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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SACRAMENTO

STATE OF CALIFORNIA, ex rel ROCKVILLE RECOVERY ASSOCIATES LTD.,

Plaintiffs,

v.

MULTIPLAN INC., et al.,

Defendants.

Case No. 34-2010-00079432

PLAINTIFFS' TRIAL BRIEF

Dept: 45
Judge: Hon. Judy Holzer Hersher

Trial Date: November 4, 2013
Complaint Filed: February 5, 2009

1130010.2

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I. INTRODUCTION

This is a straightforward case of false health care billing. This case concerns Defendants Sutter Health and its affiliates' billing for anesthesia services that were not rendered, double billed, and/or unbundled in a highly misleading manner. For their part, Defendants MultiPlan, Inc. and Private Health Care Services, Inc. ("PPO Defendants") aided and abetted Sutter's improper billing, or conspired with Sutter to commit such misconduct, through onerous contracts that severely impede health care payors' ability to detect Sutter's wrongdoing. Moreover, knowing of the falsity of Sutter's anesthesia charges, the PPO Defendants also directly submitted repriced Sutter claims to their payor clients.

The Insurance Commissioner of the State of California brings this public welfare action under the Insurance Frauds Prevention Act ("IFPA") to end Defendants' misconduct. As explained further below, the Commissioner will present evidence at trial showing that Sutter knowingly submitted false, fraudulent, and/or misleading bills for anesthesia services in violation of the IFPA. The evidence will further show that, in violation of the IFPA, the PPO Defendants knowingly aided and abetted Sutter's misconduct or conspired with Sutter to commit such misconduct, and also directly submitted Sutter's false claims to their payor clients through their repricing system.

The Commissioner's targeting of Defendants' conduct fulfills the Legislature's intent that the Department of Insurance aggressively combat false health care claims. Concerned about ballooning health care costs and Californians' wasted health care premium dollars, the Legislature provided a cause of action that imposes civil penalties and assessments on those found to submit false, fraudulent, or misleading health care claims. Ins. Code § 1871(h). For their misconduct, the Commissioner seeks the maximum allowed civil penalties and assessments against Defendants, attorneys' fees and costs, and related injunctive relief.

II. STATUTORY BACKGROUND

The IFPA is a civil *qui tam* statute the Legislature intended to counter false, fraudulent, or misleading practices that "account for billions of dollars annually in added health care costs nationally" and "losses in premium dollars." Ins. Code § 1871(h); *see also id.* § 1871.7(b)

(providing civil liability for violations of Penal Code section 550). The IFPA enables interested persons, called relators, to "bring a civil action for a violation of [the statute] for the person and for the State of California." Ins. Code § 1871.7(e)(1). The statute permits intervention by the Insurance Commissioner and other government officials. *Id.* § 1871.7(e)(4)(A).

Every person who violates Penal Code section 550, which concerns various types of false, fraudulent, and misleading practices, violates the IFPA. Ins. Code § 1871.7(b). Those who violate the IFPA "shall be subject...to a civil penalty" of between $5,000 and $10,000 per false claim, "plus an assessment of not more than three times the amount of each claim for compensation . . . pursuant to a contract of insurance." *Id.* "The penalty prescribed in this paragraph shall be assessed for each fraudulent claim presented to an insurance company by a defendant and not for each violation." *Id.* These civil penalties and assessment are to be determined by a jury, if one is demanded. Aug. 26, 2013 Order at 8-15. After the jury determines the amount of civil penalties and assessments, a court must then review the jury's award. Ins. Code § 1871.7(c). If "after considering the goals of disgorging unlawful profit, restitution, compensating the state for the costs of investigation and prosecution, and alleviating the social costs of increased insurance rates due to fraud, [the court finds that] that such a penalty would be punitive and would preclude, or be precluded by, a criminal prosecution, the court shall reduce that penalty appropriately." *Id.*

In addition to monetary relief, the IFPA permits a court to issue equitable relief. Ins. Code § 1871.7(b). A court may provide such relief "as is necessary . . . to protect the public." *Id.*

In an action in which the Commissioner intervenes, the Commissioner is entitled to attorneys' fees and costs "for time expended by attorneys employed by the department and for costs incurred." Ins. Code § 1871.7(g)(1)(A)(ii). The relator who initially brought the case is entitled to a share of the overall recovery, as well as "reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney's fees and costs." *Id.* § 1871.7(g)(1)(C).

