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CONNECTICUT APPELLATE COURT RULES THAT COVENANT NOT TO SUE NOT BINDING ON SUCCESSORS

In a case of first impression in Connecticut, the Connecticut Appellate Court held that a malpractice settlement, which included a covenant not to sue in favor of the settling defendants, did not preclude the plaintiff from pursing a claim against the corporate successors of the settling parties. The lawsuit, *Robbins v. Physicians for Women's Health, LLC,* was brought by Lisa Robbins individually and as administratrix of the estate of her son (the Plaintiff). In 2005, the Plaintiff gave birth to her son at a Connecticut hospital. While at the hospital, she was under the care of an obstetrician, and a certified nurse midwife, both of whom were employed by a physician group (the Group) (collectively, the Group Parties). The Plaintiff's son died shortly after his birth. Several months thereafter, the Group's assets were sold to two entities (the Successors). Shortly after such sale, the Plaintiff filed a suit alleging medical malpractice against the hospital, the Group Parties, and the Successors.

Ultimately, the Plaintiff settled with, and withdrew her claims against, the Group Parties and the hospital. In connection with her settlement with the Group Parties, the Plaintiff executed covenants not to sue, which stated that she forever discharged the Group Parties from all claims, including those arising from any care and treatment rendered by the Group Parties to the Plaintiff and her son. However, each covenant not to sue stated that it did not affect the Plaintiff's claims against the Successors, who remained defendants in the action.

The Successors filed a motion for summary judgment on the grounds that any liability they had as a successor to the Group was extinguished when the Plaintiff entered into a settlement with the Group, and that the covenant not to sue discharged the Group from liability. The trial court agreed and granted the Successors' motion for summary judgment. The Plaintiff appealed, arguing that a covenant not to sue is an agreement not to proceed against *a particular party*

and does not release *all parties* to the original claim.

The Appellate Court first addressed whether the Plaintiff's settlement with the Group prevented successor liability from being imposed on the Successors. The Successors argued that successor liability cannot be applied to a situation in which the Successors' predecessor, the Group, remained a viable source for recourse. The Appellate Court found that there was insufficient evidence in the record regarding the damages suffered by the Plaintiff and the assets retained by the Group. Therefore, the Appellate Court was unable to determine whether the Group represented a viable source of recovery.

The Appellate Court next addressed whether or not the covenant not to sue extended to the Successors. The Appellate Court noted the difference between a release, which would release all defendants from a claim, and a covenant not to sue, which is specifically limited to the party named in the covenant. Because neither the Appellate Court nor the Connecticut Supreme Court had addressed the application of a covenant not to sue on a successor corporation, the Appellate Court looked to other states for guidance. The Appellate Court learned that courts in other states have found that a covenant not to sue is not a legal release of liability, but rather it should be construed in accordance with the parties' intent.

The Appellate Court looked to the covenant not to sue and the parties' intent and concluded that the Plaintiff expressly reserved her right to continue to pursue her action against the Successors. Based on its conclusions, the Appellate Court reversed the trial court's grant of summary judgment to the Successors and remanded the case to the trial court for further proceedings.

This ruling may have an impact on future claims filed against successor corporations in which a plaintiff has entered into a covenant not to sue the predecessor entity.

OIG ISSUES ADVISORY OPINION: PROPOSED GROUP PURCHASING ORGANIZATION NOT SUBJECT TO SANCTIONS

The U.S. Department of Health and Human Services' Office of Inspector General (OIG) recently issued Advisory Opinion 12-01 concerning the creation of a group purchasing organization (GPO) that would be wholly owned by a parent organization that owns many participants of the GPO (Proposed Arrangement). The OIG ultimately concluded that while the Proposed Arrangement had the potential for generating prohibited remuneration under the Anti-kickback Statute (AKS), the Proposed Arrangement had sufficient safeguards to prevent a violation of AKS from occurring.

Proposed Arrangement

The parent organization (Parent Organization) of a national health system consists primarily of nonprofit corporations (Nonprofit Corporations) that own and operate health care facilities. Each Nonprofit Corporation is a separate legal entity. A subsidiary of the Parent Organization (LLC) is responsible for supply chain, materials, and resource management for the Parent Organization and the Nonprofit Corporations. While the LLC typically contracts on behalf of the Nonprofit Corporations, a separate subsidiary of the Parent Organization (Subsidiary) opts into certain GPO contracts with various suppliers on behalf of the Nonprofit Corporations.

Collectively, the Parent Organization, the Subsidiary, and the LLC are the "Requestors."

