Crowell

# CLIENT ALERT

## Managed Care Lawsuit Watch - March 2015

**March 5, 2015**

*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 law group.*

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- *U.S., ex rel. Silver v. Omnicare, Inc., et. al.*
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- *UPMC Braddock v. Perez*

***Hale v. Sharp Healthcare***
**232 Cal. App. 4th 50 (2014), reh'g denied (Dec. 10, 2014)**

Dagmar Hale filed a class action, alleging that Sharp Healthcare and Sharp Grossmont Hospital (together Sharp) violated the Unfair Competition Law and the Consumers Legal Remedies Act by billing uninsured patients "significantly more for the same services" than they charged insured patients. The trial court granted Hale's motion for class certification and certified a class of:

"All individuals who from August 11, 2003 to [December 16, 2011] (a) received emergent-care medical treatment at a Sharp Hospital … and (b) were not covered by insurance or government healthcare programs at the time of treatment (the class)…."

Sharp subsequently filed a motion to decertify the class. Sharp argued that the class was not ascertainable because Sharp did not keep records in a way to reasonably and readily identify those included in the class definition. Sharp also argued the class action device was not a superior method to litigate the matter because there was no manageable way to prove entitlement to

damages on a class wide basis without individual inquiries. The trial court granted the motion and also denied Hale's ex parte application for an order allowing her to move to amend the class definition. The Court of Appeal affirmed.

The panel found that the proposed class – comprised of those who received emergent-care after August 11, 2003 and who were not covered by insurance or government healthcare programs at the time of treatment – was not readily identifiable from Sharp's available medical data. Sharp did not make determinations about who was insured until after the patient already received treatment. As a result, the system's entries about insurance coverage did not necessarily correspond with their treatment date. Further, patients were often unaware that they had insurance or in fact were covered by a government program. Moreover, whether a patient had insurance could in fact change throughout the treatment.

The Court of Appeal also upheld the trial court's finding that common questions of law and fact did not predominate. The court found that the plaintiffs' posited theory of liability was not amenable to resolution on a class wide basis because there was no common proof to establish entitlement to damages for all class members. Some patients had their bills paid or reimbursed by third parties and others obtained negotiated rates. The Court of Appeal reasoned that this meant that each individual would have to litigate numerous and substantial issues to determine the right to recover at all.

Hale argued that liability could nevertheless be determined on a class wide basis. Hale recommended calculating the reasonable value of Sharp's services on a class wide basis and then measuring damages by subtracting the reasonable value determined for the services by the amount charged to each class member. But the Court of Appeal noted that there was no easy way to calculate whether rates were "reasonable" or what amount, if any, uninsured patients paid beyond such a rate. Reasonableness is also influenced by individualized factors such as the services given, whether procedures were performed on an inpatient or outpatient basis, the physician's orders, medical necessity and specialty services or procedures.

Last, the Court of Appeal upheld the trial court's decision to deny Hale's application to amend the class definition. The amended definition would have excluded from the class individual hospital visits for which Sharp's electronic data records show no patient payments and no current account balance, and/or one or more payments for the visit from someone other than the patient. The court noted that the proposed redefined class still would not explain how to collect the data without conducting individualized inquiries into each patient's billing records. Sharp did not maintain patient billing records in such a way that it was able to conduct aggregated searches of the data and was not required to maintain data in such a way.

***Nutrishare, Inc. v. Connecticut Gen. Life Ins. Co.***
**No. 2:13-CV-02378-JAM-AC, 2014 WL 1028351 (E.D. Cal. Mar. 14, 2014) motion to certify appeal granted, No. 2:13-CV-02378-JAM-AC, 2014 WL 2624981 (E.D. Cal. June 12, 2014)**

The U.S. District Court for the Eastern District of California denied a motion to dismiss a counterclaim by an ERISA plan administrator against an out-of-network provider alleging that the provider failed to disclose its network status to the plan's members and engaged in fraudulent billing practices.

Nutrishare, a medical provider specializing in home infusion and total parenteral nutrition, sued CIGNA based on CIGNA's role as claims administrator and insurer of employee health benefit plans governed by ERISA. Plan participants may choose to receive medical treatment from in-network or out-of-network providers, and they must pay proportionately more for services given by

out-of-network providers. Participants are informed of the covered plan benefits in Summary Plan Descriptions (SPDs) that show the variance in charges between in- and out-of-network services. Under the SPDs, CIGNA may recover any overpayments and can enforce the plan terms by invoking equitable remedies. Nutrishare is an out-of-network provider in the employee plans at issue.

