Case Nos. 85525 & 85656

In the Supreme Court of Nevada

UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Appellants, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Respondents.	Case No. 85525
UNITED HEALTHCARE INSURANCE COMPANY; UNITED HEALTH CARE SERVICES, INC.; UMR, INC.; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.; and HEALTH PLAN OF NEVADA, INC., Petitioners, *vs.* THE EIGHTH JUDICIAL DISTRICT COURT of the State of Nevada, in and for the County of Clark; and the Honorable NANCY L. ALLF, District Judge, Respondents, *vs.* FREMONT EMERGENCY SERVICES (MANDAVIA), LTD.; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C.; and CRUM STEFANKO AND JONES, LTD., Real Parties in Interest.	Case No. 85656

APPELLANTS' APPENDIX
VOLUME 14
PAGES 3251–3500

K. LEE BLALACK II
(*pro hac vice*)
JONATHAN D. HACKER (*pro hac vice forthcoming*)
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006

DANIEL F. POLSENBERG (SBN 2376)
JOEL D. HENRIOD (SBN 8492)
ABRAHAM G. SMITH (SBN 13,250)
KORY J. KOERPERICH (SBN 14,559)
LEWIS ROCA ROTHGERBER CHRISTIE LLP
3993 Howard Hughes Pkwy., Ste. 600
Las Vegas, Nevada 89169

D. LEE ROBERTS (SBN 8877)
COLBY L. BALKENBUSH (SBN 13,066)
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Ste. 400
Las Vegas, Nevada 89118

Attorneys for Appellants/Petitioners

CHRONOLOGICAL TABLE OF CONTENTS TO APPENDIX

Tab	Document	Date	Vol.	Pages
18.	Defendants' Opposition to Plaintiffs' Amended Motion to Remand	01/29/20	2	349–485
19.	Reply in Support of Amended Motion to Remand	02/05/20	2 3	486–500 501–518
20.	Order	02/20/20	3	519–524
21.	Order	02/24/20	3	525–542
22.	Notice of Entry of Order Re: Remand	02/27/20	3	543–552
23.	Defendants' Motion to Dismiss	03/12/20	3	553–698
24.	Notice of Intent to Take Default as to: (1) Defendant UnitedHealth Group, Inc. on All Claims; and (2) All Defendants on the First Amended Complaint's Eighth Claim for Relief	03/13/20	3 4	699–750 751
25.	Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	752–783
26.	Appendix of Exhibits in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	784–908
27.	Recorder's Transcript of Proceedings Re: Motions	04/03/20	4	909–918
28.	Defendants' Reply in Support of Motion to Dismiss	05/07/20	4	919–948
29.	Recorder's Transcript of Proceedings Re: Pending Motions	05/14/20	4	949-972
30.	First Amended Complaint	05/15/20	4 5	973–1000 1001–1021
31.	Recorder's Transcript of Hearing All Pending Motions	05/15/20	5	1022–1026
32.	Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint	05/26/20	5	1027–1172

Tab	Document	Date	Vol.	Pages
33.	Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	05/26/20	5	1173–1187
34.	Plaintiffs' Opposition to Defendants' Motion to Dismiss First Amended Complaint	05/29/20	5 6	1188–1250 1251–1293
35.	Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	05/29/20	6	1294–1309
36.	Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint	06/03/20	6	1310–1339
37.	Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motions to Dismiss Plaintiff's First Amended Complaint	06/03/20	6	1340–1349
38.	Transcript of Proceedings, All Pending Motions	06/05/20	6	1350–1384
39.	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
40.	Notice of Entry of Order Denying Defendants' (1) Motion to Dismiss First Amended Complaint; and (2) Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	06/24/20	6 7	1472–1500 1501–1516
41.	Notice of Entry of Stipulated Confidentiality and Protective Order	06/24/20	7	1517–1540
42.	Defendants' Answer to Plaintiffs' First Amended Complaint	07/08/20	7	1541–1590

Tab	Document	Date	Vol.	Pages
	Or, in The Alternative, Motion in Limine			
54.	Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses Production of Documents and Answers to Interrogatories	09/28/20	9	2196–2223
55.	Plaintiffs' Opposition to Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	09/29/20	9-10	2224–2292
56.	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents, and Answers to Interrogatories on Order Shortening Time	10/06/20	10	2293–2336
57.	Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures	10/07/20	10	2337–2362
58.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/08/20	10	2363–2446
59.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/22/20	10	2447–2481
60.	Defendants' Objections to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/23/20	10 11	2482–2500 2501–2572
61.	Defendants' Objections to Plaintiffs to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/26/20	11	2573–2670

Tab	Document	Date	Vol.	Pages
62.	Notice of Entry of Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on Order Shortening Time	10/27/20	11	2671–2683
63.	Notice of Entry of Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/27/20	11	2684–2695
64.	Defendants' Objections to Plaintiffs' Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs' to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	11/02/20	11	2696–2744
65.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	11/04/20	11 12	2745–2750 2751–2774
66.	Notice of Entry of Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	11/09/20	12	2775–2785
67.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/23/20	12	2786–2838
68.	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/30/20	12	2839–2859
69.	Notice of Entry of Stipulated Electronically Stored Information Protocol Order	01/08/21	12	2860–2874

Tab	Document	Date	Vol.	Pages
70.	Appendix to Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/08/21	12 13 14	2875–3000 3001–3250 3251–3397
71.	Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/11/21	14	3398–3419
72.	Plaintiffs' Opposition to Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/12/21	14	3420–3438
73.	Recorder's Partial Transcript of Proceedings Re: Motions (Unsealed Portion Only)	01/13/21	14	3439–3448
74.	Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14	3449–3465
75.	Appendix to Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14 15	3466–3500 3501–3658
76.	Recorder's Transcript of Proceedings Re: Motions	01/21/21	15	3659–3692
77.	Notice of Entry of Order Granting Defendants' Motion for Appointment of Special Master	02/02/21	15	3693–3702
78.	Notice of Entry of Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	02/04/21	15	3703–3713
79.	Motion for Reconsideration of Order Denying Defendants' Motion to Compel	02/18/21	15 16	3714–3750 3751–3756

Tab	Document	Date	Vol.	Pages
	Plaintiffs Responses to Defendants' First and Second Requests for Production			
80.	Recorder's Transcript of Proceedings Re: Motions	02/22/21	16	3757–3769
81.	Recorder's Transcript of Proceedings Re: Motions	02/25/21	16	3770–3823
82.	Recorder's Transcript of Hearing Defendants' Motion to Extend All Case Management Deadlines and Continue Trial Setting on Order Shortening Time (Second Request)	03/03/21	16	3824–3832
83.	Plaintiffs' Opposition to Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/04/21	16	3833–3862
84.	Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	16	3863–3883
85.	Errata to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/12/21	16	3884–3886
86.	Notice of Entry of Report and Recommendation #1	03/16/21	16	3887–3894
87.	Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/16/21	16	3895–3909
88.	Recorder's Transcript of Hearing All Pending Motions	03/18/21	16	3910–3915

Tab	Document	Date	Vol.	Pages
89.	Defendants' Opposition to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not be Held in Contempt and for Sanctions	03/22/21	16	3916–3966
90.	Recorder's Transcript of Hearing All Pending Motions	03/25/21	16	3967–3970
91.	Notice of Entry of Report and Recommendation #2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	03/29/21	16	3971–3980
92.	Recorder's Transcript of Hearing Motion to Associate Counsel on OST	04/01/21	16	3981–3986
93.	Recorder's Transcript of Proceedings Re: Motions	04/09/21	16 17	3987–4000 4001–4058
94.	Defendants' Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	04/12/21	17	4059–4079
95.	Notice of Entry of Report and Recommendation #3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time	04/15/21	17	4080–4091
96.	Recorder's Transcript of Hearing All Pending Motions	04/21/21	17	4092–4095
97.	Notice of Entry of Order Denying Motion for Reconsideration of Court's Order Denying Defendants' Motion to Compel Responses to	04/26/21	17	4096–4108

Tab	Document	Date	Vol.	Pages
	Defendants' First and Second Requests for Production			
98.	Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time	04/28/21	17	4109–4123
99.	Defendants' Errata to Their Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production	05/03/21	17	4124–4127
100.	Defendants' Objections to Plaintiffs' Proposed Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	05/05/21	17	4128–4154
101.	Recorder's Transcript of Hearing Motion for Leave to File Opposition to Defendants' Motion to Compel Responses to Second Set of Requests for Production on Order Shortening Time in Redacted and Partially Sealed Form	05/12/21	17	4155–4156
102.	Notice of Entry of Order of Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Question	05/26/21	17	4157–4165
103.	Recorder's Transcript of Proceedings Re: Motions	05/28/21	17	4166–4172
104.	Notice of Entry of Report and Recommendation #7 Regarding Defendants'	06/03/21	17	4173–4184

Tab	Document	Date	Vol.	Pages
	Motion to Compel Plaintiffs' Responses to Defendants' Amended Third Set of Requests for Production of Documents			
105.	Recorder's Transcript of Proceedings Re: Motions Hearing	06/03/21	17	4185–4209
106.	Recorder's Transcript of Proceedings Re: Motions Hearing	06/04/21	17	4210–4223
107.	Recorder's Transcript of Hearing Motion for Leave to File Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Second Set of Request for Production on Order Shortening Time in Redacted and Partially Sealed Form	06/09/21	17	4224–4226
108.	Defendants' Objections to Special Master Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Requests for Production of Documents	06/17/21	17	4227–4239
109.	Recorder's Transcript of Proceedings Re: Motions Hearing	06/23/21	17 18	4240–4250 4251–4280
110.	Plaintiffs' Response to Defendants' Objection to Special Master's Report and Recommendation #7 Regarding Defendants' Motion to Compel Responses to Amended Third Set of Request for Production of Documents	06/24/21	18	4281–4312
111.	Notice of Entry Report and Recommendations #9 Regarding Pending Motions	07/01/21	18	4313–4325
112.	United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents	07/12/21	18	4326–4340

Tab	Document	Date	Vol.	Pages
	About Which Plaintiffs' Witnesses Testified on Order Shortening Time			
113.	Recorder's Transcript of Proceedings Re: Motions Hearing	07/29/21	18	4341–4382
114.	Notice of Entry of Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	08/03/21	18	4383–4402
115.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection	08/09/21	18	4403–4413
116.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection	08/09/21	18	4414–4424
117.	Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection	08/09/21	18	4425–4443
118.	Amended Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Second Set of Requests for Production on Order Shortening Time and	08/09/21	18	4444–4464

Tab	Document	Date	Vol.	Pages
	Overruling Objection			
119.	Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Violating Protective Order	08/10/21	18	4465–4486
120.	Notice of Entry of Report and Recommendation #11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	08/11/21	18	4487–4497
121.	Recorder's Transcript of Proceedings Re: Motions Hearing (Unsealed Portion Only)	08/17/21	18 19	4498–4500 4501–4527
122.	Plaintiffs' Opposition to United's Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Allegedly Violating Protective Order	08/24/21	19	4528–4609
123.	Recorder's Transcript of Proceedings Re: Motions Hearing	09/02/21	19	4610–4633
124.	Reply Brief on "Motion for Order to Show Cause Why Plaintiffs Should Not Be Hold in Contempt and Sanctioned for Violating Protective Order"	09/08/21	19	4634–4666
125.	Recorder's Partial Transcript of Proceedings Re: Motions Hearing	09/09/21	19	4667–4680
126.	Recorder's Partial Transcript of Proceedings Re: Motions Hearing (Via Blue Jeans)	09/15/21	19	4681–4708
127.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions and Overruling Objection	09/16/21	19	4709–4726

Tab	Document	Date	Vol.	Pages
128.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Request for Production of Documents and Overruling Objection	09/16/21	19	4727–4747
129.	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed No to Answer and Overruling Objection	09/16/21	19 20	4748–4750 4751–4769
130.	Defendants' Motion for Partial Summary Judgment	09/21/21	20	4770–4804
131.	Defendants' Motion in Limine No. 1: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with other Market Players and Related Negotiations	09/21/21	20	4805–4829
132.	Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations	09/21/21	20	4830–4852
133.	Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Process and Reasonableness of billed Charges if Motion in Limine No. 3 is Denied	09/21/21	20	4853–4868
134.	Defendants' Motion in Limine No. 10 to Exclude Reference of Defendants' Corporate Structure (Alternative Moton to be Considered Only if court Denies Defendants' Counterpart Motion in Limine No. 9)	09/21/21	20	4869–4885

Tab	Document	Date	Vol.	Pages
135.	Defendants' Motion in Limine No. 13: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	09/21/21	20	4886–4918
136.	Defendants' Motion in Limine No. 14: Motion Offered in the Alternative to MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to Settlement Agreement Between CollectRX and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs	09/21/21	20	4919–4940
137.	Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/21/21	20	4941–4972
138.	Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	09/22/21	20 21	4973–5000 5001–5030
139.	Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided	09/22/21	21	5031–5054
140.	Defendants' Motion in Limine No. 9 to Authorize Defendants to Offer Evidence of Plaintiffs Organizational, Management, and Ownership Structure, Including Flow of Funds Between Related Entities, Operating Companies, Parent Companies, and Subsidiaries	09/22/21	21	5055–5080
141.	Defendants' Opposition to Plaintiffs' Motion	09/29/21	21	5081–5103

Tab	Document	Date	Vol.	Pages
	in Limine No. 1: to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges			
142.	Notice of Entry of Order Regarding Defendants' Objection to Special Master's Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents about which Plaintiffs' Witnesses Testified on Order Shortening Time	09/29/21	21	5104–5114
143.	Plaintiffs' Opposition to Defendants' Motion in Limine Nos. 3, 4, 5, 6 Regarding Billed Charges	09/29/21	21	5115–5154
144.	Plaintiffs' Opposition to Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/29/21	21	5155–5169
145.	Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/04/21	21	5170–5201
146.	Transcript of Proceedings Re: Motions (Via Blue Jeans)	10/06/21	21	5202–5234
147.	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/07/21	21	5235–5245
148.	Second Amended Complaint	10/07/21	21 22	5246–5250 5251–5264
149.	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and-or Argument Regarding the Fact that Plaintiffs Have	10/08/21	22	5265–5279

Tab	Document	Date	Vol.	Pages
	Dismissed Certain Claims and Parties on Order Shortening Time			
150.	Defendants' Answer to Plaintiffs' Second Amended Complaint	10/08/21	22	5280–5287
151.	Defendants' Objections to Plaintiffs' NRCP 16.1(a)(3) Pretrial Disclosures	10/08/21	22	5288–5294
152.	Plaintiffs' Objections to Defendants' Pretrial Disclosures	10/08/21	22	5295–5300
153.	Opposition to Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Regarding the Fact that Plaintiffs have Dismissed Certain Claims and Parties on Order Shortening Time	10/12/21	22	5301–5308
154.	Notice of Entry of Order Denying Defendants' Motion for Order to Show Cause Why Plaintiffs Should not be Held in Contempt for Violating Protective Order	10/14/21	22	5309–5322
155.	Defendants' Opposition to Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/18/21	22	5323–5333
156.	Media Request and Order Allowing Camera Access to Court Proceedings (Legal Newsline)	10/18/21	22	5334–5338
157.	Transcript of Proceedings Re: Motions	10/19/21	22 23	5339–5500 5501–5561
158.	Amended Transcript of Proceedings Re: Motions	10/19/21	23 24	5562–5750 5751–5784
159.	Amended Transcript of Proceedings Re: Motions	10/20/21	24	5785–5907
160.	Transcript of Proceedings Re: Motions	10/22/21	24	5908–6000

Tab	Document	Date	Vol.	Pages
			25	6001–6115
161.	Notice of Entry of Order Denying Defendants' Motion for Partial Summary Judgment	10/25/21	25	6116–6126
162.	Recorder's Transcript of Jury Trial – Day 1	10/25/21	25 26	6127–6250 6251–6279
163.	Recorder's Transcript of Jury Trial – Day 2	10/26/21	26	6280–6485
164.	Joint Pretrial Memorandum Pursuant to EDRC 2.67	10/27/21	26 27	6486–6500 6501–6567
165.	Recorder's Transcript of Jury Trial – Day 3	10/27/21	27 28	6568–6750 6751–6774
166.	Recorder's Transcript of Jury Trial – Day 4	10/28/21	28	6775–6991
167.	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 28	6992–6997
168.	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 29	6998–7000 7001–7003
169.	Defendants' Objection to Media Requests	10/28/21	29	7004–7018
170.	Supplement to Defendants' Objection to Media Requests	10/31/21	29	7019–7039
171.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 1 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with Other Market Players and Related Negotiations	11/01/21	29	7040–7051
172.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence	11/01/21	29	7052–7063

Tab	Document	Date	Vol.	Pages
	Relating to Defendants' Agreements with Other Market Players and Related Negotiations			
173.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 3 to Allow Reference to Plaintiffs' Decision Making Processes Regarding Setting Billed Charges	11/01/21	29	7064–7075
174.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Processes and Reasonableness of Billed Charges if Motion in Limine No. 3 is Denied	11/01/21	29	7076–7087
175.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 12, Paired with Motion in Limine No. 11, to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement	11/01/21	29	7088–7099
176.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 5 Regarding Argument or Evidence that Amounts TeamHealth Plaintiffs Billed for Services are Reasonable [An Alternative Motion to Motion in Limine No. 6]	11/01/21	29	7100–7111
177.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	11/01/21	29	7112–7123
178.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the	11/01/21	29	7124–7135

Tab	Document	Date	Vol.	Pages
	Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided			
179.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 10 to Exclude Evidence of Defendants' Corporate Structure (Alternative Motion to be Considered Only if Court Denies Defendants' Counterpart Motion in Limine No. 9)	11/01/21	29	7136–7147
180.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 11, Paired with Motion in Limine No. 12, to Authorize Defendants to Discuss Plaintiffs' Conduct and Deliberations in Negotiating Reimbursement	11/01/21	29	7148–7159
181.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 13 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	11/01/21	29	7160–7171
182.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 14: Motion Offered in the Alternative MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to a Settlement Agreement Between CollectRx and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs	11/01/21	29	7172–7183
183.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 15 to Preclude Reference and Testimony	11/01/21	29	7184–7195

Tab	Document	Date	Vol.	Pages
	Regarding the TeamHealth Plaintiffs Policy not to Balance Bill			
184.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 18 to Preclude Testimony of Plaintiffs' Non-Retained Expert Joseph Crane, M.D.	11/01/21	29	7196–7207
185.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 20 to Exclude Defendants' Lobbying Efforts	11/01/21	29	7208–7219
186.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	11/01/21	29	7220–7231
187.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-Of-Network Rates or Payments	11/01/21	29	7232–7243
188.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 29 to Preclude Evidence Only Relating to Defendants' Evaluation and Development of a Company that Would Offer a Service Similar to Multiplan and Data iSight	11/01/21	29 30	7244–7250 7251–7255
189.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 32 to Exclude Evidence or Argument Relating to Materials, Events, or Conduct that Occurred on or After January 1, 2020	11/01/21	30	7256–7267
190.	Notice of Entry of Order Denying Defendants' Motion in Limine to Preclude Certain Expert Testimony and Fact Witness Testimony by Plaintiffs' Non-Retained	11/01/21	30	7268–7279

Tab	Document	Date	Vol.	Pages
	Expert Robert Frantz, M.D.			
191.	Notice of Entry of Order Denying Defendants' Motion in Limine No. 38 to Exclude Evidence or Argument Relating to Defendants' use of MultiPlan and the Data iSight Service, Including Any Alleged Conspiracy or Fraud Relating to the use of Those Services	11/01/21	30	7280–7291
192.	Notice of Entry of Order Granting Plaintiffs' Motion in Limine to Exclude Evidence, Testimony And-Or Argument Regarding the Fact that Plaintiff have Dismissed Certain Claims	11/01/21	30	7292–7354
193.	Notice of Entry of Order Denying Defendants' Motion to Strike Supplement Report of David Leathers	11/01/21	30	7355–7366
194.	Plaintiffs' Notice of Amended Exhibit List	11/01/21	30	7367–7392
195.	Plaintiffs' Response to Defendants' Objection to Media Requests	11/01/21	30	7393–7403
196.	Recorder's Transcript of Jury Trial – Day 5	11/01/21	30 31	7404–7500 7501–7605
197.	Recorder's Transcript of Jury Trial – Day 6	11/02/21	31 32	7606–7750 7751–7777
198.	Defendants' Deposition Designations and Objections to Plaintiffs' Deposition Counter-Designations	11/03/21	32	7778–7829
199.	Defendants' Objections to Plaintiffs' Proposed Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	11/03/21	32	7830–7852
200.	Notice of Entry of Order Affirming and	11/03/21	32	7853–7874

Tab	Document	Date	Vol.	Pages
	Adopting Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified			
201.	Recorder's Transcript of Jury Trial – Day 7	11/03/21	32 33	7875–8000 8001–8091
202.	Notice of Entry of Order Granting Defendants' Motion in Limine No. 17	11/04/21	33	8092–8103
203.	Notice of Entry of Order Granting Defendants' Motion in Limine No. 25	11/04/21	33	8104–8115
204.	Notice of Entry of Order Granting Defendants' Motion in Limine No. 37	11/04/21	33	8116–8127
205.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 9	11/04/21	33	8128–8140
206.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 21	11/04/21	33	8141–8153
207.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 22	11/04/21	33	8154–8165
208.	Plaintiffs' Notice of Deposition Designations	11/04/21	33 34	8166–8250 8251–8342
209.	1st Amended Jury List	11/08/21	34	8343
210.	Recorder's Transcript of Jury Trial – Day 8	11/08/21	34 35	8344–8500 8501–8514
211.	Recorder's Amended Transcript of Jury Trial – Day 9	11/09/21	35	8515–8723
212.	Recorder's Transcript of Jury Trial – Day 9	11/09/21	35 36	8724–8750 8751–8932
213.	Recorder's Transcript of Jury Trial – Day 10	11/10/21	36	8933–9000

Tab	Document	Date	Vol.	Pages
			37	9001–9152
214.	Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at Trial Under Seal	11/12/21	37	9153–9161
215.	Notice of Entry of Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	11/12/21	37	9162–9173
216.	Plaintiffs' Trial Brief Regarding Defendants' Prompt Payment Act Jury Instruction Re: Failure to Exhaust Administrative Remedies	11/12/21	37	9174–9184
217.	Recorder's Transcript of Jury Trial – Day 11	11/12/21	37 38	9185–9250 9251–9416
218.	Plaintiffs' Trial Brief Regarding Specific Price Term	11/14/21	38	9417–9425
219.	2nd Amended Jury List	11/15/21	38	9426
220.	Defendants' Proposed Jury Instructions (Contested)	11/15/21	38	9427–9470
221.	Jointly Submitted Jury Instructions	11/15/21	38	9471–9495
222.	Plaintiffs' Proposed Jury Instructions (Contested)	11/15/21	38 39	9496–9500 9501–9513
223.	Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/15/21	39	9514–9521
224.	Recorder's Transcript of Jury Trial – Day 12	11/15/21	39 40	9522–9750 9751–9798
225.	Defendants' Response to TeamHealth Plaintiffs' Trial Brief Regarding Defendants' Prompt Pay Act Jury Instruction Re: Failure to Exhaust Administrative	11/16/21	40	9799–9806

Tab	Document	Date	Vol.	Pages
	Remedies			
226.	General Defense Verdict	11/16/21	40	9807–9809
227.	Plaintiffs' Proposed Verdict Form	11/16/21	40	9810–9819
228.	Recorder's Transcript of Jury Trial – Day 13	11/16/21	40 41	9820–10,000 10,001–10,115
229.	Reply in Support of Trial Brief Regarding Evidence and Argument Relating to Out-Of-State Harms to Non-Parties	11/16/21	41	10,116–10,152
230.	Response to Plaintiffs' Trial Brief Regarding Specific Price Term	11/16/21	41	10,153–10,169
231.	Special Verdict Form	11/16/21	41	10,169–10,197
232.	Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract	11/16/21	41	10,198–10,231
233.	Trial Brief Regarding Jury Instructions on Unjust Enrichment	11/16/21	41	10,232–10,248
234.	3rd Amended Jury List	11/17/21	41	10,249
235.	Defendants' Motion for Judgment as a Matter of Law	11/17/21	41 42	10,250 10,251–10,307
236.	Plaintiffs' Supplemental Jury Instruction (Contested)	11/17/21	42	10,308–10,313
237.	Recorder's Transcript of Jury Trial – Day 14	11/17/21	42 43	10,314–10,500 10,501–10,617
238.	Errata to Source on Defense Contested Jury Instructions	11/18/21	43	10,618–10,623
239.	Recorder's Transcript of Jury Trial – Day 15	11/18/21	43 44	10,624–10,750 10,751–10,946
240.	Defendants' Supplemental Proposed Jury Instructions (Contested)	11/19/21	44	10,947–10,952

Tab	Document	Date	Vol.	Pages
241.	Errata	11/19/21	44	10,953
242.	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	11/19/21	44	10,954–10,963
243.	Plaintiffs' Proposed Special Verdict Form	11/19/21	44	10,964–10,973
244.	Recorder's Transcript of Jury Trial – Day 16	11/19/21	44 45	10,974–11,000 11,001–11,241
245.	Response to Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/19/21	45 46	11,242–11,250 11,251–11,254
246.	Plaintiffs' Second Supplemental Jury Instructions (Contested)	11/20/21	46	11,255–11,261
247.	Defendants' Supplemental Proposed Jury Instruction	11/21/21	46	11,262–11,266
248.	Plaintiffs' Third Supplemental Jury Instructions (Contested)	11/21/21	46	11,267–11,272
249.	Recorder's Transcript of Jury Trial – Day 17	11/22/21	46 47	11,273–11,500 11.501–11,593
250.	Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,594–11,608
251.	Defendants' Opposition to Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,609–11,631
252.	4th Amended Jury List	11/23/21	47	11,632
253.	Recorder's Transcript of Jury Trial – Day 18	11/23/21	47 48	11,633–11,750 11,751–11,907

