean that the Constitution *requires* Congress to allow the enforcement of federal laws by private actors. This interpretation, the Court reasoned, would limit Congress's ability to guide the implementation of federal law, and it would not make sense to read such a limit into a clause that renders federal law supreme. Moreover, such a limitation would be unheard-of among state legislatures.

The providers argued that the Court's prior consideration of whether to enjoin the enforcement of state laws that violate federal law supported an implied private cause of action in the Supremacy Clause, but the Court disagreed. Judicial review of illegal executive action dates back to English common law as a judge-made remedy and is not rooted in the Supremacy Clause.

The providers also argued that they had a right to be heard in equity. Acknowledging the federal courts' broad power to enjoin unlawful executive acts, the Court found that the Medicaid Act implicitly precludes private enforcement of § 30(A). There were two reasons for this. First, Congress only provided one remedy for a State's failure to comply with the Medicaid requirements: withholding of Medicaid funds by the Secretary of Health and Human Services. While this alone might not preclude equitable relief, § 30(A) also contains "judicially unadministratable" text. Court noted that § 30(A)'s mandate was extremely broad, and Congress conferred enforcement of this text exclusively on the Secretary. These factors show that Congress intended the agency remedies to be exclusive—uniform, subject to the administrative decision-making process, and avoidant of any judicial inconsistency and misinterpretation.

The majority also addressed the dissent. The dissent argued that since Congress was undoubtedly aware of the federal courts' practice of enjoining state action, Congress should be presumed to consider such enforcement without affirmative showing of a contrary intent. The majority responded that any such practice would not justify a rule that denies § 30(A)'s "fairest reading" showing the intent to give the agency sole enforcement power. The dissent also cited § 30(A)'s legislative history, but the majority again rejected these arguments in favor of the plain text of § 30(A).

As to remedies, the Court emphasized that the providers maintained a right to relief, but it was through the Secretary rather than the courts. The Secretary, in turn, could withhold Medicaid funds from the violating State.

The dissent would have recognized a private cause of action for the providers because claims that state laws violate federal statutes are basically constitutional in nature, deriving their authority from the Supremacy Clause. While admitting that it was "somewhat misleading" to discuss an implied right of action under the Supremacy Clause, the dissent found it was nevertheless permitted for parties to enforce the Supremacy Clause by bringing suit to enjoin preempted state action. The dissent also argued that absent evidence of a contrary intent, it should be presumed that Congress meant to give federal courts equitable power to reject agencies' rate determinations. In closing, the dissent considered the consequences of the decision. In particular, if only HHS, and not individuals, could force States to increase their Medicaid payments, prior Medicaid provider shortages could return.

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***Golden v. Cal. Emergency Physicians Med. Grp.***
**782 F.3d 1083 (9th Cir. April 8, 2015)**

The U.S. Court of Appeals for the Ninth Circuit reversed and remanded an order enforcing a "no-employment" provision in a settlement agreement, holding that to determine the validity of a contract under Section 16600 of the California Business and Professions Code, courts must determine whether a provision substantially restrains professional practice. Bus. & Prof. Code Section 16600 instructs that "every contract by which anyone is restrained from engaging in a lawful profession, trade, or business of any kind is to that extent void."

Defendant California Emergency Physicians Medical Group (CEP) is a consortium of physicians that manages or staffs emergency rooms and other facilities in California and other Western states. Following the loss of his staff membership at a CEP facility, Dr. Donald Golden filed a lawsuit alleging that CEP engaged in racial discrimination. Prior to trial, Dr. Golden and CEP orally agreed in open court to settle the case. In return for payment of a negotiated amount, Golden agreed to waive all rights to employment with CEP or future employment at any medical facility that CEP owned, acquired or contracted (the "no-employment" provision). The provision also stated that CEP has the right to and will terminate Dr. Golden without any liability were it to contract with a facility at which Golden was employed in the future. Dr. Golden later refused to execute the written settlement agreement and attempted to have it set aside.

Dr. Golden's former counsel moved the district court to intervene and to enforce the settlement agreement in order to seek fees. The district court interpreted Section 16600 of the California Business and Professions Code as forbidding only non-compete covenants, and found that Golden's settlement agreement was not a non-compete covenant because it did not preclude Golden from working for CEP's competitors. The district court ordered that the settlement agreement be enforced. Golden appealed.

