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Horizon Ordered to Release OMNIA Report

By Meghan V. Hoppe, Esq.

On April 10, 2018, Superior Court Judge Robert P. Contillo ruled that Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey ("Horizon") must turn over a consultant's report that assisted the company in creating the OMNIA network of insurance plans. See Capital Health Sys. v. Horizon Healthcare Servs., No. C-369-15 (Law Div. Apr. 10, 2018). In 2016, Horizon launched the OMNIA network, which offers insurance policies that discount care provided by selected health care providers. Horizon based the OMNIA line of insurance plans on value-based "tiered" networks. OMNIA categorizes health care providers into different "tier" levels based on rates of reimbursement.

The consulting group McKinsey & Company was engaged by Horizon to assist in developing the OMNIA plan. In connection with the engagement, the company submitted a report (the "McKinsey Report") detailing the strategy behind OMNIA. The McKinsey Report was used in determining the structure of Horizon's tiered OMNIA health plan, including how it chose the participating health care providers.

The McKinsey Report currently serves as evidence in a lawsuit filed by a number of health care providers regarding their tier status. Advance Local Media LLC d/b/a NJ Advance Media joined the litigation to obtain access to the McKinsey Report, citing strong public interest.

Horizon contended that releasing the McKinsey Report would supply competitors with its research and strategy for the development of future value-based health care products. Horizon stressed that the disclosure of the McKinsey Report would be harmful in future negotiations with health care providers. Judge Contillo rejected Horizon's request to keep the McKinsey Report and other related documents under seal.

Judge Contillo wrote in his decisions that "[t]here is broad, legitimate, immediate public interest in how health care is delivered in this State, how patients are insured, and how they are incentivized to be evaluated, tested and treated by particular providers."

Horizon will appeal the decision.

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New Law Limits Out-of-Network Coverage And Prohibits Balance Billing

By Divya-Srivastav-Seth, Esq.

The New Jersey Legislature has now passed the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act" (A2039/S485) (the "Act"), which is currently with the Governor for signature. The Act prohibits the surprise balance billing of patients by out-of-network providers for amounts unpaid by insurance carriers and health plans. The Act is expected to be signed any day, and will take effect 90 days from its enactment. A link to the Alert providing detailed commentary on the Act is available here.

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United States Intervenes in Suit Against Private Equity Firm for Allegedly Violating the False Claims Act

By Daniel O. Carroll, Esq.

In February 2018, the United States filed a complaint in the Southern District of Florida to intervene in a lawsuit against Diabetic Care Rx LLC d/b/a Patient Care America ("PCA"), a compounding pharmacy alleged to have paid illegal kickbacks to increase sales of products subject to federal reimbursement. See United States ex rel. Medrano and Lopez v. Diabetic Care Rx, LLC d/b/a Patient Care America, et al., No. 15-CV-62617-CIV-BLOOM (S.D. Fla.). In addition to bringing claims against PCA, the federal government brought suit against Riordan, Lewis & Haden Inc. ("RLH"), a private equity firm that manages the private equity fund (RLH Investors III, LP) that owns a controlling stake in PCA. The complaint states that RLH managed and controlled PCA on behalf of its private equity fund through two RLH partners who served as officers and/or directors of PCA and of a holding company with an ownership interest in PCA.

What makes this case worthy of note is the federal government's uncommon move to bring suit for violating the False Claims Act, 31 U.S.C. § 3729(a)(1)(A), against the private equity firm RLH. The standard for alleging False Claims Act violations by owners and managers of a provider entity requires the government to establish that such owners and managers have knowingly caused the presentment of false claims. This standard makes it very difficult to establish and maintain a claim against investors of such provider entities. However, the complaint against RLH alleges that the level of control and participation by RLH and two RLH partners in and over PCA was sufficient to establish that RLH knew and approved of PCA's misconduct and alleged scheme to pay marketers illegal kickbacks to increase sales of products subject to federal reimbursement.

In light of the egregious conduct by RLH and its partners alleged in the complaint, such as being aware of and apparently disregarding legal advice that paying commissions to marketers could violate the federal anti-kickback statute and taking affirmative actions to maintain its kickback scheme with marketers, this case may not be a sign that the federal government will now aggressively pursue private equity investors for false claims violations. It is, however, a clear sign that the federal government believes that active investors who control and direct the actions of provider companies can and should be held liable for mismanagement and non-compliance with applicable fraud and abuse laws.