Tab	Document	Date	Vol.	Pages
254.	Recorder's Transcript of Jury Trial – Day 19	11/24/21	48	11,908–11,956
255.	Jury Instructions	11/29/21	48	11,957–11,999
256.	Recorder's Transcript of Jury Trial – Day 20	11/29/21	48 49	12,000 12,001–12,034
257.	Special Verdict Form	11/29/21	49	12,035–12,046
258.	Verdict(s) Submitted to Jury but Returned Unsigned	11/29/21	49	12,047–12,048
259.	Defendants' Proposed Second Phase Jury Instructions	12/05/21	49	12,049–12,063
260.	Plaintiffs' Proposed Second Phase Jury Instructions and Verdict Form	12/06/21	49	12,064–12,072
261.	Plaintiffs' Supplement to Proposed Second Phase Jury Instructions	12/06/21	49	12,072–12,077
262.	Recorder's Transcript of Jury Trial – Day 21	12/06/21	49	12,078–,12,135
263.	Defendants' Proposed Second Phase Jury Instructions-Supplement	12/07/21	49	12,136–12,142
264.	Jury Instructions Phase Two	12/07/21	49	12,143–12,149
265.	Special Verdict Form	12/07/21	49	12,150–12,152
266.	Recorder's Transcript of Jury Trial – Day 22	12/07/21	49 50	12,153–12,250 12,251–12,293
267.	Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,294–12,302
268.	Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,303–12,311
269.	Notice of Entry of Order Granting Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at	12/27/21	50	12,312–12,322

Tab	Document	Date	Vol.	Pages
	Trial Under Seal			
270.	Plaintiffs' Opposition to United's Motion to Seal	12/29/21	50	12,323–12,341
271.	Defendants' Motion to Apply the Statutory Cap on Punitive Damages	12/30/21	50	12,342–12,363
272.	Appendix of Exhibits to Defendants' Motion to Apply the Statutory Cap on Punitive Damage	12/30/21	50 51	12,364–12,500 12,501–12,706
273.	Defendants' Objection to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law	01/04/22	51	12,707–12,717
274.	Notice of Entry of Order Denying Defendants' Motion for Judgement as a Matter of Law	01/06/22	51	12,718–12,738
275.	Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51	12,739–12,747
276.	Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51 52	12,748–12,750 12,751–12,756
277.	Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing on Defendants' Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time	01/11/22	52	12,757–12,768
278.	Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing	01/12/22	52	12,769–12,772
279.	Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for	01/20/22	52	12,773–12,790

Tab	Document	Date	Vol.	Pages
	Entry of Judgment			
280.	Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment	01/20/22	52	12,791–12,968
281.	Notice of Entry of Order Granting Plaintiffs' Proposed Schedule for Submission of Final Redactions	01/31/22	52	12,969–12,979
282.	Notice of Entry of Stipulation and Order Regarding Schedule for Submission of Redactions	02/08/22	52	12,980–12,996
283.	Defendants' Opposition to Plaintiffs' Cross-Motion for Entry of Judgment	02/10/22	52 53	12,997–13,000 13,001–13,004
284.	Defendant' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages	02/10/22	53	13,005–13,028
285.	Notice of Entry of Order Shortening Time for Hearing Re: Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits	02/14/22	53	13,029–13,046
286.	Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time	02/15/22	53	13,047–13,053
287.	Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment	02/15/22	53	13,054–13,062
288.	Defendants' Index of Trial Exhibit Redactions in Dispute	02/16/22	53	13,063–13,073
289.	Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits	02/17/22	53	13,074–13,097
290.	Transcript of Proceedings Re: Motions Hearing	02/17/22	53	13,098–13,160

Tab	Document	Date	Vol.	Pages
291.	Objection to Plaintiffs' Proposed Judgment and Order Denying Motion to Apply Statutory Cap on Punitive Damages	03/04/22	53	13,161–13,167
292.	Notice of Entry of Judgment	03/09/22	53	13,168–13,178
293.	Notice of Entry of Order Denying Defendants' Motion to Apply Statutory Cap on Punitive Damages	03/09/22	53	13,179–13,197
294.	Health Care Providers' Verified Memorandum of Cost	03/14/22	53	13,198–13,208
295.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 1	03/14/22	53 54	13,209–13,250 13.251–13,464
296.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 2	03/14/22	54 55	13,465–13,500 13,501–13,719
297.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 3	03/14/22	55 56	13,720–13,750 13,751–13,976
298.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 4	03/14/22	56 57	13,977–14,000 14,001–14,186
299.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 5	03/14/22	57 58	14,187–14,250 14,251–14,421
300.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 6	03/14/22	58 59	14,422–14,500 14,501–14,673
301.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 7	03/14/22	59 60	14,674–14,750 14,751–14,920
302.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of	03/14/22	60 61	14,921–15,000 15,001–15,174

Tab	Document	Date	Vol.	Pages
	Cost Volume 8			
303.	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 9	03/14/22	61 62	15,175–15,250 15,251–15,373
304.	Defendants' Motion to Retax Costs	03/21/22	62	15,374–15,388
305.	Health Care Providers' Motion for Attorneys' Fees	03/30/22	62	15,389–15,397
306.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 1	03/30/22	62 63	15,398–15,500 15,501–15,619
307.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 2	03/30/22	63 64	15,620–15,750 15,751–15,821
308.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 3	03/30/22	64 65	15,822–16,000 16,001–16,053
309.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 4	03/30/22	65	16,054–16,232
310.	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 5	03/30/22	65 66	16,233–16,250 16,251–16,361
311.	Defendants Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions on Order Shortening Time	04/05/22	66	16,362–16,381
312.	Defendants' Motion for Remittitur and to Alter or Amend the Judgment	04/06/22	66	16,382–16,399
313.	Defendants' Renewed Motion for Judgment as a Matter of Law	04/06/22	66	16,400–16,448
314.	Motion for New Trial	04/06/22	66 67	16,449–16,500 16,501–16,677

Tab	Document	Date	Vol.	Pages
315.	Notice of Appeal	04/06/22	67	16,678–16,694
316.	Case Appeal Statement	04/06/22	67 68	16,695–16,750 16,751–16,825
317.	Plaintiffs' Opposition to Defendants' Rule 62(b) Motion for Stay	04/07/22	68	16,826–16,831
318.	Reply on "Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions" (*on Order Shortening Time*)	04/07/22	68	16,832–16,836
319.	Transcript of Proceedings Re: Motions Hearing	04/07/22	68	16,837–16,855
320.	Opposition to Defendants' Motion to Retax Costs	04/13/22	68	16,856–16,864
321.	Appendix in Support of Opposition to Defendants' Motion to Retax Costs	04/13/22	68 69	16,865–17,000 17,001–17,035
322.	Defendants' Opposition to Plaintiffs' Motion for Attorneys' Fees	04/20/22	69	17,036–17,101
323.	Transcript of Proceedings Re: Motions Hearing	04/21/22	69	17,102–17,113
324.	Notice of Posting *Supersedeas* Bond	04/29/22	69	17,114–17,121
325.	Defendants' Reply in Support of Motion to Retax Costs	05/04/22	69	17,122–17,150
326.	Health Care Providers' Reply in Support of Motion for Attorneys' Fees	05/04/22	69	17,151–17,164
327.	Plaintiffs' Opposition to Defendants' Motion for Remittitur and to Alter or Amend the Judgment	05/04/22	69	17,165–17,178
328.	Plaintiffs' Opposition to Defendants' Motion for New Trial	05/04/22	69 70	17,179–17,250 17,251–17,335
329.	Plaintiffs' Opposition to Defendants' Renewed Motion for Judgment as a Matter	05/05/22	70	17,336–17,373

Tab	Document	Date	Vol.	Pages
	of Law			
330.	Reply in Support of Defendants' Motion for Remittitur and to Alter or Amend the Judgment	06/22/22	70	17,374–17,385
331.	Reply in Support of Defendants' Renewed Motion for Judgment as a Matter of Law	06/22/22	70	17,386–17,411
332.	Reply in Support of Motion for New Trial	06/22/22	70	17,412–17,469
333.	Notice of Supplemental Attorneys Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees	06/24/22	70 71	17,470–17,500 17,501–17,578
334.	Defendants' Response to Improper Supplement Entitled "Notice of Supplemental Attorney Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees"	06/28/22	71	17,579–17,593
335.	Notice of Entry of Order Granting Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	06/29/22	71	17,594–17,609
336.	Transcript of Proceedings Re: Motions Hearing	06/29/22	71	17,610–17,681
337.	Order Amending Oral Ruling Granting Defendants' Motion to Retax	07/01/22	71	17,682–17,688
338.	Notice of Entry of Order Denying Defendants' Motion for Remittitur and to Alter or Amend the Judgment	07/19/22	71	17,689–17,699
339.	Defendants' Objection to Plaintiffs' Proposed Order Approving Plaintiffs' Motion for Attorneys' Fees	07/26/22	71	17,700–17,706
340.	Notice of Entry of Order Approving Plaintiffs' Motion for Attorney's Fees	08/02/22	71	17,707–17,725

Tab	Document	Date	Vol.	Pages
341.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Retax Costs	08/02/22	71	17,726–17,739
342.	Amended Case Appeal Statement	08/15/22	71 72	17,740–17,750 17,751–17,803
343.	Amended Notice of Appeal	08/15/22	72	17,804–17,934
344.	Reply in Support of Supplemental Attorney's Fees Request	08/22/22	72	17,935–17,940
345.	Objection to Plaintiffs' Proposed Orders Denying Renewed Motion for Judgment as a Matter of Law and Motion for New Trial	09/13/22	72	17,941–17,950
346.	Recorder's Transcript of Hearing Re: Hearing	09/22/22	72	17,951–17,972
347.	Limited Objection to "Order Unsealing Trial Transcripts and Restoring Public Access to Docket"	10/06/22	72	17,973–17,978
348.	Defendants' Motion to Redact Portions of Trial Transcript	10/06/22	72	17,979–17,989
349.	Plaintiffs' Opposition to Defendants' Motion to Redact Portions of Trial Transcript	10/07/22	72	17,990–17,993
350.	Transcript of Proceedings re Status Check	10/10/22	72 73	17,994–18,000 18,001–18,004
351.	Notice of Entry of Order Approving Supplemental Attorney's Fee Award	10/12/22	73	18,005–18,015
352.	Notice of Entry of Order Denying Defendants' Motion for New Trial	10/12/22	73	18,016–18,086
353.	Notice of Entry of Order Denying Defendants' Renewed Motion for Judgment as a Matter of Law	10/12/22	73	18,087–18,114
354.	Notice of Entry of Order Unsealing Trial Transcripts and Restoring Public Access to	10/12/22	73	18,115–18,125

Tab	Document	Date	Vol.	Pages
	Docket			
355.	Notice of Appeal	10/12/22	73 74	18,126–18,250 18,251–18,467
356.	Case Appeal Statement	10/12/22	74 75	18,468–18,500 18,501–18,598
357.	Notice of Entry of Order Denying "Motion to Redact Portions of Trial Transcript"	10/13/22	75	18,599–18,608
358.	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits	10/18/22	75 76	18,609–18,750 18,751–18,755
359.	Recorder's Transcript of Hearing Status Check	10/20/22	76	18,756–18,758
360.	Notice of Entry of Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts	10/25/22	76	18,759–18,769
361.	Notice of Filing of Writ Petition	11/17/22	76	18,770–18855
362.	Trial Exhibit D5502		76 77	18,856–19,000 19,001–19,143
491.	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	145 146	35,813–36,062 36,063–36,085
492.	Transcript Re: Proposed Jury Instructions	11/21/21	146	36,086–36,250

Filed Under Seal

Tab	Document	Date	Vol.	Pages
363.	Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	09/28/20	78	19,144–19,156

364.	Plaintiffs' Reply in Support of Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	04/01/21	78	19,157–19,176
365.	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	04/01/21	78	19,177–19,388
366.	Plaintiffs' Response to Defendants Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	04/19/21	78 79	19,389–19,393 19,394–19,532
367.	Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time	05/05/21	79	19,533–19,581
368.	Appendix to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time	05/21/21	79 80 81	19,582–19,643 19,644–19,893 19,894–20,065
369.	Plaintiffs' Opposition to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 and #3 on Order Shortening Time	06/01/21	81 82	20,066–20,143 20,144–20,151
370.	Defendants' Objection to the Special Master's Report and Recommendation No. 5 Regarding Defendants' Motion for Protective Order Regarding Confidentiality	06/01/21	82	20,152–20,211

	Designations (Filed April 15, 2021)			
371.	Plaintiffs' Response to Defendants' Objection to Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions	06/16/21	82	20,212–20,265
372.	United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time	06/24/21	82	20,266–20,290
373.	Appendix to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time	06/24/21	82 83 84	20,291–20,393 20,394–20,643 20,644–20,698
374.	Plaintiffs' Opposition to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time	07/06/21	84	20,699–20,742
375.	Defendants' Motion for Leave to File Defendants' Objection to the Special Master's Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Under Seal	07/15/21	84	20,743–20,750
376.	Plaintiffs' Response to Defendants' Objection to Special Master Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Questions	07/22/21	84	20,751–20,863
377.	Objection to R&R #11 Regarding United's Motion to Compel Documents About Which Plaintiffs' Witnesses Testified	08/25/21	84 85	20,864–20,893 20,894–20,898

378.	Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	09/21/21	85	20,899–20,916
379.	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders	09/21/21	85	20,917–21,076
380.	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges	09/21/21	85	21,077–21,089
381.	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges	09/21/21	85 86	21,090–21,143 21,144–21,259
382.	Motion in Limine No. 3 to Allow References to Plaintiffs' Decision Making Process Regarding Settling Billing Charges	09/21/21	86	21,260–21,313
383.	Defendants' Motion in Limine No. 5 Regarding Arguments or Evidence that Amounts TeamHealth Plaintiffs billed for Serves are Reasonable [an Alternative to Motion in Limine No. 6]	09/21/21	86	21,314–21,343
384.	Defendants' Motion in Limine No. 6 Regarding Argument or Evidence That Amounts Teamhealth Plaintiffs Billed for Services are Reasonable	09/21/21	86	21,344–21,368
385.	Appendix to Defendants' Motion in Limine No. 13 (Volume 1 of 6)	09/21/21	86 87	21,369–21,393 21,394–21,484

386.	Appendix to Defendants' Motion in Limine No. 13 (Volume 2 of 6)	09/21/21	87	21,485–21,614
387.	Appendix to Defendants' Motion in Limine No. 13 (Volume 3 of 6)	09/21/21	87 88	21,615–21,643 21,644–21,744
388.	Appendix to Defendants' Motion in Limine No. 13 (Volume 4 of 6)	09/21/21	88	21,745–21,874
389.	Appendix to Defendants' Motion in Limine No. 13 (Volume 5 of 6)	09/21/21	88 89	21,875–21,893 21,894–22,004
390.	Appendix to Defendants' Motion in Limine No. 13 (Volume 6 of 6)	09/21/21	89	22,005–22,035
391.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 1 of 8	09/21/21	89 90	22,036–22,143 22,144–22,176
392.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 2 of 8	09/21/21	90	22,177–22,309
393.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 3 of 8	09/22/21	90 91	22,310–22,393 22,394–22,442
394.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 4 of 8	09/22/21	91	22,443–22,575
395.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 5 of 8	09/22/21	91	22,576–22,609
396.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 6 of 8	09/22/21	91 92 93	22,610–22,643 22,644–22,893 22,894–23,037
397.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7a of 8	09/22/21	93 94	23,038–23,143 23,144–23,174
398.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7b of 8	09/22/21	94	23,175–23,260
399.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8a of 8	09/22/21	94 95	23,261–23,393 23,394–23,535
400.	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8b of 8	09/22/21	95 96	23,536–23,643 23,634–23,801
401.	Defendants' Motion in Limine No. 11 Paired	09/22/21	96	23,802–23,823

	with Motion in Limine No. 12 to Authorize Defendants to Discuss Plaintiffs' Conduct and deliberations in Negotiating Reimbursement			
402.	Errata to Defendants' Motion in Limine No. 11	09/22/21	96	23,824–23,859
403.	Defendants' Motion in Limine No. 12 Paired with Motion in Limine No. 11 to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement	09/22/21	96	23,860–23,879
404.	Errata to Defendants' Motion in Limine No. 12	09/22/21	96 97	23,880–23,893 23,894–23,897
405.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 1)	09/22/21	97	23,898–24,080
406.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 2)	09/22/21	97 98	24,081–24,143 24,144–24,310
407.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 3)	09/22/21	98 99 100	24,311–24,393 24,394–24,643 24,644–24,673
408.	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 4)	09/22/21	100 101 102	24,674–24,893 24,894–25,143 25,144–25,204
409.	Appendix to Defendants' Motion in Limine No. 14 – Volume 1 of 6	09/22/21	102	25,205–25,226
410.	Appendix to Defendants' Motion in Limine No. 14 – Volume 2 of 6	09/22/21	102	25,227–25,364
411.	Appendix to Defendants' Motion in Limine No. 14 – Volume 3 of 6	09/22/21	102 103	25,365–25,393 25,394–25,494
412.	Appendix to Defendants' Motion in Limine No. 14 – Volume 4 of 6	09/22/21	103	25,495–25,624
413.	Appendix to Defendants' Motion in Limine	09/22/21	103	25,625–25,643

	No. 14 – Volume 5 of 6		104	25,644–25,754
414.	Appendix to Defendants' Motion in Limine No. 14 – Volume 6 of 6	09/22/21	104	25,755–25,785
415.	Plaintiffs' Combined Opposition to Defendants Motions in Limine 1, 7, 9, 11 & 13	09/29/21	104	25,786–25,850
416.	Plaintiffs' Combined Opposition to Defendants' Motions in Limine No. 2, 8, 10, 12 & 14	09/29/21	104	25,851–25,868
417.	Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders	09/29/21	104 105	25,869–25,893 25,894–25,901
418.	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 1	09/29/21	105 106	25,902–26,143 26,144–26,216
419.	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 2	09/29/21	106 107	26,217–26,393 26,394–26,497
420.	Plaintiffs' Opposition to Defendants' Motion for Partial Summary Judgment	10/05/21	107	26,498–26,605
421.	Defendants' Reply in Support of Motion for Partial Summary Judgment	10/11/21	107 108	26,606–26,643 26,644–26,663
422.	Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/17/21	108	26,664–26,673
423.	Appendix of Exhibits in Support of Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for	10/17/21	108 109	26,674–26,893 26,894–26,930

	Partial Summary Judgment			
424.	Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/21/21	109	26,931–26,952
425.	Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties	10/31/21	109	26,953–26,964
426.	Plaintiffs' Response to Defendants' Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties	11/08/21	109	26,965–26,997
427.	Excerpts of Recorder's Transcript of Jury Trial – Day 9	11/09/21	109	26,998–27003
428.	Preliminary Motion to Seal Attorneys' Eyes Documents Used at Trial	11/11/21	109	27,004–27,055
429.	Appendix of Selected Exhibits to Trial Briefs	11/16/21	109	27,056–27,092
430.	Excerpts of Recorder's Transcript of Jury Trial – Day 13	11/16/21	109	27,093–27,099
431.	Defendants' Omnibus Offer of Proof	11/22/21	109 110	27,100–27,143 27,144–27,287
432.	Motion to Seal Certain Confidential Trial Exhibits	12/05/21	110	27,288–27,382
433.	Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits	12/08/21	110 111	27,383–27,393 27,394–27,400
434.	Motion to Seal Certain Confidential Trial Exhibits	12/13/21	111	27,401–27,495
435.	Defendant's Omnibus Offer of Proof for Second Phase of Trial	12/14/21	111	27,496–27,505

436.	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 1	12/14/21	111 112	27,506–27,643 27,644–27,767
437.	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 2	12/14/21	112 113	27,768–27,893 27,894–27,981
438.	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 3	12/14/21	113 114	27,982–28,143 28,144–28,188
439.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18	12/24/21	114	28,189–28,290
440.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18	12/24/21	114 115	28,291–28,393 28,394–28,484
441.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18	12/24/21	115 116	28,485–28,643 28,644–28,742
442.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18	12/24/21	116 117	28,743–28,893 28,894–28,938
443.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18	12/24/21	117	28,939–29,084
444.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18	12/24/21	117 118	29,085–29,143 29,144–29,219
445.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18	12/24/21	118	29,220–29,384
446.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18	12/24/21	118 119	29,385–29,393 29,394–29,527

447.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18	12/24/21	119 120	29,528–29,643 29,644–29,727
448.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 10 of 18	12/24/21	120 121	29,728–29,893 29,894–29,907
449.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18	12/24/21	121	29,908–30,051
450.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18	12/24/21	121 122	30,052–30,143 30,144–30,297
451.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18	12/24/21	122 123	30,298–30,393 30,394–30,516
452.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18	12/24/21	123 124	30,517–30,643 30,644–30,677
453.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18	12/24/21	124	30,678–30,835
454.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18	12/24/21	124 125	30,836–30,893 30,894–30,952
455.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18	12/24/21	125	30,953–31,122
456.	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18	12/24/21	125 126	30,123–31,143 31,144–31,258
457.	Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits	01/05/22	126	31,259–31,308
458.	Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial	01/05/22	126	31,309–31,393

	Exhibits		127	31,394–31,500
459.	Transcript of Proceedings Re: Motions	01/12/22	127	31,501–31,596
460.	Transcript of Proceedings Re: Motions	01/20/22	127 128	31,597–31,643 31,644–31,650
461.	Transcript of Proceedings Re: Motions	01/27/22	128	31,651–31,661
462.	Defendants' Index of Trial Exhibit Redactions in Dispute	02/10/22	128	31,662–31,672
463.	Transcript of Proceedings Re: Motions Hearing	02/10/22	128	31,673–31,793
464.	Transcript of Proceedings Re: Motions Hearing	02/16/22	128	31,794–31,887
465.	Joint Status Report and Table Identifying the Redactions to Trial Exhibits That Remain in Dispute	03/04/22	128 129	31,888–31,893 31,894–31,922
466.	Transcript of Proceedings re Hearing Regarding Unsealing Record	10/05/22	129	31,923–31,943
467.	Transcript of Proceedings re Status Check	10/06/22	129	31,944–31,953
468.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 1)	10/07/22	129 130	31,954–32,143 32,144–32,207
469.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 2)	10/07/22	130 131	32,208–32,393 32,394–32,476
470.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 3)	10/07/22	131 132	32,477–32,643 32,644–32,751
471.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume	10/07/22	132 133	32,752–32,893 32,894–33,016

	4)			
472.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 5)	10/07/22	133 134	33,017–33,143 33,144–33,301
473.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 6)	10/07/22	134 135	33,302–33,393 33,394–33,529
474.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 7)	10/07/22	135 136	33,530–33,643 33,644–33,840
475.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 8)	10/07/22	136 137	33,841–33,893 33,894–34,109
476.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 9)	10/07/22	137 138	34,110–34,143 34,144–34,377
477.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 10)	10/07/22	138 139 140	34,378–34,393 34,394–34,643 34,644–34,668
478.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 11)	10/07/22	140 141	34,669–34,893 34,894–34,907
479.	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 12)	10/07/22	141 142	34,908–35,143 35,144–35,162
480.	Appendix B to Order Granting in Part and	10/07/22	142	35,163–35,242

	Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 13)			
481.	Exhibits P473_NEW, 4002, 4003, 4005, 4006, 4166, 4168, 4455, 4457, 4774, and 5322 to "Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits" (Tabs 98, 106, 107, 108, 109, 111, 112, 113, 114, 118, and 119)	10/07/22	142	35,243–35,247
482.	Transcript of Status Check	10/10/22	142	35,248–35,258
483.	Recorder's Transcript of Hearing re Hearing	10/13/22	142	35,259–35,263
484.	Trial Exhibit D5499		142 143	35,264–35,393 35,394–35,445
485.	Trial Exhibit D5506		143	35,446
486.	Appendix of Exhibits in Support of Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	09/28/20	143	35,447–35,634
487.	Defendants' Motion to Supplement Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time	05/24/21	143 144	35,635–35,643 35,644–35,648
488.	Motion in Limine No. 3 to Allow References to Plaintiffs; Decision Making Processes Regarding Setting Billed Charges	09/21/21	144	35,649–35,702
489.	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: to Exclude Evidence Subject to the Court's Discovery Orders (Exhibit 43)	09/29/21	144	35,703–35,713
490.	Notice of Filing of Expert Report of Bruce Deal, Revised on November 14, 2021	04/18/23	144	35,714–35,812

ALPHABETICAL TABLE OF CONTENTS TO APPENDIX

Tab	Document	Date	Vol.	Pages
468	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 1) (Filed Under Seal)	10/07/22	129 130	31,954–32,143 32,144–32,207
469	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 2) (Filed Under Seal)	10/07/22	130 131	32,208–32,393 32,394–32,476
470	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 3) (Filed Under Seal)	10/07/22	131 132	32,477–32,643 32,644–32,751
471	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 4) (Filed Under Seal)	10/07/22	132 133	32,752–32,893 32,894–33,016
472	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 5) (Filed Under Seal)	10/07/22	133 134	33,017–33,143 33,144–33,301
473	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 6) (Filed Under Seal)	10/07/22	134 135	33,302–33,393 33,394–33,529
474	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 7) (Filed Under Seal)	10/07/22	135 136	33,530–33,643 33,644–33,840
475	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 8) (Filed Under Seal)	10/07/22	136 137	33,841–33,893 33,894–34,109
476	Appendix B to Order Granting in Part and	10/07/22	137	34,110–34,143

Tab	Document	Date	Vol.	Pages
	Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 9) (Filed Under Seal)		138	34,144–34,377
477	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 10) (Filed Under Seal)	10/07/22	138 139 140	34,378–34,393 34,394–34,643 34,644–34,668
478	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 11) (Filed Under Seal)	10/07/22	140 141	34,669–34,893 34,894–34,907
479	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 12) (Filed Under Seal)	10/07/22	141 142	34,908–35,143 35,144–35,162
480	Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits (Volume 13) (Filed Under Seal)	10/07/22	142	35,163–35,242
321	Appendix in Support of Opposition to Defendants' Motion to Retax Costs	04/13/22	68 69	16,865–17,000 17,001–17,035
280	Appendix in Support of Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment	01/20/22	52	12,791–12,968
306	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 1	03/30/22	62 63	15,398–15,500 15,501–15,619
307	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 2	03/30/22	63 64	15,620–15,750 15,751–15,821
308	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees	03/30/22	64 65	15,822–16,000 16,001–16,053

Tab	Document	Date	Vol.	Pages
	Volume 3			
309	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 4	03/30/22	65	16,054–16,232
310	Appendix of Exhibits in Support of Health Care Providers' Motion for Attorneys' Fees Volume 5	03/30/22	65 66	16,233–16,250 16,251–16,361
295	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 1	03/14/22	53 54	13,209–13,250 13.251–13,464
296	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 2	03/14/22	54 55	13,465–13,500 13,501–13,719
297	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 3	03/14/22	55 56	13,720–13,750 13,751–13,976
298	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 4	03/14/22	56 57	13,977–14,000 14,001–14,186
299	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 5	03/14/22	57 58	14,187–14,250 14,251–14,421
300	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 6	03/14/22	58 59	14,422–14,500 14,501–14,673
301	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 7	03/14/22	59 60	14,674–14,750 14,751–14,920
302	Appendix of Exhibits in Support of Health Care Providers' Verified Memorandum of Cost Volume 8	03/14/22	60 61	14,921–15,000 15,001–15,174
303	Appendix of Exhibits in Support of Health	03/14/22	61	15,175–15,250