The Ninth Circuit held that the district court erred by categorically excluding the settlement agreement from the ambit of Section 16600 on the sole ground that the "no-employment" provision did not constitute a covenant not to compete. The Court emphasized that the text of Section16600 does not contain the words "compete" or "competition," "and does not even implicitly constrain itself to contracts concerning employment." Although the California Supreme Court has not expressly addressed whether a contract can impermissibly restrain practice within the meaning of Section 16600 even if it does not prevent a former employee from working with competitors, the majority found that existing California precedent supports a broad reading of the statute. District courts must direct their inquiry under Section 16600 to the question of whether the challenged contract provision substantially "restrain[s anyone] from engaging in a lawful profession, trade, or business of any kind." Because of the lack of a developed record, the Ninth Circuit remanded the case to decide whether the settlement agreement actually constitutes a restraint of a substantial character on Golden's medical practice.

Judge Kozinski dissented. He argued that the settlement agreement did not implicate Section 16600 because the agreement only barred Golden's continued employment with CEP and did not restrict his overall ability to practice medicine.

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***Johnson v. U.S. Office of Pers. Mgmt.***
**783 F.3d 655, 658 (7th Cir. April 14, 2015)**

The plaintiffs, U.S. Senator Ron Johnson and his legislative counsel, Brooke Ericson, filed suit in the Eastern District of Wisconsin challenging an OPM regulation implementing a provision in the ACA (OPM Rule). The challenged OPM Rule limits health care options available to members of Congress and their staffs by mandating that the only health plans available to them through the federal government are plans created under the ACA or offered through a health insurance exchange established under the ACA. The plaintiffs sought a declaration that the OPM Rule is unlawful and void under the Administrative Procedure Act because it allows the government to make pre-tax employer contributions to non-FEHBP plans and makes members of Congress and their staffs eligible for an ACA insurance exchange reserved for small businesses.

Defendants OPM and its director Katherine Archuleta moved to dismiss plaintiffs' complaint on the grounds that the district court lacked subject matter jurisdiction. The district court granted the motion to dismiss, finding that the plaintiffs failed to allege they suffered injury that was traceable to the challenged regulation and therefore did not have Article III standing. Plaintiffs appealed.

On appeal, the plaintiffs argued that they suffered three injuries traceable to the OPM Rule and therefore had standing. First, they argued that because the Rule forces Senator Johnson and his staff to determine which staff members are "congressional staff" within the meaning of the OPM Rule and the ACA on a yearly basis, it imposes an administrative burden on them. Second, the plaintiffs argued that the OPM Rule deprives them of their "statutory and constitutional rights" to equal treatment with Senator Johnson's constituents. Finally, Senator Johnson argued that the OPM Rule causes him "reputational and electoral injury" because (i) it requires him to engage in conduct he thinks is illegal and (ii) it gives him "special treatment" that is not available to his constituents.

The court rejected plaintiffs' arguments as to all three alleged injuries and affirmed the district court's dismissal of plaintiffs' complaint for lack of standing. First, the court rejected plaintiffs' administrative burden argument, finding that the aspects of the OPM Rule that they alleged were illegal were unrelated to the aspects of the OPM Rule that allegedly imposed an administrative burden. The court explained that plaintiffs' alleged injury was not traceable, i.e. "the result of" or "a consequence of" the conduct they challenged and therefore, even if the plaintiffs were to prevail on the merits of their case, any remedy that alleviated the substantive legal concerns identified by plaintiffs would not cure their alleged administrative injury.

Second, the court rejected plaintiffs' claim that they were denied equal treatment guaranteed by the ACA and the Constitution. The court first rejected plaintiffs' equal treatment claim to the extent that it was based on the ACA, because the ACA provision does not create a private right of equal treatment. Next, the court rejected plaintiffs' alleged denial of equal treatment guaranteed by the Constitution, finding that the "mere allegation of unequal treatment, absent some kind of actual injury, is insufficient to create standing." The court noted that this was especially true in this case because the plaintiffs appeared to be alleging that they were being treated "too favorably."

Finally, the court rejected plaintiffs' argument that the OPM Rule imposes reputational and electoral harms on Members and their staffs by giving them special treatment and making them complicit in the violation of a congressionally enacted statute. The court concluded that a political figure's allegation that the receipt (or option of receiving) a benefit will be harmful

to his or her reputational or electoral prospects is insufficient to establish Article III standing, finding that such a possibility is too "conjectural or hypothetical."

