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Client Alert

Managed Care Lawsuit Watch - September 2017

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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.

Cases in this issue:

- *Kindred Nursing Centers L.P. v. Clark,*
- *McCulloch Orthopaedic Surgical Servs. PLLC v. Aetna Inc., et al.*
- *Pacific Bay Recovery, Inc. v. Cal. Physicians' Servs., Inc.*
- *Sanjiv Goel M.D., Inc. v. Regal Med. Grp., Inc.*
- *Graves v. Plaza Medical Centers, Corp.,*
- *Prime Aid Pharma. Corp. v. Express Scripts, Inc.,*

Kindred Nursing Centers L.P. v. Clark,
581 U.S. __, 137 S.Ct. 1421 (2017)

The United States Supreme Court held that Kentucky's "clear statement" rule requiring a nursing home resident's power of attorney document to expressly include arbitration agreements in their grant of authority violated the Federal Arbitration Act ("FAA") by singling out arbitration agreements for disfavored treatment.

The plaintiffs, the estates of two deceased nursing home patients, brought suit against Kindred Nursing Centers alleging that its substandard care caused their deaths. Kindred moved to dismiss the cases, arguing that arbitration agreements signed by the plaintiffs' agents required that disputes be determined by binding arbitration and not in court. The Kentucky Supreme Court disagreed and held that its state constitution rendered the arbitration agreements invalid because neither power of attorney document specifically granted the agents the power to enter into arbitration agreements on behalf of the patients.

First, the Supreme Court noted that the FAA makes arbitration agreements "valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract." This establishes the equal-treatment principle, which allows a court to invalidate an arbitration agreement based on generally applicable contract defenses, but not based on laws that apply exclusively to arbitration agreements or arise from the fact that arbitration is at issue in the agreement. The Supreme Court noted that because the FAA

preempts any state rule that discriminates against arbitration, the Kentucky Supreme Court's rule, which imposed a requirement specifically on arbitration agreements, could not stand.

Second, Kindred argued that the FAA did not apply to rules about contract formation, such as the Kentucky rule in this case. The Supreme Court disagreed, pointing to the FAA's text, which states that the FAA addresses not only about the "enforce[ment]" of arbitration agreements, but also about their initial "valid[ity]." The decision reinforces the principle that under the FAA an arbitration agreement is subject to generally applicable contract defenses, but not legal rules that only apply when an agreement to arbitrate is at issue.

For more information, please contact: Avi Rutschman and Harsh P. Parikh.

McCulloch Orthopaedic Surgical Servs. PLLC v. Aetna Inc., et al.
857 F.3d 141 (2d Cir. 2017)

The United States Court of Appeals for the Second Circuit held that ERISA did not completely preempt an out-of-network health care provider's state promissory estoppel claim against a health insurer where the provider (1) did not receive a valid assignment for payment under the health care plan and (2) received an independent promise from the insurer that he would be paid for certain medical services provided to the insured.

Plaintiff Dr. Kenneth E. McCulloch, an orthopedic surgeon and out-of-network health care provider, filed a promissory estoppel claim against Defendants Aetna Inc. and several of its affiliates (collectively, "Aetna") in New York state court. McCullock sought reimbursement for performing two knee surgeries on a patient who is a member of an Aetna-administered health care plan that is governed by ERISA. Aetna removed the case to federal court on the grounds that ERISA completely preempted the state-law claim. McCulloch then filed a motion to remand. The United States District Court for the Southern District of New York denied McCulloch's motion, and McCulloch moved for reconsideration. The district court denied McCulloch's motion for reconsideration and dismissed the action. McCulloch timely appealed.

On appeal, McCulloch argued that the District Court erred in denying his motion to remand. Specifically, McCulloch argued that his state-law claim is not completely preempted by ERISA because: (1) he did not receive a valid assignment for payment under the health care plan and (2) Aetna's oral statements gave rise to a duty that was distinct and independent from its obligations under the patient's health care plan.

A defendant may remove state law claims to federal court when a federal statute wholly displaces state-law causes of action. With respect to ERISA, the panel noted that, the U.S. Supreme Court in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004) established a two-prong test to determine whether a state-law claim for recovery of plan benefits is completely preempted by ERISA § 502. Under the first prong, the claim must be brought by an individual who could have brought his claim under ERISA § 502. Under the second prong, the claim must involve no independent legal duty that is implicated by a defendant's actions. The Second Circuit remanded the case to state court holding that neither prong was met, because: (1) McCulloch did not receive a valid assignment, and

thus is not the type of party that can bring a claim pursuant to §502, and (2) Aetna's oral statements gave rise to the duty of reimbursement that was distinct and independent from its obligations under the health care plan.