Tab	Document	Date	Vol.	Pages
	Care Providers' Verified Memorandum of Cost Volume 9		62	15,251–15,373
486	Appendix of Exhibits in Support of Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time (Filed Under Seal)	09/28/20	143	35,447–35,634
423	Appendix of Exhibits in Support of Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/17/21	108 109	26,674–26,893 26,894–26,930
379	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal)	09/21/21	85	20,917–21,076
381	Appendix of Exhibits in Support of Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges (Filed Under Seal)	09/21/21	85 86	21,090–21,143 21,144–21,259
26	Appendix of Exhibits in Support of Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	784–908
491	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	145 146	35,813–36,062 36,063–36,085
365	Appendix of Exhibits in Support of Plaintiffs' Renewed Motion for Order to	04/01/21	78	19,177–19,388

Tab	Document	Date	Vol.	Pages
	Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions (Filed Under Seal)			
272	Appendix of Exhibits to Defendants' Motion to Apply the Statutory Cap on Punitive Damage	12/30/21	50 51	12,364–12,500 12,501–12,706
436	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 1 (Filed Under Seal)	12/14/21	111 112	27,506–27,643 27,644–27,767
437	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 2 (Filed Under Seal)	12/14/21	112 113	27,768–27,893 27,894–27,981
438	Appendix of Exhibits to Defendants' Omnibus Offer of Proof for Second Phase of Trial – Volume 3 (Filed Under Seal)	12/14/21	113 114	27,982–28,143 28,144–28,188
429	Appendix of Selected Exhibits to Trial Briefs (Filed Under Seal)	11/16/21	109	27,056–27,092
405	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 1) (Filed Under Seal)	09/22/21	97	23,898–24,080
406	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 2) (Filed Under Seal)	09/22/21	97 98	24,081–24,143 24,144–24,310
407	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 3) (Filed Under Seal)	09/22/21	98 99 100	24,311–24,393 24,394–24,643 24,644–24,673
408	Appendix to Defendants' Exhibits to Motions in Limine: 1, 9, 15, 18, 19, 22, 24, 26, 29, 30, 33, 37 (Volume 4) (Filed Under Seal)	09/22/21	100 101 102	24,674–24,893 24,894–25,143 25,144–25,204
391	Appendix to Defendants' Motion for Partial Summary Judgment Volume 1 of 8 (Filed Under Seal)	09/21/21	89 90	22,036–22,143 22,144–22,176

Tab	Document	Date	Vol.	Pages
392	Appendix to Defendants' Motion for Partial Summary Judgment Volume 2 of 8 (Filed Under Seal)	09/21/21	90	22,177–22,309
393	Appendix to Defendants' Motion for Partial Summary Judgment Volume 3 of 8 (Filed Under Seal)	09/22/21	90 91	22,310–22,393 22,394–22,442
394	Appendix to Defendants' Motion for Partial Summary Judgment Volume 4 of 8 (Filed Under Seal)	09/22/21	91	22,443–22,575
395	Appendix to Defendants' Motion for Partial Summary Judgment Volume 5 of 8 (Filed Under Seal)	09/22/21	91	22,576–22,609
396	Appendix to Defendants' Motion for Partial Summary Judgment Volume 6 of 8 (Filed Under Seal)	09/22/21	91 92 93	22,610–22,643 22,644–22,893 22,894–23,037
397	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7a of 8 (Filed Under Seal)	09/22/21	93 94	23,038–23,143 23,144–23,174
398	Appendix to Defendants' Motion for Partial Summary Judgment Volume 7b of 8 (Filed Under Seal)	09/22/21	94	23,175–23,260
399	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8a of 8 (Filed Under Seal)	09/22/21	94 95	23,261–23,393 23,394–23,535
400	Appendix to Defendants' Motion for Partial Summary Judgment Volume 8b of 8 (Filed Under Seal)	09/22/21	95 96	23,536–23,643 23,634–23,801
385	Appendix to Defendants' Motion in Limine No. 13 (Volume 1 of 6) (Filed Under Seal)	09/21/21	86 87	21,369–21,393 21,394–21,484
386	Appendix to Defendants' Motion in Limine No. 13 (Volume 2 of 6) (Filed Under Seal)	09/21/21	87	21,485–21,614
387	Appendix to Defendants' Motion in Limine	09/21/21	87	21,615–21,643

Tab	Document	Date	Vol.	Pages
	No. 13 (Volume 3 of 6) (Filed Under Seal)		88	21,644–21,744
388	Appendix to Defendants' Motion in Limine No. 13 (Volume 4 of 6) (Filed Under Seal)	09/21/21	88	21,745–21,874
389	Appendix to Defendants' Motion in Limine No. 13 (Volume 5 of 6) (Filed Under Seal)	09/21/21	88 89	21,875–21,893 21,894–22,004
390	Appendix to Defendants' Motion in Limine No. 13 (Volume 6 of 6) (Filed Under Seal)	09/21/21	89	22,005–22,035
409	Appendix to Defendants' Motion in Limine No. 14 – Volume 1 of 6 (Filed Under Seal)	09/22/21	102	25,205–25,226
410	Appendix to Defendants' Motion in Limine No. 14 – Volume 2 of 6 (Filed Under Seal)	09/22/21	102	25,227–25,364
411	Appendix to Defendants' Motion in Limine No. 14 – Volume 3 of 6 (Filed Under Seal)	09/22/21	102 103	25,365–25,393 25,394–25,494
412	Appendix to Defendants' Motion in Limine No. 14 – Volume 4 of 6 (Filed Under Seal)	09/22/21	103	25,495–25,624
413	Appendix to Defendants' Motion in Limine No. 14 – Volume 5 of 6 (Filed Under Seal)	09/22/21	103 104	25,625–25,643 25,644–25,754
414	Appendix to Defendants' Motion in Limine No. 14 – Volume 6 of 6 (Filed Under Seal)	09/22/21	104	25,755–25,785
373	Appendix to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	06/24/21	82 83 84	20,291–20,393 20,394–20,643 20,644–20,698
70	Appendix to Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/08/21	12 13 14	2875–3000 3001–3250 3251–3397
368	Appendix to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time (Filed	05/21/21	79 80 81	19,582–19,643 19,644–19,893 19,894–20,065

Tab	Document	Date	Vol.	Pages
	Under Seal)			
418	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 1 (Filed Under Seal)	09/29/21	105 106	25,902–26,143 26,144–26,216
419	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders - Volume 2 (Filed Under Seal)	09/29/21	106 107	26,217–26,393 26,394–26,497
489	Appendix to Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: to Exclude Evidence Subject to the Court's Discovery Orders (Exhibit 43) (Filed Under Seal)	09/29/21	144	35,703–35,713
75	Appendix to Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14 15	3466–3500 3501–3658
316	Case Appeal Statement	04/06/22	67 68	16,695–16,750 16,751–16,825
356	Case Appeal Statement	10/12/22	74 75	18,468–18,500 18,501–18,598
16	Civil Order to Statistically Close Case	12/10/19	2	309
1	Complaint (Business Court)	04/15/19	1	1–17
284	Defendant' Reply in Support of Their Motion to Apply the Statutory Cap on Punitive Damages	02/10/22	53	13,005–13,028
435	Defendant's Omnibus Offer of Proof for Second Phase of Trial (Filed Under Seal)	12/14/21	111	27,496–27,505

Tab	Document	Date	Vol.	Pages
	Trial Under Seal			
130	Defendants' Motion for Partial Summary Judgment	09/21/21	20	4770–4804
312	Defendants' Motion for Remittitur and to Alter or Amend the Judgment	04/06/22	66	16,382–16,399
131	Defendants' Motion in Limine No. 1: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with other Market Players and Related Negotiations	09/21/21	20	4805–4829
134	Defendants' Motion in Limine No. 10 to Exclude Reference of Defendants' Corporate Structure (Alternative Moton to be Considered Only if court Denies Defendants' Counterpart Motion in Limine No. 9)	09/21/21	20	4869–4885
401	Defendants' Motion in Limine No. 11 Paired with Motion in Limine No. 12 to Authorize Defendants to Discuss Plaintiffs' Conduct and deliberations in Negotiating Reimbursement (Filed Under Seal)	09/22/21	96	23,802–23,823
403	Defendants' Motion in Limine No. 12 Paired with Motion in Limine No. 11 to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement (Filed Under Seal)	09/22/21	96	23,860–23,879
135	Defendants' Motion in Limine No. 13: Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	09/21/21	20	4886–4918
136	Defendants' Motion in Limine No. 14: Motion Offered in the Alternative to MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to Settlement Agreement	09/21/21	20	4919–4940

Tab	Document	Date	Vol.	Pages
	Between CollectRX and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs			
132	Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations	09/21/21	20	4830–4852
137	Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/21/21	20	4941–4972
383	Defendants' Motion in Limine No. 5 Regarding Arguments or Evidence that Amounts TeamHealth Plaintiffs billed for Serves are Reasonable [an Alternative to Motion in Limine No. 6] (Filed Under Seal)	09/21/21	86	21,314–21,343
384	Defendants' Motion in Limine No. 6 Regarding Argument or Evidence That Amounts Teamhealth Plaintiffs Billed for Services are Reasonable (Filed Under Seal)	09/21/21	86	21,344–21,368
138	Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	09/22/21	20 21	4973–5000 5001–5030
139	Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided	09/22/21	21	5031–5054
140	Defendants' Motion in Limine No. 9 to Authorize Defendants to Offer Evidence of	09/22/21	21	5055–5080

Tab	Document	Date	Vol.	Pages
	Plaintiffs Organizational, Management, and Ownership Structure, Including Flow of Funds Between Related Entities, Operating Companies, Parent Companies, and Subsidiaries			
271	Defendants' Motion to Apply the Statutory Cap on Punitive Damages	12/30/21	50	12,342–12,363
71	Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/11/21	14	3398–3419
52	Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	09/21/20	8 9	1998–2000 2001–2183
23	Defendants' Motion to Dismiss	03/12/20	3	553–698
32	Defendants' Motion to Dismiss Plaintiffs' First Amended Complaint	05/26/20	5	1027–1172
348	Defendants' Motion to Redact Portions of Trial Transcript	10/06/22	72	17,979–17,989
304	Defendants' Motion to Retax Costs	03/21/22	62	15,374–15,388
277	Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing on Defendants' Motion to Seal Certain Confidential Trial Exhibits on Order Shortening Time	01/11/22	52	12,757–12,768
487	Defendants' Motion to Supplement Record Supporting Objections to Reports and Recommendations #2 & #3 on Order Shortening Time (Filed Under Seal)	05/24/21	143 144	35,635–35,643 35,644–35,648
169	Defendants' Objection to Media Requests	10/28/21	29	7004–7018

Tab	Document	Date	Vol.	Pages
339	Defendants' Objection to Plaintiffs' Proposed Order Approving Plaintiffs' Motion for Attorneys' Fees	07/26/22	71	17,700–17,706
273	Defendants' Objection to Plaintiffs' Proposed Order Denying Defendants' Motion for Judgment as a Matter of Law	01/04/22	51	12,707–12,717
94	Defendants' Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	04/12/21	17	4059–4079
98	Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time	04/28/21	17	4109–4123
370	Defendants' Objection to the Special Master's Report and Recommendation No. 5 Regarding Defendants' Motion for Protective Order Regarding Confidentiality Designations (Filed April 15, 2021) (Filed Under Seal)	06/01/21	82	20,152–20,211
61	Defendants' Objections to Plaintiffs to Plaintiffs' Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/26/20	11	2573–2670
151	Defendants' Objections to Plaintiffs' NRCP 16.1(a)(3) Pretrial Disclosures	10/08/21	22	5288–5294
64	Defendants' Objections to Plaintiffs' Order Denying Defendants' Motion to Compel	11/02/20	11	2696–2744

Tab	Document	Date	Vol.	Pages
	Motion for Entry of Judgment		53	13,001–13,004
322	Defendants' Opposition to Plaintiffs' Motion for Attorneys' Fees	04/20/22	69	17,036–17,101
155	Defendants' Opposition to Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	10/18/21	22	5323–5333
141	Defendants' Opposition to Plaintiffs' Motion in Limine No. 1: to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges	09/29/21	21	5081–5103
417	Defendants' Opposition to Plaintiffs' Motion in Limine No. 3: To Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal)	09/29/21	104 105	25,869–25,893 25,894–25,901
50	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, Or, in The Alternative, Motion in Limine on Order Shortening Time	09/04/20	8	1846–1932
56	Defendants' Opposition to Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents, and Answers to Interrogatories on Order Shortening Time	10/06/20	10	2293–2336
251	Defendants' Opposition to Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,609–11,631
89	Defendants' Opposition to Plaintiffs' Renewed Motion for Order to Show Cause	03/22/21	16	3916–3966

Tab	Document	Date	Vol.	Pages
	Why Defendants Should Not be Held in Contempt and for Sanctions			
220	Defendants' Proposed Jury Instructions (Contested)	11/15/21	38	9427–9470
259	Defendants' Proposed Second Phase Jury Instructions	12/05/21	49	12,049–12,063
263	Defendants' Proposed Second Phase Jury Instructions-Supplement	12/07/21	49	12,136–12,142
313	Defendants' Renewed Motion for Judgment as a Matter of Law	04/06/22	66	16,400–16,448
421	Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/11/21	107 108	26,606–26,643 26,644–26,663
74	Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/19/21	14	3449–3465
28	Defendants' Reply in Support of Motion to Dismiss	05/07/20	4	919–948
36	Defendants' Reply in Support of Motion to Dismiss Plaintiffs' First Amended Complaint	06/03/20	6	1310–1339
325	Defendants' Reply in Support of Motion to Retax Costs	05/04/22	69	17,122–17,150
457	Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	01/05/22	126	31,259–31,308
37	Defendants' Reply in Support of Their Supplemental Brief in Support of Their Motions to Dismiss Plaintiff's First Amended Complaint	06/03/20	6	1340–1349
334	Defendants' Response to Improper Supplement Entitled "Notice of	06/28/22	71	17,579–17,593

Tab	Document	Date	Vol.	Pages
	Supplemental Attorney Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees"			
286	Defendants' Response to Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits on Order Shortening Time	02/15/22	53	13,047–13,053
225	Defendants' Response to TeamHealth Plaintiffs' Trial Brief Regarding Defendants' Prompt Pay Act Jury Instruction Re: Failure to Exhaust Administrative Remedies	11/16/21	40	9799–9806
12	Defendants' Statement of Removal	05/30/19	1	123–126
33	Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	05/26/20	5	1173–1187
247	Defendants' Supplemental Proposed Jury Instruction	11/21/21	46	11,262–11,266
240	Defendants' Supplemental Proposed Jury Instructions (Contested)	11/19/21	44	10,947–10,952
48	Errata	08/04/20	7	1684
241	Errata	11/19/21	44	10,953
402	Errata to Defendants' Motion in Limine No. 11 (Filed Under Seal)	09/22/21	96	23,824–23,859
404	Errata to Defendants' Motion in Limine No. 12 (Filed Under Seal)	09/22/21	96 97	23,880–23,893 23,894–23,897
54	Errata to Plaintiffs' Motion to Compel Defendants' List of Witnesses Production of Documents and Answers to Interrogatories	09/28/20	9	2196–2223
85	Errata to Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for	03/12/21	16	3884–3886

Tab	Document	Date	Vol.	Pages
	Sanctions			
238	Errata to Source on Defense Contested Jury Instructions	11/18/21	43	10,618–10,623
430	Excerpts of Recorder's Transcript of Jury Trial – Day 13 (Filed Under Seal)	11/16/21	109	27,093–27,099
427	Excerpts of Recorder's Transcript of Jury Trial – Day 9 (Filed Under Seal)	11/09/21	109	26,998–27003
481	Exhibits P473_NEW, 4002, 4003, 4005, 4006, 4166, 4168, 4455, 4457, 4774, and 5322 to "Appendix B to Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits" (Tabs 98, 106, 107, 108, 109, 111, 112, 113, 114, 118, and 119) (Filed Under Seal)	10/07/22	142	35,243–35,247
30	First Amended Complaint	05/15/20	4 5	973–1000 1001–1021
13	Freemont Emergency Services (MANDAVIA), Ltd's Response to Statement of Removal	05/31/19	1	127–138
226	General Defense Verdict	11/16/21	40	9807–9809
305	Health Care Providers' Motion for Attorneys' Fees	03/30/22	62	15,389–15,397
326	Health Care Providers' Reply in Support of Motion for Attorneys' Fees	05/04/22	69	17,151–17,164
294	Health Care Providers' Verified Memorandum of Cost	03/14/22	53	13,198–13,208
44	Joint Case Conference Report	07/17/20	7	1606–1627
164	Joint Pretrial Memorandum Pursuant to EDRC 2.67	10/27/21	26 27	6486–6500 6501–6567
465	Joint Status Report and Table Identifying	03/04/22	128	31,888–31,893

Tab	Document	Date	Vol.	Pages
	the Redactions to Trial Exhibits That Remain in Dispute (Filed Under Seal)		129	31,894–31,922
221	Jointly Submitted Jury Instructions	11/15/21	38	9471–9495
255	Jury Instructions	11/29/21	48	11,957–11,999
264	Jury Instructions Phase Two	12/07/21	49	12,143–12,149
347	Limited Objection to "Order Unsealing Trial Transcripts and Restoring Public Access to Docket"	10/06/22	72	17,973–17,978
156	Media Request and Order Allowing Camera Access to Court Proceedings (Legal Newsline)	10/18/21	22	5334–5338
167	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 28	6992–6997
168	Media Request and Order Allowing Camera Access to Court Proceedings (Dolcefino Communications, LLC)	10/28/21	28 29	6998–7000 7001–7003
314	Motion for New Trial	04/06/22	66 67	16,449–16,500 16,501–16,677
119	Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Violating Protective Order	08/10/21	18	4465–4486
79	Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	02/18/21	15 16	3714–3750 3751–3756
488	Motion in Limine No. 3 to Allow References to Plaintiffs; Decision Making Processes Regarding Setting Billed Charges (Filed Under Seal)	09/21/21	144	35,649–35,702

Tab	Document	Date	Vol.	Pages
382	Motion in Limine No. 3 to Allow References to Plaintiffs' Decision Making Process Regarding Settling Billing Charges (Filed Under Seal)	09/21/21	86	21,260–21,313
133	Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Process and Reasonableness of billed Charges if Motion in Limine No. 3 is Denied	09/21/21	20	4853–4868
11	Motion to Remand	05/24/19	1	101–122
432	Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	12/05/21	110	27,288–27,382
434	Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	12/13/21	111	27,401–27,495
267	Motion to Seal Defendants' Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,294–12,302
275	Motion to Seal Defendants' Reply in Support of Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51	12,739–12,747
276	Motion to Seal Defendants' Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits	01/10/22	51 52	12,748–12,750 12,751–12,756
268	Motion to Seal Defendants' Supplement to Motion to Seal Certain Confidential Trial Exhibits	12/15/21	50	12,303–12,311
315	Notice of Appeal	04/06/22	67	16,678–16,694
355	Notice of Appeal	10/12/22	73 74	18,126–18,250 18,251–18,467
292	Notice of Entry of Judgment	03/09/22	53	13,168–13,178
115	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 2	08/09/21	18	4403–4413

Tab	Document	Date	Vol.	Pages
	Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order and Overruling Objection			
116	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time and Overruling Objection	08/09/21	18	4414–4424
127	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions and Overruling Objection	09/16/21	19	4709–4726
128	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 7 Regarding Defendants' Motion to Compel Responses to Defendants' Amended Third Set of Request for Production of Documents and Overruling Objection	09/16/21	19	4727–4747
129	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed No to Answer and Overruling Objection	09/16/21	19 20	4748–4750 4751–4769
200	Notice of Entry of Order Affirming and Adopting Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	11/03/21	32	7853–7874

Tab	Document	Date	Vol.	Pages
340	Notice of Entry of Order Approving Plaintiffs' Motion for Attorney's Fees	08/02/22	71	17,707–17,725
351	Notice of Entry of Order Approving Supplemental Attorney's Fee Award	10/12/22	73	18,005–18,015
357	Notice of Entry of Order Denying "Motion to Redact Portions of Trial Transcript"	10/13/22	75	18,599–18,608
40	Notice of Entry of Order Denying Defendants' (1) Motion to Dismiss First Amended Complaint; and (2) Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended Complaint Addressing Plaintiffs' Eighth Claim for Relief	06/24/20	6 7	1472–1500 1501–1516
274	Notice of Entry of Order Denying Defendants' Motion for Judgement as a Matter of Law	01/06/22	51	12,718–12,738
352	Notice of Entry of Order Denying Defendants' Motion for New Trial	10/12/22	73	18,016–18,086
154	Notice of Entry of Order Denying Defendants' Motion for Order to Show Cause Why Plaintiffs Should not be Held in Contempt for Violating Protective Order	10/14/21	22	5309–5322
161	Notice of Entry of Order Denying Defendants' Motion for Partial Summary Judgment	10/25/21	25	6116–6126
338	Notice of Entry of Order Denying Defendants' Motion for Remittitur and to Alter or Amend the Judgment	07/19/22	71	17,689–17,699
171	Notice of Entry of Order Denying Defendants' Motion in Limine No. 1 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Agreements with Other Market Players and Related Negotiations	11/01/21	29	7040–7051

Tab	Document	Date	Vol.	Pages
172	Notice of Entry of Order Denying Defendants' Motion in Limine No. 2: Motion Offered in the Alternative to MIL No. 1, to Preclude Plaintiffs from Offering Evidence Relating to Defendants' Agreements with Other Market Players and Related Negotiations	11/01/21	29	7052–7063
173	Notice of Entry of Order Denying Defendants' Motion in Limine No. 3 to Allow Reference to Plaintiffs' Decision Making Processes Regarding Setting Billed Charges	11/01/21	29	7064–7075
174	Notice of Entry of Order Denying Defendants' Motion in Limine No. 4 to Preclude References to Defendants' Decision Making Processes and Reasonableness of Billed Charges if Motion in Limine No. 3 is Denied	11/01/21	29	7076–7087
175	Notice of Entry of Order Denying Defendants' Motion in Limine No. 12, Paired with Motion in Limine No. 11, to Preclude Plaintiffs from Discussing Defendants' Approach to Reimbursement	11/01/21	29	7088–7099
176	Notice of Entry of Order Denying Defendants' Motion in Limine No. 5 Regarding Argument or Evidence that Amounts TeamHealth Plaintiffs Billed for Services are Reasonable [An Alternative Motion to Motion in Limine No. 6]	11/01/21	29	7100–7111
177	Notice of Entry of Order Denying Defendants' Motion in Limine No. 7 to Authorize Defendants to Offer Evidence of the Costs of the Services that Plaintiffs Provided	11/01/21	29	7112–7123
178	Notice of Entry of Order Denying	11/01/21	29	7124–7135

Tab	Document	Date	Vol.	Pages
	Defendants' Motion in Limine No. 8, Offered in the Alternative to MIL No. 7, to Preclude Plaintiffs from Offering Evidence as to the Qualitative Value, Relative Value, Societal Value, or Difficulty of the Services they Provided			
179	Notice of Entry of Order Denying Defendants' Motion in Limine No. 10 to Exclude Evidence of Defendants' Corporate Structure (Alternative Motion to be Considered Only if Court Denies Defendants' Counterpart Motion in Limine No. 9)	11/01/21	29	7136–7147
180	Notice of Entry of Order Denying Defendants' Motion in Limine No. 11, Paired with Motion in Limine No. 12, to Authorize Defendants to Discuss Plaintiffs' Conduct and Deliberations in Negotiating Reimbursement	11/01/21	29	7148–7159
181	Notice of Entry of Order Denying Defendants' Motion in Limine No. 13 Motion to Authorize Defendants to Offer Evidence Relating to Plaintiffs' Collection Practices for Healthcare Claims	11/01/21	29	7160–7171
182	Notice of Entry of Order Denying Defendants' Motion in Limine No. 14: Motion Offered in the Alternative MIL No. 13 to Preclude Plaintiffs from Contesting Defendants' Defenses Relating to Claims that were Subject to a Settlement Agreement Between CollectRx and Data iSight; and Defendants' Adoption of Specific Negotiation Thresholds for Reimbursement Claims Appealed or Contested by Plaintiffs	11/01/21	29	7172–7183
183	Notice of Entry of Order Denying	11/01/21	29	7184–7195

Tab	Document	Date	Vol.	Pages
	Defendants' Motion in Limine No. 15 to Preclude Reference and Testimony Regarding the TeamHealth Plaintiffs Policy not to Balance Bill			
184	Notice of Entry of Order Denying Defendants' Motion in Limine No. 18 to Preclude Testimony of Plaintiffs' Non-Retained Expert Joseph Crane, M.D.	11/01/21	29	7196–7207
185	Notice of Entry of Order Denying Defendants' Motion in Limine No. 20 to Exclude Defendants' Lobbying Efforts	11/01/21	29	7208–7219
186	Notice of Entry of Order Denying Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	11/01/21	29	7220–7231
187	Notice of Entry of Order Denying Defendants' Motion in Limine No. 27 to Preclude Evidence of Complaints Regarding Defendants' Out-Of-Network Rates or Payments	11/01/21	29	7232–7243
188	Notice of Entry of Order Denying Defendants' Motion in Limine No. 29 to Preclude Evidence Only Relating to Defendants' Evaluation and Development of a Company that Would Offer a Service Similar to Multiplan and Data iSight	11/01/21	29 30	7244–7250 7251–7255
189	Notice of Entry of Order Denying Defendants' Motion in Limine No. 32 to Exclude Evidence or Argument Relating to Materials, Events, or Conduct that Occurred on or After January 1, 2020	11/01/21	30	7256–7267
191	Notice of Entry of Order Denying Defendants' Motion in Limine No. 38 to Exclude Evidence or Argument Relating to	11/01/21	30	7280–7291