Navigating the minefield of the highly regulated health-care industry can be a daunting task for providers and their partners. Nevertheless, the healthcare industry remains attractive target for private investors. Cases like the current one and Allstate Ins. Co. v. Northfield Med. Ctr., P.C., 228 N.J. 596 (2017) (involving liability for violations of the restrictions on the corporate practice of medicine), highlight the need for private investors to fully appreciate the differences and risks attendant to an investment in an industry which requires compliance with a maze of complicated regulations both prior to and during the term of investment. The full gambit of standard corporate strategies and commercial means for protecting an investment may not be always be available to investors and may, in fact, expose investors to liability for regulatory non-compliance.

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OIG Launches Compliance Resource Portal

By Deborah A. Cmielewski, Esq.

On April 16, 2018, the Office of Inspector General ("OIG") announced the launch of a new compliance resource portal available to the public. The user-friendly portal contains links to such items as compliance webcasts and presentation materials, compliance program guidance, OIG Advisory Opinions, Special Fraud Alerts and other resources designed to help interested parties to comply with federal health care laws. The portal also includes

links to resources for health care boards, physicians and accountable care organizations (ACOs). The portal is available here https://go.usa.gov/xQjRJ.

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New Jersey Supreme Court Holds Argument on Status of Offer of Judgment Sanction Provision Following High-Low Agreement Before Verdict

By James B. Sharp, Esq. and Benjamin A. Hooper, Esq.

Earlier this month the New Jersey Supreme Court held oral argument in the matter of Serico v. Rothberg, 448 N.J. Super. 604 (App. Div. 2017). The issue argued before the Supreme Court was the interplay between the Offer of Judgment Rule 4:58 (the "Offer of Judgment Rule" or the "Rule") and "high-low" settlement agreements. The underlying case was brought by the estate of man who died of colon cancer, with the specific allegation being that the physician defendant failed to identify the signs of cancer during a 2007 colonoscopy. The disease was discovered two years later and subsequently claimed the plaintiff's life.

While awaiting a trial date, plaintiff filed an offer to accept judgment against the defendant in the amount of $750,000. The Offer of Judgment was issued pursuant to the Rule. That Rule permits a party to demand judgment for a sum certain. If the offer/demand is not accepted by the adverse party and the party who tendered the offer obtains a verdict at trial in an amount that is 120 percent or more of the offer amount, the party is entitled to attorney's fees, costs and interest running from the date of the offer to take judgment through the date of the verdict. See R. 4:58-3. The stated policy purpose behind the Rule is to induce settlement by discouraging the rejection of reasonable offers of compromise. The goal is to be achieved through the imposition of financial consequences, i.e. interest, fees and costs, where an offer/demand figure turns out to be significantly more favorable to the adverse party than the verdict figure.

During the ensuing trial in Serico, while the jury was deliberating, the parties entered into a high-low settlement agreement. A high-low agreement is a settlement in which a defendant agrees to pay plaintiff a minimum recovery, in the event of a verdict in favor of the defendant, in return for plaintiff's agreement to accept a maximum sum in the event of a verdict in favor of the plaintiff in an amount equal to or greater than the maximum sum. In this particular instance, the terms, as placed on the record by counsel, provided for a "low" of $300,000 and a "high" of $1 million. During the course of the negotiations, neither party referenced the previously filed and rejected Offer of Judgment. Plaintiff's counsel never expressed any intention to pursue the Offer of Judgment remedies. The jury returned a verdict in favor of plaintiff for $6 million. As a result, plaintiff was entitled to the entry of a judgment against defendant, pursuant to the high-low settlement agreement, in the amount of $1 million, (noted to be more than 120% of the amount of the Offer of Judgment). Notwithstanding the settlement of the case, plaintiff thereafter filed a motion for an award of attorney's fees and costs, pursuant to R. 4:58-3.

The trial court denied plaintiff's motion, with the trial judge stating that he had never encountered, in forty-two years of experience as a judge and litigator, a case in which plaintiff's counsel attempted to claim entitlement to the Offer of Judgment remedies after entering into a high-low settlement agreement. A high-low agreement is viewed by the case law as a negotiated settlement-agreement, despite the fact that the specific settlement amount is contingent upon the returned verdict.

In a published decision, the Appellate Division stated that the fundamental assumption of high-low settlement agreements is that a plaintiff cannot recover more than the amount agreed to as the "high" limit. Although case law, most notably Malick v. Seaview Lincoln Mercury, 398 N.J. Super. 182 (App. Div. 2008), established that a plaintiff could expressly reserve his or her right to an amount

beyond the maximum under a high-low agreement, in this particular situation plaintiff's counsel remained silent as to any intention to reserve the Offer of Judgment remedies. Thus, it was the Appellate panel's position that the high-low settlement agreement affectively nullified the Offer of Judgment, and the Court affirmed the denial of plaintiff's claim for fees and costs.