III. PROCEDURAL HISTORY

On February 5, 2009, Relator Rockville Recovery Associates initiated this action, filing it under seal as the IFPA required. Ins. Code § 1871.7(e)(2). The case remained under seal for a

lengthy period of time. On May 5, 2011, the Commissioner intervened.

During a lengthy pleadings phase, the Court denied a series of motions by Sutter, including three demurrers, two motions to strike, a motion to compel arbitration, and a motion to strike Plaintiffs' jury demand. *See* Orders of Jan. 11, 2011, Mar. 11, 2011, Sept. 1, 2011, and Dec. 19, 2011. The Court also dismissed Sutter's cross-complaint against the Commissioner.

Defendants have filed four summary judgment motions. On March 2, 2012, Sutter filed its first motion for summary judgment, which concerned its statute of limitations defense. On June 7, 2012, the motion was decided largely in Plaintiffs' favor. The Court held that the Relator's claims prior to February 5, 2006 were barred, but that the Commissioner's claims extended back the full statutory period until February 5, 2001.

On June 22, 2012, Sutter filed a second motion for summary judgment, which concerned the falsity element of Plaintiffs' claims. On January 30, 2013, the Special Master recommended denying Sutter's motion and its objections to the testimony of Plaintiffs' expert, Dr. Henry Miller. On April 18, 2013, the Court overruled Sutter's objections to the Special Master's January 30 Order and denied Sutter's June 22 summary judgment motion. On July 11, 2013, the Court of Appeal summarily denied Sutter's writ concerning the Court's April 18 Order.

Also on June 22, 2012, the PPO Defendants filed a motion for summary judgment on their liability. On April 30, 2013, the Special Master recommended granting the motion. On July 23, the Court sustained Plaintiffs' objections to the Special Master's April 30 Order and denied the PPO Defendants' motion. On August 16, the PPO Defendants petitioned the Court of Appeal to stay this action and issue a writ of mandate compelling this Court to grant their motion for summary judgment. That petition remains pending.

On February 7, 2013, Sutter filed its third motion for summary judgment, which concerned the purported specific intent element of Plaintiffs' claim. On July 18, 2013, the Special Master recommended denying Sutter's motion. Sutter's objections to the July 18, 2013 Order remain pending before this Court.

Finally, on September 6, 2013, Sutter filed a Petition for Writ of Mandate or Other Prohibition in response to the Court's August 26, 2013 order denying Sutter's motion to strike

Plaintiffs' jury demand.

IV. CAUSES OF ACTION AND SUPPORTING EVIDENCE

A. Cause of Action Against Sutter

1. Elements

The Commissioner alleges that Sutter violated the IFPA by committing violations of portions of Penal Code sections 550(a) and 550(b). To prevail at trial, the Commissioner can prove that Sutter committed one of the following violations of section 550, among others:

> [K]nowingly ma[de] or caused to be made a false or fraudulent claim for payment of a health-care benefit.
>
> or
>
> [P]resent[ed] or caus[ed] to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

Pen. Code §§ 550(a)(6) , (b)(1); *see also* CACI 2000. Broken down, proving these violations requires the Commissioner to show:

- False, fraudulent, or misleading claims for payment, either through
  - a false or fraudulent claim for payment of a health-care benefit; or
  - any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact; and
- Sutter's knowledge of the false, fraudulent, or misleading nature of the claims or statements.

Sutter has implicitly acknowledged that these are elements of the Commissioner's claims, filing summary judgment motions on both.