In its suit against CIGNA, Nutrishare alleged that CIGNA violated § 502(a)(3) of ERISA and the California unfair competition law (UCL) and committed fraud. CIGNA then filed a counterclaim alleging that Nutrishare (1) failed to disclose it was out-of-network to CIGNA members; (2) promised some members that they would not be billed for Nutrishare services; and (3) billed CIGNA exorbitant amounts while misrepresenting the amounts it usually accepts for these services.

Nutrishare moved to dismiss the counterclaim, arguing: (1) lack of standing; (2) failure to exhaust administrative remedies; (3) failure to comply with Cal. Ins. Code § 10123.145; (4) failure to plead a viable fraud claim; and (5) preemption. The court rejected Nutrishare's motion to dismiss. CIGNA had standing under ERISA and the UCL as a plan administrator with discretionary authority and control over claims. Exhaustion of administrative remedies was not required because CIGNA made equitable claims. Section 10123.134 of the Insurance Code, related to provider responsibilities when given notice of overpayment, was inapplicable. CIGNA pled its fraud claim with the requisite particularity under the Federal Rules of Civil Procedure.

Finally, CIGNA's claims were not preempted under either of ERISA's preemption provisions. First, conflict preemption under ERISA 514(a) did not apply because CIGNA's state law fraud and UCL claims do not create an alternative enforcement mechanism for securing benefits under the ERISA plan terms. Complete preemption under ERISA 502(a) did not apply. As held in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 210 (2004), ERISA completely preempts a state law claim if (1) an individual could have brought the claim under ERISA § 502(a); and (2) there is no other independent legal duty that is implicated by a defendant's action. Here, Nutrishare's alleged false representations implicated an independent legal duty, meaning that the second part of the *Davila* test was not satisfied.

***Greenville Hosp. Sys. v. Employee Welfare Benefits Plan for Employees of Hazlehurst Mgmt. Co., Underwritten by Aetna Life Ins. Co.***
**No. CA 6:14-1919-TMC, 2014 WL 4976588 (D.S.C. Oct. 3, 2014)**

In *Greenville Hospital Services v. Aetna*, the U.S. District Court for the District of South Carolina dismissed a hospital's claim against a payor without prejudice, forcing the hospital to adhere to the arbitration provision in the parties' hospital services agreement.

Greenville Hospital Services (GHS) and Aetna had entered into a hospital services agreement ("agreement"), according to which, GHS became a preferred Aetna provider and gained the ability to directly bill Aetna for any services provided to Aetna members. In exchange, Aetna required GHS to abide by certain terms, including seeking precertification for its services and using mandatory arbitration for disputes. Under the agreement, the arbitration was to be controlled by the FAA and would be used to resolve "any controversy or claim arising out of or relating to the agreement."

A controversy arose when GHS failed to obtain precertification before providing services to an Aetna member and Aetna denied the claim. GHS ignored the agreement's mandatory arbitration provision and instead filed an action in federal court based on the

patient's assignment to GHS. GHS argued that the arbitration provision in its provider agreement did not prevent it from pursuing a separate, non-arbitrable ERISA claim based on the patient's assignment. The court disagreed.

First, the court noted that the FAA embodies a federal policy that favors resolution of disputes through arbitration. Under the FAA, a party can compel arbitration as long as "the litigant can demonstrate: (1) the existence of a dispute between the parties, (2) a written agreement that includes an arbitration provision which purports to cover the dispute, (3) the relationship of a transaction, which is evidenced by the agreement, to interstate or foreign commerce, and (4) the failure, neglect, or refusal of the party to arbitrate the dispute." The court also noted that, under the FAA, valid arbitration provisions in a written contract are irrevocable.

Next, the court examined whether the claims brought by GHS fell within the scope of the agreement's arbitration provision. Because the language of the provision was broad and sweeping, the court determined that a dispute would trigger arbitration as long as a "significant relationship existed between the asserted claims and the contract …." This standard was easily satisfied. The two claims brought by GHS, concerning failure to pay benefits and failure to provide plan documentation, were based on the terms of the agreement.