The Supreme Court certified the case. At oral argument, the plaintiff-appellant contended that consistent with the Offer of Judgment's underlying purpose of encouraging settlement, the defendant should be liable to pay plaintiff's fees and costs because the recovery of $1 million implicated the Offer of Judgment, triggering the remedy provisions. Plaintiff maintained that the policy of promoting settlement would be more strongly supported through enforcement of the sanction provisions, even in circumstances where a high-low agreement governed the recovery.

The defendant-respondent argued that the Offer of Judgment was effectively withdrawn, once the parties entered into the high-low settlement agreement. Defendant contended that the high-low agreement entered into at trial was identical to a settlement agreement prior to trial. Consequently, enforcement of the sanction provisions would serve to penalize the defendant for entering into a settlement agreement, defeating the very objective of the Offer of Judgment Rule. Moreover, defendant respondent argued that the plaintiff had failed to follow the good practice and ordinary candor expected between litigants, by remaining silent as to any intention on his part to seek fees under the Rule.

The argument before the New Jersey Supreme Court was punctuated by pointed questioning of the litigants regarding the technical and practical operation of the Offer of Judgment Rule. Based on the questions posed by the Justices it is possible that the Rule may be referred to the Civil Practice Committee for clarification. The New Jersey Supreme Court's opinion is to be published in the coming months and may resolve whether a party may claim entitlement to the Offer of Judgment remedies after entering into a high-low settlement agreement.

James B. Sharp, Esq. of Schenck Price Smith & King, LLP represented the defendant-respondent before the New Jersey Supreme Court.

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Third Party Vendor Causes HIPAA Violation and Exposes Virtua Medical Group to Liability for Breach

By Sharmila D. Jaipersaud, Esq.

On April 4, 2018, the New Jersey Attorney General, Gurbir S. Grewal, and the State Division of Consumer Affairs (the "Division") announced a settlement with Virtua Medical Group, P.A. ("Virtua"), which requires Virtua to pay approximately $418,000 and improve its data security practices in order to settle allegations that it failed to properly protect patient health information ("PHI") for over 1,650 patients. This settlement serves as a reminder to large physician networks and health systems that the State of New Jersey will not hesitate to exercise its own enforcement authority when it comes to breaches of PHI. It also highlights the risks to which third party vendors can expose large healthcare providers.

Virtua contracted with Best Medical Transcription ("Best Medical"), a Georgia-based vendor, who was hired to transcribe dictations of medical notes, letters and reports by doctors at three of the Virtua practices. The breach occurred when Best Medical updated software on a password-protected File Transfer Protocol website ("FTP Site") where the transcribed documents were kept. During the update, Best Medical unintentionally misconfigured the web server, allowing the FTP Site to be accessed without a password.

Due to the misconfiguration, anyone running a Google search for any information in the dictation, including patient names, doctor names or medical terms, could access and download documents on the FTP Site. Best Medical corrected the server misconfiguration, removed

the transcribed documents from the FTP Site and restored the password protection on January 15, 2016. However, Google retained cached indexes of the files, which remained publicly accessible on the internet, even after the correction. Best Medical, aware of the lack of password and a potential breach, did not notify Virtua that data had been exposed. Virtua later received a call from a patient whose daughter's medical records were accessible online.

Once it became aware of the breach caused by Best Medical, Virtua took several steps to address and mitigate it. Virtua completed an internal investigation on February 4, 2016, contacted the New Jersey State Police and the FBI to report the security incident, and placed a request to remove the entire FTP Site from Google's cache. It went to each of the 462 Virtua compromised patient records it had found and identified on Google and, over a period of many hours, successfully removed them, one at a time, from Google. Patients were notified in March 2016.

Despite its efforts, the Division concluded that it was Virtua that failed to comply with federal healthcare data security standards stating, "[a]lthough it was a third-party vendor that caused this data breach, [Virtua] is being held accountable because it was their patient data and it was their responsibility to protect it," said Sharon M. Joyce, Acting Director of the Division of Consumer Affairs. She further stated, "[t]his enforcement action sends a message to medical practices that having a good handle on your own cybersecurity is not enough. You must fully vet your vendors for their security as well."

The New Jersey Attorney General reiterated that the buck stops with the healthcare providers who are entrusted with sensitive patient information and it is their legal responsibility to ensure the privacy and security of such information regardless of the location or medium of retention.

As a result of the settlement and in addition to its payment of approximately $418,000, Virtua agreed to implement a corrective action plan that includes hiring a third-party professional to conduct a thorough analysis of security risks associated with the storage, transmission and receipt of electronic protected health information.

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