Under the Proposed Arrangement, the LLC would form and operate a new GPO (Proposed GPO). The Proposed GPO would initially be comprised of the Nonprofit Corporations and organizations affiliated with the Parent Organization or the Subsidiary, and would also be open to outside participants (Nonaffiliated Participants) (collectively, the Participants). There would be no participation fees charged to Participants. According to the Requestors, the purpose of the Proposed GPO would be to utilize the Participants' purchasing power, negotiate contracts and develop a contract portfolio, and obtain cost savings.

To accomplish these goals, the Proposed GPO would enter into written agreements with the Participants (Participant Agreements) and suppliers (Supplier Agreements), which would enable the Proposed GPO to arrange for discounts on goods or services. The Participant Agreements and Supplier Agreements would require each Participant and supplier to comply with all cost reporting rules.

Pursuant to the Supplier Agreements, the Proposed GPO would collect administrative fees from each supplier. The Proposed GPO would retain some of these administrative fees to offset its administrative costs and distribute any remaining administrative fees to the Participants. The Proposed GPO would require suppliers to provide the Proposed GPO with information on Participant spending and purchasing to adequately allocate excess administrative fees to Participants.

In addition, the Proposed GPO would maintain a website. The website would inform vendors that administrative fees in excess of the Proposed GPO's operating costs may be passed through to the Participants. Vendors also could utilize the website to view and obtain contract information and Participant purchasing information.

OIG Findings

The AKS makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services paid by a federal health care program. Under the AKS, remuneration can include the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Since the AKS is so broad, the OIG has issued regulatory safe harbors, which define certain practices that are not subject to the AKS (and therefore in a safe harbor), because it is believed that such practices are unlikely to result in fraud or abuse. The failure to satisfy the requirements of a safe harbor does not mean that a particular arrangement or practice constitutes a violation of the AKS; it simply means that the arrangement will not receive safe harbor protection and may be subject to scrutiny.

The OIG determined that three aspects of the Proposed GPO raise issues under the AKS: (1) the use of vendor discounts, (2) the distribution by the Proposed GPO of administrative fees that exceed its costs, and (3) the administrative fees retained by the Proposed GPO. However, the OIG found that the Proposed GPO contained five factors that, in combination, lowered the risk of fraudulent conduct under the AKS and would not be subject to sanctions by the OIG. The five factors were as follows:

- A separate legal entity would host the Proposed GPO, rather than the Participants. The Proposed GPO would only retain administrative fees necessary to offset costs, and it would distribute excess administrative fees to Participants.
- Each Affiliated Participant would be required to report the full amount of administrative

fees allocated by the Proposed GPO to such Participant as rebates, regardless of whether such fees were actually distributed to such Participant. Nonaffiliated Participants would be required to report the full amount of actual administrative fee distributions from the Proposed GPO as rebates.
- Through its website, the Proposed GPO would inform vendors and the public that administrative fees in excess of its costs may be distributed to Participants. Additionally, the Proposed GPO would directly notify vendors that excess administrative fees may be passed through to Participants as rebates, thus allowing vendors to comply with their own price reporting requirements.
- Participation in the Proposed GPO would be open to Nonaffiliated Participants.
- The Parent Organization would continue to utilize independent GPO's when better cost value may be obtained through such GPO's.

While the OIG stressed that the Advisory Opinion was limited to the Proposed GPO, health care organizations contemplating the formation of a GPO may consider the Advisory Opinion as informal guidance.

ROBINSON & COLE HEALTH LITIGATION ATTORNEYS WIN TWO FALSE CLAIMS ACT CASES

Health litigation and administrative advocacy attorneys Michael J. Kolosky, Theodore J. Tucci, and Jean E. Tomasco recently obtained dismissal of all *qui tam* charges in two cases involving the federal False Claims Act.

Brief Overview: False Claims Alleged Against Federally Qualified Health Center

Robinson & Cole attorneys represented a federally qualified health center (FQHC) in a *qui tam* case brought by a former billing manager who alleged that the FQHC violated the federal False Claims Act (FCA) by submitting false claims for reimbursement and by making false statements in federal grant applications. The firm obtained dismissal of all fraud claims prior to discovery being taken.

Brief Overview: Anti-Kickback Violations Alleged Against Specialty Pharmacy Company

Robinson & Cole attorneys represented a national specialty pharmacy company in a qui tam case brought by the former sales manager of a pharmaceutical manufacturer. The relator alleged violations of the Anti-Kickback Statute and the federal and state False Claims Acts arising out of kickbacks that the pharmaceutical manufacturer allegedly paid the specialty pharmacy to induce its purchase of Risperdal Consta, an antipsychotic medication. The firm obtained dismissal of all federal claims prior to discovery being taken.