The Commissioner need not prove Sutter's specific intent to defraud. Even if proof of such intent was an element of a civil case under the IFPA, which the Commissioner has contended it is not, such intent can be inferred based on Sutter submitting false, fraudulent, or

misleading claims for payment. As the Special Master explained,

> There is no dispute that the Sutter Defendants presented claims to insurers for payment. The court has already found that there is a triable issue of fact regarding whether the claims for payment here were false or fraudulent. . . . If a jury finds that Sutter had knowledge of the falsity or fraudulent nature of the submitted or presented claims, then an intent to defraud will be inferred. As stated by the court in *People v. Scofield*, 17 Cal.App.3d 1018, 1026 (1971), a person or entity "who willfully submits a claim, knowing it to be false, necessarily does so with intent to defraud."

Special Master's July 18, 2013 Order on Mot. of Sutter Defs. for Summ. J. on Specific Element of Pls.' Claim at 6:22-7:2. Sutter's counsel admitted the same during the hearing on Sutter's motion for summary judgment regarding scienter, stating, "[I]f you know when you submit a claim that it is fraudulent, the inference arises that you did it to try to get money that you would not otherwise have been entitled to get. . . ." Desai Decl., Ex. 39 at 13:1-4 (Tr. of June 27, 2013 Proceeding); *see also id.* at 14:1-7.

2. Supporting Factual Evidence

Below is a non-exhaustive list of the evidence the Commissioner will present to prove that Sutter violated the IFPA. The evidence identified below was presented in opposition to Defendants' motions for summary judgment, and Plaintiffs do not repeat all of it in detail here. Plaintiffs contend that this evidence not only warrants denial of Sutter's final motion for summary judgment, but will also establish Sutter's liability at trial.

When Sutter bills chronometrically for anesthesia services, it bills for services not rendered because no Sutter employee provides anesthesia services for the duration of the time billed. The only person associated with Sutter's time-based anesthesia charge is the anesthesia technician. Yet, this technician has limited to no medical training, is not present for medical procedures involving anesthesia, and has no ongoing obligation or responsibilities to the patient during the billed period. At best, the technician is one of several operating room personnel who prepare operating rooms in between cases, and typically has only a few minutes' involvement in any given procedure. Yet, the technician is billed simultaneously in as many as six operating rooms and anesthetizing locations at a time, and for the entirety of each of those procedures, demonstrating double, triple, or quadruple billing, or even worse. Indeed, there appear to be no

other circumstances where Sutter bills on a timed basis when its professionals do not have patient care responsibility over the billed period, let alone circumstances where Sutter bills *two* timed charges simultaneously – here, the operating room ("OR") and Anesthesia charges – without providing two distinct services for them throughout that billed period.

Sutter is aware of its wrongful billing for anesthesia because, while it bills chronometrically for conscious sedation, it provides personnel during the billed period. Whereas Sutter's time-based 37x charges for anesthesia involve no service, its time-based 37x charges for conscious sedation (a mild form of anesthesia), do involve a service. Time and again, Sutter has acknowledged that it should not be adding a timed 37x conscious sedation charge to patients' bills unless one of its nurses provides an additional anesthesia service to the patient throughout the billed period. Sutter willfully ignores this basic principle for its anesthesia charges, thereby reaping many hundreds of millions of dollars in additional revenue throughout all of its operating room procedures.

Sutter's billing for anesthesia in labor and delivery (L&D) demonstrates its knowledge of false billing for anesthesia in the OR. L&D patients sometimes require anesthesia in the form of epidurals, and require physiological monitoring, just like a patient receiving anesthesia in an operating room. When an independent, non-Sutter anesthesiologist provides that epidural, Sutter does *not* impose a 37x charge beyond the L&D hourly charges, even though the anesthesia equipment will be in use, because it knows *it* is not providing an additional anesthesia service. Rather, just as in the OR, the *anesthesiologist* is providing that service and he or she bill separately. By contrast, if a *Sutter-employed* certified registered nurse anesthetist ("CRNA") provides the epidural, then Sutter *will* generate a 37x charge beyond the L&D hourly charges. Yet, it provides no comparable service for its OR-based anesthesia charges.

