UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

CASE NO. 1:17-cv-20039-KMW

MSPA CLAIMS 1, LLC, a Florida limited liability company, as assignee of Florida Healthcare Plus, on behalf of itself and all other similarly situated Medicare Advantage Organizations in the State of Florida,

Plaintiff,

v.

TENET FLORIDA, INC., a Foreign Profit Corporation, and ST. MARY'S MEDICAL CENTER, INC., a Florida Profit Corporation,

Defendants.
_________________________________/

DEFENDANTS ST. MARY'S MEDICAL CENTER INC.'S AND TENET FLORIDA, INC.'S CASE DISPOSITIVE MOTION TO DISMISS PLAINTIFF'S SECOND AMENDED COMPLAINT AND SUPPORTING MEMORANDUM OF LAW

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Pursuant to Federal Rules of Civil Procedure 12(b)(1) and (6), Defendants, St. Mary's Medical Center, Inc. ("Hospital" or "St. Mary's") and Tenet Florida, Inc. ("Tenet Florida") (collectively referred to herein as "Defendants"), by and through undersigned counsel, respectively move this Court to dismiss with prejudice Plaintiff MSPA Claims 1, LLC's ("Plaintiff") Second Amended Complaint [Dkt. 17] ("SAC") in its entirety for lack of subject-matter jurisdiction and failure to state a claim. In support of this Motion, the Defendants state as follows:

FACTUAL AND PROCEDURAL BACKGROUND

This is Plaintiff's third attempt to pursue reimbursement of monies that were fully repaid to Florida Healthcare Plus, Inc. ("FHCP"), the proper party-in-interest, nearly two years before Plaintiff filed its initial complaint, and to "recoup" monies that were never paid at all to Defendants. Moreover, Plaintiff seeks to invalidate contracts to which it is not a party, and which could not be assigned to Plaintiff. Plaintiff's claims are not cognizable as a matter of fact or law, and should be dismissed with prejudice, as any further amendments would be futile.

Defendant St. Mary's operates an acute care hospital located in Palm Beach County. Tenet Florida, on behalf of St. Mary's, entered into a Hospital Services Agreement with FHCP, effective May 1, 2013 ("Agreement"), which was in effect at all relevant times hereto. A copy of the Agreement is attached to the Second Amended Complaint as Exhibit E [Dkt. 17-5]. The Agreement contains, among other things, provisions addressing payment obligations by FHCP (¶ 4.1), coordination of benefits and subrogation (¶ 4.4), and overpayments (¶ 4.5).

Specifically, ¶ 4.4 permits the Hospital to bill FHCP as well as other parties, in whole or in part, for the services rendered by the Hospital to a patient who is an FHCP member:

> 4.4 Coordination of Benefits and Subrogation. Coordination of Benefits means a method of sequentially assigning responsibility for the payment of Covered Services rendered to a Member when a party other than [FHCP] is identified as having primary responsibility for payment of or reimbursement for Covered

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> Services. If [FHCP] is other than primary, [FHCP] will pay amounts which, when added to amounts to be received by Hospital from other sources, equal to the sum of the compensation amounts set forth in this Agreement plus Copayments, Coinsurance, and Deductible, but in no event any more than the amount that would have been paid had the [FHCP] been primary. **Nothing herein shall prohibit Hospital from pursuing any other amounts that they are legally entitled to pursue for providing Covered Services to Members. Hospital shall be timely compensated by [FHCP]** in accordance with Section 4.1 and Exhibit D of this Agreement **as if [FHCP] has primary responsibility for such Covered Services while Coordination of Benefits and/or subrogation rights regarding Members are being pursued by [FHCP]**. (emphasis added).

The Agreement also provides the mechanism and remedy for any overpayments to the Hospital:

> 4.5 Overpayments. [FHCP] specifically agree [sic] not to offset, deduct or recoup any amounts from any other payments that [FHCP] believes that Hospital, any entity affiliated with Hospital, or Hospital, owes [FHCP] or [FHCP] or any entity affiliated with [FHCP], under this Agreement or any other agreement. All requests for refunds shall be submitted to Hospital in writing within twelve (12) months from the date of initial payment on the claim in order to be eligible for repayment. Any requests received after this time shall be void as to the claims for such twelve-month period, and the initial payment of such claims shall be final. If [FHCP] returns a refund sent to [FHCP] by Hospital, Hospital shall keep the returned refund and [FHCP] shall not attempt to collect refund again.

The Agreement also contains an express non-assignment provision which prohibits FHCP from assigning its rights under the contract, in whole or in part, without the Hospital's consent:

> 6.7 Assignment. Neither party may assign this Agreement in whole or in part without the express written consent of the other party. Further, this Agreement shall not inure to the benefit of any successors in interest without the express written consent of the other party.

Though Plaintiff recognizes the applicability of the Agreement and ¶¶ 4.4 and 4.5 to this matter throughout the Second Amended Complaint, Plaintiff fails to acknowledge the anti-assignment provision.