Nor could GHS avoid arbitration by ignoring its own contract claim and proceeding instead on the patient's potential ERISA claim. While the ERISA claims may have been valid, they were not central to GHS's claims. Rather, the key issue, failure to obtain precertification, was one that was controlled entirely by the agreement. The conjunction of the provision's broad language, the policy embodied in the FAA, and the nature of claims left GHS with no option but to seek relief through arbitration. The court granted Aetna's motion to dismiss. Finally, because all of GHS's claims were subject to mandatory arbitration, the court dismissed GHS's claim rather than granting a mandatory stay pending the outcome of the arbitration proceedings.

***U.S., ex rel. Graves v. Plaza Med. Centers Corp.***
**No. 10-23382-CIV, 2014 WL 5040284 (S.D. Fla. Oct. 8, 2014)**

On October 7, 2014, the U.S. District Court for the Southern District of Florida granted defendants' motion to dismiss relator's claims. Relator Olivia Graves brought a *qui tam* action under the False Claims Act, alleging defendants submitted false claims to Medicare that resulted in defendants receiving overpayments from the Centers for Medicare and Medicaid Services (CMS) under the Medicare Advantage program. Relator alleged that defendant Michael Cavanaugh (Cavanaugh), a doctor employed by Plaza Medical Centers Corporation (PMC), improperly diagnosed 28 patients, resulting in the submission of false Medicare claims. In turn, Medicare increased its monthly capitation payments to defendant Humana, Inc. (Humana), as plan administrator for each patient. A percentage of the increased payments would then flow to all defendants, which included PMC, Dr. Cavanaugh, and the defendant Spencer Angel, president of a medical corporation that "worked closely" with Dr. Cavanugh. Relator's First Amended Complaint alleged four counts against all defendants under the False Claim Acts: (1) the submission of false claims; (2) the making or using false records material to a false or fraudulent claim; (3) conspiracy; and (4) the making of false records to get claims paid.

Each defendant moved to dismiss Relator's First Amended Complaint, arguing that Relator failed to present evidence of the "presentment" of false claims by defendants, and that no facts supported a conspiracy amongst the defendants. Defendants also argued that the Relator's claims must be limited to the patients identified in the complaint.

The District Court determined that the claims asserted are limited to only those patients and alleged misdiagnoses identified in the complaint. The court dismissed all claims against Mr. Angel and PMC because the complaint was devoid of allegations to put Mr. Angel on notice of any wrongdoing. Simply alleging that Mr. Angel was the president of the medical plaza, or that he worked closely with Dr. Cavanaugh and may have profited from the scheme, was not sufficient. Similarly, the court found that generalized allegations against the medical office in which Dr. Cavanaugh worked did not meet the heightened pleading standard under Rule 9(b).

The court also dismissed the conspiracy claim without prejudice because the complaint was devoid of any specific factual allegations that the defendants had entered into an agreement or committed an overt act.

Finally, with respect to the claim that Humana and Dr. Cavanaugh made a false record to get paid (count four), the court dismissed the claim without prejudice. But the court noted that the Fraud Enforcement and Recovery Act of 2009 (FERA) impacted the applicable standard , making liable a defendant who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(A)(1)(B). Courts have found this revised standard to apply to payment of claims after June 7, 2008, under which general allegation of improper government payment could satisfy the Rule 9(b).

The court thus noted that the Relator should correct the pre- and post-June 7, 2008 claims distinction in the fourth cause of action as to defendants Humana and Dr. Cavanaugh, and that the corrected factual allegations would likely be sufficient under Rule 8 and Rule 9(b) to state a claim for relief.

***U.S., ex rel. Fox Rx, Inc. v. Dr. Reddy's Inc.***
**No. 13CV3779 DLC, 2014 WL 6750786 (S.D.N.Y. Dec. 1, 2014)**

Fox Rx, Inc. brought a qui tam action against Dr. Reddy's, Inc., Omnicare, Inc., and its subsidiary, NeighborCare, Inc. alleging various violations of Medicare and Medicaid billing rules. Fox alleged that (1) Dr. Reddy's paid per-unit rebates to Omnicare were in violation of the Anti-Kickback Statute (AKS), which Omnicare did not report to CMS; and (2) Omnicare either double-billed both Fox and SNFs for dispensing fees for prescriptions that were reimbursed under both Part A and Part D or inappropriately charged Fox for dispensing fees and waived the fee for SNFs.