Sutter's misrepresentations to B, a patient's guardian, demonstrate its knowledge that its billing practices are indefensible. In May 2011, the guardian of a minor patient at a Sutter hospital demanded to know the basis for the 37x GENRL ANES charges incurred in addition to the anesthesiologist's fee and various other hospital charges. Sutter provided evasive answers and ultimately asserted that an "anesthesia nurse" was present, which the evidence does not

support. Rather than substantiate its explanation and rationale for the charge, Sutter opted to drop the charge. Thus, Sutter sought to justify the separate 37x charge by falsely claiming that an additional nurse was present, evincing Sutter's knowledge that a Sutter professional who provides monitoring care for the patient must be present to justify a separate 37x charge.

Sutter knows that equipment included in the anesthesia charge is included in the separate OR charge. Sutter seeks to support its charges based on a single piece of equipment that is part and parcel of the operating room – the anesthesia machine. Yet, all available industry guidance makes clear that this machine is a part of the OR and billed as part of the already-running, and substantial, timed OR charge under revenue code 36x. Two of Sutter's guidelines likewise admit that OR equipment is part of the OR charge, and Sutter's CDM Director Cathy Meeter admitted the same. So have other Sutter personnel. To claim a second, simultaneous charge for one piece of equipment that is part and parcel of the OR that is already being billed is a plain double bill, and as Plaintiffs' expert Dr. Henry Miller will explain, a particularly misleading unbundling scheme that allows Sutter to bill more without providing an additional service.

Sutter's OR practices show that it knows that it bills improperly for anesthesia services. Among other things, Sutter personnel acknowledge that Sutter does not bill for OR staff who are on standby but not providing a service, and that Sutter does not bill a patient separately for transfusion services in the OR because no one goes to the OR solely for a transfusion. These practices and their underlying rationale further show Sutter's knowledge that its anesthesia billing practices are improper.

Sutter double bills for anesthesia gases, including them as part of their anesthesia services charges and their pharmacy charges. Evidence shows that, in over 140,000 instances, numerous Sutter facilities charge twice for anesthesia gases, under both revenue code 25x for Pharmacy and 37x for Anesthesia. Having learned of this fraud, key Sutter personnel, including CDM Director Cathy Meeter and ethics and compliance officer Kelly Wittmeyer, did nothing to advise payors or patients of the double charges. One of Sutter's largest facilities *continues* to double bill gases in this manner.

Sutter personnel and guidelines discourage use of general charge descriptions, knowing

they can obscure what the charges are for. Echoing Sutter guidelines, Ms. Meeter acknowledged that a charge description should give the patient "some semblance of what it was." Sutter's descriptions for its anesthesia charges offer no such insight, precluding payors and patients from understanding the nature of the charges. Moreover, Sutter's so-called "anesthesia service" has virtually nothing to do with time, and yet Sutter has structured the charge to run by the minute.

3. Supporting Expert Evidence

Several expert witnesses have confirmed the Commissioner's allegations, offering opinions supporting Sutter's liability under the IFPA. Below are brief summaries of the testimony the experts are expected to give at trial.

Henry Miller, Ph.D. Dr. Miller has more than 40 years of experience as a health care consultant and, among other things, has testified before Congress, state legislatures, and various arbitral forums. Dr. Miller will testify that, based on his review of materials, Sutter's charges for anesthesia services in the OR are for a service not rendered, are double billed, and/or are the product of a misleading unbundling scheme. Dr. Miller has also reviewed internal Sutter documents and will be prepared to testify that the way Sutter bills for anesthesia services under 370 in the OR setting is inconsistent with how Sutter bills for services elsewhere. Thus, Dr. Miller will testify, Sutter's billing practice results in the submission of false, fraudulent or misleading claims to payers. Moreover, Dr. Miller will explain to the jury the limited ability and incentive payors have to identify false charges buried in chargemasters with tens of thousands of entries.