Tab	Document	Date	Vol.	Pages
	Defendants' use of MultiPlan and the Data iSight Service, Including Any Alleged Conspiracy or Fraud Relating to the use of Those Services			
190	Notice of Entry of Order Denying Defendants' Motion in Limine to Preclude Certain Expert Testimony and Fact Witness Testimony by Plaintiffs' Non-Retained Expert Robert Frantz, M.D.	11/01/21	30	7268–7279
293	Notice of Entry of Order Denying Defendants' Motion to Apply Statutory Cap on Punitive Damages	03/09/22	53	13,179–13,197
62	Notice of Entry of Order Denying Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on Order Shortening Time	10/27/20	11	2671–2683
78	Notice of Entry of Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	02/04/21	15	3703–3713
193	Notice of Entry of Order Denying Defendants' Motion to Strike Supplement Report of David Leathers	11/01/21	30	7355–7366
353	Notice of Entry of Order Denying Defendants' Renewed Motion for Judgment as a Matter of Law	10/12/22	73	18,087–18,114
97	Notice of Entry of Order Denying Motion for Reconsideration of Court's Order Denying Defendants' Motion to Compel Responses to Defendants' First and Second Requests for Production	04/26/21	17	4096–4108

Tab	Document	Date	Vol.	Pages
77	Notice of Entry of Order Granting Defendants' Motion for Appointment of Special Master	02/02/21	15	3693–3702
269	Notice of Entry of Order Granting Defendants' Motion for Leave to File Defendants' Preliminary Motion to Seal Attorneys' Eyes Only Documents Used at Trial Under Seal	12/27/21	50	12,312–12,322
202	Notice of Entry of Order Granting Defendants' Motion in Limine No. 17	11/04/21	33	8092–8103
203	Notice of Entry of Order Granting Defendants' Motion in Limine No. 25	11/04/21	33	8104–8115
204	Notice of Entry of Order Granting Defendants' Motion in Limine No. 37	11/04/21	33	8116–8127
205	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 9	11/04/21	33	8128–8140
206	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 21	11/04/21	33	8141–8153
207	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion in Limine No. 22	11/04/21	33	8154–8165
341	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Retax Costs	08/02/22	71	17,726–17,739
358	Notice of Entry of Order Granting in Part and Denying in Part Defendants' Motion to Seal Certain Confidential Trial Exhibits	10/18/22	75 76	18,609–18,750 18,751–18,755
215	Notice of Entry of Order Granting in Part and Denying in Part Plaintiffs' Motion in Limine to Exclude Evidence Subject to the	11/12/21	37	9162–9173

Tab	Document	Date	Vol.	Pages
	Court's Discovery Orders			
147	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/07/21	21	5235–5245
242	Notice of Entry of Order Granting Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment	11/19/21	44	10,954–10,963
192	Notice of Entry of Order Granting Plaintiffs' Motion in Limine to Exclude Evidence, Testimony And-Or Argument Regarding the Fact that Plaintiff have Dismissed Certain Claims	11/01/21	30	7292–7354
63	Notice of Entry of Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	10/27/20	11	2684–2695
335	Notice of Entry of Order Granting Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	06/29/22	71	17,594–17,609
281	Notice of Entry of Order Granting Plaintiffs' Proposed Schedule for Submission of Final Redactions	01/31/22	52	12,969–12,979
114	Notice of Entry of Order Granting Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	08/03/21	18	4383–4402
53	Notice of Entry of Order Granting, in Part Plaintiffs' Motion to Compel Defendants'	09/28/20	9	2184–2195

Tab	Document	Date	Vol.	Pages
	Production of Claims for At-Issue Claims, Or, in The Alternative, Motion in Limine			
102	Notice of Entry of Order of Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Question	05/26/21	17	4157–4165
22	Notice of Entry of Order Re: Remand	02/27/20	3	543–552
142	Notice of Entry of Order Regarding Defendants' Objection to Special Master's Report and Recommendation No. 11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents about which Plaintiffs' Witnesses Testified on Order Shortening Time	09/29/21	21	5104–5114
66	Notice of Entry of Order Setting Defendants' Production & Response Schedule Re: Order Granting Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time	11/09/20	12	2775–2785
285	Notice of Entry of Order Shortening Time for Hearing Re: Plaintiffs' Motion to Unlock Certain Admitted Trial Exhibits	02/14/22	53	13,029–13,046
354	Notice of Entry of Order Unsealing Trial Transcripts and Restoring Public Access to Docket	10/12/22	73	18,115–18,125
86	Notice of Entry of Report and Recommendation #1	03/16/21	16	3887–3894
120	Notice of Entry of Report and Recommendation #11 Regarding Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs'	08/11/21	18	4487–4497

Tab	Document	Date	Vol.	Pages
	Witnesses Testified			
91	Notice of Entry of Report and Recommendation #2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order	03/29/21	16	3971–3980
95	Notice of Entry of Report and Recommendation #3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Requests for Production on Order Shortening Time	04/15/21	17	4080–4091
104	Notice of Entry of Report and Recommendation #7 Regarding Defendants' Motion to Compel Plaintiffs' Responses to Defendants' Amended Third Set of Requests for Production of Documents	06/03/21	17	4173–4184
41	Notice of Entry of Stipulated Confidentiality and Protective Order	06/24/20	7	1517–1540
69	Notice of Entry of Stipulated Electronically Stored Information Protocol Order	01/08/21	12	2860–2874
289	Notice of Entry of Stipulation and Order Regarding Certain Admitted Trial Exhibits	02/17/22	53	13,074–13,097
360	Notice of Entry of Stipulation and Order Regarding Expiration of Temporary Stay for Sealed Redacted Transcripts	10/25/22	76	18,759–18,769
282	Notice of Entry of Stipulation and Order Regarding Schedule for Submission of Redactions	02/08/22	52	12,980–12,996
111	Notice of Entry Report and Recommendations #9 Regarding Pending Motions	07/01/21	18	4313–4325

Tab	Document	Date	Vol.	Pages
490	Notice of Filing of Expert Report of Bruce Deal, Revised on November 14, 2021 (Filed Under Seal)	04/18/23	144	35,714–35,812
361	Notice of Filing of Writ Petition	11/17/22	76	18,770–18855
24	Notice of Intent to Take Default as to: (1) Defendant UnitedHealth Group, Inc. on All Claims; and (2) All Defendants on the First Amended Complaint's Eighth Claim for Relief	03/13/20	3 4	699–750 751
324	Notice of Posting *Supersedeas* Bond	04/29/22	69	17,114–17,121
10	Notice of Removal to Federal Court	05/14/19	1	42–100
333	Notice of Supplemental Attorneys Fees Incurred After Submission of Health Care Providers' Motion for Attorneys Fees	06/24/22	70 71	17,470–17,500 17,501–17,578
291	Objection to Plaintiffs' Proposed Judgment and Order Denying Motion to Apply Statutory Cap on Punitive Damages	03/04/22	53	13,161–13,167
345	Objection to Plaintiffs' Proposed Orders Denying Renewed Motion for Judgment as a Matter of Law and Motion for New Trial	09/13/22	72	17,941–17,950
377	Objection to R&R #11 Regarding United's (Filed Under Seal)Motion to Compel Documents About Which Plaintiffs' Witnesses Testified (Filed Under Seal)	08/25/21	84 85	20,864–20,893 20,894–20,898
320	Opposition to Defendants' Motion to Retax Costs	04/13/22	68	16,856–16,864
153	Opposition to Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Regarding the Fact that Plaintiffs have Dismissed Certain Claims and Parties on Order Shortening Time	10/12/21	22	5301–5308

Tab	Document	Date	Vol.	Pages
20	Order	02/20/20	3	519–524
21	Order	02/24/20	3	525–542
337	Order Amending Oral Ruling Granting Defendants' Motion to Retax	07/01/22	71	17,682–17,688
2	Peremptory Challenge of Judge	04/17/19	1	18–19
415	Plaintiffs' Combined Opposition to Defendants Motions in Limine 1, 7, 9, 11 & 13 (Filed Under Seal)	09/29/21	104	25,786–25,850
416	Plaintiffs' Combined Opposition to Defendants' Motions in Limine No. 2, 8, 10, 12 & 14 (Filed Under Seal)	09/29/21	104	25,851–25,868
145	Plaintiffs' Motion for Leave to File Second Amended Complaint on Order Shortening Time	10/04/21	21	5170–5201
422	Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/17/21	108	26,664–26,673
378	Plaintiffs' Motion in Limine to Exclude Evidence Subject to the Court's Discovery Orders (Filed Under Seal)	09/21/21	85	20,899–20,916
380	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and/or Argument Relating to (1) Increase in Insurance Premiums (2) Increase in Costs and (3) Decrease in Employee Wages/Benefits Arising from Payment of Billed Charges (Filed Under Seal)	09/21/21	85	21,077–21,089
149	Plaintiffs' Motion in Limine to Exclude Evidence, Testimony and-or Argument	10/08/21	22	5265–5279

Tab	Document	Date	Vol.	Pages
	Regarding the Fact that Plaintiffs Have Dismissed Certain Claims and Parties on Order Shortening Time			
363	Plaintiffs' Motion to Compel Defendants' List of Witnesses, Production of Documents and Answers to Interrogatories on Order Shortening Time (Filed Under Seal)	09/28/20	78	19,144–19,156
49	Plaintiffs' Motion to Compel Defendants' Production of Claims File for At-Issue Claims, or, in the Alternative, Motion in Limine on Order Shortening Time	08/28/20	7 8	1685–1700 1701–1845
250	Plaintiffs' Motion to Modify Joint Pretrial Memorandum Re: Punitive Damages on Order Shortening Time	11/22/21	47	11,594–11,608
194	Plaintiffs' Notice of Amended Exhibit List	11/01/21	30	7367–7392
208	Plaintiffs' Notice of Deposition Designations	11/04/21	33 34	8166–8250 8251–8342
152	Plaintiffs' Objections to Defendants' Pretrial Disclosures	10/08/21	22	5295–5300
328	Plaintiffs' Opposition to Defendants' Motion for New Trial	05/04/22	69 70	17,179–17,250 17,251–17,335
420	Plaintiffs' Opposition to Defendants' Motion for Partial Summary Judgment (Filed Under Seal)	10/05/21	107	26,498–26,605
327	Plaintiffs' Opposition to Defendants' Motion for Remittitur and to Alter or Amend the Judgment	05/04/22	69	17,165–17,178
144	Plaintiffs' Opposition to Defendants' Motion in Limine No. 24 to Preclude Plaintiffs from Referring to Themselves as Healthcare Professionals	09/29/21	21	5155–5169
143	Plaintiffs' Opposition to Defendants' Motion	09/29/21	21	5115–5154

Tab	Document	Date	Vol.	Pages
	in Limine Nos. 3, 4, 5, 6 Regarding Billed Charges			
279	Plaintiffs' Opposition to Defendants' Motion to Apply Statutory Cap on Punitive Damages and Plaintiffs' Cross Motion for Entry of Judgment	01/20/22	52	12,773–12,790
374	Plaintiffs' Opposition to Defendants' Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	07/06/21	84	20,699–20,742
25	Plaintiffs' Opposition to Defendants' Motion to Dismiss	03/26/20	4	752–783
34	Plaintiffs' Opposition to Defendants' Motion to Dismiss First Amended Complaint	05/29/20	5 6	1188–1250 1251–1293
349	Plaintiffs' Opposition to Defendants' Motion to Redact Portions of Trial Transcript	10/07/22	72	17,990–17,993
278	Plaintiffs' Opposition to Defendants' Motion to Seal Courtroom During January 12, 2022 Hearing	01/12/22	52	12,769–12,772
369	Plaintiffs' Opposition to Defendants' Motion to Supplement the Record Supporting Objections to Reports and Recommendations #2 and #3 on Order Shortening Time (Filed Under Seal)	06/01/21	81 82	20,066–20,143 20,144–20,151
329	Plaintiffs' Opposition to Defendants' Renewed Motion for Judgment as a Matter of Law	05/05/22	70	17,336–17,373
317	Plaintiffs' Opposition to Defendants' Rule 62(b) Motion for Stay	04/07/22	68	16,826–16,831
35	Plaintiffs' Opposition to Defendants' Supplemental Brief in Support of Their Motion to Dismiss Plaintiffs' First Amended	05/29/20	6	1294–1309

Tab	Document	Date	Vol.	Pages
	Complaint Addressing Plaintiffs' Eighth Claim for Relief			
83	Plaintiffs' Opposition to Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/04/21	16	3833–3862
55	Plaintiffs' Opposition to Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures on an Order Shortening Time	09/29/20	9-10	2224–2292
72	Plaintiffs' Opposition to Motion to Compel Responses to Defendants' First and Second Requests for Production on Order Shortening Time	01/12/21	14	3420–3438
122	Plaintiffs' Opposition to United's Motion for Order to Show Cause Why Plaintiffs Should Not Be Held in Contempt and Sanctioned for Allegedly Violating Protective Order	08/24/21	19	4528–4609
270	Plaintiffs' Opposition to United's Motion to Seal	12/29/21	50	12,323–12,341
222	Plaintiffs' Proposed Jury Instructions (Contested)	11/15/21	38 39	9496–9500 9501–9513
260	Plaintiffs' Proposed Second Phase Jury Instructions and Verdict Form	12/06/21	49	12,064–12,072
243	Plaintiffs' Proposed Special Verdict Form	11/19/21	44	10,964–10,973
227	Plaintiffs' Proposed Verdict Form	11/16/21	40	9810–9819
84	Plaintiffs' Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions	03/08/21	16	3863–3883

Tab	Document	Date	Vol.	Pages
287	Plaintiffs' Reply in Support of Cross Motion for Entry of Judgment	02/15/22	53	13,054–13,062
364	Plaintiffs' Reply in Support of Renewed Motion for Order to Show Cause Why Defendants Should Not Be Held in Contempt and for Sanctions (Filed Under Seal)	04/01/21	78	19,157–19,176
366	Plaintiffs' Response to Defendants Objection to the Special Master's Report and Recommendation No. 2 Regarding Plaintiffs' Objection to Notice of Intent to Issue Subpoena Duces Tecum to TeamHealth Holdings, Inc. and Collect Rx, Inc. Without Deposition and Motion for Protective Order (Filed Under Seal)	04/19/21	78 79	19,389–19,393 19,394–19,532
195	Plaintiffs' Response to Defendants' Objection to Media Requests	11/01/21	30	7393–7403
371	Plaintiffs' Response to Defendants' Objection to Report and Recommendation #6 Regarding Defendants' Motion to Compel Further Testimony from Deponents Instructed Not to Answer Questions (Filed Under Seal)	06/16/21	82	20,212–20,265
376	Plaintiffs' Response to Defendants' Objection to Special Master Report and Recommendation No. 9 Regarding Defendants' Renewed Motion to Compel Further Testimony from Deponents Instructed not to Answer Questions (Filed Under Seal)	07/22/21	84	20,751–20,863
110	Plaintiffs' Response to Defendants' Objection to Special Master's Report and Recommendation #7 Regarding Defendants' Motion to Compel Responses to Amended	06/24/21	18	4281–4312

Tab	Document	Date	Vol.	Pages
	Third Set of Request for Production of Documents			
367	Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Motion to Compel Responses to Defendants' Second Set of Request for Production on Order Shortening Time (Filed Under Seal)	05/05/21	79	19,533–19,581
426	Plaintiffs' Response to Defendants' Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal)	11/08/21	109	26,965–26,997
246	Plaintiffs' Second Supplemental Jury Instructions (Contested)	11/20/21	46	11,255–11,261
261	Plaintiffs' Supplement to Proposed Second Phase Jury Instructions	12/06/21	49	12,072–12,077
236	Plaintiffs' Supplemental Jury Instruction (Contested)	11/17/21	42	10,308–10,313
248	Plaintiffs' Third Supplemental Jury Instructions (Contested)	11/21/21	46	11,267–11,272
216	Plaintiffs' Trial Brief Regarding Defendants' Prompt Payment Act Jury Instruction Re: Failure to Exhaust Administrative Remedies	11/12/21	37	9174–9184
223	Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/15/21	39	9514–9521
218	Plaintiffs' Trial Brief Regarding Specific Price Term	11/14/21	38	9417–9425
428	Preliminary Motion to Seal Attorneys' Eyes Documents Used at Trial (Filed Under Seal)	11/11/21	109	27,004–27,055
211	Recorder's Amended Transcript of Jury Trial – Day 9	11/09/21	35	8515–8723

Tab	Document	Date	Vol.	Pages
73	Recorder's Partial Transcript of Proceedings Re: Motions (Unsealed Portion Only)	01/13/21	14	3439–3448
125	Recorder's Partial Transcript of Proceedings Re: Motions Hearing	09/09/21	19	4667–4680
126	Recorder's Partial Transcript of Proceedings Re: Motions Hearing (Via Blue Jeans)	09/15/21	19	4681–4708
31	Recorder's Transcript of Hearing All Pending Motions	05/15/20	5	1022–1026
88	Recorder's Transcript of Hearing All Pending Motions	03/18/21	16	3910–3915
90	Recorder's Transcript of Hearing All Pending Motions	03/25/21	16	3967–3970
96	Recorder's Transcript of Hearing All Pending Motions	04/21/21	17	4092–4095
82	Recorder's Transcript of Hearing Defendants' Motion to Extend All Case Management Deadlines and Continue Trial Setting on Order Shortening Time (Second Request)	03/03/21	16	3824–3832
101	Recorder's Transcript of Hearing Motion for Leave to File Opposition to Defendants' Motion to Compel Responses to Second Set of Requests for Production on Order Shortening Time in Redacted and Partially Sealed Form	05/12/21	17	4155–4156
107	Recorder's Transcript of Hearing Motion for Leave to File Plaintiffs' Response to Defendants' Objection to the Special Master's Report and Recommendation No. 3 Regarding Defendants' Second Set of Request for Production on Order Shortening Time in Redacted and Partially Sealed Form	06/09/21	17	4224–4226
92	Recorder's Transcript of Hearing Motion to Associate Counsel on OST	04/01/21	16	3981–3986

Tab	Document	Date	Vol.	Pages
483	Recorder's Transcript of Hearing re Hearing (Filed Under Seal)	10/13/22	142	35,259–35,263
346	Recorder's Transcript of Hearing Re: Hearing	09/22/22	72	17,951–17,972
359	Recorder's Transcript of Hearing Status Check	10/20/22	76	18,756–18,758
162	Recorder's Transcript of Jury Trial – Day 1	10/25/21	25 26	6127–6250 6251–6279
213	Recorder's Transcript of Jury Trial – Day 10	11/10/21	36 37	8933–9000 9001–9152
217	Recorder's Transcript of Jury Trial – Day 11	11/12/21	37 38	9185–9250 9251–9416
224	Recorder's Transcript of Jury Trial – Day 12	11/15/21	39 40	9522–9750 9751–9798
228	Recorder's Transcript of Jury Trial – Day 13	11/16/21	40 41	9820–10,000 10,001–10,115
237	Recorder's Transcript of Jury Trial – Day 14	11/17/21	42 43	10,314–10,500 10,501–10,617
239	Recorder's Transcript of Jury Trial – Day 15	11/18/21	43 44	10,624–10,750 10,751–10,946
244	Recorder's Transcript of Jury Trial – Day 16	11/19/21	44 45	10,974–11,000 11,001–11,241
249	Recorder's Transcript of Jury Trial – Day 17	11/22/21	46 47	11,273–11,500 11.501–11,593
253	Recorder's Transcript of Jury Trial – Day 18	11/23/21	47 48	11,633–11,750 11,751–11,907
254	Recorder's Transcript of Jury Trial – Day 19	11/24/21	48	11,908–11,956
163	Recorder's Transcript of Jury Trial – Day 2	10/26/21	26	6280–6485
256	Recorder's Transcript of Jury Trial – Day 20	11/29/21	48 49	12,000 12,001–12,034

Tab	Document	Date	Vol.	Pages
262	Recorder's Transcript of Jury Trial – Day 21	12/06/21	49	12,078–,12,135
266	Recorder's Transcript of Jury Trial – Day 22	12/07/21	49 50	12,153–12,250 12,251–12,293
165	Recorder's Transcript of Jury Trial – Day 3	10/27/21	27 28	6568–6750 6751–6774
166	Recorder's Transcript of Jury Trial – Day 4	10/28/21	28	6775–6991
196	Recorder's Transcript of Jury Trial – Day 5	11/01/21	30 31	7404–7500 7501–7605
197	Recorder's Transcript of Jury Trial – Day 6	11/02/21	31 32	7606–7750 7751–7777
201	Recorder's Transcript of Jury Trial – Day 7	11/03/21	32 33	7875–8000 8001–8091
210	Recorder's Transcript of Jury Trial – Day 8	11/08/21	34 35	8344–8500 8501–8514
212	Recorder's Transcript of Jury Trial – Day 9	11/09/21	35 36	8724–8750 8751–8932
27	Recorder's Transcript of Proceedings Re: Motions	04/03/20	4	909–918
76	Recorder's Transcript of Proceedings Re: Motions	01/21/21	15	3659–3692
80	Recorder's Transcript of Proceedings Re: Motions	02/22/21	16	3757–3769
81	Recorder's Transcript of Proceedings Re: Motions	02/25/21	16	3770–3823
93	Recorder's Transcript of Proceedings Re: Motions	04/09/21	16 17	3987–4000 4001–4058
103	Recorder's Transcript of Proceedings Re: Motions	05/28/21	17	4166–4172
43	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	07/09/20	7	1591–1605

Tab	Document	Date	Vol.	Pages
45	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	07/23/20	7	1628–1643
58	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/08/20	10	2363–2446
59	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	10/22/20	10	2447–2481
65	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	11/04/20	11 12	2745–2750 2751–2774
67	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/23/20	12	2786–2838
68	Recorder's Transcript of Proceedings Re: Motions (via Blue Jeans)	12/30/20	12	2839–2859
105	Recorder's Transcript of Proceedings Re: Motions Hearing	06/03/21	17	4185–4209
106	Recorder's Transcript of Proceedings Re: Motions Hearing	06/04/21	17	4210–4223
109	Recorder's Transcript of Proceedings Re: Motions Hearing	06/23/21	17 18	4240–4250 4251–4280
113	Recorder's Transcript of Proceedings Re: Motions Hearing	07/29/21	18	4341–4382
123	Recorder's Transcript of Proceedings Re: Motions Hearing	09/02/21	19	4610–4633
121	Recorder's Transcript of Proceedings Re: Motions Hearing (Unsealed Portion Only)	08/17/21	18 19	4498–4500 4501–4527
29	Recorder's Transcript of Proceedings Re: Pending Motions	05/14/20	4	949-972
51	Recorder's Transcript of Proceedings Re: Pending Motions	09/09/20	8	1933–1997
15	Rely in Support of Motion to Remand	06/28/19	2	276–308
124	Reply Brief on "Motion for Order to Show	09/08/21	19	4634–4666

Tab	Document	Date	Vol.	Pages
	Cause Why Plaintiffs Should Not Be Hold in Contempt and Sanctioned for Violating Protective Order"			
19	Reply in Support of Amended Motion to Remand	02/05/20	2 3	486–500 501–518
330	Reply in Support of Defendants' Motion for Remittitur and to Alter or Amend the Judgment	06/22/22	70	17,374–17,385
57	Reply in Support of Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiff to Supplement Their NRCP 16.1 Initial Disclosures	10/07/20	10	2337–2362
331	Reply in Support of Defendants' Renewed Motion for Judgment as a Matter of Law	06/22/22	70	17,386–17,411
332	Reply in Support of Motion for New Trial	06/22/22	70	17,412–17,469
87	Reply in Support of Motion for Reconsideration of Order Denying Defendants' Motion to Compel Plaintiffs Responses to Defendants' First and Second Requests for Production	03/16/21	16	3895–3909
344	Reply in Support of Supplemental Attorney's Fees Request	08/22/22	72	17,935–17,940
229	Reply in Support of Trial Brief Regarding Evidence and Argument Relating to Out-Of-State Harms to Non-Parties	11/16/21	41	10,116–10,152
318	Reply on "Defendants' Rule 62(b) Motion for Stay Pending Resolution of Post-Trial Motions" (*on Order Shortening Time*)	04/07/22	68	16,832–16,836
245	Response to Plaintiffs' Trial Brief Regarding Punitive Damages for Unjust Enrichment Claim	11/19/21	45 46	11,242–11,250 11,251–11,254

Tab	Document	Date	Vol.	Pages
230	Response to Plaintiffs' Trial Brief Regarding Specific Price Term	11/16/21	41	10,153–10,169
424	Response to Sur-Reply Arguments in Plaintiffs' Motion for Leave to File Supplemental Record in Opposition to Arguments Raised for the First Time in Defendants' Reply in Support of Motion for Partial Summary Judgment (Filed Under Seal)	10/21/21	109	26,931–26,952
148	Second Amended Complaint	10/07/21	21 22	5246–5250 5251–5264
458	Second Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits (Filed Under Seal)	01/05/22	126 127	31,309–31,393 31,394–31,500
231	Special Verdict Form	11/16/21	41	10,169–10,197
257	Special Verdict Form	11/29/21	49	12,035–12,046
265	Special Verdict Form	12/07/21	49	12,150–12,152
6	Summons – Health Plan of Nevada, Inc.	04/30/19	1	29–31
9	Summons – Oxford Health Plans, Inc.	05/06/19	1	38–41
8	Summons – Sierra Health and Life Insurance Company, Inc.	04/30/19	1	35–37
7	Summons – Sierra Health-Care Options, Inc.	04/30/19	1	32–34
3	Summons - UMR, Inc. dba United Medical Resources	04/25/19	1	20–22
4	Summons – United Health Care Services Inc. dba UnitedHealthcare	04/25/19	1	23–25
5	Summons – United Healthcare Insurance Company	04/25/19	1	26–28
433	Supplement to Defendants' Motion to Seal Certain Confidential Trial Exhibits (Filed	12/08/21	110 111	27,383–27,393 27,394–27,400

Tab	Document	Date	Vol.	Pages
	Under Seal)			
170	Supplement to Defendants' Objection to Media Requests	10/31/21	29	7019–7039
439	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 1 of 18 (Filed Under Seal)	12/24/21	114	28,189–28,290
440	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 2 of 18 (Filed Under Seal)	12/24/21	114 115	28,291–28,393 28,394–28,484
441	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 3 of 18 (Filed Under Seal)	12/24/21	115 116	28,485–28,643 28,644–28,742
442	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 4 of 18 (Filed Under Seal)	12/24/21	116 117	28,743–28,893 28,894–28,938
443	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 5 of 18 (Filed Under Seal)	12/24/21	117	28,939–29,084
444	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 6 of 18 (Filed Under Seal)	12/24/21	117 118	29,085–29,143 29,144–29,219
445	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 7 of 18 (Filed Under Seal)	12/24/21	118	29,220–29,384
446	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 8 of 18 (Filed Under Seal)	12/24/21	118 119	29,385–29,393 29,394–29,527
447	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 9 of 18 (Filed Under Seal)	12/24/21	119 120	29,528–29,643 29,644–29,727
448	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial	12/24/21	120 121	29,728–29,893 29,894–29,907