Plaintiff alleges that on or about September 3, 2013, a patient[1] ("Enrollee") involved in an auto accident presented at St. Mary's for treatment. The Hospital billed the Enrollee's auto

[1] Plaintiff acknowledges that the patient was an insured of FHCP and refers to the patient as "Enrollee." SAC, p. 2 & n. 1. For consistency, the patient is referred to herein as "Enrollee".

insurance, Allstate Fire and Casualty Insurance Company ("Allstate"), and the Enrollee's health insurance, FHCP, pursuant to the Agreement. Plaintiff alleges that Allstate paid first, and FHCP paid second, and that the two insurers paid different amounts:

> 48. On October 18, 2013, Allstate, as a primary payer, was billed $2,086.00 and paid $1,251.60 to St. Mary's for the medical items and services provided to Enrollee.
>
> 49. On November 18, 2013, FHCP, as a secondary payer, was billed $2,086.00 and paid $285.75 to St. Mary's for the medical items and services provided to Enrollee.

SAC ¶¶ 48-49.

On August 29, 2014, St. Mary's reimbursed FHCP $285.75, the full amount FHCP had paid to St. Mary's. Plaintiff admits that FHCP received back from St. Mary's the full amount FHCP had paid St. Mary's, and attaches the reimbursement check to the Second Amended Complaint. *See* SAC ¶ 53 and Check #003480696, attached thereto as Ex. G [Dkt. 17-7].[2]

FHCP was placed into receivership in December 2014 and was ordered liquidated effective January 1, 2015. *See* SAC ¶ 9. The State of Florida Department of Financial Services ("DSF") is the Court-appointed receiver for FHCP. *Id*. Plaintiff does not allege, nor could it, that FHCP ever alerted St. Mary's of any purported assignment to Plaintiff or requested St. Mary's approval of any assignment, or that St. Mary's consented to any assignment to Plaintiff.

On June 9, 2016, Plaintiff filed a two-count complaint in Florida state court against St. Mary's only, alleging (i) violation of Florida's Deceptive and Unfair Trade Practices Act ("FDUTPA") (Count I) and (ii) unjust enrichment (Count II) (the "Initial Complaint"). Tenet Florida, Inc. was not named in, and was not a party to, the Initial Complaint. The crux of the Initial Complaint alleged that St. Mary's wrongfully billed both Allstate and FHCP, and retained payment

[2] Plaintiff attached an incomplete copy of the check to the Second Amended Complaint. A complete copy of the check, reflecting the endorsement by FHCP and deposit at Sabadell United Bank, is attached hereto as Exhibit 1.

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from FHCP which it was not entitled to retain. The Initial Complaint made no mention of the Agreement or the full reimbursement St. Mary's made to FHCP nearly two years prior, and sought no relief under the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)(3)(A) ("MSP Act").

St. Mary's moved to dismiss the Initial Complaint [Dkt. 7-16] for improper venue and on other grounds. On December 6, 2016, the day before the motion was to be heard by the Florida state court, Plaintiff served an Amended Complaint [Dkt. 7-22]. The Amended Complaint added Tenet Florida, Inc. as a party, and two new claims against both Defendants: (i) for violation of the MSP Act, 42 U.S.C. § 1395y(b)(3)(A) (Count I); and (ii) for declaratory relief, in part requesting a declaration of Plaintiff's rights under 42 C.F.R. § 422.108(f) (Count IV), in addition to reasserting claims for violation of FDUTPA (Count II) and for unjust enrichment (Count III).

On January 5, 2017, Defendants removed this matter to this Court and, on January 12, 2017, filed a Motion to Dismiss the Amended Complaint [Dkt. 6]. The Motion to Dismiss identified numerous pleading deficiencies in the Amended Complaint, including that Plaintiff lacked standing, the MSP Act does not apply to this matter and, even if it did, all actions alleged in the Amended Complaint were permissible pursuant to the Agreement and the MSP Act.

In response, Plaintiff filed a Second Amended Complaint on February 9, 2017. The Second Amended Complaint is substantively identical to the Amended Complaint, and asserts the same five claims in the Amended Complaint:

Count I – Violation of the MSP Act against St. Mary's;
Count II – Violation of FDUTPA against St. Mary's;
Count III – Unjust enrichment against St. Mary's;
Count IV – Declaratory action against Tenet Florida; and
Count V – Declaratory action against St. Mary's.

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SUMMARY OF ARGUMENT

Plaintiff's claims in the Second Amended Complaint are all based on the same fundamentally flawed bases asserted in the previous complaints. As a preliminary matter, the Second Amended Complaint should be dismissed in its entirety because Plaintiff lacks standing. A non-assignment provision in FHCP's contract with St. Mary's negated any purported assignment to Plaintiff. Moreover, because St. Mary's issued a full refund to FHCP two years before this suit was initiated, this is no injury in fact.

Even if there were standing (which there is not), Plaintiff's claims all fail on their merits. Count I (the MSP Act) should be dismissed because 1) Congress only created a private right of action against primary payers, not providers, and 2) the relationship between St. Mary's and FHCP is governed by their Agreement, not the MSP Act.

Count II (FDUTPA) should be dismissed because 1) conduct cannot violate FDUTPA where it is expressly permitted by the parties' contract, 2) federal law regarding coordination of benefits would preempt any state law claim, and 3) St. Mary's fully refunded FHCP's payment and therefore FHCP suffered no actual injury. Count III (unjust enrichment) should be dismissed because 1) St. Mary's fully refunded FHCP's payment and 2) the parties had an express contract that governed the subject payments.