Errol Lobo, Ph.D., M.D. Dr. Lobo is Professor and Vice Chairman of the Department of Anesthesia and Perioperative Care and Director of Anesthesia Care at Moffitt-Long Hospital at the University of California, San Francisco. Among other things, Dr. Lobo will testify that only anesthesiologists and certified registered nurse anesthetists provide direct patient care with respect to anesthesia; anesthesia technicians do not. Dr. Lobo will testify that a technician has very limited physical interactions with patients, if any at all.

Jack Needleman, Ph.D., FAAN. Dr. Needleman is a Professor of Health Policy and

Management at the University of California, Los Angeles Fielding School of Public Health. He has over 40 years of experience in health care finance and payment issues. Dr. Needleman will testify about Sutter's substantial market power in Northern California, which compels payors to accede to Sutter's chosen billing practices and to its unfavorable audit provisions. Moreover, Dr. Needleman will explain payors' general lack of incentive to challenge the practices of a dominant provider like Sutter, so long as the payors can retain parity with one another. Thus, while Sutter will contend that payors' alleged silence proves it has not defrauded anyone, Dr. Needleman's analysis will provide much needed context to that purported fact.

Robb Cohen. Mr. Cohen has over 25 years of experience in health care finance and management. He has served on state task forces addressing hospital rates and has been involved in negotiations between hospitals and payors concerning hospital charges. To demonstrate that Sutter's anesthesia billing has no basis in fact, Mr. Cohen will testify that Sutter facilities' anesthesia charges as compared to their anesthesia costs, as reported on filings with the federal government, are astronomically high. These filings show anesthesia "charge to cost ratios" ranging from 1838% to 3408%, meaning that Sutter charged $18.38 to $34.08 for every dollar it spent on anesthesia costs, providing strong circumstantial evidence of the lack of any basis for these timed charges. Further, Mr. Cohen will also address Sutter's defense that payors have not challenged its anesthesia billing. Mr. Cohen will testify, based on his experience in many payor-provider contract negotiations, that Sutter's audit restrictions are extraordinarily severe, impeding payors' ability to challenge Sutter's claims. Mr. Cohen will also address Sutter's defense that payors have access to chargemasters, which list a hospital's charges using vague terms. Mr. Cohen will testify that payers have a very limited focus on chargemasters and, as a practical matter, do not and cannot review chargemasters on a line-by-line basis.

Mark R. Lipis. Mr. Lipis has had almost 35 years of experience in designing compensation and benefits plans for publicly- and privately-held companies, and nonprofit organizations. Sutter is expected to assert at trial that it is a nonprofit hospital that does substantial charitable work. In response to this anticipated assertion, Mr. Lipis will testify that Sutter is nonprofit in name only, compensating its executives at above, and sometimes well

above, market rates.

Allen Dobson, Ph.D. Dr. Dobson is a health economist who has had over 40 years of experience in the field. He has served as Director in the Office of Research at Centers for Medicare & Medicaid Services (then known as the Health Care Financing Administration) when a nationwide payment system was being developed and implemented. Dr. Dobson will testify about which claims, charges, and payments are at issue in this litigation based on the legal framework ultimately adopted by the Court.

4. Sutter's Defenses

As it has in its motions for summary judgment, Sutter will argue that its charges are not false, and that even if they were, it did not act with knowledge. These defenses will fail for the reasons outlined above. Sutter will also argue that its anesthesia charges are consistent with industry practice. This argument would only complicate and confuse the trial (*see* Plaintiffs' MIL No. 6), but even assuming the Court permits it, others' purported misconduct does not excuse Sutter's. *People v. Casa Blanca Convalescent Homes*, 159 Cal.App.3d 509, 527-28 (1984) ("Wrongdoing is not excused merely because others engaged in it.").