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***U.S. ex. rel. Robert Whipple v. Chattanooga-Hamilton Hosp. Auth.***
**782 F.3d 260 (6th Cir. Feb. 25, 2015)**

The U.S.Court of Appeals for the Sixth Circuit reversed a district court's order dismissing a relator's FCA action for lack of subject matter jurisdiction. In dismissing the case, the district court noted that because the purported fraud had already been the subject of a government audit and investigation, the FCA's public-disclosure bar prevented the relator, Robert Whipple, from bringing the claim. The Sixth Circuit disagreed with the district court's interpretation of the public-disclosure rule and held that the government audit and investigation did not bar Whipple's claim.

In his complaint, Whipple alleged that the defendant, Chattanooga-Hamilton County Hospital Authority, had engaged in upcoding and other improper billing practices. Whipple alleged that he discovered this fraud in 2006 while employed by the Defendant. However, unbeknownst to Whipple, the U.S. Government had been concurrently investigating the Defendant's billing practices.

An anonymous phone call to the Office of the Inspector General (OIG) triggered the Government's investigation. The OIG referred the tip to the region's Medicare Part A Program Safeguard Contractor, AdvanceMed. In turn, AdvanceMed substantiated the anonymous tip by uncovering a series of fraudulent claims. OIG's Office of Investigations and Office of Counsel to the Inspector General then began an administrative investigation of the Defendant and informed the Defendant of their findings. The Defendant reacted by performing its own internal investigation and hiring Deloitte Financial Advisory Services, LLP to conduct an internal audit. Ultimately, the Government decided not to bring any civil or criminal actions against the defendant, the OIG closed the administrative investigation, and the Defendant provided the Government with a voluntary refund of $477,140.72.

While the district court held that the above chain of events was enough to prohibit Whipple from bringing his claim, the Sixth Circuit disagreed. The Sixth Circuit noted that the district court had properly held that "no court shall have jurisdiction over a *qui tam* action that is based upon the public disclosure of allegations or transactions [1] in a criminal, civil, or administrative hearing, [2] in a congressional administrative, or [GAO] report, hearing, audit, or investigation, or [3] from the news media, unless . . . the person bringing the action is an original source of the information." However, the Sixth Circuit concluded that the district court had improperly interpreted the meaning of "public disclosure."

The Sixth Circuit held that the disclosure of information to the Government could not by itself be enough to constitute public disclosure. The Sixth Circuit reasoned that the term "public" would be made superfluous if the public-disclosure bar could be triggered by a government audit or investigation. Additionally, the Sixth Circuit noted that equating the term "public" with "government" would create inconsistencies in the use of the term "government" throughout the FCA's statutory framework. Therefore, the panel determined that "[t]he mere fact that . . . disclosures are contained in a government file someplace, or even that the government is conducting an investigation behind the scenes, does not itself constitute public disclosure."

The Sixth Circuit also disagreed with the defendant's argument that the revelation of information to AdvanceMed and Deloitte constituted public disclosure. AdvanceMed was acting as a government contractor during the investigation and was bound to keep the information confidential. Deloitte was similarly bound to keep the information confidential, and the defendant disclosed the information to Deloitte only so that Deloitte could assist in the investigation. Therefore, neither party was a "stranger to the fraud," and the disclosure of information to them did not constitute public disclosure.

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***U.S. ex rel. Oughatiyan v. IPC The Hospitalist Co., Inc.***
**No. 09-C-5418 (N.D. Ill. Feb. 17, 2017)**

The U.S. District Court for the Northern District of Illinois allowed a claim under the FCA to proceed based on an alleged pattern of fraudulent billing by hospitalists affiliated with defendant IPC, a nationwide hospitalist physician group practice. IPC, like other physician group practices, submitted claims to the federal government under Medicare based on codes reflecting services rendered by the group's physicians. The government, as intervener in this case, alleged that IPC's interactions with its physicians encouraged "upcoding," or billing for services in excess of those actually provided.

Specifically, the government took issue with IPC's tracking of individual physicians' billing practices and encouragement of use of higher billing codes. In general, the billing codes at issue reflected the level of complexity of medical services and the amount of time spent rendering them. For example, Code A1 applied to initial hospital care where a physician spends 30 minutes at the patient's bedside and makes relatively low-complexity medical decisions, and Code A2 applied to initial care where the physician spends 50 minutes and makes moderately complex medical decisions. Code A1 was reimbursed at a rate of $82.16, compared to $121.40 for Code A2.