Count V (declaratory relief against St. Mary's) should be dismissed because 1) Plaintiff is not a party to (or proper assignee of) the contract, 2) the MSP Act does not prohibit an MAO and a provider from negotiating their own contractual terms, and 3) St. Mary's full refund to FHCP negates any actual controversy to adjudicate. And with respect to Count IV, in addition to the reasons necessitating dismissal of the declaratory relief claim against St. Mary's, the declaratory relief claim against Tenet Florida should also be dismissed because 1) Tenet Florida was an agent with a disclosed principal, and

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therefore is not a party to the Agreement, and 2) the statute of limitations bars Plaintiff's claim against Tenet Florida.

For all of these reasons, as set forth more fully below, Plaintiff's claims are not cognizable as a matter of law, and the Second Amended Complaint should be dismissed with prejudice.

MEMORANDUM OF LAW

A. The Second Amended Complaint Should Be Dismissed with Prejudice in Its Entirety for Lack of Standing

Standing is a threshold jurisdictional question. *Stalley ex rel. U.S. v. Orlando Reg'l Healthcare Sys., Inc.*, 524 F.3d 1229, 1232 (11th Cir. 2008). A dismissal for lack of standing has the same effect as a dismissal for lack of subject matter jurisdiction. *Id.* A motion to dismiss for lack of subject matter jurisdiction under Rule 12(b)(1) of the Federal Rules of Civil Procedure can be either a "facial attack" or a "factual attack." *Lawrence v. Dunbar*, 919 F.2d 1525, 1528-29 (11th Cir. 1990). "A facial attack on the complaint requires the court merely to look and see if the plaintiff has sufficiently alleged a basis of subject matter jurisdiction, and the allegations in his complaint are taken as true for the purposes of the motion." *McElmurray v. Consol. Gov't of Augusta-Richmond Cty.*, 501 F.3d 1244, 1251 (11th Cir. 2007). Plaintiff lacks standing because 1) FHCP is the real party in interest and the Agreement's anti-assignment provision precluded FHCP from assigning the rights that Plaintiff purports to assert, and 2) FHCP suffered no injury-in-fact because the Hospital refunded the full amount of the payment remitted by FHCP.

1. Plaintiff's Claims are Barred by the Anti-Assignment Provision of the Agreement

All of Plaintiff's claims are premised upon a purported assignment of contractual rights to Plaintiff. Plaintiff details the purported assignment of rights in ¶¶ 6-18 of the Second Amended Complaint and attaches the purported assignment agreements at Exhibits A-D. Specifically, Plaintiff alleges that, just prior to the receivership, FHCP assigned its rights under the Agreement to La Ley

Recovery Systems, Inc. ("La Ley") and La Ley, in turn, assigned these rights to Plaintiff. SAC ¶¶ 6-18. Plaintiff alleges that these assignments provide standing for Plaintiff to pursue claims against Defendants for the allegedly improper payments made by FHCP. *Id.*

Plaintiff's assertions regarding standing are belied the express terms of the Agreement, which is attached as Exhibit E to the Second Amended Complaint. *See* SAC ¶¶ 56-60 and Exhibit E. As discussed above, the Agreement contains an express anti-assignment provision which prohibits FHCP from assigning its rights under the contract, in whole or in part, without the Hospital's consent. *See* Agreement, ¶ 6.7. Plaintiff does not (and cannot) allege that either Defendant provided express, written consent to either assignment.

In an attempt to circumvent the Agreement's express anti-assignment provision, Plaintiff alleges that DFS, "stepping into the shoes of FHCP," unilaterally approved the assignment. SAC ¶ 9. A party cannot assign its rights, however, where a contractual assignment provision requires consent. *See e.g. Amjems, Inc. v. F.R. Orr Const. Co., Inc.*, 617 F. Supp. 273, 277 (S.D. Fla. 1985) (holding that, where consent was a requirement to the assignment, and no consent was given, no assignment took place). Therefore, any assignments from FHCP to La Ley and from La Ley to Plaintiff are invalid with respect to Defendants. *See L.V. McClendon Kennels, Inc. v. Inv. Corp. of S. Florida*, 490 So. 2d 1374, 1375 (Fla. 3d DCA 1986) (explaining that contractual rights are not assignable if the contract prohibits assignment).

Moreover, in several recent decisions involving Plaintiff and/or its affiliates, this Court has held that Plaintiff lacked standing as an assignee where consent was required, but not given, for an assignment to be valid. For example, this Court ruled that Plaintiff – suing as a purported assignee of FHCP via La Ley, just as it does here – "does not have standing to bring this action because it does not hold a valid assignment." *MSPA Claims 1, LLC v. United Automobile Ins. Co.*,

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16-CV-20486-KMW, ECF No. 40 (S.D. Fla. Aug. 29, 2016); *MSPA Claims 1, LLC v. First Acceptance Ins. Co.*, 16-CV-20314-KMW, ECF No. 57 (S.D. Fla. Aug. 29, 2016) (same),