First, the Court held McCulloch could not have brought his state-law claim under ERISA because he did not receive a valid assignment. Although McCulloch obtained an assignment of the patient's right to payment under the plan, the assignment was not valid in light of an "anti-assignment" provision in the plan document prohibiting the patient from assigning rights to out-of-network providers. Therefore, Aetna failed to show that McCulloch, an out-of-network health care provider who did not have a valid assignment for payment, is the type of party who can bring claims pursuant to ERISA §502.

Second, the Court held Aetna's oral statements gave rise to a duty that was distinct and independent from its obligations under the patient's health care plan. McCulloch's state-law claim rested on whether Aetna promised to reimburse him for the usual and customary rate, whether he reasonably and foreseeably relied on that promise, and whether he suffered a resulting injury. The health care plan simply provided the context for McCulloch's state-law claim – his claim rests on whether Aetna made a promise to reimburse him. Therefore, the Second Circuit ruled that any legal duty Aetna has to reimburse McCulloch was distinct and independent from its obligations under the patient's health care plan.

This decision has important implications for payor-provider reimbursement disputes in cases where out-of-network medical providers seek to assert state-law claims against ERISA-governed plans. The decision stands for the proposition that medical providers can sue plans in their own capacity seeking payment for treatments rendered if the claim has a legal basis separate and apart from the ERISA plan. The decision also supports the view that oral promises made by insurers during the insurance verification process can, in some instances, form the basis for a medical provider's state-law claim that escapes ERISA's preemptive scope.

For more information, please contact: Harsh P. Parikh.

Pacific Bay Recovery, Inc. v. Cal. Physicians' Servs., Inc.
12 Cal.App.5th 200 (Ct. App. 2017), reh'g denied (June 8, 2017)

The California Court of Appeal for the Fourth District affirmed the dismissal of a complaint against a health plan, holding that it was not obligated to pay a substance abuse provider the "usual, reasonable, and customary" rates for its services since it was not an emergency services provider, did not render emergency services, and there was no contractual agreement to do so.

Plaintiff Pacific Bay Recovery, Inc. is a substance abuse and narcotic addiction provider. Defendant is California Physicians' Services, doing business as Blue Shield of California, is a health care service plan licensed under California's Knox-Keene Act. Pacific Bay billed Blue Shield for a 31-day facility stay, but Blue Shield reimbursed Pacific Bay for just six of the days at the usual, reasonable and customary rate. After exhausting Blue Shield's internal appeals process, Pacific Bay filed suit for its full billed charges. Under California law, emergency services

by non-contracted providers to plan members are required to be reimbursed at the "usual, reasonable and customary rate." 28 Cal. Code of Regulations § 1300.71(a)(3)(B). But, non-emergency services by non-contracted providers are typically reimbursed at the rate set forth in the health plan member's evidence of coverage (EOC). 28 Cal. Code of Regulations § 1300.71(a)(3)(C).

In its complaint, Pacific Bay asserted that it was a non-contracted emergency services provider that should be reimbursed at the market rate. Pacific Bay alleged that it had contacted Blue Shield to obtain prior authorization and was led to believe that it would be paid a "portion or percent" or total billed charges that "correlated with usual, reasonable and customary" amount. Blue Shield demurred to the complaint, arguing that per California law, it was not required to pay more that was required under the EOC, and that Pacific Bay had not pled any facts that would require payment of anything more. The trial court sustained the demurrer without leave to amend finding that Pacific Bay did not allege facts that it provided emergency services within the meaning of the Knox-Keene Act, and it did not have a contractual claim that Blue Shield either requested the services or agreed to pay the amount requested.

The Court of Appeal affirmed the judgment of dismissal. The Court found that Pacific Bay did not allege that it provided emergency services or that it held a contract with Blue Shield, and determined its right to reimbursement, if any, would be found under the applicable Blue Shield EOC. In so doing, the California Court addressed the novel idea that Pacific Bay should be classified as an emergency provider because many of its patients suffer from drug and alcohol addiction and often, like many emergency room patients, lack the ability to engage in "thorough examinations of the marketplace and frequently act out of desperation.'" However, the Court noted that Pacific Bay cited no authority to support its novel theory. The panel then turned to Pacific Bay's reliance on *Gould v. Workers' Comp. Appeals Bd.*, 4 Cal.App.4th 1059 (1992), the case that established the six factors used to determine the usual, reasonable and customary payment amount for non-contracted, emergency services. The Court found that because *Gould* did not involve a dispute regarding a medical provider's *entitlement* to be paid by a health plan, but instead involved the *amount* that a provider should be paid for services covered by workers' compensation.

The Court of Appeal then proceeded to address Pacific Bay's implied breach of contract and quantum meruit claims. The Court found that a phone conversation with Blue Shield was not specific enough to support an implied contract claim and that a partial payment did not give rise to an implied contract because it did not show mutual intent to pay for the remainder. The Court found the quantum meruit claim unfounded because Pacific Bay did not allege that Blue Shield either authorized a certain amount of treatment or agreed to pay a specific amount. The Court also noted that the quantum meruit claim would frustrate the purpose of the Knox-Keene claims settlement practices regulation.