Tab	Document	Date	Vol.	Pages
	Exhibits – Volume 10 of 18 (Filed Under Seal)			
449	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 11 of 18 (Filed Under Seal)	12/24/21	121	29,908–30,051
450	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 12 of 18 (Filed Under Seal)	12/24/21	121 122	30,052–30,143 30,144–30,297
451	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 13 of 18 (Filed Under Seal)	12/24/21	122 123	30,298–30,393 30,394–30,516
452	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 14 of 18 (Filed Under Seal)	12/24/21	123 124	30,517–30,643 30,644–30,677
453	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 15 of 18 (Filed Under Seal)	12/24/21	124	30,678–30,835
454	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 16 of 18 (Filed Under Seal)	12/24/21	124 125	30,836–30,893 30,894–30,952
455	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 17 of 18 (Filed Under Seal)	12/24/21	125	30,953–31,122
456	Supplemental Appendix of Exhibits to Motion to Seal Certain Confidential Trial Exhibits – Volume 18 of 18 (Filed Under	12/24/21	125 126	30,123–31,143 31,144–31,258

Tab	Document	Date	Vol.	Pages
	Seal)			
466	Transcript of Proceedings re Hearing Regarding Unsealing Record (Filed Under Seal)	10/05/22	129	31,923–31,943
350	Transcript of Proceedings re Status Check	10/10/22	72 73	17,994–18,000 18,001–18,004
467	Transcript of Proceedings re Status Check (Filed Under Seal)	10/06/22	129	31,944–31,953
157	Transcript of Proceedings Re: Motions	10/19/21	22 23	5339–5500 5501–5561
160	Transcript of Proceedings Re: Motions	10/22/21	24 25	5908–6000 6001–6115
459	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/12/22	127	31,501–31,596
460	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/20/22	127 128	31,597–31,643 31,644–31,650
461	Transcript of Proceedings Re: Motions (Filed Under Seal)	01/27/22	128	31,651–31,661
146	Transcript of Proceedings Re: Motions (Via Blue Jeans)	10/06/21	21	5202–5234
290	Transcript of Proceedings Re: Motions Hearing	02/17/22	53	13,098–13,160
319	Transcript of Proceedings Re: Motions Hearing	04/07/22	68	16,837–16,855
323	Transcript of Proceedings Re: Motions Hearing	04/21/22	69	17,102–17,113
336	Transcript of Proceedings Re: Motions Hearing	06/29/22	71	17,610–17,681
463	Transcript of Proceedings Re: Motions Hearing (Filed Under Seal)	02/10/22	128	31,673–31,793

Tab	Document	Date	Vol.	Pages
464	Transcript of Proceedings Re: Motions Hearing (Filed Under Seal)	02/16/22	128	31,794–31,887
38	Transcript of Proceedings, All Pending Motions	06/05/20	6	1350–1384
39	Transcript of Proceedings, All Pending Motions	06/09/20	6	1385–1471
46	Transcript of Proceedings, Plaintiff's Motion to Compel Defendants' Production of Unredacted MultiPlan, Inc. Agreement	07/29/20	7	1644–1663
482	Transcript of Status Check (Filed Under Seal)	10/10/22	142	35,248–35,258
492	Transcript Re: Proposed Jury Instructions	11/21/21	146	36,086–36,250
425	Trial Brief Regarding Evidence and Argument Relating to Out-of-State Harms to Non-Parties (Filed Under Seal)	10/31/21	109	26,953–26,964
232	Trial Brief Regarding Jury Instructions on Formation of an Implied-In-Fact Contract	11/16/21	41	10,198–10,231
233	Trial Brief Regarding Jury Instructions on Unjust Enrichment	11/16/21	41	10,232–10,248
484	Trial Exhibit D5499 (Filed Under Seal)		142 143	35,264–35,393 35,394–35,445
362	Trial Exhibit D5502		76 77	18,856–19,000 19,001–19,143
485	Trial Exhibit D5506 (Filed Under Seal)		143	35,446
372	United's Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified on Order Shortening Time (Filed Under Seal)	06/24/21	82	20,266–20,290
112	United's Reply in Support of Motion to Compel Plaintiffs' Production of Documents About Which Plaintiffs' Witnesses Testified	07/12/21	18	4326–4340

Tab	Document	Date	Vol.	Pages
	on Order Shortening Time			
258	Verdict(s) Submitted to Jury but Returned Unsigned	11/29/21	49	12,047–12,048

CERTIFICATE OF SERVICE

I certify that on April 18, 2023, I submitted the foregoing appendix for filing *via* the Court's eFlex electronic filing system.

Electronic notification will be sent to the following:

Pat Lundvall
Kristen T. Gallagher
Amanda M. Perach
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102

Attorneys for Respondents (case no. 85525)/Real Parties in Interest (case no. 85656)

Richard I. Dreitzer
FENNEMORE CRAIG, PC
9275 W. Russell Road, Suite 240
Las Vegas, Nevada 89148

Attorneys for Real Parties in Interest (case no. 85656)

Dennis L. Kennedy
Sarah E. Harmon
BAILEY KENNEDY
8984 Spanish Ridge Avenue
Las Vegas, Nevada 89148

Attorneys for Respondents (case no. 85525)

Constance. L. Akridge
Sydney R. Gambee
HOLLAND & HART LLP
9555 Hillwood Drive, Second Floor
Las Vegas, Nevada 89134

Attorneys for Amicus Curiae (case no. 85656)

I further certify that I served a copy of this document by mailing a true and correct copy thereof, postage prepaid, at Las Vegas, Nevada, addressed as follows:

The Honorable Nancy L. Allf
DISTRICT COURT JUDGE – DEPT. 27
200 Lewis Avenue
Las Vegas, Nevada 89155

Respondent (case no. 85656)

Joseph Y. Ahmad
John Zavitsanos
Jason S. McManis
Michael Killingsworth
Louis Liao
Jane L. Robinson
Patrick K. Leyendecker
AHMAD, ZAVITSANOS, & MENSING, PLLC
1221 McKinney Street, Suite 2500
Houston, Texas 77010

Justin C. Fineberg
Martin B. Goldberg
Rachel H. LeBlanc
Jonathan E. Feuer
Jonathan E. Siegelaub
David R. Ruffner
Emily L. Pincow
Ashley Singrossi
LASH & GOLDBERG LLP
Weston Corporate Centre I
2500 Weston Road Suite 220
Fort Lauderdale, Florida 33331

Attorneys for Respondents (case no. 85525)/Real Parties in Interest (case no. 85656)

/s/ Jessie M. Helm
An Employee of Lewis Roca Rothgerber Christie LLP

percent) less in the six months preceding an episode and $783.08 (6.8 percent) less in the 12 months preceding an episode. In Appendix Figure 7, we show the average Charlson co-morbidity score and six-month historical spending levels of patients, by month, at hospitals where EmCare and TeamHealth entered. There is no evidence of immediate changes in these outcomes after a change in management.

Crucially, however, we find the same discrete changes in hospital and physician activity appearing across all health severity groups of patients, including patients in the least severe group. In Appendix Table 16, we estimate Equation (13a) using several different sample restrictions and sets of controls for the health of the patients. We focus on the impact that the entry of EmCare had on the frequency that physicians code using the CPT code for the most intensive emergency. We find that even among patients with low historical spending and no comorbidities, there was a substantial increase in the rate they had episodes that included physician claims coded using the highest intensity CPT code. In Column 1, we estimate Equation (13a) with no patient controls; in Column 2, we re-estimate Equation (13a) controlling for patients' age, sex, and race; and in Column 3, we control for patients' age, sex, race, and their Charlson comorbidity score. Across all three estimates, the point estimate on the impact of entry on the rate of using the highest-intensity CPT code for emergency physician visits is consistent and ranges from 0.148 to 0.151. In Column 4, we estimate Equation (13a) and limit our analysis to patients throughout our sample who have a Charlson comorbidity score of 0 (e.g., patients who have no comorbidities). In Column 5, we estimate Equation (13a) and limit our analysis to patients throughout our data who have a non-zero Charlson score. The point estimates in Columns 4 and 5 illustrate that whether or not they had comorbidities, patients were almost equally more likely to have physician visits coded using the CPT code for the most intensive emergency after EmCare entered a hospital. Likewise, in Columns 6, 7, and 8, we estimate Equation (13a) on the samples of patients in the lower third ($0 to $279.67), the middle-third ($279.68 to $2,033.59), and the top-third ($2,033.60 to $115,499.30) of the distribution of historical six-month patient health spending. Across all three sub-samples, the entry of EmCare led to an increase in the rate patients had physician claims coded using the CPT code for the most severe emergency.

In Appendix Table 17, we repeat this analysis and examine the impact of the entry of EmCare on facility spending across different samples of the data. We see that there was

003251

003251

003251

increased facility spending across patients with and without comorbidities and with high and low historical spending. Likewise, controlling for patients' comorbidities does little to alter the impact of the entry of EmCare on facility spending. In Appendix Table 18, we see similarly robust findings for imaging studies. After the entry of EmCare into a hospital, patients with no comorbidities are 4.9 percent more likely to receive an imaging study.

Finally, in Appendix Table 19, we analyze whether we observe higher hospital admission rates for patients with low historical spending and no comorbidities following the entry of EmCare. In Column 4, we find that after EmCare entered a hospital, patients with no comorbidities were 20 percent more likely to be admitted to the hospital. In Column 6, we find patients with low historical spending (e.g., less than $279.67 in the previous six months) were 17 percent more likely to be admitted to the hospital after EmCare took over the management of the hospital ED.

5.8 Generalizability of Our Data

003252

Our data come from a single insurer that operates across all fifty states. Our data capture nearly $28 billion in economic activity, so it constitutes an interesting sample to study regardless of generalizability. However, to gauge the generalizability of our results, we compare the mean out-of-network rates we observe to the mean out-of-network rates presented in Garmon and Chartock (2017) (the only other study that examines out-of-network rates nationally).[29] Garmon and Chartock (2017) use 2007 to 2014 data from the Truven Health MarketScan database. They focus on whether patients at in-network hospitals saw any out-of-network physicians. This is slightly different from our measure; we focus on the network participation of the primary physician on ED cases at in-network hospitals. Garmon and Chartock (2017) find that emergency cases that had an admission had out-of-network bills in one in five cases; outpatient emergency cases had out-of-network bills in 14 percent of cases. These results are fairly similar to our descriptive finding concerning the average prevalence of out-of-network billing. Likewise, Garmon and Chartock (2017) present a map of the variation in out-of-network billing rates across states. Their results are similar to the national variation Cooper and Scott Morton (2016) observed using a sample of the data used in this analysis.

[29] Cooper and Scott Morton (2016) is a national study, but it uses the same data used in this analysis.

003252

6. New York State's Laws to Address Surprise Out-of-Network Billing

6.1 Background on the New York Law

On April 1, 2014, New York State passed a law designed to protect patients who receive emergency care from out-of-network physicians. The law has two components. The first is a hold harmless provision, which requires that if a patient sees an out-of-network ED physician, they pay no more in cost sharing than they would pay if they were treated by an in-network physician. The second component is an arbitration process to determine what providers are paid when they treat a patient and do not participate in the patient's insurer's network. Ultimately, the law stipulates that insurers must develop reasonable payment rates for out-of-network care, illustrate how their out-of-network payments were calculated, and show how they compare to usual and customary rates (Hoadley et al. 2015).[30]

In practice, under this law in New York, when a patient is seen out-of-network, the insurer makes its payment to the provider. If the out-of-network provider does not accept the payer's offer, the provider can initiate an independent dispute resolution process. The independent dispute resolution process is judged by practicing physicians who use baseball rules arbitration: the arbitrator can stipulate that the provider will be paid the insurer's original payment or alternatively the provider's original charge. Ultimately, this policy disadvantages providers that bill for unreasonably high charges and punishes insurers that offer unreasonably low initial payments. The law also encourages physicians and payers to negotiate independently and avoid arbitration. Technically, the law applies only to fully insured insurance products, as states cannot regulate ASO plans (which account for the majority of privately insured products in the US) (Kaiser Family Foundation 2017). However, because most providers are unaware of a patient's plan funding, their bill is likely chosen to reflect the possibility of arbitration.

6.2 Analyzing the Impact of New York State's Law

As Appendix Table 20 shows, our data include 323,936 ED episodes delivered at New York hospitals between 2011 and 2015, which captures approximately $1 billion in emergency health care spending. In addition, 90.2 percent of the patients in our data in New York are in ASO

[30] Usual and customary rates are defined in the New York State law as the 80th percentile of charges based on the Fair Health database, which captures physician charges in the states for most medical procedures.

products.[31] To test the impact of the New York State laws, we run a difference-in-difference regression and compare New York hospitals' out-of-network rates, physician payment rates, and facility payment rates before and after the passage of the out-of-network legislation to outcomes in hospitals in New Jersey, Pennsylvania, Connecticut, Vermont, and Massachusetts. To do so, we estimate:

$$Y_{i,h,t} = \beta_0 + \beta_1 NY_h + \beta_2 Post_t + \beta_3 NY_h Post_t + \gamma_h + \mu_t + \varepsilon_{i,h,t}, \quad (14)$$

where the dependent variable is our outcome of interest for patient i, treated at hospital h, in quarter t. We include an indicator for whether a hospital is located in New York. This is our treatment variable and it takes a value of 1 for all time periods if a hospital is located in New York (e.g. is in our treated group). $Post_t$ takes value of 1 for all periods from April 1, 2014, onward, after New York State passed its out-of-network billing laws. Our β_3 coefficient is the coefficient of interest and captures the interaction between our treatment variable (that a hospital is located in New York) and our post variable, which is turned on after the out-of-network billing law was passed. All standard errors are clustered around hospitals.[32] In addition, we introduce a non-parametric specification of Equation (14) where our treatment variable is interacted with dummy variables for each quarter. This allows us to illustrate graphically the parallel trends between New York and other the control states before the passage of the New York State law.

003254

003254

6.3 The Impact of New York State's Out-of-Network Billing Laws

Table 9 presents least-squares estimates of Equation (14) and shows the impact of the New York State law on hospitals' out-of-network rates, physician charges and payments, and hospital charges and payments. As Column 1 illustrates, the New York State law reduced out-of-network rates by 6.8 percentage points relative to changes observed in other New England states. Figure 8 presents non-parametric estimates of Equation (14) graphically. The out-of-network rates in New York and the other New England states followed similar trends before the introduction of the New York State out-of-network protection law in 2014. However, almost immediately after the law was passed (and before the required implementation date), there was a marked reduction in out-of-network billing in the state. Figure 9 shows the distribution of out-of-network rates across hospitals in 2013 and 2015. The out-of-network rate in New York in 2013 was 20.1 percent. Two

[31] Unfortunately, we do not have hospitals with EDs managed by EmCare or TeamHealth in our data for New York.
[32] Our results are also robust to clustering around HRRs.

003254

years later, the rate was 6.4 percent, and the reduction in out-of-network rates was driven by reductions in out-of-network rates across nearly all hospitals, including those that previously had high rates of out-of-network billing.

Columns 6 and 7 in Table 9 show that although the law applied only to fully insured insurance products, the reduction in out-of-network rates occurred for patients with fully insured insurance plans and those covered by ASO policies. If physicians cannot infer whether a patient has an ASO or fully insured insurance product before sending a bill, they will want to charge a moderate amount in order to win in any arbitration. Columns 2 through 5 in Table 9 illustrate the impact of the law on physician charges and payments and facility charges and payments. As we illustrate in Column 3, the law lowered average physician payments by $43.74 (13 percent). We do not find that the law had a precisely estimated impact on facility payments.

7. A Policy to Address Out-of-Network Billing: Regulating Hospital/Insurer Contracts

003255

Out-of-network ED bills arise from a very specific market failure. Unlike most doctors, ED physicians are not chosen and cannot be avoided by patients. As a result, ED physicians can move out-of-network without reducing the quantity of patients they treat. This, in turn, significantly reduces the pressure ED physicians face to negotiate prices with insurers. Without a negotiated reimbursement rate in a contract between insurers and physicians, physicians bill their charges which has the harmful effects documented above. In addition, having the ability to go out-of-network raises the disagreement payoff of the physicians which allows them to raise their negotiated in-network rates.

003255

At present, about a quarter of states have laws aimed at addressing out-of-network billing. Most states' surprise billing laws include a hold harmless provision to protect patients from financial risks (e.g., these laws stipulate that patients cannot be charged more than their usual in-network cost sharing during emergencies). The harder problem for the state is choosing the "missing" price when there is no contract between physicians and insurers. To do this, most states' laws set out-of-network provider payment rates via regulation as the greatest of either a fixed percentage of Medicare payment rates or usual and customary payment rates, which are themselves set as a fixed percentage of average charges. However, it is extremely unlikely that a regulated price of this sort will match the market price for any given insurer–physician pair in a particular year. As soon as the regulated price set by states differs from the market price, either

003255

the insurer or the physician will take advantage of a regulated price that favors them (e.g., insurers will cease to build networks or physicians will cease to join networks).

Alternatively, states could require arbitration between physicians and insurers to settle out-of-network bills as New York does. New York State's laws are the most ambitious in the nation to date, and our results suggest the law has been effective at lowering out-of-network rates. However, the New York State law is administratively complex and potentially costly. If patients receive a surprise out-of-network bill and are charged out-of-network rates, they must be aware that the protections exist and fill out the form included in Appendix 2. Likewise, the state has to fund and administer the arbitration process in perpetuity. Moreover, because states cannot regulate ASO products, the New York protections only offer formal protection to individuals covered by fully insured insurance products.

Going forward, policy-makers should have two objectives when they seek to address out-of-network ED billing. The first is to protect consumers from large, unexpected bills. The second is to establish an environment in which the price that insurers pay out-of-network physicians for their services generates a price that is either competitively set or is as close to the competitively set price as possible.

003256

003256

One might imagine the solution is to require physicians to participate in the same insurance networks as the hospitals where they work. Although this strategy would protect consumers from surprise bills by eliminating the possibility of attending an in-network hospital and being treated by an out-of-network physician, it would give significant bargaining leverage to insurers in their negotiations with physicians. Insurers would be aware that physicians would be required by law to enter into a contract with them in order to be able to practice in a hospital; this could allow insurers to drive down payment rates below what would occur in a competitive equilibrium.

In our view, the best option for addressing out-of-network billing is not for the state to try to regulate the missing price, but instead to regulate the ***form*** of the contract, so that the resulting physician payment is generated by market forces. When patients choose an ED, they are choosing a package of emergency services that includes the services of the hospital and physicians. Under our preferred policy, states could require hospitals to sell, and insurers to contract, for an ED service package that includes physician and facility services. Hospitals would purchase the inputs for ED services the way they purchase other labor inputs, such as nursing

003256

care and non-labor inputs, such as bandages and needles. All care provided in the ED would be included when the hospital contracted to be "in-network" with an insurer. This type of policy would require the hospital to buy ED physician services in a local labor market, which would expose hospitals and physicians to competitive forces and produce a market price for ED physician services. Hospitals would then submit a single bill to insurers.

With this type of policy in place, patients consuming emergency services would be protected from surprise bills as long as the patients chose in-network facilities. More subtly, this policy is also likely to lower the equilibrium prices for in-network ED physicians. At present, ED physicians can opt to exit insurer networks without a loss of revenue – indeed, they likely see an increase in revenue when they do so. This is a very strong outside option that increases physicians' bargaining leverage when they negotiate in-network payments. Thus, absent intervention, in-network payments will tend to display the effects of out-of-network billing and are likely to be above competitive levels.

This policy also solves the inability of states to regulate ASO products. Rather than regulating insurance, this would be a form of hospital regulation. As a result, it would apply to all patients in a state regardless of the type of insurance they have. Further, the law could be implemented by a state or at the federal level. For example, the federal government could require these combined physician/facility ED payments be a requirement for a hospital receiving Medicare payments.

003257

003257

In what follows, we produce back-of-the-envelope calculations of the savings from our policy. To do so, we compare ED physician payment rates to payment rates for orthopedic surgeons. Orthopedic surgeons form an interesting comparison group because, according to a recent survey, they have the highest salaries among physicians in the US (Grisham 2017). However, whereas the average in-network ED physician payment was 266 percent of the Medicare payment rates (and the average out-of-network payment was 637 percent of the Medicare payment rates), within our data, the average in-network payments to orthopedic surgeons for performing knee replacements during our sample period was 178 percent of the Medicare payment rates. If we assumed our policy proposal would generate competition that lowered ED physicians' payment levels to approximate the payment rate of orthopedic surgeons in our data (178 percent of the Medicare payment rates), this would lower total ED physician spending by 46 percent. If we assume that private spending is one-third of total health spending

003257

in the US and ED physicians are about 1 percent of total private spending, a reasonable back of the envelope calculation would suggest that addressing this issue would produce savings in the range of $5 billion annually.[33]

8. Conclusions

Each year, one in five people in the US visits an ED for medical care (Morganti et al., 2013). What most patients with private health insurance do not realize is that the physicians working in a hospital may not participate in the same insurance networks as the hospital itself. As a result, it is possible for a privately insured patient to attend an in-network hospital but receive care from an out-of-network physician. These out-of-network bills can expose patients to significant financial risk. Moreover, when physicians and physician groups can bill out-of-network without seeing a reduction in the number of patients they treat, it undercuts the functioning of health care markets by changing the outside option physicians face when negotiating with insurers over their prices.

In this paper, we find that approximately 15 percent of U.S. hospitals have extremely high out-of-network billing rates. Moreover, we observe that two leading ED physician outsourcing firms – EmCare and TeamHealth - use out-of-network billing to significantly raise the amounts they are paid, although each utilize a distinct strategy. These two examples are instructive in their differences and provide a nice illustration of the economics of bargaining.

We find that after EmCare takes over the management of ED services at a hospital, it raises out-of-network billing rates by over 80 percentage points. This allows the firm to collect higher payments from insurers and from patients. We calculate that the payments they received from insurers increased by 122 percent and patient cost sharing increased by 83 percent. Crucially, this increase in patient costs represents a lower bound of the cost exposure patients could face when they are treated by an out-of-network ED physician. The insurer supplying our data, in most instances, pays out-of-network physicians their charges. However, in practice, many insurers either do not pay out-of-network physicians anything (leaving the patient to pay their physicians themselves) or they only pay standard in-network rates (leaving patients to pay the difference between the physician's charges and the insurer's payments).

[33] These numbers are from Morganti et al. (2013) and Hartman et al. (2017).

When ED physicians bill out-of-network, it likely creates reputational harm for the in-network hospitals where they work. We find evidence that EmCare offsets the costs of harm for hospitals by providing transfers. Such transfers takes the form of EmCare-affiliated physicians engaging in clinical behavior leading to increased hospital billing, such as increasing imaging rates and rates patients are admitted to the hospital, which generate additional revenue for the hospitals.

TeamHealth pursues a different strategy. When TeamHealth enters a hospital, they also increase out-of-network rates significantly. However, after several months, TeamHealth returns in-network. Notably, when TeamHealth goes back in-network, their in-network payment amounts are 68 percent higher than they were before the firm entered the hospital. We posit that TeamHealth uses its stronger outside option to negotiate higher in-network payments. Interestingly, the number of patients seen in the TeamHealth ED increases, which may be a sign of efficiencies.

Ultimately, this paper shows that outsourcing in emergency medicine per se is not the problem. The problem is that emergency physicians working inside in-network hospitals face inelastic demand. There are many healthcare markets that have pockets of inelastic demand, which can be exploited by providers (for example, the demand for air ambulances in emergencies or the demand for neonatologists following a premature baby delivery). Our analysis shows that providers with less concern for patient welfare can take advantage of that inelasticity and dramatically increase their prices.

003259

003259

What is the appropriate policy response to surprise out-of-network billing? A variety of states have implemented different policies to protect consumers. One of the most innovative policies was introduced in New York. In 2014, the state passed a law that banned balanced billing and required insurers and physicians to enter into binding arbitration to settle disputed bills. We assessed the impact of this law and found that it reduced out-of-network billing. However, the law still bases out-of-network ED payments on physicians' charges, which are not competitively set, and its arbitration provision has high transaction costs. Additionally, the law cannot formally protect individuals enrolled in ASO insurance products, who account for approximately half of individuals with private insurance in the US.

The limits of the New York law have helped motivate our policy proposal to require hospitals to sell an "ED package" to insurers that includes both physician and hospital services.

003259

Thus far, most states have tried to address out-of-network billing by regulating the missing price for emergency physician services. Ultimately, a regulated price will, in general, not be equal to a market-determined price. We argue that mandating the right contract structure will generate competitive prices, and thus generate higher welfare relative to regulated prices.

References:

Baker, Laurence C.; M. Kate Bundorf; Anne B. Royalty and Zachary Levin. 2014. "Physician Practice Competition and Prices Paid by Private Insurers for Office Visits." *JAMA*, 312(16), 1653-62.

Barnett, Michael L.; Andrew R. Olenski and Anupam B. Jena. 2017. "Opioid-Prescribing Patterns of Emergency Physicians and Risk of Long-Term Use." *New England Journal of Medicine*, 376(7), 663-73.

Board of the Governors of the Federal Reserve System. 2016. "Report on the Economic Well-Being of U.S. Households in 2015," Washington, DC: Federal Reserve Board, May 5. https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf, accessed February 2018.

Cantlupe, Joe. 2013. "Keys to Better Flow, Better Care in EDs." *HealthLeaders*. June 8. http://www.healthleadersmedia.com/community-rural/4-keys-better-emergency-department, accessed February 2018.

Chan, David C., Jr. 2015. "The Efficiency of Slacking Off: Evidence from the Emergency Department." *National Bureau of Economic Research Working Paper Series*, No. 21002.

Charlson, Mary E.; Peter Pompei; Kathy L. Ales and C. Ronald MacKenzie. 1987. "A New Method of Classifying Prognostic Comorbidity in Longitudinal Studies: Development and Validation." *Journal of Chronic Diseases*, 40(5), 373-83.

Consumers Union. 2015. "Surprise Medical Bills Survey: 2015 Nationally-Representative Online Survey," Washington, DC: Consumer Reports National Research Center, May 5. http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf, accessed February 2018.

Cooper, Zack and Fiona Scott Morton. 2016. "Out-of-Network Emergency-Physician Bills—An Unwelcome Surprise." *New England Journal of Medicine*, 375(20), 1915-8.

Dalavagas, Jason. 2014. "Coverage Initiation: Envision Healthcare Holdings." *Educational Articles*. http://www.valueline.com/Stocks/Highlights/Coverage_Initiation__Envision_Healthcare_Holdings.aspx#.WRyVe_nyuUk, accessed February 2018.