This Court has reached that same decision in several other cases as well against the same Plaintiff. *MSPA Claims 1, LLC v. Covington Specialty Ins. Co.*, 16-CV-20338-JAL, ECD No. 53 (S.D. Fla. Sep. 30, 2016); *MSPA Claims 1, LLC v. Infinity Auto Ins. Co.*, No. 1620320-CIV-COOKE/TORRES, 2016 WL 4531943, at *1 (S.D. Fla. Aug. 30, 2016); *MSPA Claims 1, LLC v. Nat'l Specialty Ins. Co.*, 16–CV–20401–MGC, ECF No. 61, 2016 WL 4479372 (S.D. Fla. Aug. 25, 2016); *MSPA Claims 1, LLC v. Tower Hill Prime Ins. Co.*, No. 16–CV–20459–KMM, ECF No. 42, 2016 WL 4157592 (S.D. Fla. Aug. 3, 2016); *MSPA Claims 1, LLC v. Tower Hill Prime Ins. Co.*, 16–CV–20460–KMM, ECF No. 27, 2016 WL 4157593 (S.D. Fla. Aug. 3, 2016); *MSPA Claims 1, LLC v. Kingsway Amigo Ins. Co.*, No. 16–CV–20212–JLK, ECF No. 35, 2016 WL 4154266 (S.D. Fla. July 27, 2016). In *Kingsway,* which this Court has repeatedly followed, this Court held that "[w]ithout a valid assignment of rights from Florida Healthcare Plus, Plaintiff does not have standing." *Kingsway*, 2016 WL 4154266 at *2. Consequently, Plaintiff's Second Amended Complaint should be dismissed with prejudice for lack of standing.

2. Plaintiff Suffered No "Injury-In-Fact"

In addition, to establish standing to bring suit, "a plaintiff must show (1) it has suffered an 'injury in fact' that is (a) concrete and particularized and (b) actual or imminent, not conjectural or hypothetical; (2) the injury is fairly traceable to the challenged action of the defendant; and (3) it is likely, as opposed to merely speculative, that the injury will be redressed by a favorable decision." *Birmingham v. Walgreen Co.*, 2014 WL 12479929 (S.D. Fla. Jan. 7, 2014) (Williams, J.). Further, "standing cannot be created after a complaint has been filed; it must exist at the time of the filing of the complaint." *See MSPA Claims 1, LLC v. Nat'l Specialty Ins. Co.*, 16–CV–20401–MGC, ECF No.

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61, 2016 WL 4479372 (S.D. Fla. Aug. 25, 2016) (recognizing that the Plaintiff in this case, having received numerous decisions of dismissal for lack of standing, "well knows" this principle). "If at any point in the litigation the plaintiff ceases to meet all three requirements for constitutional standing, the case no longer presents a live case or controversy, and the federal court must dismiss the case for lack of subject matter jurisdiction." *Id.*, citing *Fla. Wildlife Fed'n, Inc. v. S. Fla. Water Mgmt. Dist.,* 647 F.3d 1296, 1302 (11th Cir. 2011).

Plaintiff alleges that FHCP paid St. Mary's $285.75 (SAC ¶ 49), and St. Mary's repaid FHCP $285.75 nearly two years prior to Plaintiff bringing suit. *Id.* ¶ 53. Thus, the Second Amended Complaint demonstrates that FHCP lost no money and suffered no "injury-in-fact." Because St. Mary's repaid FHCP the full $285.75 in November 2014, even assuming Plaintiff were a valid assignee (which it is not), Plaintiff had no standing when it filed its initial complaint. As such, its claims for monetary damages must be dismissed with prejudice.

B. Count I Against St. Mary's Should be Dismissed with Prejudice

Even if Plaintiff did have standing (which it does not), the MSP Act claim fails to state a claim for relief, and should be dismissed with prejudice pursuant to Rule 12(b)(6), Fed. R. Civ. P.

1. The Private Right of Action Under the MSP Act Does Not Apply to Providers

The limited private action right under the MSP Act pursuant to 42 U.S.C. §1395y(3)(A) applies only "in the case of a primary plan which fails to provide for primary payment." Specifically, paragraph 3(A) states as follows:

> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

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42 U.S.C. §1395y(3)(A).[3] A "primary plan" is a group health plan, worker's compensation plan or law, automobile or other liability insurance policy or plan, no-fault insurance, or self-insured plan that has made or can reasonably be expected to make payment for an item or service. 42 U.S.C. § 1395y(b)(2)(A); *Humana Med. Plan, Inc. v. W. Heritage Ins. Co.*, 832 F.3d 1229, 1233 (11th Cir. 2016). As explained in *MSP Recovery, LLC v. Allstate Ins. Co.*, 835 F.3d 1351, 1355 (11th Cir. 2016):

> … though the MSP Act uses the term "primary plan" to describe entities with a primary responsibility to pay, that term covers more than just health insurance plans. The law defines a "primary plan" as "a group health plan or large group health plan, ... a workmen's compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan) or no fault insurance...." 42 U.S.C. § 1395y(b)(2) (A). Thus, it is clear that the defendants in this case—which are all personal injury protection no-fault carriers—are primary plans within the meaning of the MSP Act.
>
> The mechanics of the reimbursement process are set out in the statute as follows. The law requires a primary plan to reimburse Medicare "if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service." 42 U.S.C. § 1395y(b)(2)(B)(ii). (Emphasis added).

See also Humana Med. Plan, 832 F.3d at 1238 ("We conclude that paragraph (3)(A), the MSP private cause of action, permits an MAO to sue a primary plan that fails to reimburse an MAO's secondary payment.") (emphasis added).