With regard to the rebates claim, the court noted that one of the safe harbors to the AKS allows discounts where certain conditions are met, including where: (1) the discount is made at the time of sale, (2) the amount of the discount is fixed and disclosed in writing at the time of the initial sale, (3) the buyer provides information regarding the discount to the Secretary of Health and Human Services (or a requesting state agency) upon request, and (4) the discount is fully disclosed on the invoice to the buyer. The court analyzed the transactions that Fox alleged to be fraudulent and determined that Fox "did not plausibly allege" a violation of the AKS because Fox did not allege that either Omnicare or Dr. Reddy's had failed to meet any provision of the applicable safe harbor. The court likewise rejected Fox's allegation of a reverse false claim based on failure to remit the rebates to CMS, holding that because the rebates were not illegal, Omnicare was not required to remit them.

The second claim was that Omnicare inappropriately charged dispensing fees to both the SNFs and the Part D plan where a prescription dispensed bridged the transition from coverage under a Part A SNF stay to coverage under Part D. Fox argued that

where a dispensing fee would be covered under a Part A SNF stay pursuant to 42 U.S.C. § 1395w-102(e)(2)(B) (establishing that Part D does not cover drugs covered under Part A or B), charging a dispensing fee to the Part D plan violates the law. But the court found no law that would prevent the pharmacy from splitting the dispensing fee between the SNF and the Part D plan or from allocating the full dispensing fee to the Part D plan. While Fox argued that, rather than splitting the fee, Omnicare either charged the full fee to both the SNF and the Part D plan or waived the dispensing fee to SNFs, it did not allege any facts in support of its contention.

***Collins v. Wellcare Healthcare Plans, Inc.,***
**No. CIV.A. 13-6759, 2014 WL 7239426 (E.D. La. Dec. 16, 2014)**

The U.S. District Court for the Eastern District of Louisiana ruled on defendant Wellcare Healthcare Plans, Inc.'s (Wellcare) motion for summary judgment. Plaintiff Collins was injured in an automobile accident and required medical treatment. Wellcare, a Medicare Advantage Organization (MAO), paid Collins' medical bills. Plaintiff Collins then recovered in a settlement with a tortfeasor for the injuries she sustained in the automobile accident and sought a declaratory judgment that Wellcare was not entitled to reimbursement from the tort recovery settlement fund. Wellcare responded by arguing that Collins failed to exhaust her administrative remedies, and filed a counterclaim against Collins to seek reimbursement. Wellcare ultimately moved for summary judgment on the counterclaim.

Collins argued that Wellcare's exhaustion argument was inapplicable because Collins filed her action in state court applying state law and was not seeking Medicare benefits or services such that the Medicare exhaustion requirement applied. Responding to Wellcare's counterclaim, Collins argued that Wellcare did not have a private right of action against Collins because Collins is not a "group plan" as she alleged is required by the Medicare Secondary Payer Statute (MSP). She also claimed that the MSP did not confer a private right of action on MAOs.

The court ruled that Collins was obligated to exhaust her administrative remedies. Plaintiffs are obligated to exhaust their administrative remedies for claims that "arise under" Medicare and should not be allowed to circumvent the administrative process by filing separate attacks on Medicare organizations and focusing on state law. While Collins fashioned her claims as a declaratory judgment and invoked Louisiana State Law, she is ultimately sought to retain benefits premised on the argument that the Medicare Act did not provide Wellcare with a subrogation right. Thus, this claim arose under the Medicare Act and Collins was obligated to exhaust her administrative remedies.

The court next addressed Wellcare's counterclaim for reimbursement. The court found that Wellcare did have a private cause of action under the MSP and was entitled to reimbursement. First, the court explained that the MSP permits a cause of action "in the case of a primary plan," and Collins' tort settlement constitutes a "primary plan." The fact that the money changed hands from the tortfeasor or his insurer to the beneficiary did not alter the nature of the settlement funds. Second, the court held that a MSP private cause of action is not limited to group health plans. The definition of a primary plan in the MSP specifies plans other than group health plans, so a logical reading of the statute compels the conclusion that a private right of action is not limited to health plans that satisfy the definition of group health plans.