Department of Financial Services. 2012. "An Unwelcome Surprise: How New Yorkers Are Getting Stuck with Unexpected Medical Bills from Out-of-Network Providers," New York, NY: New York State Department of Financial Services, http://www.statecoverage.org/files/NY-Unexpected_Medical_Bills-march_7_2012.pdf, accessed February 2018.

Department of Regulatory Agencies. 2010. "Report of the Commissioner of Insurance to the Colorado General Assembly on §10-17-704(3), C.R.S. Consumer Protections Against Balance Billing," Denver, CO: Colorado Department of Regulatory Agencies, January

003260

003260

003260

21. http://hermes.cde.state.co.us/drupal/islandora/object/co%3A8599/datastream/OBJ/view, accessed February 2018.

DeRoma, Tris. 2012. "ER Transition Expected to be Smooth at LAMC." *The Los Alamos Monitor*. July 26. http://www.lamonitor.com/content/er-transition-expected-be-smooth-lamc, accessed February 2018.

Deutsche Bank. 2013. "Markets Research - Envision Healthcare."

EmCare. 2014. "Cross-Departmental Initiative Leads to Nationally Recognized Stroke Treatment Program." https://www.emcare.com/resources/case-studies/pdf/emcare6_casestudyholyoke.pdf, accessed February 2018.

Esposito, Lisa. 2015. "Enduring Really Long Waits at the Emergency Room: What Can You Do When You're Last on the List?" *U.S. News and World Report*. May 8. https://health.usnews.com/health-news/patient-advice/articles/2015/05/08/enduring-really-long-waits-at-the-emergency-room, accessed February 2018.

Finkelstein, Amy; Matthew Gentzkow and Heidi Williams. 2016. "Sources of Geographic Variation in Health Care: Evidence from Patient Migration." *Quarterly Journal of Economics*, 131(4), 1681-726.

Garmon, Christopher and Benjamin Chartock. 2017. "One In Five Inpatient Emergency Department Cases May Lead To Surprise Bills." *Health Affairs*, 36(1), 177-81.

Gooch, Kelly. 2016. "Texas Sees Dramatic Rise in Balanced Billing Complaints: 3 Things to Know." *Becker's Hospital Review*. February 12. https://www.beckershospitalreview.com/finance/texas-sees-dramatic-rise-in-balanced-billing-complaints-3-things-to-know.html, accessed February 2018.

Grisham, Sarah. 2017. "Medscape Physician Compensation Report." *Medscape Medical News*. April 5. https://www.medscape.com/slideshow/compensation-2017-overview-6008547#4, accessed February 2018.

Groth, Heather; Hans House; Rachel Overton and Eric DeRoo. 2013. "Board-Certified Emergency Physicians Comprise a Minority of the Emergency Department Workforce in Iowa." *Western Journal of Emergency Medicine*, 14(2), 186-90.

Hamel, Liz; Mira Norton; Karen Pollitz; Larry Levitt; Gary Claxton and Mollyann Brodie. 2016. "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey," The Henry J. Kaiser Family Foundation, January 5. https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf, accessed February 2018.

Hartman, Micah; Anne B. Martin; Nathan Espinosa; Aaron Catlin and Team The National Health Expenditure Accounts. 2017. "National Health Care Spending In 2016: Spending And Enrollment Growth Slow After Initial Coverage Expansions." *Health Affairs*, 37(1), 150-60.

Hing, Esther and Farida Bhuiya. 2012. "Wait Time for Treatment in Hospital Emergency Departments: 2009," Hyattsville, MD: National Center for Health Statistics, August 1. https://www.cdc.gov/nchs/data/databriefs/db102.pdf, accessed February 2018.

Hoadley, Jack; Sandy Ahn and Kevin Lucia. 2015. "Balance Billing: How Are States Protecting Consumers from Unexpected Charges?," Washington, DC: The Center on Health Insurance Reforms. Georgetown University Health Policy Institute, June 15.

003261

003261

003261

https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966, accessed February 2018.

Hsia, Renee Y.; Arthur L. Kellermann and Yu-Chu Shen. 2011. "Factors Associated with Closures of Emergency Departments in the United States." *JAMA*, 305(19), 1978-85.

Institute of Medicine. 2006. *Hospital-Based Emergency Care: At the Breaking Point*. Washington, DC: The National Academies Press.

Kaiser Family Foundation. 2017. "Employer Health Benefits Annual Survey: 2017," Menlo Park, CA: The Henry J. Kaiser Family Foundation. September 19. http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2017, accessed February 2018.

Kyanko, Kelly A.; Leslie A. Curry and Susan H. Busch. 2013. "Out-of-Network Physicians: How Prevalent Are Involuntary Use and Cost Transparency?" *Health Services Research*, 48(3), 1154-72.

McGirr, Joseph; Janet M. Williams and John E. Prescott. 1998. "Physicians in Rural West Virginia Emergency Departments: Residency Training and Board Certification Status." *Academic Emergency Medicine*, 5(4), 333-6.

Morganti, Kristy G.; Sebastian Bauhoff; Janice C. Blanchard; Mahshid Abir; Neema Iyer; Alexandria C. Smith; Joseph V. Vesely; Edward N. Okeke and Arthur L. Kellermann. 2013. "The Evolving Role of Emergency Departments in the United States," Santa Monica, CA: RAND Health. RAND Corporation, June 16. https://www.rand.org/pubs/research_reports/RR280.html, accessed February 2018.

Newhouse, Joseph P. 1970. "Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital." *American Economic Review*, 60(1), 64-74.

Osborne, Martin J and Ariel Rubinstein. 1990. *Bargaining and Markets*. San Diego, CA: Emerald Group Publishing Limited.

Pogue, Stacey and Megan Randall. 2014. "Surprise Medical Bills Take Advantage of Texans," Austin, TX: Center for Public Policy Priorities. September 15. https://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf, accessed February 2018.

Rice, Sabriya. 2016. "Cutting Emergency Department Wait Times as Patient Volumes Rise." *Modern Healthcare*. February 13. http://www.modernhealthcare.com/article/20160213/MAGAZINE/302139996, accessed February 2018.

Rosenthal, Elisabeth. 2014a. "After Surgery, $117,000 Bill For Doctor He Didn't Know." *The New York Times*, September 21. https://www.nytimes.com/2014/09/21/us/drive-by-doctoring-surprise-medical-bills.html, accessed February 2018.

____. 2014b. "Costs Can Go Up Fast When E.R. Is in Network But the Doctors Are Not." *The New York Times*, September 29. https://www.nytimes.com/2014/09/29/us/costs-can-go-up-fast-when-er-is-in-network-but-the-doctors-are-not.html, accessed February 2018.

Rui, P.; K. Kang and M. Albert. 2013. "National Hospital Ambulatory Medical Care Survey: 2013 Emergency Department Summary Tables," Washington, DC: Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2013_ed_web_tables.pdf, accessed February 2018.

Sanger-Katz, Margot and Reed Abelson. 2016. "Surprise! Insurance Paid the E.R. but Not the Doctor." *The New York Times*. November 16.

003262

003262

003262

https://www.nytimes.com/2016/11/17/upshot/first-comes-the-emergency-then-comes-the-surprise-out-of-network-bill.html, accessed February 2018.
Schuur, Jeremiah and Arjun Venkatesh. 2012. "The Growing Role of Emergency Departments in Hospital Admissions." *New England Journal of Medicine*, 367(5), 391-93.
TeamHealth. 2009. "TeamHealth Holdings, Inc. - Initial Public Offering."
Wadman, Michael C.; Robert L. Muelleman; David Hall; T. Paul Tran and Richard A. Walker. 2005. "Qualification Discrepancies Between Urban and Rural Emergency Department Physicians." *Journal of Emergency Medicine*, 28(3), 273-6.
Wilson, Michael and David Cutler. 2014. "Emergency Department Profits Are Likely To Continue As The Affordable Care Act Expands Coverage." *Health Affairs*, 33(5), 792-9.

003263

003263

003263

Table 1: ED Episodes Per Year

	Emergency Episodes	Total Facility Spending (millions)	Total Physician Spending (millions)	Mean Physician In-Network Payment (% Medicare)	Pat. Cost-Sharing on Physicians	Pat. Cost-Sharing Hospitals	Hospital Out-of-Network Frequency
2011	1,699,451	$4,291	$572	$278.70 (228%)	$43.58	$347.41	28.6%
2012	1,899,513	$4,856	$696	$293.62 (245%)	$49.85	$368.17	28.0%
2013	1,820,059	$5,010	$741	$324.91 (269%)	$59.17	$416.61	26.1%
2014	1,745,100	$5,037	$751	$348.98 (284%)	$67.60	$451.80	24.2%
2015	1,749,073	$5,262	$779	$383.33 (303%)	$70.40	$464.16	21.9%
Total	8,913,196	$24,458	$3,538	$325.91(266%)	$58.12	$409.63	25.8%

003264
003264

Notes: The table shows episodes per year, facility spending per year, physician spending per year, the mean payment to an in-network ED physician (and the mean expressed as a percentage of Medicare payments), patient payments for physician fees, patient payments for hospital fees, and yearly out-of-network rates. The physician payment is the sum of the insurer and patient contribution. All dollar amounts are in 2015 dollars. We observe that over 99% of ED care occurred at in-network hospitals.

003264

Table 2: The Impact of EmCare and TeamHealth Entry on Hospitals' Out-of-Network Rates

	(1)	(2)	(3)
	Hospitals with OON Rates Above 97% Prior to Entry	Hospitals with OON Rates Below 97% Prior to Entry	All Hospitals
	EmCare Entry		TeamHealth Entry
	OON Indicator		OON Indicator
Management Company Entry	-0.030	0.815***	0.326***
	(0.044)	(0.061)	(0.030)
Hospital FE	Yes	Yes	Yes
Month FE	Yes	Yes	Yes
Mean	0.209	0.204	0.226
SD	0.407	0.403	0.419
Observations	8,401,884	8,351,799	8,661,796
Control	All Non-Entry Hospitals	All Non-Entry Hospitals	All Non-Entry Hospitals

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equations (13a) and (13b). In Column (1), we focus on hospitals that EmCare entered that had out-of-network rates prior to entry that were above 97%. In Column (2), we focus on hospitals that had out-of-network rates prior to entry below 97% (in practice, all hospitals with out-of-network rates below 97% had out-of-network rates below 11%). In Column (3), we focus on the sample of all hospitals where TeamHealth entered. The dependent variable in all regressions is a binary indicator for whether a patient at an in-network hospital was treated by an out-of-network physician. Our analysis is run at the patient-level. The control groups are all hospitals in the US that did not outsource their ED management to EmCare or TeamHealth. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Mean and standard deviation are drawn from the analytic sample population underlying the regression. In Appendix Table 3, we show these estimates using alternative control groups.

Table 3: The Impact of the Entry of EmCare on Physician Charges, Payments, and Coding

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Potential Balanced Bill	Total Patient Cost Exposure	CPT Severity
EmCare Entry	556.84***	402.67***	45.23***	447.90***	108.94***	154.17***	0.148***
	(62.12)	(54.52)	(4.38)	(55.16)	(38.71)	(35.12)	(0.030)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	578.95	329.17	54.47	383.64	195.32	249.79	0.347
SD	364.61	290.13	108.72	297.99	225.12	243.57	0.476
Observations	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We windsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table 4 and Appendix Table 5, we show these estimates using alternative control groups.

Table 4: The Impact of the Entry of TeamHealth on Physician Charges, Payments, and Coding

	(1)	(2)	(3)	(4)	(5)	(6)
	Physician Charge	Insurer Payment (In-network)	Insurer Payment (Out-of-network)	Patient Cost Sharing	Total Payment	CPT Severity
TeamHealth Entry	52.49	236.56***	203.09***	21.85***	269.01***	0.016
	(35.90)	(12.87)	(73.66)	(3.43)	(19.06)	(0.015)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes
Mean	589.58	263.95	597.44	55.92	395.38	0.346
SD	374.63	226.87	371.14	110.54	310.46	0.476
Observations	8,661,796	6,700,621	1,961,175	8,661,796	8,661,796	8,661,796
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

003267
003267

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13b). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to TeamHealth.We windsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table 6 and Appendix Table 7, we show these estimates using alternative control groups.

003267

Table 5: Comparison of Physician Payments as a Percent of Medicare

(1)	(2)	(3)	(4)	(5)
Orthopedist Hip Replacement Payment Rate	Internist Office Visit Payment Rate	ED Physician Standard Visit Rate (In-network)	TeamHealth ED Physician Standard Visit Rate	EmCare ED Physician Standard Visit Rate
		(% of Medicare)		
178%	158%	266%	364%	536%

Notes: This table shows physician payments as a percentage of Medicare based on speciality. Columns (3,4,5) are derived from our analytic sample of ED episodes. Columns (4,5) include all physician payments to physicians working in Emcare and TeamHealth hospitals identified in our data. Columns (1) and (2) are based on claims from the same period as the ED claims and were paid by the same payer.

003268

003268

003268

Table 6: The Impact of the Entry of EmCare on Hospital Charges, Payments, and Activity

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
EmCare Entry	1683.63***	240.70**	53.88***	294.58***	0.014***	0.021***	-104.0
	(401.04)	(98.68)	(17.91)	(113.64)	(0.005)	(0.006)	(218.1)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,304.63	2,350.46	393.81	2,744.27	0.278	0.090	1,695.5
SD	12,415.53	4,885.15	561.89	5,034.47	0.448	0.286	1,566.5
Observations	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

003269
003269

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We windsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table 9 and Appendix Table 10, we show these estimates using alternative control groups.

003269

Table 7: The Impact of the Entry of TeamHealth on Hospital Charges, Payments, and Activity

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
TeamHealth Entry	170.17	-76.61	24.42**	-52.19	-0.008**	-0.006**	515.4***
	(174.03)	(76.82)	(12.41)	(82.70)	(0.003)	(0.002)	(182.8)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,400.68	2,355.70	394.19	2,749.89	0.279	0.091	1,692.1
SD	12,555.33	4,891.99	561.51	5,041.25	0.448	0.287	1,557.4
Observations	8,661,796	8,661,796	8,661,796	8,661,796	8,661,796	8,661,796	8,661,796
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

003270

003270

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13b). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to TeamHealth. We windsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars. In Appendix Table 11 and Appendix Table 12, we show these estimates using alternative control groups.

003270

Table 8: Comparison EmCare and TeamHealth Hospital Characteristics

	All Hospitals	EmCare Hospitals	P-value from two-sided t-test	All Hospitals	TeamHealth Hospitals	P-value from two-sided t-test
Hospital Characteristics						
For-profit	0.19	0.56	0.00	0.21	0.29	0.09
Non-profit	0.66	0.26	0.00	0.63	0.57	0.28
Government	0.15	0.17	0.50	0.15	0.13	0.63
Teaching	0.09	0.05	0.06	0.09	0.04	0.09
Hospital Beds	227.32	185.43	0.01	225.74	197.63	0.21
Technologies	55.26	44.38	0.00	54.84	47.79	0.04
Hospital HHI	0.55	0.57	0.57	0.55	0.59	0.35
Proportion Medicare	47.45	48.04	0.56	47.36	51.42	0.00
Proportion Medicaid	19.88	19.14	0.39	19.83	20.15	0.78
ED Physicians per Capita (per 10,000)	0.77	0.66	0.00	0.77	0.70	0.04
Physicians per Capita (per 10,000)	22.11	21.21	0.01	22.04	22.66	0.23
Physician HHI	0.43	0.41	0.37	0.43	0.41	0.39
Insurer HHI	0.38	0.36	0.32	0.38	0.36	0.23
Household Income ($)	36,862.23	37,277.03	0.41	36,904.38	36,287.42	0.38
Gini Coefficient	0.32	0.33	0.00	0.32	0.33	0.04

003271
003271

Notes: The table compares characteristics of identified EmCare and Teamhealth hospitals to the entire sample of hospitals. Identified Emcare and TeamHealth hospitals are excluded from all hospitals. The p-value is reported from a two-sided t-test comparing the difference in means between all hospitals and identified EmCare and Teamhealth hospitals.

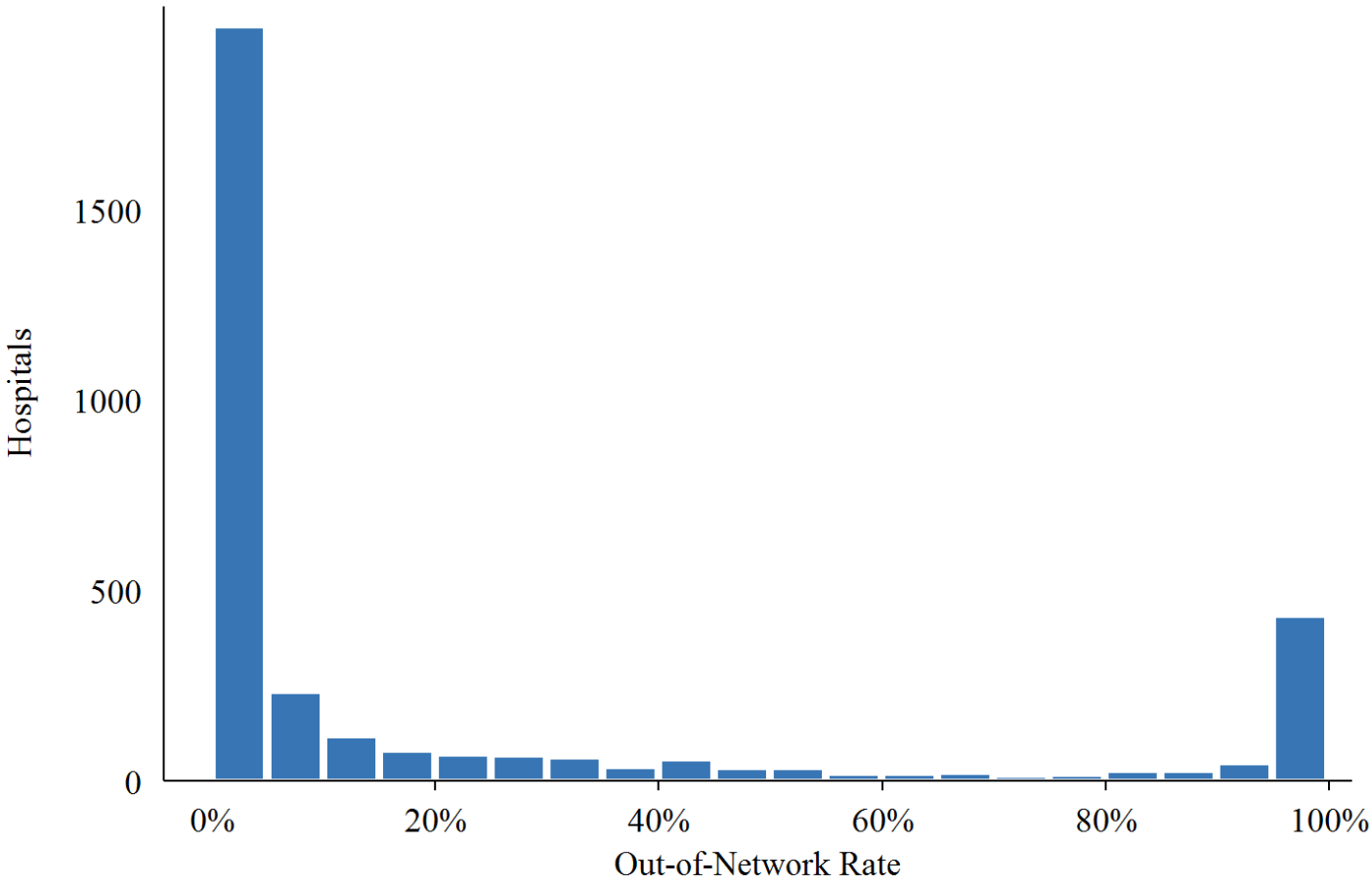
003271

Table 9: Estimating the Impact of the New York State Surprise Billing Law

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Out-of-Network Rate	Physician Charge	Physician Payment	Facility Charge	Facility Payment	Out-of-Network Rate (ASO)	Out-of-Network Rate (Full Insurance)
NY*Post dummy	-0.068**	21.46	-43.74***	-98.73	-1.21	-0.069**	-0.062**
	(0.030)	(20.74)	(11.51)	(148.39)	(81.85)	(0.031)	(0.031)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Quarterly FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.202	499.17	335.86	6,100.52	2,571.28	0.198	0.227
SD	0.401	313.11	251.95	12,693.62	5,122.37	0.399	0.419
Observations	905,441	905,441	905,441	905,441	905,441	787,005	116,642
R-Square	0.636	0.435	0.488	0.113	0.114	0.629	0.687

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (14). All regressions are run at the patient level. Each regression includes an indicator variable for whether the episode occurred in New York. The post dummy turns on in 2014 Q1 (when the NY vote was passed). Hospital and physician payments are winsorized at the top and bottom one percentile. The control states included are NJ, PA, CT, VT, and PA. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

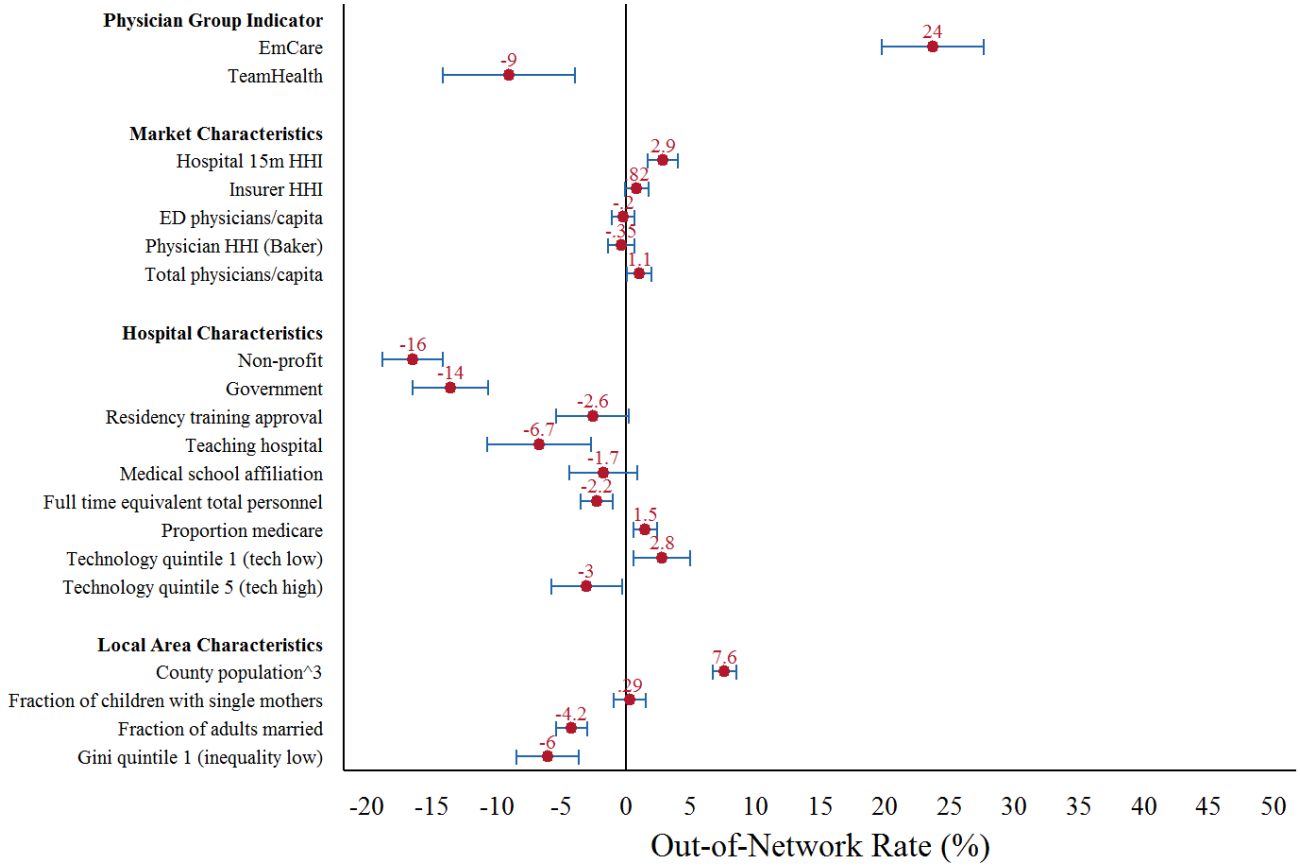
Figure 1: The Distribution of Hospital Out-of-Network Billing Rates in 2015



	10th Perc.	25th Perc.	50th Perc.	75th Perc.	90th Perc.
Out-of-Network Rate	0	0	0.011	0.278	0.990

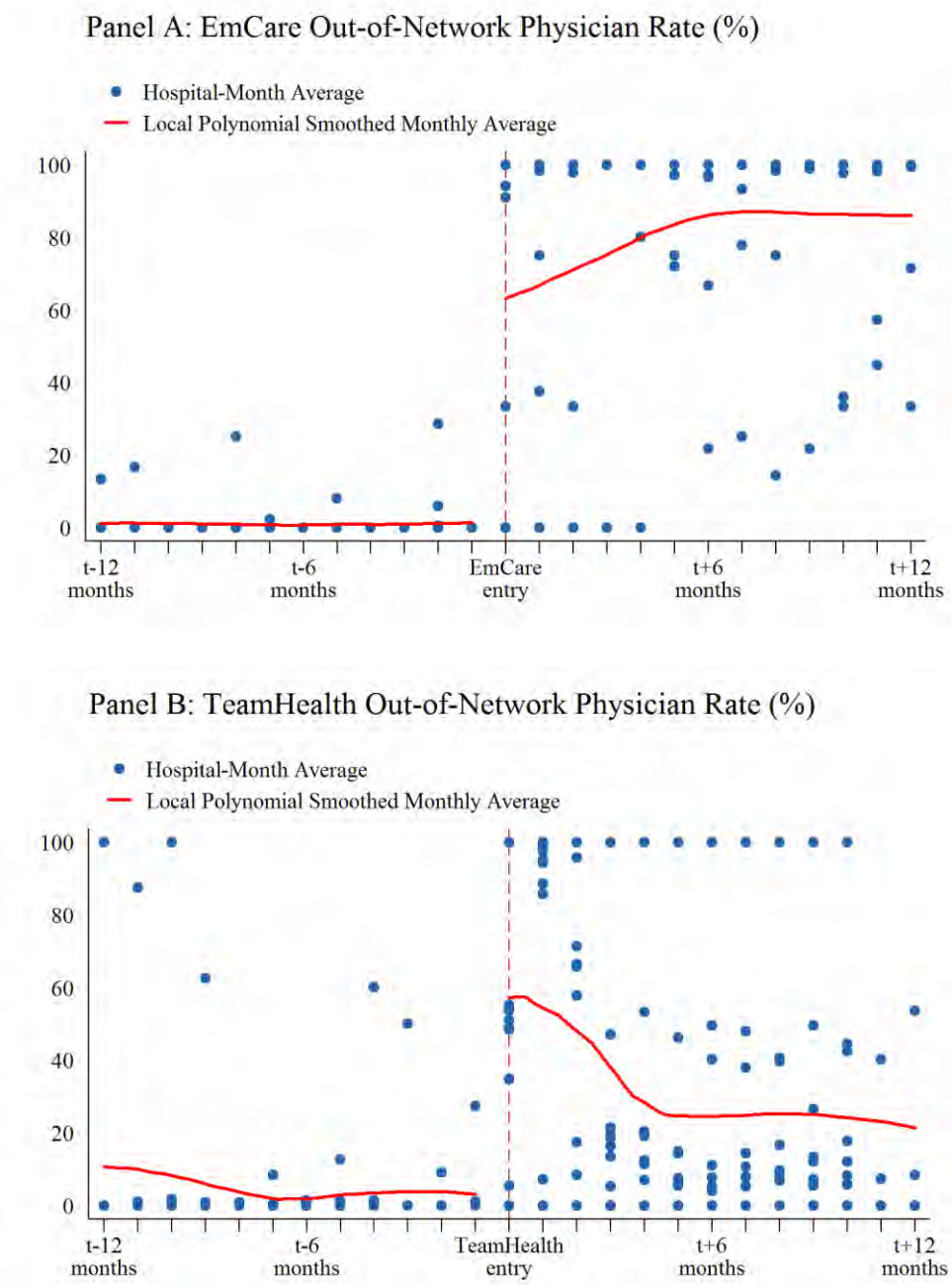
Notes: The figure shows the distribution of ED physicians out-of-network rates across hospitals in 2015.