By its express terms, the MSP Act does not apply to providers. Though the Eleventh Circuit

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[3] Incredibly, in yet another effort to re-write the MSP Act, Plaintiff contends that St. Mary's was required to refund to FHCP the total amount the Hospital billed for its services, notwithstanding the amount FHCP, in fact, paid. Compare SAC ¶ 49 ("FHCP … was billed $2,086.00 and paid $285.75 to St. Mary's") with SAC ¶ 53 ("St. Mary's was required to pay $2,086.00, representing the charged amount billed to Plaintiff within sixty (60) days of the receipt of the payment"). There is no provision under the MSP Act which entitles an MAO to a refund based on charges which it did not pay in the first instance. *See generally Humana Med. Plan*, 832 F.3d at 1238 ("We have held that paragraph (3)(A) [of the MSP Act] is not a *qui tam* statute but is instead available only when the plaintiff has suffered an injury in fact."). If Plaintiff were to receive $2,086 from St. Mary's, it would result in a windfall to Plaintiff. Consequently, Plaintiff's claim for damages in the amount of billed charges must be stricken.

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Court of Appeals has not directly addressed this issue[4], it has repeatedly recognized that the private right of action under the MSP Act applies to primary plans. *See e.g. Humana Med. Plan,* 832 F.3d at 1234 ("[t]he MSP private cause of action is not a *qui tam* statute but is available to a Medicare beneficiary whose primary plan has not paid Medicare or the beneficiary's healthcare provider."), citing *Stalley ex rel. U.S. v. Orlando Reg'l Healthcare Sys., Inc.*, 524 F.3d 1229, 1234 (11th Cir. 2009); *Glover*, 459 F.3d at 1310 (explaining that the MSP private cause of action is available against a primary plan). Similarly, the Ninth Circuit Court of Appeals declined to extend the MSP Act beyond a primary plan, finding that the plaintiff made no claim against the primary plan, nor had that plan failed to provide for payment. *See Parra v. PacifiCare of Ariz., Inc.*, 715 F.3d 1146 (9th Cir. 2013).

Plaintiff concedes that the MSP Act private cause of action is aimed at primary plans. *See* SAC at ¶ 121 ("The MSP private cause of action and its corresponding regulations permit an MAO to sue a primary plan that fails to reimburse an MAO's secondary payment.") (emphasis added). Plaintiff further alleges that the rights it was purportedly assigned were only those against a primary plan. *See id.* at ¶ 6 ("FHCP assigned all its aforementioned subrogation claims, recovery, and reimbursement rights against any liable primary payer") (emphasis added); ¶ 18 ("Plaintiff possesses all of FHCP's subrogation rights to pursue and recover all medical claims, bills, and expenses FHCP provided on behalf of its MA enrollee from and against any liable primary payer") (emphasis added).

Because Plaintiff does not allege that St. Mary's is a primary plan (nor could it), Plaintiff's claim against St. Mary's under the MSP Act in Count I of the Second Amended Complaint fails

[4] The Eleventh Circuit recently declined to address the issue. *See Humana Med. Plan,* 832 F.3d at 1237, n. 4 ("The parties do not argue and we do not consider whether the Government cause of action described in paragraph (2)(B) [to recover from an entity that has received payment from a primary plan] was intended to be available to MAOs.").

as a matter of law.

2. The Payments Made to St. Mary's by FHCP Were Made Pursuant to the Agreement, Not the MSP Act

In addition, the payments and claims which are the subject of this case do not arise under the MSP Act, but rather are governed by the terms of the Agreement. "[W]hen the exhibits contradict the general and conclusory allegations of the pleading, the exhibits govern." *Hernandez v. J.P. Morgan Chase Bank, N.A.*, No. 14-24254-CIV-Goodman, 2015 WL 9302827, at *6 (S.D. Fla. Dec. 21, 2015) (quoting *Griffin Indus., Inc. v. Irvin*, 496 F.3d 1189, 1206 (11th Cir. 2007)). Because the terms of the Agreement negate Plaintiff's MSP Act claim, Count I should be dismissed pursuant to Rule 12(b)(6), Fed. R. Civ. P., for failure to state a claim against Defendants.

Plaintiff recognizes that the Agreement governs these transactions. *See, e.g.,* SAC ¶¶ 56-58, 123-125, 132-134. In an apparent effort to avoid the plain terms of the Agreement which defeat its claims, Plaintiff seeks to invalidate those provisions of the Agreement. To do so, Plaintiff wrongly contends that a regulation promulgated by the United States Department of Health and Human Services ("HHS"), 42 C.F.R. § 422.108(f), should be read to preempt all private contract provisions regarding reimbursement to an MAO. Not so.

The regulation provides:

> Consistent with § 422.402 concerning the Federal preemption of State law, the rules established under this section supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to MA plans.

42 C.F.R. § 422.108(f). By its express terms, this regulation only applies to state contract regulations that conflict with federal contract regulations, which are not at issue here. It does not, as Plaintiff contends, prohibit private parties from negotiating contractual payment terms. *See generally Fairfield Cty. Med. Ass'n v. United Healthcare of New England*, 985 F. Supp. 2d 262, 270 (D. Conn. 2013), *aff'd as modified sub nom. Fairfield Cty. Med. Ass'n v. United Healthcare of*

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New England, Inc., 557 F. App'x 53 (2d Cir. 2014) ("[T]he Medicare Act requires that states do not interfere with the scope, implementation, or performance of Medicare plans offered by private organizations. It does not, however, preempt courts from reviewing agreements between physicians/providers and private Medicare plan providers to enforce the procedural rights set forth in those agreements.").