Using a "dashboard" for each hospitalist, IPC tracked revenue per patient encounter to rate physicians' performance, ranked them against other IPC doctors, pressured them to use higher billing codes, and paid bonuses based on these figures. By incentivizing higher revenues per patient encounter, IPC allegedly encouraged its physicians to upcode services they provided. In addition, the dashboard did very little to guard against excessive billing. For example, IPC's Code V3, which is used for highly-complex care after the hospitalist's initial assessment, was used at a national average rate of 20 percent, whereas the dashboard would only raise an alert if Code V3 was billed over a 95 percent rate.

The government used case studies of a few IPC physicians as evidence of the alleged scheme. Based on the minimum amount of time necessary to complete the codes billed, 11 IPC hospitalists had billed for services within one day that would have taken more than 24 hours, including five who did so regularly. On one day, one particular physician billed services that would have taken at least 43 hours to perform.

Moreover, the pleadings supported the government's allegation that IPC was responsible for the claims to federal programs pursuant to the fraudulent billing scheme. IPC was responsible for administrative services for the group, audited bills for accuracy, and stated in its own financial documentation that IPC "assume[s] responsibility for all billing, reimbursement and collection processes relating to hospitalists and practice groups."

After flatly rejecting IPC's argument that the government lacked standing, the court found unpersuasive IPC's argument under Fed R. Civ. P. 9(b) that the government had failed to "state with particularity the circumstances constituting fraud or mistake." IPC argued that the government had merely identified billing errors, but had not sufficiently pleaded three "essential elements" of the fraudulent scheme: (1) who was involved in the conduct at issue, (2) where the occurred, and (3) how the conduct occurred. The court concluded that although Rule 9(b) requires a level of detail that *may* be met by addressing the "who, what, where, when, and how" of the allegedly-fraudulent conduct, none of these is an "essential element" of the requirement.

The court held that the government's complaint met the burden by alleging that beginning January 1, 2003, IPC "knowingly billed federal payors for higher and more expensive levels of medical service than were actually performed." The court granted the motion to dismiss other defendants, which were subsidiaries and affiliates of IPC, based on failure to plead the specific involvement of each in the fraudulent scheme alleged. The role of IPC in a fraudulent scheme, however, was alleged with sufficient specificity for the case to proceed against it.

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***Rumble v. Fairview Health Servs.***
**No. 14-CV-2037 SRN/FLN, 2015 WL 1197415, (D. Minn. Mar. 16, 2015)**

The U.S. District Court for the District of Minnesota refused to dismiss a complaint that alleged gender discrimination during a patient's emergency room visit and admission.

Plaintiff Jakob Tiarnan Rumble, a self-identified female-to-male transgender man, filed suit against Fairview Southdale Hospital and Emergency Physicians PA, alleging that his treatment at the Edina hospital was discriminatory in violation of section 1557 of the Affordable Care Act, and Minnesota law.

Rumble went to an emergency room after inflammation and extreme pain in his genitalia. Upon arrival to Fairview Southdale Hospital, plaintiff alleged that the hospital intake staff and nurses incorrectly identified Rumble as a female, and treated other patients with less urgent needs before treating Rumble. When the emergency room physician, Dr. Steinman, arrived almost five hours later, Rumble alleged that Dr. Steinman treated him with hostility and aggression, made disparaging comments, and conducted an "assaultive" physical examination by repeatedly jabbing Rumble's genitalia. Rumble alleged additional discriminatory conduct during his six-day inpatient admission, including a notation of "OBY/GYN" near his hospital bed that upset and embarrassed Rumble, poor hygienic precautions taken by his infectious disease doctor, and repeated mistreatment by the hospital's nurses.

The defendants moved to dismiss the plaintiff's complaint for failure to state a claim. In one of the first cases interpreting Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116, the district court refused to dismiss Rumble's complaint. The court concluded that Rumble plausibly alleged violations of Affordable Care Act Section 1557, which prohibits discrimination in health care.

Judge Susan Richard Nelson noted that Section 1557 references four civil rights statutes in order to identify the grounds on which discrimination is prohibited in health care (race, sex, age, and disability). Judge Nelson further commented that the same

standard and burden of proof likely applies in a Section 1557 case regardless of the plaintiff's protected class. The court, however, did not decide the precise standard that may apply.