The court thus dismissed Collins' claim for declaratory judgment, holding that Wellcare was entitled to reimbursement and had a private cause of action under the MSP. The court held that it lacked sufficient information to determine the amount of reimbursement to which Wellcare is entitled, but otherwise granted Wellcare's motion for summary judgment.

***American Hospital. Ass'n v. Burwell***
**No. CV 14-851(JEB), 2014 WL 7205335 (D.D.C. Dec. 18, 2014)**

In *American Hospital Assocation, et al. v. Sylvia M. Burwell*,the U.S. District Court for the District of Columbia dismissed a motion for mandamus relief brought by a contingency of hospitals and the American Hospital Association (collectively, "Plaintiffs"). The Plaintiffs filed the motion in the hopes of compelling the court to thin a significant clog that had developed in the third phase of the Medicare claims appeal process, requiring a hearing before an administrative law judge.

All denied Medicare claims are entitled to a four-stage appeal. The process operates under the auspices of the Centers for Medicare & Medicaid Services within the Department of Health and Human Services. First, the provider must request that the Medicare Administrative Contractor, the party that initially denied the claim, reconsider its decision. This is followed by a review conducted by a Qualified Independent Contract. The Qualified Independent Contractor analyzes both the findings and evidence upon which the Medicare Administrative Contractor based its review as well as any relevant evidence submitted by the parties. After these two phases, the provider may then seek a hearing before an administrative law judge. This presents the first opportunity during which the provider may present an oral argument and respond to questions raised by the deciding body in real time. Finally, the provider may present its appeal to the Medicare Appeals Council, which will issue the final appeal decision, subject only to judicial review.

To ensure timely payment of monies owed, each phase of the appeals process is controlled by a statutory timeline. Review by an administrative law judge is required to take place within 90 days of the end of the previous appellate phase. However, this time frame has recently become illusory, and administrative law judges often take more than 16 months to issue a ruling. Even though providers may seek "escalation" and skip any phase in the appeals process that exceeds its statutorily imposed timeframe, providers are often unwilling to do so because it may result in them forfeiting important opportunities to develop their records.

Plaintiffs argued that the inability to have their claims reviewed within the statutorily mandated timeframe warranted mandamus relief, and attempted to bolster their argument by stating that the delays constituted a public health crises by hindering payment for necessary repairs and equipment purchases. The court disagreed.

In reaching its decision, the court considered four factors. These included:

"[1] the Secretary's failure to comply with statutory deadlines . . . [2] the consequences of non-intervention to Plaintiffs and the public . . . [3] the effect intervention might have on competing agency priorities . . . [4] the Secretary's good faith in addressing the problem."

First, the court noted that while HHS had violated the statutory timeframe imposed by Congress, failure to adhere to the required timeline did not trigger an automatic right to mandamus relief. Rather, the court was required to review the context in which the delays were taking place to see if the violations were at all alleviated by budgetary and policy concerns.

Second, the court noted that plaintiffs failed to present a convincing argument that delays in the appeals process resulted in harm to human welfare. While recognizing that the plaintiffs would have to scale back to some degree, the court noted that there was no indication that any specific services were less available to the public as a result of the delays.

Third, the court noted that intervention was not appropriate because there was no indication that HHS was misusing agency resources. The Secretary had finite resources with which to address the flood of appeals, and a number of other concerns were competing over that very same pool of resources. The court also noted that the likely culprit behind the flood of delays, the Recovery Audit Contractors program, was created by Congress, and therefore, Congress and the Secretary were best suited to concoct a solution.

Last, the court noted that there was no indication of bad-faith on the part of the Secretary. The Secretary had taken steps to ease the burden on administrative law judges by introducing electronic filing, hiring additional administrative law judges, and increasing the support services offered to administrative law judges.

Upon weighing the factors, the court ultimately decided that the bottleneck formed at the administrative law judge phase of the Medicare claims appeal process was not so egregious as to warrant judicial meddling.