Indeed, when HHS promulgated regulations to implement the Medicare Advantage program, it expressly authorized MAOs, such as FHCP, and providers, such as the Hospital, to contract upon their own agreed-upon terms:

> (b)(1) Contracts between MA organizations and providers and suppliers. Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, **the terms of which are developed and agreed to by both the MA organization and the relevant provider**.
>
> (2) **The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider**. (emphasis added).

42 C.F.R. § 422.520(b). HHS clearly reinforced these basic and fundamental principles in two extensively reasoned *amicus* briefs, submitted nearly ten years apart:

> Unlike the relationship between a Medicare Advantage organization and its plan enrollees, which is heavily regulated by federal law and federal contract, **the terms of the contractual relationship between the Medicare Advantage organization and its providers are left largely to the parties to define**. In particular, with exceptions that are not relevant here (*see, e.g.,* 42 C.F.R. § 422.208), **federal law does not prescribe the financial terms of contracts between Medicare Advantage organizations and health care providers**. Thus, if a Medicare Advantage HMO contracts with a hospital to provide inpatient care, **the financial arrangements between the HMO and the hospital are left to the parties to determine by private contract. If a dispute subsequently develops over the amount or timing of payments due the hospital under the contract, neither the Medicare Advantage statute nor CMS's regulations nor the agency's contract with the HMO provides any rule of decision for the dispute**. (emphasis added).

Brief for U.S. Dep't of Health & Human Servs. as *Amicus Curiae*, *Christus Health Gulf Coast v.*

Aetna, Inc., 237 S.W.3d 338 (Tex. 2007), *available at* 2006 WL 985225, at *6.[5] In another case nearly ten years later, HHS reiterated:

> Unlike the relationships between MAOs and their enrollees—which are regulated by the Medicare Act, CMS regulations, and the contracts between the MAOs and CMS—**the terms of MAOs' contractual relationships with providers are largely left to the parties to define**. MAOs have wide latitude in negotiating the financial terms of these arrangements. Cf., e.g., 42 C.F.R. § 422.208 (example of one of the few restrictions—barring certain "physician incentive plans"). (emphasis added).

Brief for U.S. Dep't of Health & Human Servs. as *Amicus Curiae*, *Ohio State Chiropractic Ass'n v. Humana Health Plan Inc.*, No. 15-3130, 2016 WL 2641121, at 3 (6th Cir. May 9, 2016).[6]

Thus, HHS has very clearly pronounced that a hospital, like St. Mary's, may negotiate and contract for payment terms with an MAO, like FHCP, including treatment of overpayment refunds, that are free from federal regulation and that differ from the payment terms applicable under the traditional Medicare program. In short, HHS's interpretation of its own regulations, which should be accorded "substantial deference" by this Court, conclusively defeats Plaintiff's strained (and wrong) contrary interpretation.[7]

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[5] A copy of the Amicus Brief is attached hereto as Exhibit 2.

[6] A copy of the Amicus Brief is attached hereto as Exhibit 3.

[7] An agency's interpretation of a statute that it is charged with applying, including an interpretation that is first set forth in an amicus brief, is entitled to "substantial deference" under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944), "depending upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Pugliese v. Pukka Dev., Inc.*, 550 F.3d 1299, 1305 (11th Cir. 2008) (citations and internal quotations omitted). In *Pugliese*, the Court deferred to a federal administrative agency's interpretation of a statute that was set forth in an amicus brief, because the amicus brief was "thoroughly reasoned and demonstrates a high level of consideration given to the issue" and was "consistent with earlier and later pronouncements" by the agency. 550 F.3d at 1305. The Court here should likewise accord "substantial deference" to HHS's interpretation of its own regulations, stated in two separate and thoroughly reasoned *amicus* briefs nearly ten years apart, providing that federal law does not dictate the terms of the relationship between an MAO and a provider and that the MAO's contract terms with the provider govern.

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Plaintiff alleges that St. Mary's violated the MSP Act by initially submitting claims to two payers and by failing to timely refund FHCP's payment. St. Mary's, however, had bargained for and contracted with FHCP regarding the payment terms under the Agreement. The Agreement provides that FHCP was responsible for coordination of benefits for its enrollees with other potentially responsible payers, that FHCP would have to pay promptly even where another payer might have primary responsibility, and that FHCP would have to request refunds in writing within 12 months of initial payment. *See* Agreement, §§ 4.4, 4.5.[8] Pursuant to the Medicare Advantage regulations, *e.g.* 42 C.F.R. 422.520, *supra*, St. Mary's negotiated terms with FHCP, *i.e.* the Agreement, define its obligations to FHCP. Significantly, the Agreement did not prohibit the Hospital from submitting bills to more than one potentially responsible party simultaneously, did not allocate to the Hospital the responsibility for identifying payments from different payers related to the same service, did not impose a 60-day deadline for refunding payments if a second payer remitted payment, and did not provide for double damages in the event of an overpayment.