B. Cause of Action against the PPO Defendants

1. Elements

The Commissioner alleges that the PPO Defendants violated the IFPA by aiding and abetting Sutter's misconduct or by conspiring with Sutter to commit such conduct. The Commissioner also alleges that the PPO Defendants violated the IFPA by submitted false, fraudulent, or misleading bills for anesthesia services through its re-pricing of Sutter's claims for anesthesia services.

To prove that the PPO Defendants aided and abetted Sutter's unlawful conduct, the Commissioner must show that (1) they substantially assisted or encouraged Sutter to bill for anesthesia services in a false, fraudulent, or misleading manner and (2) they had knowledge that Sutter was billing in such a manner. July 23, 2013 Order Denying the PPO Defs.' Mot. for Summ. J. at 8-9; *see also Fiol v. Doellstedt*, 50 Cal.App.4th 1318, 1325 (1996) (explaining aider and abettor liability).

To prove that the PPO Defendants conspired with Sutter to commit unlawful conduct, the Commissioner must show that (1) they agreed to Sutter's billing for anesthesia services in a false, fraudulent, or misleading manner and (2) pursuant to their agreement, they committed acts that resulted in damage. July 23, 2013 Order Denying Defs.' MultiPlan's & PHCS's Mot. for Summ. J. at 10; *see also Applied Equip. Corp. v. Litton Saudi Arabia, Ltd.*, 7 Cal.4th 503, 511 (1994) ("The elements of an action for civil conspiracy are the formation and operation of the conspiracy and damage resulting to plaintiff from an act or acts done in furtherance of the common design.").

To prove that the PPO Defendants committed violated the IFPA through its re-pricing activities, the Commissioner can prove that the PPO Defendants committed one of the following violations of section 550, among others:

> Knowingly prepar[ed], ma[de], or subscribe[d] any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim;
>
> or
>
> [P]resent[ed] or caus[ed] to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

Pen. Code §§ 550(a)(5), (b)(1); *see also* CACI 2000.

2. <u>Supporting Factual Evidence</u>

Below is a non-exhaustive list of the evidence the Commissioner will present to prove that the PPO Defendants violated the IFPA. The evidence identified below was presented in opposition to the PPO Defendants' motion for summary judgment. The Court held that this evidence created triable issues of fact regarding the Commissioner's theories of liability. Jul 23, 2013 Order Denying the PPO Defs.' Mot. for Summ. J. at 9-11.

The PPO Defendants agreed to systemwide agreements that curtailed payers' audit rights. During renegotiations with Sutter of existing agreements, the PPO Defendants agreed to provisions that severely limited payers' ability to audit Sutter's claims. They did so because of their concerns they would lose Sutter as part of their business.

The PPO Defendants never informed payors about the audit restrictions, which was a material change. Despite assuring its payor clients that the agreements with Sutter would not be materially altered, the PPO Defendants agreed to the changes mentioned above without notifying their payors.

One of their payor clients notified the PPO Defendants of Sutter's false anesthesia charges. Upon receiving this notification, the relevant PHCS official evinced her understanding that the issue was not just the size of Sutter's 37x charges, but their false and fraudulent nature.

The PPO Defendants were aware of numerous disputes payors had with Sutter. Throughout the relevant period, the PPO Defendants knew that Sutter had various billing disputes with payors, including a dispute regarding anesthesia services.

The PPO Defendants understood Sutter's interest in shielding its claims from scrutiny. Various documents, correspondence, and notes from the period negotiations were ongoing show that the PPO Defendants understood the importance Sutter gave to limiting payors' audit rights.

V. CONCLUSION

Plaintiffs contend that both sets of Defendants will be held liable under the IFPA for the reasons outlined above. Plaintiffs look forward to putting on a streamlined and focused case in chief that should take about 7-9 trial days.

Dated: September 9, 2013

Respectfully submitted,

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