Defendant Emergency Physicians argued that Rumble failed to allege that he sought medical care from a health program or activity that received federal funds. The court determined that Medicare and Medicaid payments received by Emergency Physicians constituted federal financial assistance for purposes of Section 1557, and that Rumble need not prove how the funds were used until summary judgment or trial. The physician group also argued that the facts were insufficient to allege adverse action or differential treatment on the basis of sex. The court disagreed, finding that the allegations of disparate treatment and unprofessional behavior evidenced that Dr. Steinman mistreated Rumble because of his gender identity.

Without determining whether the vicarious liability standards apply to a Section 1557 claim, the court also rejected the Fairview Southdale Hospital's argument that it is not vicariously liable for Dr. Steinman's conduct. The district court determined that the plaintiff sufficiently alleged that the hospital is directly liable for Dr. Steinman's actions because the complaint alleged that (1) Dr. Steinman's actions barred Rumble's access to reasonable, non-harassing medical care; (2) an appropriate person at the Fairview knew of Dr. Steinman's discriminatory acts; (3) that the hospital official acted with deliberate indifference; and (4) the hospital has substantial control over Dr. Steinman and the emergency room. Moreover, the court determined that the allegation of the hospital staff's misconduct were also actionable under Section 1557.

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***MHA, LLC v. Healthfirst, Inc.***
**No. 2:13-CV-06036-SDW-MC, 2015 WL 858051 (D.N.J. Feb. 27, 2015)**

The U.S. District Court for the District of New Jersey dismissed MHA LLC's $30 Million claim against HMO Healthfirst Inc. MHA, doing business as Meadowlands Hospital Medical Center, operates a general acute hospital in Secaucus, New Jersey. Defendant Healthfirst, Inc. owns and operates health plans throughout the country including HealthFirst Health Plan of New Jersey, Inc., which provides Medicaid coverage in New Jersey.

MHA claimed that Healthfirst did not reimburse it for services provided to Medicaid beneficiaries. Specifically, MHA alleged that Healthfirst denied coverage to patients who received emergency care, downgraded the state of emergency patient conditions, refused to pay legitimate claims, and denied and/or improperly limited MHA's level of responsibility when HFNJ Medicaid beneficiaries received emergency room treatment.

The district court ruled that MHA failed to exhaust its administrative remedies under New Jersey law. The New Jersey Health Claims Authorization, Processing and Payment Act (HCAPPA), calls for an administrative resolution to claims disputes between providers and HMOs. HCAPPA requires that organizations such as HealthFirst establish an internal appeal mechanism to resolve health care provider disputes. If the dispute is not resolved through the internal appeal mechanism, the appeal must be resolved through arbitration. The court dismissed MHA's Medicaid-based claims because neither the complaint nor the proposed amended complaint alleged that MHA availed itself of, or exhausted all of, the statutorily available procedures for resolving disputed claims.

MHA had several other claims—for negligent misrepresentation, violation of the Unfair Claim Settlement Practices section of the Insurance Trade Practices Act, and two Medicare-based claims—that it voluntarily dismissed. The court also dismissed MHA's two remaining claims for unjust enrichment and quantum meruit explaining that federal law preempts these common law claims.

The case is on appeal to the Third Circuit Court of Appeals.

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***State Dep't of Pub. Health v. Superior Court of Sacramento Cnty.***
**60 Cal. 4th 940 (2015)**

The Center for Investigative Reporting (the "Center") filed a Public Records Act request to the California Department of Public Health (DPH) for copies of all citations the DPH issued to state-owned long-term health care facilities that treated mentally ill and developmentally disabled individuals. The DPH released the requested records but only after applying heavy redactions to them, citing its obligation under the Lanterman-Petris-Short Act not to release confidential information "obtained in the course of providing services" to mentally ill and developmentally disabled individuals. The Center filed a petition for writ of mandate for the release of the redacted information in a California Superior Court and the case eventually reached the California Supreme Court.

The Center argued that Lanterman Act's requirements do not apply to the citation records because the citations were not "obtained in the course of providing services." The California Supreme Court rejected this argument, noting that when DPH investigates a facility governed by the Lanterman Act, it inevitably relies upon records from that facility in carrying out its investigation. That this information was then passed on to a DPH investigator and incorporated into a DPH citation does not change the fact that it is deemed confidential by statute.