Because St. Mary's and FHCP negotiated their own payment terms, St. Mary's was permitted to submit simultaneous claims to both Allstate and FHCP, FHCP was required to pay the Hospital promptly notwithstanding the claim submitted to Allstate, and FHCP was obligated to request a refund from St. Mary's in writing within 12 months if it believed one was due. Moreover, even if St. Mary's had an obligation to refund FHCP's payment within 60 days (which it did not), the contractual requirement that FHCP request a refund of any purported overpayment in writing within 12 months as a condition precedent to any obligation on the part of the Hospital

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[8] Considering that FHCP necessarily has a direct contractual relationship with its Enrollee and is therefore better positioned than the Hospital to seek information from its Enrollee regarding other potentially responsible parties, the parties' decision to allocate responsibility for coordinating benefits and for requesting refunds from the insurer, rather than the service provider, is logical and is in fact common throughout the industry.

is enforceable. *See, e.g., Galindo v. ARI Mutual Ins. Co.,* 203 F.3d 771 (11th Cir. 2000) (recognizing failure to comply with conditions precedent under insurance contract); *Ferrer v. Fidelity and Guaranty Ins. Co.,* 10 F.Supp.2d 1324 (S.D. Fla. 1998). Having failed to request a refund within twelve months of payment (and having already received a full refund of all amounts paid), FHCP failed to fulfill a condition precedent under the Agreement and FHCP (or Plaintiff) cannot assert a right to any repayment now. In sum, the terms of the Agreement, not the MSP Act, control the subject relationship between FHCP and St. Mary's, and conclusively defeat Plaintiff's claim for the alleged violation of the MSP Act.

C. Count II for Violation of FDUTPA Against St. Mary's Should be Dismissed with Prejudice

Count II should be dismissed because St. Mary's billing practices were expressly permitted by the Agreement, because federal law regarding coordination of benefits would preempt a state law FDUTPA claim and because Plaintiff suffered no injury.

To the extent Plaintiff contends that St. Mary's submission of bills to both Allstate and FHCP was an unlawful practice, its claim fails as a matter of law because the Agreement expressly permits the Hospital to bill FHCP as well as other parties, in whole or in part, for the services rendered by the Hospital to a patient who is an FHCP member. *See* Agreement, ¶ 4.4. A FDUTPA claim does not lie where the alleged unfair or deceptive conduct is permitted by a contract between the parties. *See, e.g., Zlotnick v. Premier Sales Group, Inc.*, 431 F.Supp.2d 1290, 1295 (S.D. Fla. 2006) ("Plaintiff has failed to state a claim under FDUTPA because the express terms of the contract allowed" defendant's alleged conduct).

The Agreement specifically contemplates that St. Mary's would bill FHCP *and* other possibly responsible insurers concurrently for the same services. Indeed, the Agreement explicitly obligates FHCP to make timely payment to the Hospital "as if it has primary responsibility," even where there

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may be another payer which has primary responsibility, and allocates the responsibility for coordinating the Enrollee's benefits to FHCP, not to the Hospital. *See* Agreement, ¶ 4.4. The Agreement also provides the mechanism and remedy for any resulting overpayments to the Hospital. *See* Agreement, ¶ 4.5. Because FHCP and the Hospital expressly agreed to terms for billing, payment and refunds of any overpayments, this billing mechanism cannot be an unfair or deceptive trade practice as a matter of law. *See Zlotnick*, 431 F.Supp.2d at 1295.

Moreover, even if St. Mary's and FHCP had not bargained for payment terms and the MSP Act applied (which it does not), federal law specifically provides for coordination of benefits in cases where Medicare is not the primary payer. Like the Agreement, 42 U.S.C. § 1395y(b)(2)(B) provides for conditional payments to healthcare providers when a Medicare payer is not or may not be the primary payer and for appropriate reimbursement. *See also* SAC ¶ 36 ("The MSP Law creates a federal coordination of benefits framework"). This federal law governing the coordination of benefits when a Medicare payer is not the primary payer preempts any claim that such coordination of benefits practices are unfair or deceptive under Florida law. *See United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 622–23 (1st Cir. 1996) (holding that the coordination of benefits provisions of the MSP Act preempt state law purporting to effect coordination of Medicare benefit practices); *see also Humana Med. Plan*, 832 F.3d at 1232 (explaining that "the Medicare Act … expressly preempts state law"). As the Eleventh Circuit explained:

> Frequently, more than one insurer is liable for an individual's medical costs. For example, a car accident victim may be entitled to recover medical expenses from both her health insurer and a tortfeasor's liability insurer. To address such situations, the MSP allocates liability between Medicare and other insurers, known as "primary plans."

Id. at 1233. Because federal law permitted St. Mary's to bill multiple potentially responsible parties

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concurrently, Plaintiff's claim that such a practice violates FDUTPA is preempted.

Plaintiff's FDUTPA claim also fails because Plaintiff incurred no actual injury. *See Rollins, Inc. v. Butland*, 951 So.2d 860 (Fla. 2d DCA 2006) (holding that FDUTPA requires actual loss and does not provide for the recovery of nominal or speculative damages). Any assertion that St. Mary's billing or reimbursement of FHCP was a deceptive and unfair trade practice is belied by Plaintiff's allegation that St. Mary's refunded FHCP's payment in full. SAC ¶ 53 & Exh. G.

For these reasons, Plaintiff's claim for violation of FDUTPA should be dismissed with prejudice, and Defendant St. Mary's should be awarded its costs and fees pursuant to Fla. Stat. §§ 501.2105 & 501.211.