For more information, please contact: Jesse Martin and Harsh P. Parikh.

Sanjiv Goel M.D., Inc. v. Regal Med. Grp., Inc.
11 Cal.App.5th 1054 (Ct. App. 2017), *review filed* (June 30, 2017)

The California Court of Appeal affirmed the trial court's judgement that the amounts paid by Regal Medical Group, Inc. to Sanjiv Goel, M.D., Inc. constituted the "usual, reasonable and customary" value for emergency services.

Plaintiff Dr. Goel is a cardiologist that provided emergency medical services to four Regal patients. Dr. Goel did not have a contract with Regal. Under California law, emergency services provided by non-contracted providers are reimbursed at the usual, reasonable and customary rate. 28 Cal. Code of Regulations § 1300.71(a)(3)(B). Goel billed Regal for $275,383.16 for the emergency services provided, but Regal paid Goel only $9,660.86, contending that was the "usual, reasonable and customary" value. The trial court ruled in Regal's favor after evaluating the amounts charged by other providers and Medicare rates, and Goel appealed, arguing that the trial court erred in considering such evidence.

The Court of Appeal affirmed the trial court's judgment and held that the court properly considered the amounts charged by other providers and Medicare rates to determine the reasonable amounts payable. The Court reasoned that under *Children's Hosp. Cent. California v. Blue Cross of California*, 226 Cal. App. 4th 1260 (2014), courts may consider a "wide variety of evidence," including other providers' rates and Medicare rates in determining the reasonable value for medical services consistent with the law on quantum meruit. In so doing, the Court acknowledged that the *Children's Hospital* decision was less clear as to whether it was appropriate to consider Medicare rates for emergency services. In *Children's Hospital* court concluded that all rates "that are the subject of contract or negotiation," including rates paid by government payors are relevant to determine the reasonable value of medical services. The Court noted that physicians are required by law to perform emergency services and a physician's performance of emergency services is not the product of any agreement or negotiation. The Court of Appeal ultimately concluded that the difference might affect the weight that a court gives to evidence of Medicare rates in a particular case, but "a bright line rule precluding consideration of Medicare rates [] would be inappropriate under quantum meruit principles...."

This case demonstrates that health plans may use a wide range of evidence to determine the "usual, reasonable and customary" value of their reimbursement rates. Health plans, however, should also be cautious, that simply relying on Medicare rates as evidence of market value for rendered emergency services may not be sufficient and, depending on the circumstances, may not be given much weight.

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Graves v. Plaza Medical Centers, Corp.
2017 WL 1102840 (S.D. Fla. Feb. 2, 2017) *report and recommendation adopted*, No. 10-23382-CIV, 2017 WL 1102907 (S.D. Fla. Mar. 20, 2017))

A Magistrate Judge for the United States District Court for the Southern District of Florida recommended that Humana, Inc.'s motion for summary judgment on the relator's claims based on the False Claims Act ("FCA") be denied. The Magistrate Judge found that evidence in the record raised genuine issues of material fact as to

whether inaccurate risk adjustment data Humana submitted to the Centers for Medicare and Medicaid Services ("CMS") from two providers, Plaza Medical Centers and Dr. Cavanaugh, rose to the level of reckless disregard under the FCA. The District Court adopted the findings and recommendations of the Magistrate Judge.

The relator alleged that Humana submitted false diagnosis codes from the providers and that Humana concealed and improperly avoided returning overpayments to the government in violation of the reverse false claims provision of the FCA. The relator contended that, while Humana had no actual knowledge of the falsity of the claims, it acted with reckless disregard or deliberate ignorance of the falsity of the diagnosis codes it submitted to CMS, thus satisfying the scienter requirement under the FCA. The Magistrate Judge noted that federal regulations require that Medicare Advantage Organizations (MAOs) like Humana to adopt and implement an effective compliance program. These compliance programs must include measures that prevent, detect, and correct fraud, waste, and abuse through internal monitoring and audits. The Magistrate Judge also noted that MAOs must also expressly certify, based on best knowledge, information, and belief, that the data they submit, including diagnosis codes, is accurate, complete, and truthful. In its motion for summary judgment, Humana argued that its alleged conduct did not constitute "reckless disregard" because it established a compliance program and a Special Investigations Unit to meet CMS's obligations. The relator countered by arguing that Humana did not make "good faith efforts to implement an effective compliance system because its system, including its audit procedures, was not designed, intended, or reasonably calculated to detect fraud." For example, the relator argued that Humana declined to design or implement any meaningful barriers to fraudulent upcoding, and that its Medicare Risk Adjustment reviewers never understood fraud detection to be a job responsibility. The relator also argued that Humana demonstrated reckless disregard by ignoring red flags that should have led it to investigate the accuracy of Plaza Medical Center's risk adjustment scores. For instance, the relator pointed out that Humana identified Plaza Medical Centers' risk adjustment scores as outliers; ignored evidence that as many as 35% of codes it audited at Plaza Medical Centers could not be validated; routinely violated its policy and failed to implement any procedures it did have; and policed fraud only when fraud was brought to its attention despite the fact that it continuously certified the accuracy of its data submissions to CMS. The Magistrate Judge determined that these allegations were sufficient to show reckless disregard or deliberate ignorance toward the truth of the submissions Humana provided to CMS.