Figure 2: Conditional Correlates of Hospital Out-of-Network Billing



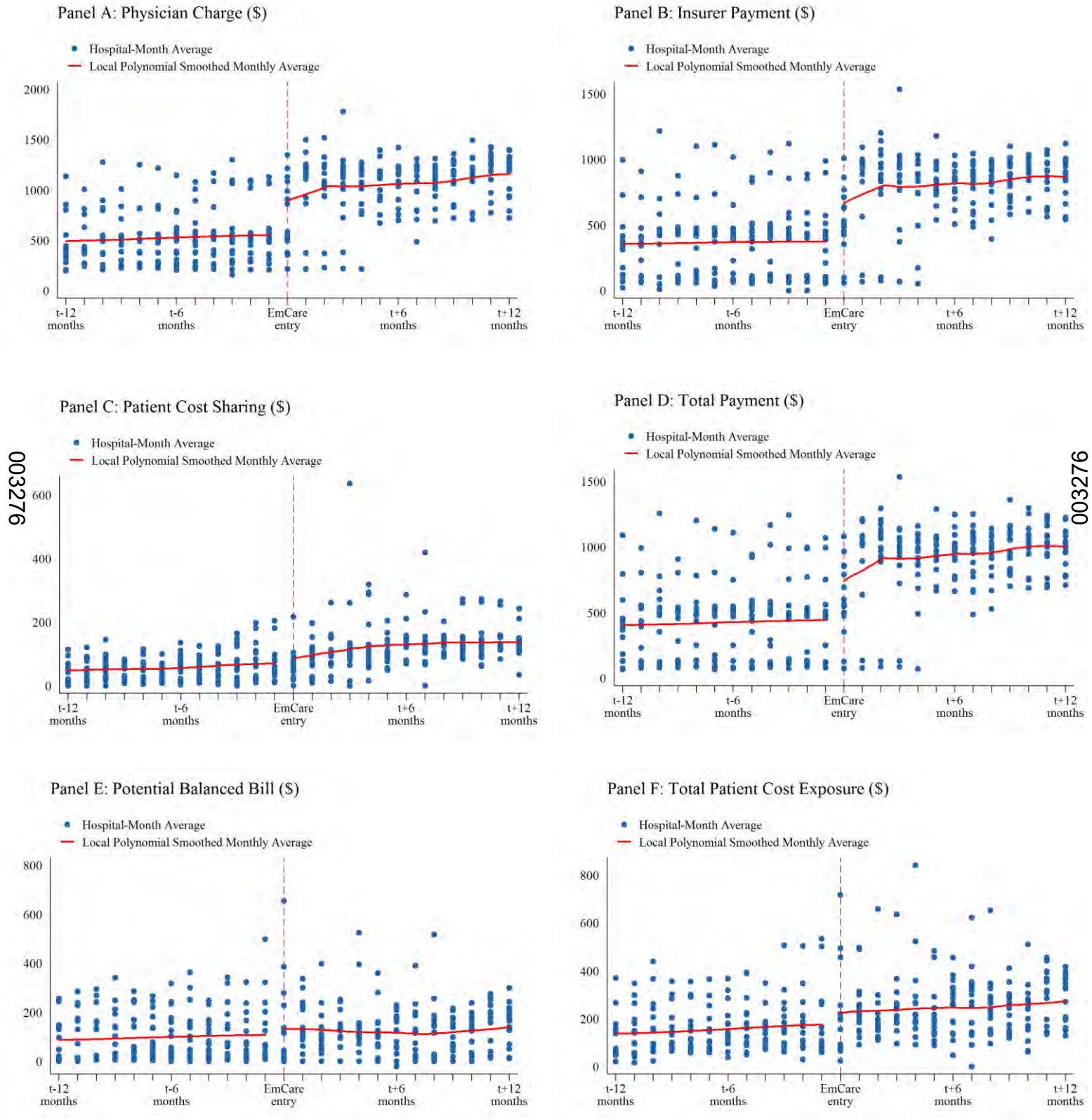
Notes: The figure shows the point estimates from a least-squared regression of hospital out-of-network rates on variables chosen from our Lasso. We used data from 2011 through 2015. Each observation is a hospital-year rate of out-of-network billing. The regression includes year fixed-effects. For continuous variables, the point estimates can be interpreted as the percentage point change in out-of-network rate for a one standard deviation increase in the explanatory variable. For binary variables, the point estimate illustrates the impact of having the variable take a value of one. To obtain these results, we first run a Lasso with all possible variables (90 in total). We then square and cube continuous variables chosen from the Lasso and run a second Lasso that includes all variables in addition to those that are now squared and cubed. We then run an OLS regression of hospital out-of-network rates on variables chosen from the Lasso. We also included measures of physician, hospital and insurer market concentration and physician group indicators.

Figure 3: Discontinuity Analysis of Out-of-Network Rates at Hospitals Where EmCare and TeamHealth Took Over Management of ED Services

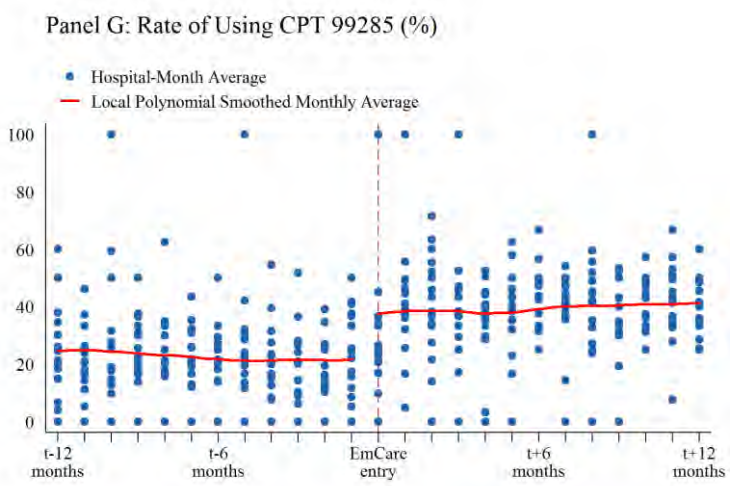


Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare or TeamHealth entered the hospital. For Panel A, we limit our analysis to hospitals with out-of-network rates below 97% in 2011.

Figure 4: Discontinuity Analysis of Physician Billing at Hospitals Where EmCare Took Over Management of ED Services



003276
003276
003276



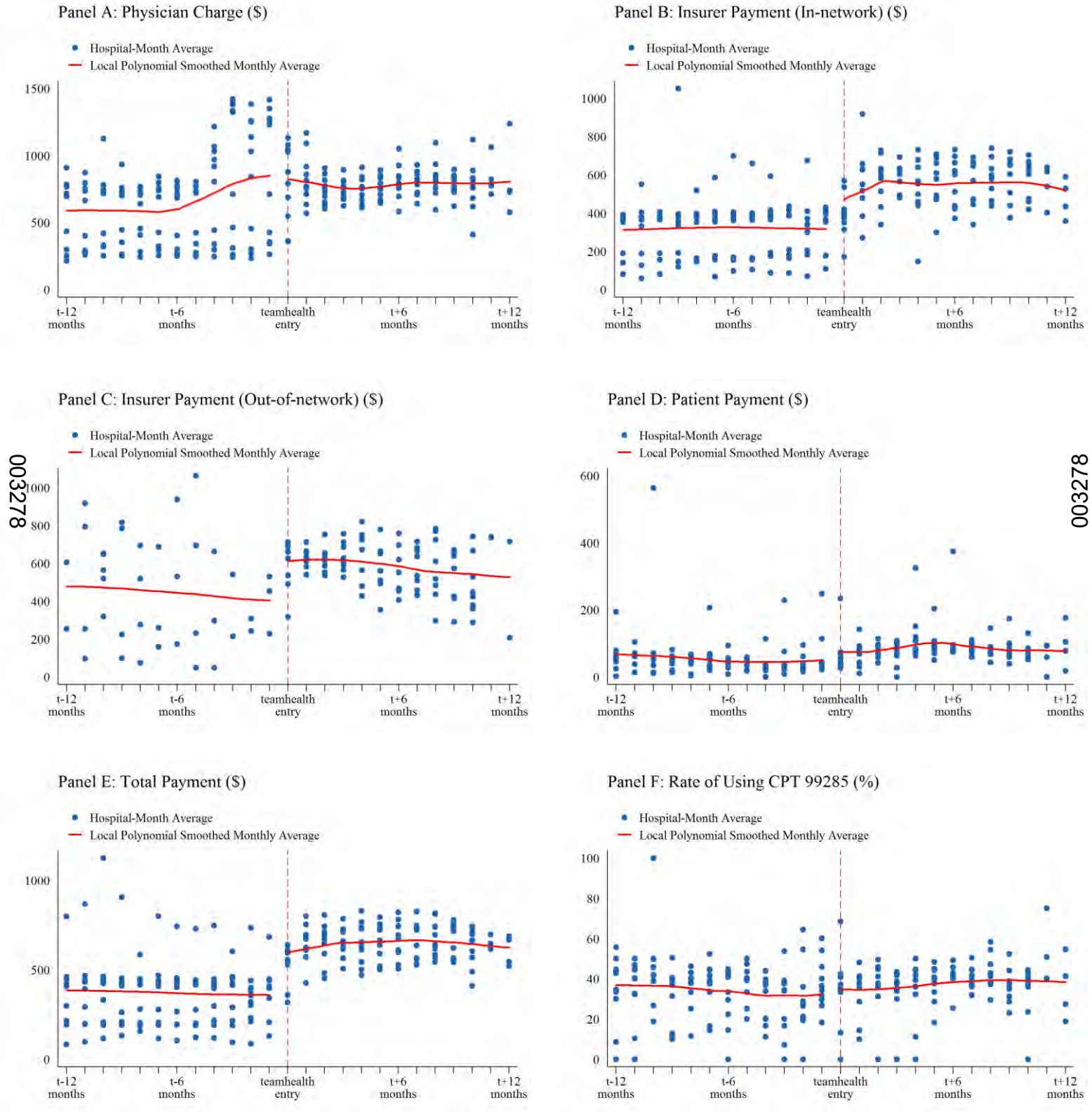
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare entered the hospital.

003277

003277

003277

Figure 5: Discontinuity Analysis of Physician Billing at Hospitals Where TeamHealth Took Over Management of ED Services



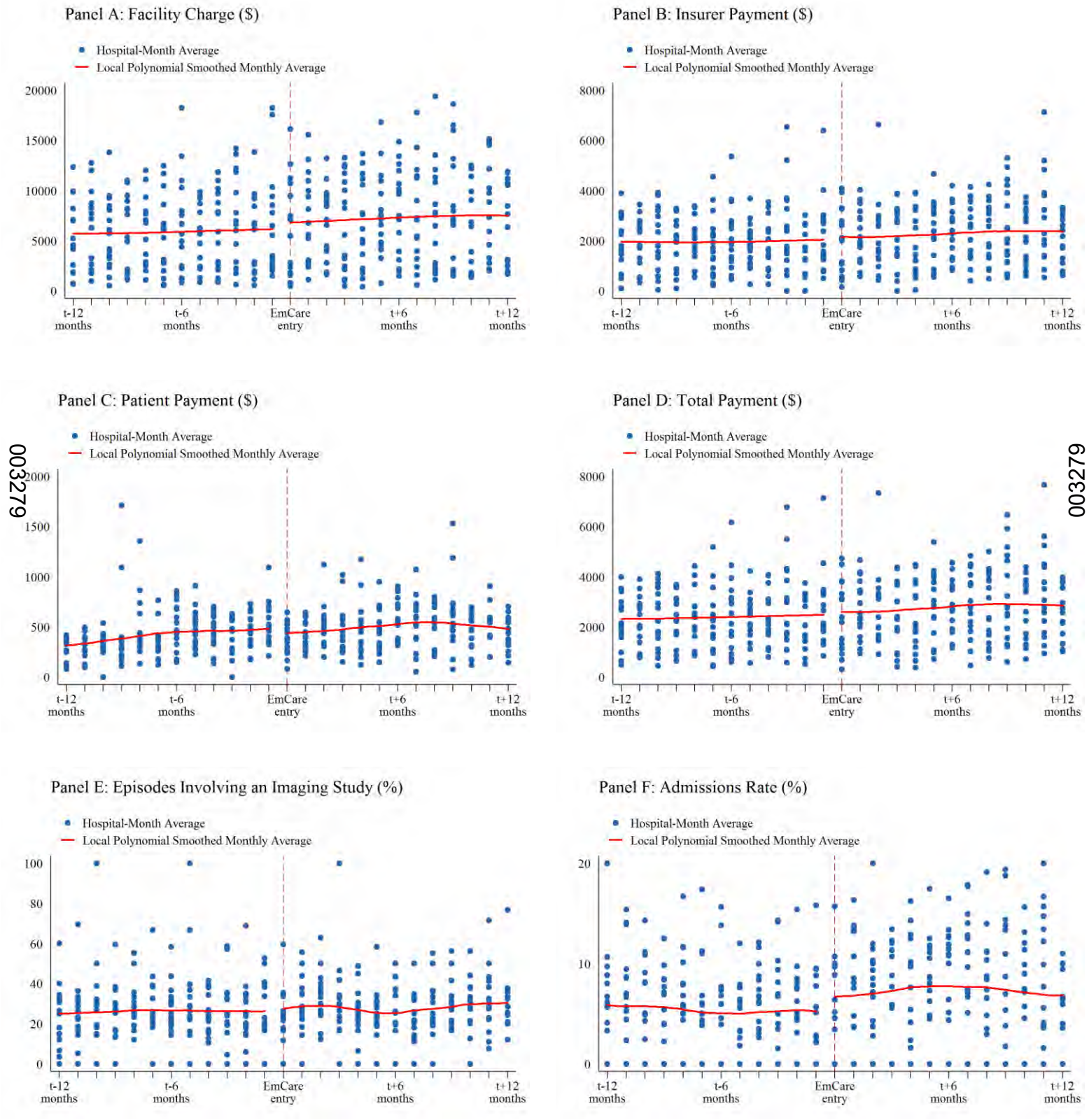
003278

003278

Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after TeamHealth entered the hospital.

003278

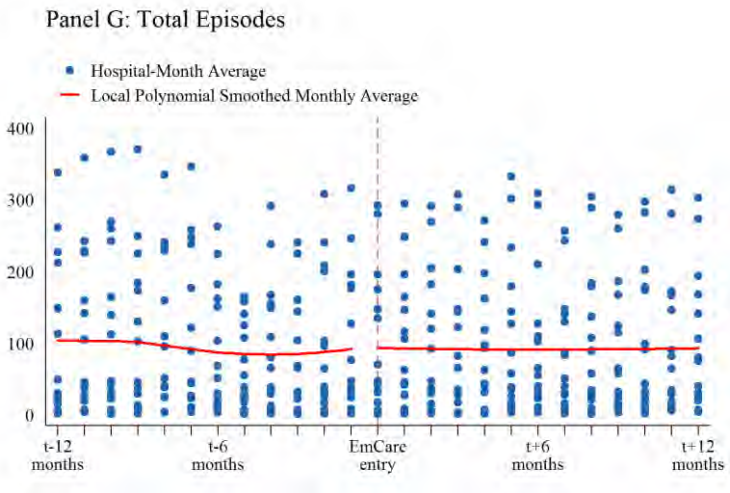
Figure 6: Discontinuity Analysis of Hospital Activity at Hospitals Where EmCare Took Over Management of ED Services



003279

003279

003279



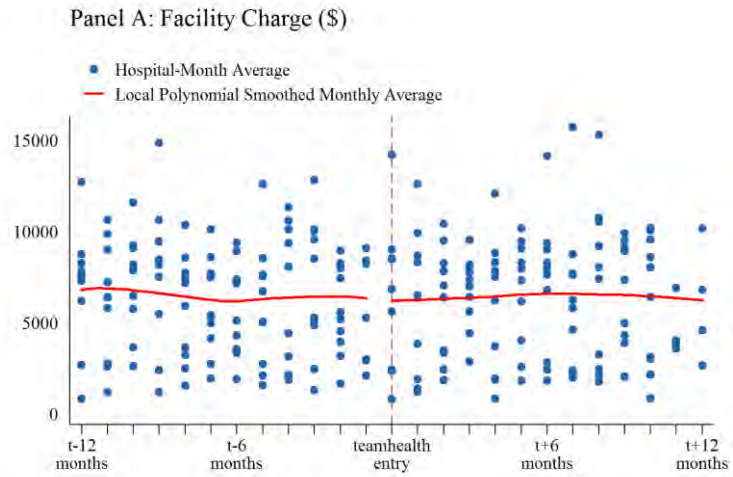
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare entered the hospital.

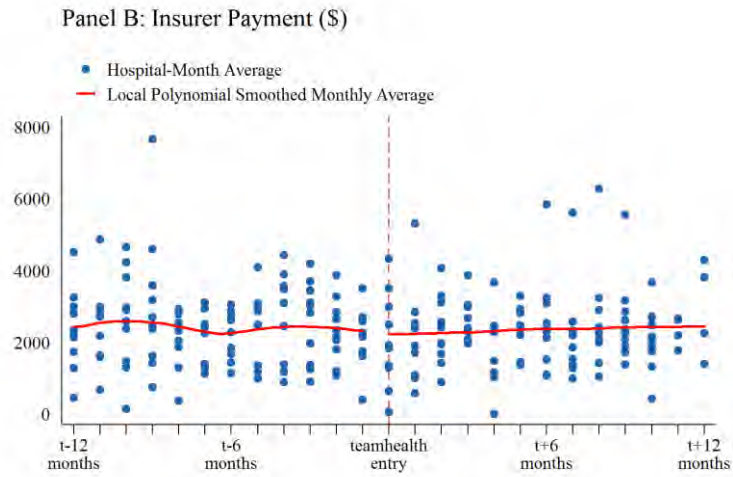
003280

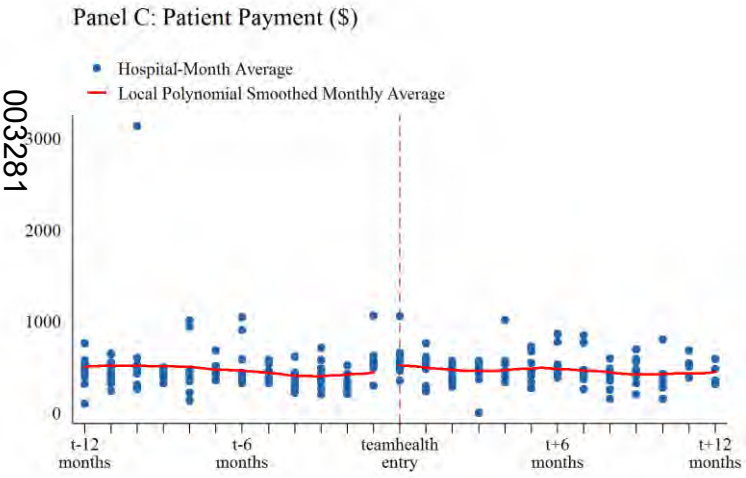
003280

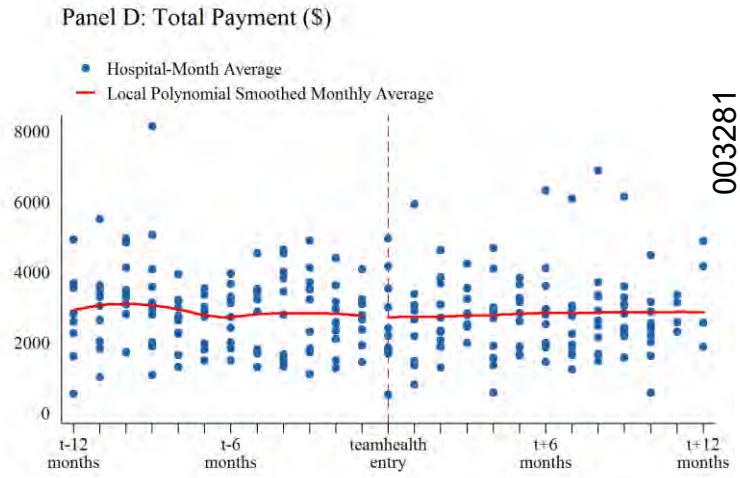
003280

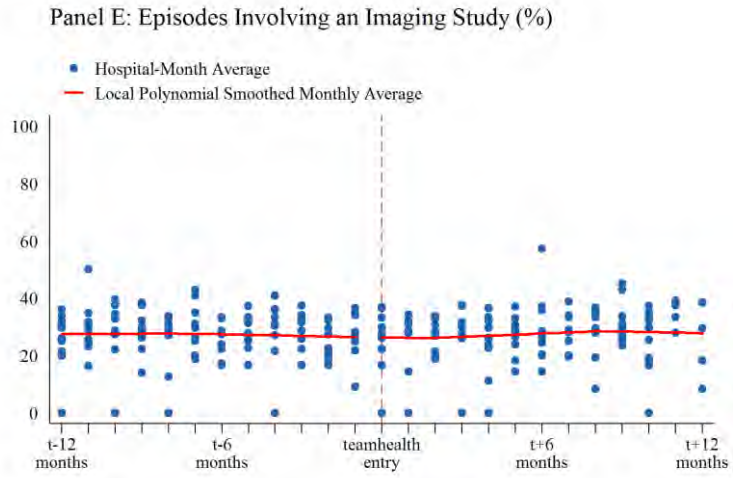
Figure 7: Discontinuity Analysis of Hospital Activity at Hospitals Where TeamHealth Took Over Management of ED Services

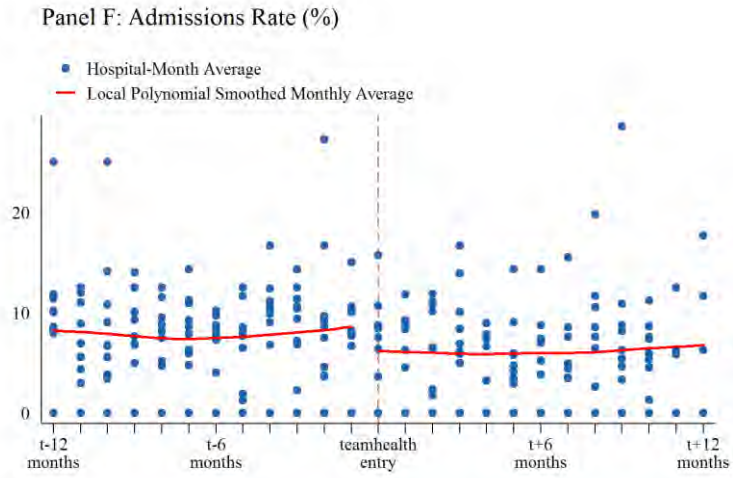








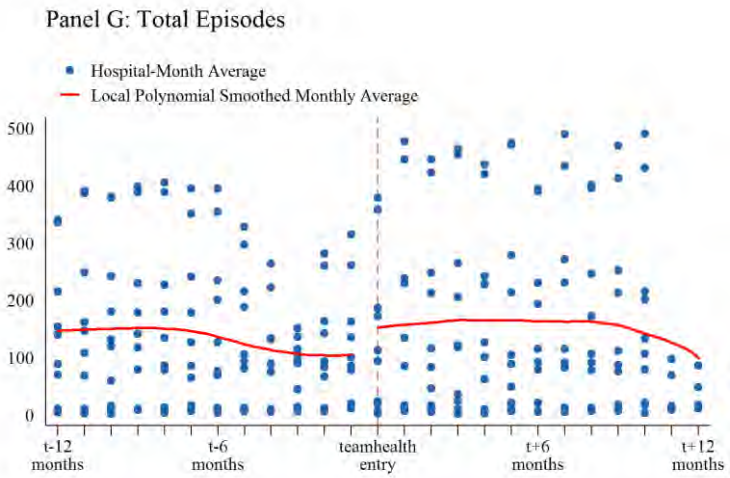




003281

003281

003281



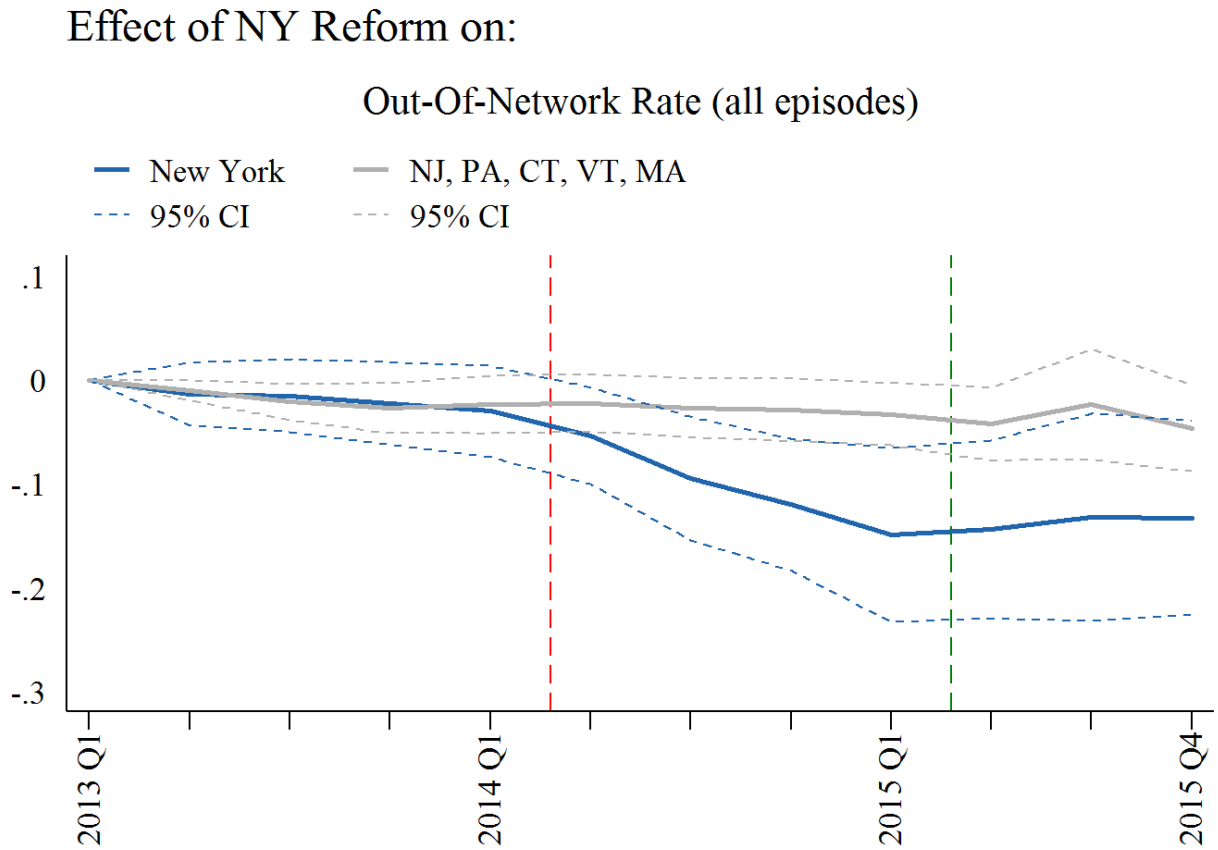
Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after TeamHealth entered the hospital.