D. Count III for Unjust Enrichment Against St. Mary's Should be Dismissed with Prejudice

Plaintiff's claim for unjust enrichment against St. Mary's should be dismissed with prejudice because the Hospital repaid FHCP in full and an express contract governed the payment.

First, Plaintiff alleges that "St. Mary's failed to appropriately reimburse Plaintiff" and that it would be "unjust and inequitable for St. Mary's to keep monies which belong to Plaintiff." SAC ¶¶ 117-118. Yet, Plaintiff alleges that FHCP conferred a direct benefit upon St. Mary's of $285.75, and that St. Mary's refunded the $285.75 to FHCP nearly two years before Plaintiff filed suit. *Id. See* ¶¶ 49, 53. Plaintiff even attaches the repayment check to the Second Amended Complaint. Having admitted that St. Mary's returned to FHCP all moneys that FHCP had paid to St. Mary's, Plaintiff's claim must be dismissed with prejudice. *See* SAC Exhibit G.

Second, even if St. Mary's had not fully refunded FHCP's payment, a claim for unjust enrichment cannot be asserted where an express contract governs the dispute. *See Alhassid v. Bank of Am., N.A.*, 60 F.Supp.3d. 1302, 1322 (S.D. Fla. 2014) ("It is well settled that the law will not imply a contract where an express contract exists concerning the same subject matter …Therefore, an unjust

enrichment claim [is] precluded by the existence of an express contract between the parties concerning the same subject matter.") (internal quotes omitted). Because the Agreement governed the relationship between FHCP and the Hospital, Plaintiff's claim for unjust enrichment fails as a matter of law.

E. Count V Seeking Declaratory Relief Against St. Mary's Should be Dismissed with Prejudice

Plaintiff's declaratory relief claim against St. Mary's fails for the same reasons that negate its other claims. First, because Plaintiff is not a party to the Agreement (and cannot be an assignee), it has no standing to seek an interpretation of or to invalidate the contract. *See supra* at 6-8. Second, the MSP Act does not prohibit an MAO and a provider from negotiating their own payment and reimbursement terms. *See supra* at 12-16. And third, Plaintiff's claims regarding the Agreement are moot. *See generally Nat'l Parks Conservation Ass'n, Inc. v. U.S. Army Corps of Eng'rs*, 574 F. Supp. 2d 1314, 1327 (S.D. Fla. 2008) ("The test for determining whether complaint seeking declaratory relief survives a mootness challenge is whether there exists a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment.") (internal quotes omitted); *Blitz Telecom Consulting, LLC v. Peerless Network, Inc.*, 151 F. Supp. 3d 1294, 1302 (M.D. Fla. 2015) ("a controversy is not sufficiently immediate or real where the parties' dispute is only hypothetical and not yet ripe, has been rendered moot, or where the court's resolution of the matter would be purely academic."). Because FHCP received back all of the money it paid to St. Mary's, there is no substantial controversy regarding its rights under the Agreement. Moreover, because FHCP has been liquidated, there are no adverse interests of sufficient immediacy to warrant a declaratory judgment.

F. Count IV Seeking Declaratory Relief Against Tenet Florida Should be Dismissed with Prejudice

Plaintiff's sole claim against Tenet Florida, also a declaratory relief claim, fails for the

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same reasons applicable to the declaratory relief claim against St. Mary's and two additional reasons. Tenet Florida is not a proper defendant to a declaratory relief claim regarding the Agreement because Tenet Florida signed the contract expressly and only in its capacity as an agent for St. Mary's and the other identified hospitals. *See* Agreement, p.1. "The Restatement (Second) of Agency § 320 (1958) states: Unless otherwise agreed, a person making or purporting to make a contract with another as agent for a disclosed principal does not become a party to the contract." *Philip Schwartz, Inc. v. Gold Coast Graphics, Inc.*, 623 So. 2d 819, 820 (Fla. 4th DCA 1993). Because Tenet Florida was not a party to the Agreement, it is not subject to a declaratory relief claim regarding its terms.

Finally, the claim against Tenet Florida is barred by the applicable statute of limitations. The MSP Act contains a 3-year limitations period "beginning on the date on which the item or service was furnished." 42 U.S.C.A. § 1395y (b)(2)(B)(vi); *see also Humana Med. Plan,* 832 F.3d at 1234 (11th Cir. 2016) (recognizing that 42 U.S.C. § 1395y (b)(2)(B)(vi) "establish[es] a limitations period."). All of Plaintiff's claims in this case arise from a payment made for a date of service on September 3, 2013. SAC ¶ 44. The Amended Complaint, which added Tenet Florida for the first time, was not filed until December 6, 2016 – more than three years later. Consequently, Count IV against Tenet Florida must be dismissed with prejudice.

CONCLUSION

WHEREFORE, for the foregoing reasons, Defendants St. Mary's Medical Center, Inc. and Tenet Florida, Inc. respectfully request that the Court: (i) grant Defendants' Motion to Dismiss the Second Amended Complaint in its entirety with prejudice; (ii) award St. Mary's its fees and costs pursuant to §§ 501.2105 and 501.211, Florida Statutes; and (iii) grant any and all further relief as the Court deems just and proper.

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 9th day of March, 2017, I electronically filed the foregoing with the Clerk of Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record identified on the attached Service List in the manner specified, either via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically Notices of Electronic filing.

By: /s/ Greg J. Weintraub
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