***U.S., ex rel. Silver v. Omnicare, Inc., et al.***
**CIV No. A. 11-1326, 2014 WL 4827410 (D.N.J. Sept. 29, 2014)**

In a *qui tam* relator action filed under federal and state versions of the False Claims Act (FCA), relator Marc Silver alleged several defendants, including defendant PharMerica Corp. (PharMerica), participated in an illegal kickback scheme involving a practice known as "swapping." According to Silver, defendant offered commercially unreasonable, below market prices for prescription drugs to nursing homes for the nursing homes' Medicare Part A patients, in exchange for the opportunity to provide the same drugs at significantly higher, above market costs to the nursing home's Medicaid and Medicare Part D patients. Silver further alleged that PharMerica provided various kickbacks to nursing homes (such as steeply discounted or free drugs) in exchange for the revenue provided by government payors.

Defendant PharMerica moved to dismiss for the reasons detailed below.

- **Pleading with Particularity.** PharMerica argued that Silver failed to plead his FCA claims with particularity, as required under Federal Rule of Civil Procedure 9(b). PharMerica specifically argued that the complaint failed to allege as to PharMerica specific details about the submitted government claims, including the dates of the claims, the contents of the forms or bills submitted, ID numbers, and the amount of money charged to the government, among other things. Citing recent Third Circuit authority, the court found that Silver did not need to allege that much specificity at the pleading stage. Instead, the court found that Silver only needed to "provide particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted," which he did here, according to the court.

- **Anti-Kickback Statute.** PharMerica argued that the complaint failed to allege facts to support the allegation that the prices offered to nursing homes violated the Anti-Kickback Statute. The court similarly dismissed this argument. Among

other things, the court noted that Silver alleged that (1) PharMerica provided value in the form of discounts for Part A services that were not justified by normal business considerations; (2) nursing homes were improperly choosing institutional pharmacies based on the inducement they could get; and that (3) PharMerica's government reimbursements rose consistently from 2006 to 2012. While Silver did not provide the exact prices charged to a particular nursing home, or the amount of business PharMerica received in return, "exact figures are not required…"

- **Conspiracy.** PharMerica argued that Count III of the complaint, which alleges a conspiracy to violate the FCA, failed to allege any agreement between PharMerica and its nursing home customers to submit false claims to the government, or an overt act in furtherance of such agreement. The court disagreed, finding that Silver alleged that PharMerica "executed a scheme to defraud the government and paid kickbacks to [Skilled Nursing Facilities]" and "[a]ccordingly, [Silver] has alleged sufficient facts to support a claim of conspiracy."

- **Statute of Limitations.**
    - The court granted PharMerica's motion to dismiss with respect to portions of Silver's Federal FCA claim. The court found that the time limitation for filing an FCA action in Section 3731(b) is six years, or if the U.S. government intervenes, the limitations period is extended by another three years. The Government declined to intervene here, meaning that actions filed outside the six-year limitation were invalid. Plaintiff countered that the Wartime Suspension of Limitations Act extended the statute of limitations to October 11, 2002, the date on which hostilities with Iraq were initiated. But the court observed that the WSLA does not apply to FCA claims, "especially when those cases do not involve military or war-related contracts.:
    - The court rejected PharMerica's motion that the state claims should be dismissed to the extent they rely upon conduct that predates the effective date of the state fraud statutes (enacted after 1999) or the applicable statute of limitations. The court observed that the *Ex Post Facto* clause only prevents retroactive punishment and that PharMerica failed to show that the FCA's statutory scheme was so punitive as to negate the State's intention to deem it civil.

- **Kindred or Chem Rx.** PharMerica argued that the conduct alleged in the complaint pertaining to PharMerica was not conduct attributable to Pharmerica, but actually the conduct of Kindred or Chem Rx and that these, which are separate corporate entities from PharMerica. Silver argued that PharMerica and Kindred merged to form defendant PharMerica. The Court declined to decide this issue on a motion to dismiss, reasoning that it involved a determination of certain facts more appropriate on a motion for summary judgment.

- **State Law Procedure.** The court rejected PharMerica's argument that Silver's claims should be dismissed because Silver did not allege that he properly served government officials, noting that PharMerica did not show that Silver was required to provide such allegations in the complaint

***In the Matter of H.I.G. Bayside Debt & LBO Fund II, L.P. and Crestview Partners, L.P.***
**File No. 141-0183 (Federal Trade Commission)**

The FTC filed a complaint against HIG, alleging that its proposed acquisition of Symbion, Inc., an ASC chain, would violate both the FTC Act and the Clayton Act with regard to two ASCs in Orange City, FL, located in southwestern Volusia County. The two

ASCs in question, Orange City Surgery Center (operated by Surgery Partners, owned by HIG) and Blue Springs Surgery Center (operated by Symbion), were located less than a mile from one another and constituted each other's primary competition in the geographic region. The two facilities were the only two multi-specialty ASCs in the Orange City/Deltona area. FTC considered all lines of outpatient surgery services as a cluster rather than assessing each type of outpatient service individually.