The Court determined that there was a genuine issue of material fact as to whether Humana complied with the CMS regulations that require that an MAO make good faith efforts to certify the accuracy of its data submissions, and maintain an effective compliance program. The Court also ruled that Humana could have violated the FCA even if the regulations on certifying the accuracy of data and maintaining an effective compliance program were ambiguous because of evidence that Humana chose to ignore that certain diagnosis codes submitted were inaccurate.

The Magistrate Judge also recommended that the District Court deny Humana's motion for summary judgment on the relator's reverse FCA retention of overpayments claim. The reverse false claims provision imposes liability on anyone who "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government" failing to report and return any overpayment received from Medicare or Medicaid funds within 60 days of the date on which the overpayment was identified. The

reverse false claims provision requires "actual knowledge of the existence of the overpayment." Relying on the red flags discussed above, and Humana's receipt of the relator's unsealed complaint, the Magistrate Judge found a genuine issue of material fact as to Humana's scienter regarding retention of overpayments due to the erroneous code submissions.

All of the findings and recommendations by the Magistrate Judge were adopted by the District Court. This case highlights the risks that MAOs face in connection with their risk adjustment data submissions.

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Prime Aid Pharma. Corp. v. Express Scripts, Inc., .
No. 4:16-CV-1237 (E.D. Mo. May 12, 2017)

The United States District Court for the Eastern District of Missouri held that, in a specialty pharmacy's action against Express Scripts, Inc. ("ESI") for dropping the pharmacy from its network, ESI's counterclaims for breach of contract and unjust enrichment could survive a motion to dismiss, but its claim for fraudulent inducement could not.

Prime Aid Pharmacy Corp. ("Prime Aid")—a licensed pharmacy that provides retail and specialty medications—sued ESI—a pharmacy benefits manager—claiming breach of contract when ESI terminated Prime Aid from its network. Under the provider agreement, Prime Aid could submit a claim to ESI for reimbursement after it filled prescriptions, and ESI would immediately respond stating whether the claim was approved and the amount of copayment that Prime Aid should collect from the member. If the prescription was not picked up in ten days, Prime Aid had three days to reverse the claim.

In its counterclaims, ESI alleged that Prime Aid failed to timely reverse seven invalid pharmacy claims and that Prime Aid did not reverse the claims until ESI asked for confirmation that the prescriptions were delivered. Alleging that Prime Aid accepted payment for prescriptions it never actually dispensed to patients, ESI asserted counterclaims for fraudulent inducement, breach of contract, and unjust enrichment. Prime Aid moved to dismiss.

The District Court dismissed ESI's claim for fraudulent inducement but held that its claims for breach of contract and unjust enrichment could go forward. The Court dismissed ESI's counterclaim for fraudulent inducement because ESI failed to plead that Prime Aid acted with the requisite intent primarily because the provider agreement allowed Prime Aid to submit claims before the members picked up their prescriptions. ESI failed to allege any facts that Prime Aid knew its prescriptions would not be picked up when it filed the claims. Further, the economic loss doctrine barred ESI's fraudulent inducement counterclaim because did not suffer any economic harm as Prime Aid reversed the subject claims after ESI's inquiries.

The District Court also held that ESI stated a plausible claim for breach of contract and unjust enrichment based on the allegation that Prime Aid failed to reverse claims and improperly retained monies it was not entitled to keep. ESI alleged that Prime Aid failed to timely reverse over 1,800 claims, collect copayments, and failed to maintain required records demonstrating that it actually dispensed medications to patients. Prime Aid argued that ESI failed to allege that it suffered any damages. The Court held that while ESI failed to allege damages for Prime Aid's untimely reversal of claims, ESI stated a plausible claim for breach of contract based on its allegations that Prime Aid failed to reverse claims and retained monies it was not entitled to keep.

ESI is facing litigation initiated by a number of independent pharmacies, like Prime Aid, that claim that ESI is attempting to divert its business to its subsidiary specialty pharmacies. Other pharmacy benefits managers may face similar litigation when terminating participating pharmacies from their network.

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