Full Summary: False Claims Alleged Against Federally Qualified Health Center

The former billing manager of the defendant health clinic, a federally qualified health center (FQHC), filed a *qui tam* case against the FQHC and two former executives alleging that they had made false statements to the federal government and submitted false claims to the Medicare and Medicaid programs in violation of the False Claims Act. The relator also alleged that the defendants retaliated against her in violation of the FCA's anti-retaliation provision after

she raised concerns to management regarding the FQHC's billing practices.

The relator alleged that the defendants engaged in a concerted effort and scheme to maximize reimbursement from Medicare and Medicaid by submitting bills to both programs that contained false information about the identity of the treating providers and the nature of the services provided. In count one, she alleged that the defendants routinely substituted the names of the actual treating providers with the names of clinicians who did not have a face-to-face encounter with the patient, and that defendants instructed her to "upcode" the claims by using a code that described a higher intensity of services. In count two, the relator alleged that defendants misrepresented services as having been performed by clinicians individually credentialed by Medicare and Medicaid, rather than identifying the noncredentialed clinicians whom she alleged to have actually provided the services. The relator's count three alleged the defendants falsified information in federal grant applications regarding their use of a sliding fee scale to charge patient copays.

The federal court granted the defendants' motion to dismiss all three of the relator's fraud counts against the FQHC. The court held that, in order for the relator to state a claim under count one, she must allege that the defendants "knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim." Consistent with prior precedent in the Second Circuit, the court held that a fraudulent claim is a claim "aimed at extracting money the government otherwise would not have paid." The court agreed with the defendants' argument that, because FQHCs are reimbursed on a flat, all-inclusive case rate, the codes used to describe the services and the identity of the treating providers who performed the services do not influence the government's decision to pay. Accordingly, the court dismissed count one for failure to state a claim.

Defendants argued that count two, alleging that the FQHC billed services provided by noncredentialed providers as being provided by credentialed providers, failed to state a claim upon which relief can be granted because the law does not require clinicians at FQHCs to be individually credentialed by Medicaid or Medicare. The court agreed, and dismissed count two.

The court dismissed count three on the ground that the relator failed to allege facts sufficient to state a claim that defendants misrepresented their use of the sliding fee scale. Federal law requires the defendant FQHC to establish a sliding fee schedule of discounts based on patients' ability to pay, and forbids the FQHC from denying care based on a patient's inability to pay. Although the relator alleged that the defendant did not follow its established fee scale and instead billed at a maximum fixed rate, she failed to allege that the defendant FQHC did not prepare a fee schedule as required, or that it ever turned away patients based on their inability to pay the allegedly fixed rate. The court concluded that the relator failed to allege that the defendant FQHC violated any of the sliding fee scale requirements under federal law, and dismissed count three for failure to state a claim upon which relief could be granted.

The retaliation claim is the only aspect of the case remaining after the motion to dismiss.

Full Summary: Anti-Kickback Violations Alleged Against Specialty Pharmacy Company

A former sales manager of a pharmaceutical company filed a *qui tam* complaint alleging that the company paid illegal kickbacks to induce a specialty pharmacy to purchase and distribute Risperdal Consta, an antipsychotic medication. The relator also alleged that the pharmaceutical company manipulated Medicaid rebate amounts owed to the government and falsely reported the "average manufacturer price" (AMP) and "best price" of certain drugs in order to "market

the spread" to downstream purchasers.

Robinson & Cole filed a motion to dismiss all counts alleged against the specialty pharmacy. The specialty pharmacy argued that the relator was not the original source of the alleged kickback violations, and that the relator's claim was barred by the "first-to-file" exception because other litigants had alleged similar conduct in lawsuits that were already pending at the time the relator filed his complaint.

The court agreed and dismissed the relator's claims under the public disclosure and first-to-file bars. With respect to public disclosure, the court noted that the relator's claims were preceded by a parade of previously filed cases against the pharmaceutical company. The court also observed that, prior to relator's complaint, several published media reports described the business practices that relator alleged to constitute illegal "schemes." Despite the fact that the prior suits and media reports did not identify the specialty pharmacy as a participant in the alleged scheme, the court found that the information contained in the public record was similar enough to relator's allegations as to bar the relator's claims as against both defendants. The court also rejected the relator's claim that he was an "original source" of the publicly disclosed information on the ground that he made no showing that he had first-hand knowledge of the scheme alleged in his complaint. With respect to the first-to-file bar, the court found that the previously filed suits involved conduct nearly identical to that described in relator's complaint, and held that the similarity between the suits was fatal to the relator's claim.

If you have questions about any of these topics, please contact a member of Robinson & Cole's Health Law Group.

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