The Center also argued that the Long-Term Care Act implicitly repealed the Lanterman Act with respect to the citation records since the statutes are in conflict and the Long-Term Care Act is more specific and was enacted more recently. The Court found that it was not reasonably possible to reconcile the differences between the two statutes. The Court observed that on the one hand, the Long-Term Care Act requires that information contained in DPH-issued citations—not including patient names that would be redacted—constitute public records. On the other, the Lanterman Act's express terms would render most of the information included in a DPH citation confidential and therefore not subject to disclosure—including all information and records obtained in the course of providing services to patients and residents under the enumerated statutory divisions.

In deciding that the two statutes are in conflict, the California Supreme Court also rejected the appellate court's attempts to harmonize the statutes. The appellate court found that the two Acts share a "common purpose," i.e. "to promote and protect the health and safety of mental health patients." The appellate court then harmonized the statute by considering whether disclosure of the various types of information listed as public records in the Long-Term Care Act would serve this purpose. The California Supreme Court rejected this approach because it resulted in a disclosure scheme that was inconsistent with both statutes—requiring DPH to release some information that the Lanterman Act would require DPH to redact and requiring DPH to redact some information that the Long-Term Act would require DPH to release. The Supreme Court also questioned the logic of

the appellate court's solution in light of the purposes of both statutes: it required the redaction of information that would help understand why DPH issued the citations and would simultaneously fail to protect the patient from knowing he or she is the subject of the citation.

The Court ultimately concluded that with respect to the citations, where there was a conflict about what to release and redact, the terms of the Long-Term Act should apply. The Court noted that if conflicting statutes cannot be reconciled, later enactments supersede earlier ones, and more specific provisions supersede more general ones—with specificity being more important. The Court determined that the Long-Term Act was the more specific statute. The Long-Term Act focuses specifically on the disclosure and redaction of DPH citations while the Lanterman Act addresses the confidentiality of records obtained in the course of treating mentally ill and developmentally disabled individuals generally. The Long-Term Care Act was also enacted more recently; it was enacted a year after the relevant provision in the Lanterman Act was amended and reenacted.

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***Commonwealth v. Partners Healthcare System, Inc. et. al.***
**Mass. Sup. Crt. # 2014-02033-BLS2 (Jan. 29, 2015)**
**Mass. Sup. Crt. # 2014-02033-BLS2 (Feb. 17, 2015)**

Over the years, the non-profit Partners Healthcare System, Inc. has assembled a broad system of hospitals and affiliated physician groups which includes two tertiary flagship hospitals—Massachusetts General Hospital and Brigham and Women's Hospital—and also reportedly has employed a range of "all or nothing" type contracting practices with health plans. Less than a year ago, on June 24, 2014, the Attorney General of Massachusetts simultaneously filed a complaint and a proposed consent judgment with Partners regarding Partners' acquisition of South Shore and two hospitals operated by Hallmark Health Corp.

The consent judgment would have permitted the acquisitions of both South Shore and Hallmark, but imposed a range of time-limited conduct remedies affecting Partners' contracting with health plans and expansion of its controlled panel of physicians. Specifically, the consent judgment included four components: (a) a general price cap, and a cap based on total medical expenses that would expire in six and a half years; (b) permitting insurers to negotiate to purchase only certain components of the Partner' facility network instead of the entire Partners network for ten years; (c) prohibiting doctors who were not associated through a Partners' affiliated physician hospital organization from jointly contracting with Partners; and (d) imposing certain restrictions on physician and network growth.

After heavy criticism of the proposed consent judgment in public comments, including comments by the Commonwealth's own Health Policy Commission and comments drafted by Crowell & Moring for the Massachusetts Association of Health Plans, the newly elected Attorney General withdrew support for a modified version of the consent judgment that had been filed. In February, the consent judgment was then disapproved by the Commonwealth's Superior Court judge. Judge Sanders concluded that the proposed judgment did not reasonably and adequately address the harm of loss of competition, in part because it employed conduct remedies not structural ones. Moreover, the court also determined that the terms of the settlement required undue ongoing oversight by the court, and thus posed difficulty enforceability challenges.

Following this decision, on February 17, 2015, Partners dropped its bid to acquire South Weymouth based South Shore Hospital and the Attorney General voluntarily dismissed its complaint. With respect to its other acquisition, Partners and Hallmark have publicly stated that they will "take a pause" to "reflect on [] next steps." The Attorney General of the Commonwealth and the Department of Justice will continue to evaluate whether to allow Partners to acquire Hallmark's two community hospitals.

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