FTC analyzed the acquisition in terms of its impact on each ASC's sale of services to commercial insurance payors and commercially insured patients. If the merger was to proceed, both commercial health plans and commercially insured patients would have only one alternative for ASC services in the geographic region. The decreased competition in southwestern Volusia County would result in increased prices offered to commercial health plans for the outpatient surgical services offered by the ASCs and thus decreased quality and availability of the services.

FTC also alleged that the merger would increase the market concentration, resulting in a post-merger Herfindahl-Hirschman Index (HHI) of greater than 2,500 and a delta of greater than 1,000. It also determined that new entries into the market would be unlikely to offset the anticompetitive effects of the merger.

The Consent Order requires that Surgery Partners hold Blue Springs separate from the rest of its assets after completing the merger, with divestiture to take place within 60 days of entry of the final order. The purchaser would be subject to approval by the Commission, and Surgery Partners would be responsible, for a period of six months following the sale, for assisting the purchaser in establishing and maintaining a viable business.

***UPMC Braddock v. Perez***
**584 F. App'x 1 (D.C. Cir. 2014)**

UPMC Braddock, UPMC McKeesport, and UPMC Southside contracted with an HMO, UPMC health plan, which had contracted with OPM to furnish medical services benefits to federal employees who participate in the FEHBP. Because the hospitals provided medical services through FEHBP, the OFCCP concluded that the hospitals qualified as government "subcontractors" and were thus required to comply with EEO requirements under EO 11246, the Rehabilitation Act, and the VEVRAA. After the hospitals refused to comply with the affirmative action and non-discrimination requirements, the OFCCP filed an enforcement action against them. A DOL ALJ sided with the OFFCP and the agency's ARB upheld the ALJ's decision and ordered the hospitals to comply with OFCCP requirements. The hospitals filed suit in the District Court for the District of Columbia asking the court to set aside the ARB's decision and enjoin the DOL from enforcing it. In an extensive opinion, the district court rejected the hospitals' arguments and upheld the ARB's decision.

At the district court, the hospitals argued that they were not government "subcontractors" and that therefore they were not subject to the OFCCP's jurisdiction or the EEO requirements The hospitals emphasized that their contracts with the HMO omitted the relevant EEO clauses. However, the court held that a contract provision that violates federal law by omitting clauses required to be included, including the one found in the hospitals' respective contracts with the HMO, is unenforceable. The court also rejected the hospitals' argument that they did not provide "nonpersonal" services to the UPMC Health Plan and were not actually performing subcontracted services given the nature of the plan's contract with OPM, and thus could not be subcontractors subject to the OFCCP's jurisdiction. After analyzing the Federal Acquisition Regulations, the district court concluded that the term "nonpersonal services" does not refer to the relationship between the employees of a subcontractor

and those individuals benefiting from subcontractors, but instead to the relationship between a subcontractor's personnel and the agency. Finally, the court held that the hospitals' contracts with the UPMC Health Plan were subcontracts because the medical services that the hospitals provided were essential to the fulfillment of the contract between the UPMC Health Plan and the OPM.

The hospitals appealed to the United States Court of Appeals for the District of Columbia Circuit. In a two-page unpublished opinion, the appeals court dismissed the hospitals' appeal as moot and ordered that the district court's judgment be vacated and the case be remanded to the district court with directions that it vacate the ARB's decision. Since the district court's ruling, UMPC Braddock and UPMC Southside stopped operating as independent hospitals. According to the appeals court, the final hospital, UPMC McKeesport, is a TRICARE subcontractor and therefore eligible for the DOL's recently announced, five-year moratorium on the enforcement of the EEO requirements for subcontractors carrying out that program, enacted after Congress passed legislation relating to the applicability of OFCCP requirements to TRICARE providers. In light of the moratorium, while the appeal was pending, the DOL administratively closed EEO compliance reviews with respect to UPMC McKeesport. As such, none of the three appellants were injured and the court dismissed the appeal as moot.

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