003282

003282

003282

Figure 8: Out-of-Network Billing Rates in New York Versus Surrounding States



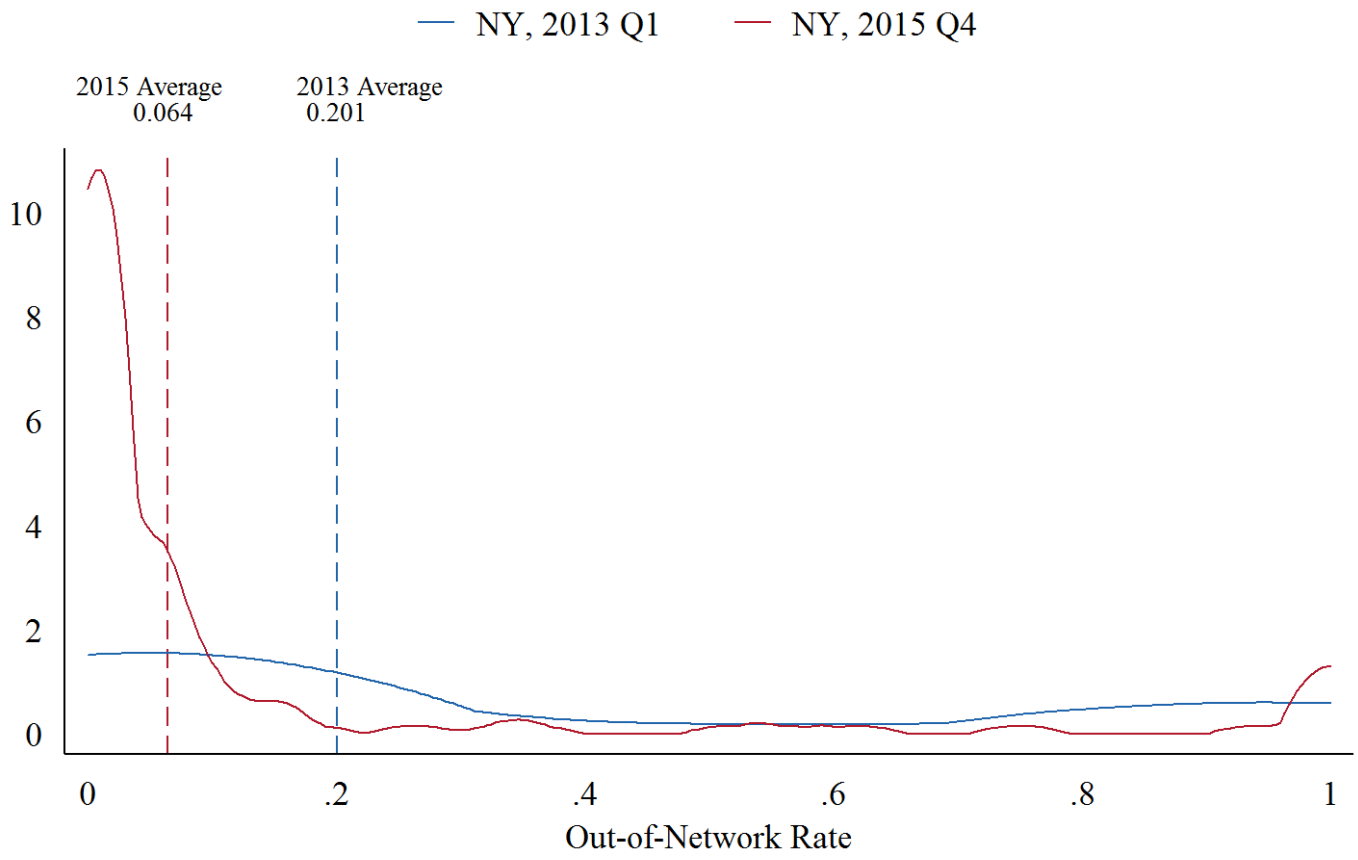
003283

003283

Notes: The figure presents least-squares estimates of an episode-level regression where the dependent variable is whether or not a patient at an in-network ED received a bill from an out-of-network physician. We regress that against an indicator for whether the episode occurred in the state of New York, a vector of quarterly fixed effects, and the interaction of the New York indicator and the quarterly fixed effects. Patient age, gender, race, and Charlson scores are included as controls. The omitted category is Q1 2013. We include a vector of hospital fixed effects. The control group is composed of ED episodes that occurred in New Jersey, Pennsylvania, Connecticut, Vermont, and Massachusetts. Standard errors are clustered around hospitals. The red dotted line denotes when the NY vote passed, and the green dotted line denotes when the NY law was enacted.

003283

Figure 9: The Distribution of Out-of-Network Billing in New York in 2013 and 2015



Notes: The figure shows the kernel density distribution of hospital out-of-network rates in New York in 2013 and 2015

Appendix – For Online Publication

Appendix 1: Variables Used in Lasso

	Description	Source
aha_admtot	Total facility admissions	AHA
aha_births	Total births (excluding fetal deaths)	AHA
aha_c_g	Government	AHA
aha_c_np	Non-profit	AHA
aha_fte	Full-time equivalent total personnel	AHA
aha_ftelpn	Full-time equivalent licensed practical or vocational nurses	AHA
aha_ftemd	Full-time equivalent physicians and dentists	AHA
aha_fteoth94	Full-time equivalent all other personnel	AHA
aha_fteres	Full-time equivalent medical and dental residents and interns	AHA
aha_ftern	Full-time equivalent registered nurses	AHA
aha_ftetran	Full-time equivalent other trainees	AHA
aha_ftettrn	Full-time equivalent total trainees	AHA
aha_ftlab	Full-time lab techs	AHA
aha_ftlpntf	Full-time licensed nurses	AHA
aha_ftmdtf	Full-time physicians and dentists	AHA
aha_ftres	Full-time medical & dental residents, interns	AHA
aha_fttoth	Total full-time hospital unit personnel	AHA
aha_fttotlt	Total full-time nursing home personnel	AHA
aha_fttran84	Full-time other trainees	AHA
aha_hcount_15m	Hospital count 15m	AHA
aha_hmocon	# HMO contracts	AHA
aha_hospbd	Total hospital beds	AHA
aha_mapp1	Accreditation by JCAHO	AHA
aha_mapp10	Medicare certification	AHA
aha_mapp11	Accreditation by American Osteopathic Association	AHA
aha_mapp12	Internship approved by AOA	AHA
aha_mapp13	Residency approved by AOA	AHA
aha_mapp16	Catholic church operated	AHA
aha_mapp19	Rural Referral Center	AHA

003286
003286

003286

	Description	Source
aha_mapp2	Cancer program approved by ACS	AHA
aha_mapp20	Sole Community Provider	AHA
aha_mapp21	DNV	AHA
aha_mapp3	Residency training approval	AHA
aha_mapp5	Medical school affiliation	AHA
aha_mapp6	Hospital-controlled professional nursing school	AHA
aha_mapp7	Accreditation by CARF	AHA
aha_mapp8	Teaching hospital	AHA
aha_mapp9	Blue Cross contracting or participating	AHA
aha_mcddc	Total facility Medicaid discharges	AHA
aha_mcdipd	Total facility Medicaid days	AHA
aha_mcrdc	Total facility Medicare discharges	AHA
aha_npayben	Total facility employee benefits	AHA
aha_paytot	Facility payroll expenses	AHA
aha_prop_caid	Proportion medicaid	AHA
aha_prop_care	Proportion medicare	AHA
aha_ptlab	Part-time laboratory technicians	AHA
aha_ptlpntf	Part-time licensed practical or vocational nurses	AHA
aha_ptmdtf	Part-time physicians and dentists	AHA
aha_ptphr	Part-time pharmacists, licensed	AHA
aha_ptpht	Part-time pharmacy technicians	AHA
aha_ptrad	Part-time radiology technicians	AHA
aha_ptres	Part-time medical and dental residents and interns	AHA
aha_ptresp	Part-time respiratory therapists	AHA
aha_pttoth	Total part-time hospital unit personnel	AHA
aha_pttotlt	Total part-time nursing home personnel	AHA
aha_pttran84	Part-time other trainees	AHA
aha_sunits	Separate nursing home	AHA
aha_suropip	Inpatient surgical operations	AHA

003287
003287

003287

	Description	Source
aha_suroptot	Total surgical operations	AHA
aha_syshhi_15m	Hospital 15m HHI	AHA
aha_techtotal	Technology (put into quintiles)	AHA
aha_vem	Emergency room visits	AHA
aha_vtot	Total outpatient visits	AHA
eop_cs00_seg_inc	Income segregation	Equality of Opportunity Project
eop_cs_divorced	fraction of divorced adults	Equality of Opportunity Project
eop_cs_elf_ind_man	manufacturing employment share	Equality of Opportunity Project
eop_cs_fam_wkidsinglemom	Fraction of children with single mothers	Equality of Opportunity Project
eop_cs_labforce	Labor participation rate	Equality of Opportunity Project
eop_cs_married	Fraction of adults married	Equality of Opportunity Project
eop_cs_race_bla	Fraction black	Equality of Opportunity Project
eop_cs_race_theil_2000	Theil Index of racial segregation	Equality of Opportunity Project
eop_frac_traveltime_lt15	Fraction with commute less than 15 minutes	Equality of Opportunity Project
eop_gini	Gini (includes top 1%)	Equality of Opportunity Project
eop_hhinc00	Household Income (put into quintiles)	Equality of Opportunity Project
eop_inc_share_1perc	Top 1% income share	Equality of Opportunity Project
eop_incgrowth0010	income growth, 2000-2006/10	Equality of Opportunity Project
eop_intersects_msa	Urban indicator	Equality of Opportunity Project
eop_mig_inflow	Migration inflow rate	Equality of Opportunity Project
eop_mig_outflow	migration outflow rate	Equality of Opportunity Project
eop_rel_tot	Fraction religious	Equality of Opportunity Project
eop_subcty_expend	Local government expenditures/capita	Equality of Opportunity Project
eop_taxrate	local tax rate	Equality of Opportunity Project
baker_hhi	Physician HHI	Baker et. al
hli_hhi_all	Insurer HHI	Health Leader Interstudy
hli_share	Insurer share of market	Health Leader Interstudy
cen_countypop	County population	US Census Bureau
ska_ed_phys_per_capita	ED Physicians/capita	SKA
ska_phys_per_capita	Physicians/capita	SKA
EmCare	Indicator for EmCare hospitals	Internal
TeamHealth	Indicator for TeamHealth hospitals	Internal

003288
003288

Notes: AHA: American Hospital Association Annual Survey. Equality of Opportunity Project: Selected variables from (http://www.equality-of-opportunity.org/data/). Baker et. al: Physician HHI constructed by Laurence Baker, Kate Bundorf, and Anne Royalty. Health Leader Interstudy: Data from US Managed Market Solutions, formerly Health Leader Interstudy. SK&A: Healthcare database with list of physicians for marketing purposes. Internal: See Appendix Figure1A and 1B. These are all variables that may be selected from the Lasso. Hospitals missing any of these variables or not appearing in all 5 years of the data are not included. A total of 1,602 unique hospitals are included.

Appendix 2: Surprise Billing Forms from New York State

New York State Out-of-Network Surprise Medical Bill

You may not be responsible for a surprise bill for out-of-network services

A "Surprise Bill" is when you have insurance coverage issued in the State of NY:

Hospital or surgical centers: You are a patient at a participating hospital or ambulatory surgical center and you receive services for which:

- A network doctor was not available
- An out-of-network doctor provided without your knowledge
- Unforeseen medical circumstances arose at the time the health care services were provided.

It will not be a surprise bill if you chose to receive services from an out-of-network doctor instead of form an available network doctor.

Referrals: Your network doctor did not ask your consent to refer you to an out-of-network doctor, lab or other health care provider, and did not tell you it would result in costs not covered by your health plan.

An independent dispute resolution entity (IDRE) can determine if you need to pay the bill. You, the plan or your doctor may request an independent dispute resolution (IDR) for surprise bills and referrals. Use the form on the next page to submit your request. You do not have to pay the bill in order to be eligible to submit the dispute for review to an IDRE.

003289

Dispute resolution process

1. **Submit your request for independent review:** Complete the form on the next page. You can call Customer Service if you need help completing the form. The phone number is on you ID card. You may mail the form to us at:

   Consolidated Health Plans
   2077 Roosevelt Ave.
   Springfield, MA 01104

   Or send the form electronically to:
   customerservice@consolidatedheathplan.com

2. **An independent dispute resolution entity (IDRE) approved by the State of New York will screen your request for eligibility.**

   If the IDRE needs more information, it will contact the health plan or health care provider. If the requested information is not submitted with three business days, or if the application is not eligible, the IDRE will reject the application.

3. **The IDRE will send a letter to the person who initiated the request (you, the doctor, CHP)**

   The letter will include:

   - A request for the information needed to complete the review
   - A request for any additional information that may be available to support the request
   - Where to send the information

4. **You must submit any requested information within five business days of receiving the letter**

   If IDRE receives a partial response or no response, the dispute will be decided based on the available information. You cannot ask for reconsideration by submitting additional information after the decision is made.

5. **The IDRE will make a determination within 30 days of receiving the request**

   If IDRE feels either the provider's bill or the health plan's coverage policy is extreme, it may direct them to attempt a good faith negotiation for settlement. They will have up to ten business days for this negotiation.

   A neutral and impartial reviewer with training and experience in health care billing, reimbursement, and usual and customary charges will review the dispute. The IDRE will forward copies of its decision to the health plan, the physician, superintendent, and as applicable, the nonparticipating referred health care provider and the patient, within two business days of making the decision.

003289

003289

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the **Department of Financial Services at 1-800-342-3736**.

A surprise bill is when:

1. You received services from a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a nonparticipating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a nonparticipating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a nonparticipating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a nonparticipating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a nonparticipating laboratory pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent/s) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent/s received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent/s used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

003290

Your Name: _____

Your Address: _____

Insurer Name: _____

Your Insurance ID No: _____

Provider Name: _____ Provider Phone Number: _____

Provider Address: _____

Date of Service: _____

003290

Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____

_____

(Signature of patient) (Date of signature)

003290

Appendix Table 1: Hospital Entry from EmCare and TeamHealth

	EmCare	TeamHealth
2012	3 Hospitals	1 Hospital
2013	1 System (8 hospitals); 1Hospital	2 Hospitals
2014	4 Hospitals	1 Hospital
2015	0	1 System (5 hospitals); 1 Hospital
Total	*9 Entries (16 hospitals)*	*5 Entries (10 hospitals)*

Notes: We identified hospitals that entered into an outsourcing contract with EmCare and TeamHealth between 2011 and 2015 based on press releases and news stories.

003291

003291

003291

Appendix Table 2: ED Episode Descriptives

	Mean	SD	Min	P10	P25	P50	P75	P90	Max
Physician Payment	412.09	320.02	49.15	106.43	182.40	314.33	543.82	872.11	1,642.45
Physician Charge	614.92	385.70	107.10	224.64	332.80	519.18	787.52	1,136.10	2,146.42
Physician Insurer Payment	354.02	310.78	0.00	45.01	135.23	271.20	483.00	789.36	1,642.45
Physician Patient Payment	58.07	114.61	0.00	0.00	0.00	0.00	65.31	185.17	679.45
Potential Balance Bill	202.90	237.04	0.00	0.00	41.68	135.66	274.96	484.55	2,067.52
Patient Cost Exposure	260.94	256.20	0.00	0.00	87.40	190.90	352.26	592.98	2,146.42
Facility Payment	2,850.62	5,218.31	119.22	400.40	689.52	1,139.04	2,418.20	6,379.46	36,286.11
Facility Charge	6,642.39	13,011.33	172.38	552.70	1,065.90	2,325.69	5,802.44	15,300.48	90,184.31
Facility Insurer Payment	2,441.31	5,063.87	0.00	0.00	367.69	862.51	2,001.42	5,629.37	36,286.11
Facility Patient Payment	409.31	581.84	0.00	0.00	104.00	200.96	444.60	1,081.61	3,352.42
Admissions	0.09	0.29	0	0	0	0	0	0	1
Imaging	0.28	0.45	0	0	0	0	1	1	1
Length of Stay	0.58	1.97	0	0	0	0	0	1	30
CPT 99281	0.05	0.21	0	0	0	0	0	0	1
CPT 99282	0.13	0.34	0	0	0	0	0	1	1
CPT 99283	0.48	0.50	0	0	0	0	1	1	1
CPT 99284	0.50	0.50	0	0	0	0	1	1	1
CPT 99285	0.35	0.48	0	0	0	0	1	1	1
Hispanic	0.08	0.28	0	0	0	0	0	0	1
Black	0.10	0.30	0	0	0	0	0	1	1

003292
003292

003292

White	0.48	0.50	0	0	0	0	1	1	1
Ages 57-65	0.17	0.38	0	0	0	0	0	1	1
Ages 47-56	0.18	0.38	0	0	0	0	0	1	1
Ages 37-46	0.17	0.37	0	0	0	0	0	1	1
Ages 27-36	0.16	0.36	0	0	0	0	0	1	1
Ages 20-26	0.13	0.33	0	0	0	0	0	1	1
Ages 0-19	0.20	0.40	0	0	0	0	0	1	1
Charlson Scores	0.34	0.99	0	0	0	0	0	1	17
6-month Spending	6,248	17,195	0	0	149	757	3,548	14,254	115,499
Episodes per hospital	2,665	3,821	60	190	442	1,177	3,279	6,964	47,599

003293

Notes: These are the descriptive statistics for all ED episodes in our data. These are limited to episodes that occurred at in-network hospitals. Payment and charges are winsorized at the top and bottom one percentiles. Payments and charges are also inflation adjusted into 2015 dollars using the BLS All Consumer Price Index.

003293

003293

Appendix Table 3: The Impact of the Entry of EmCare and TeamHealth on Hospital Out-of-Network Rates

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	Hospitals with Out-of-Network Rates Above 97% Prior to Entry			Hospitals with Out-of-Network Rates Below 97% Prior to Entry			All Hospitals Where TeamHealth Entered		
	OON Indicator			OON Indicator			OON Indicator		
Management Company Entry	-0.030	0.035	-0.032	0.815***	0.846***	0.896***	0.326***	0.376***	0.261***
	(0.044)	(0.048)	(0.060)	(0.061)	0.073	(0.156)	(0.03)	(0.034)	0.082
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.209	0.392	0.896	0.204	0.372	0.549	0.226	0.305	0.232
SD	0.407	0.488	0.306	0.403	0.483	0.498	0.419	0.460	0.422
Observations	8,401,884	1,704,541	85,741	8,351,799	1,654,456	34,876	8,661,796	2,118,144	132,549
Control	All Non-Entry Hospitals	Hospitals in Same State	Propensity Score Match	All Non-Entry Hospitals	Hospitals in Same State	Propensity Score Match	All Non-Entry Hospitals	Hospitals in Same State	Propensity Score Match

003294
003294

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a) separately on hospitals with out-of-network (OON) rates below 11% (Columns 1-3) and above 97% (Columns 4-6). We also estimate Equation (13b) for hospitals with TeamHealth entry in Columns (7-9). The dependent variable in all regressions is a binary indicator for whether a patient at an in-network hospital was treated by an out-of-network physician. Our analysis is run at the patient-level. The control groups for Columns (1,4,7) are all hospitals in the US that did not outsource their ED management to EmCare or TeamHealth. The control groups for Columns (2,5,8) are all hospitals in same states as the treated hospitals, excluding hospitals that outsourced their ED services to EmCare or TeamHealth The control groups in Columns (3,6,9) are hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Mean and standard deviation are drawn from the analytic sample population underlying the regression.

003294

Appendix Table 4: The Impact of the Entry of EmCare on Physician Charges, Payments, and Coding
Same-State Hospitals Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Potential Balanced Bill	Total Patient Cost Exposure	CPT Severity
EmCare Entry	548.40***	396.98***	46.23***	443.22***	105.18***	151.42***	0.148***
	(62.97)	(55.28)	(4.53)	(56.13)	(38.86)	(35.28)	(0.030)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	615.73	409.62	61.68	471.30	144.42	206.11	0.357
SD	386.33	327.27	111.05	340.41	215.56	236.11	0.479
Observations	1,720,883	1,720,883	1,720,883	1,720,883	1,720,883	1,720,883	1,720,883
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

003295
003295

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We windsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollars amounts are adjusted into 2015 dollars.

003295

Appendix Table 5: The Impact of the Entry of EmCare on Physician Charges, Payments, and Coding Propensity Score Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Potential Balanced Bill	Total Patient Cost Exposure	CPT Severity
EmCare Entry	478.19***	390.28***	42.21***	432.50***	45.69	87.90**	0.144***
	(77.87)	(62.71)	(5.51)	(64.73)	(38.02)	(38.39)	(0.034)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	817.20	578.37	83.43	661.80	155.40	238.83	0.357
SD	485.98	427.60	130.57	452.12	313.02	325.70	0.479
Observations	130,263	130,263	130,263	130,263	130,263	130,263	130,263
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

003296
003296

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status.We windsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollars amounts are adjusted into 2015 dollars.

003296

Appendix Table 6: The Impact of the Entry of TeamHealth on Physician Charges, Payments, and Coding Same-State Hospitals Control Group

	(1)	(2)	(3)	(4)	(5)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	CPT Severity
TeamHealth Entry	13.63	230.63***	18.45***	249.08***	0.0225
	(37.39)	(17.79)	(3.71)	(20.91)	(0.015)
Hospital FE	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes
Mean	635.76	389.46	62.21	451.66	0.362
SD	397.92	327.93	112.14	342.54	0.481
Observations	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

003297

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13b). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We windsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003297

003297

Appendix Table 7: The Impact of the Entry of TeamHealth on Physician Charges, Payments, and Coding Propensity Score Control Group

	(1)	(2)	(3)	(4)	(5)
	Physician Charge	Insurer Payment	Patient Cost Sharing	Total Payment	CPT Severity
TeamHealth Entry	-28.41	215.21***	18.82***	234.04***	0.0267
	(44.01)	(24.77)	(6.53)	(27.91)	(0.024)
Hospital FE	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes
Mean	705.85	442.41	61.54	503.96	0.387
SD	372.52	296.61	108.89	304.59	0.487
Observations	132,549	132,549	132,549	132,549	132,549
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

003298

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13b). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status.We windsorized the top and bottom percentile of hospital and physician payments. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003298

003298

Appendix Table 8: Physician Payment Rates for ED Visits

	Mean	S.D.	P25	P50	P75	Max
In-Network ED Physician Payment	$326.70	$238.99	$156.55	$267.14	$422.12	$1,642.45
(Percent Medicare)	(266%)					
Out-of-Network ED Physician Charge	$785.91	$443.86	$440.64	$680.34	$1,013.29	$2,146.42
(Percent Medicare)	(637%)					

Notes: We limit our data to hospitals with more than 10 episodes per year from 2011 to 2015. Physician charges and payments are winsorized at the top and bottom percentile. Prices are inflation adjusted using the BLS All Consumer Price Index.

003299
003299

003299

Appendix Table 9: The Impact of the Entry of EmCare on Hospital Charges, Payments, and Activity
Same-State Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
EmCare Entry	1522.14***	191.94*	45.47**	237.41**	0.012***	0.017***	-188.98
	(395.07)	(98.48)	(17.79)	(112.91)	(0.005)	0.0062	(219.4)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,304.63	2,350.46	393.81	2,744.271	0.278	0.090	1,695.5
SD	12,415.53	4,885.15	561.89	5,034.470	0.448	0.286	1,566.5
Observations	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226	8,418,226
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

003300
003300

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We windsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003300

Appendix Table 10: The Impact of the Entry of EmCare on Hospital Charges, Payments, and Activity Propensity Score Match Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
EmCare Entry	1238.37***	88.38	32.52	120.90	0.018	0.011	-58.62
	(412.95)	(114.20)	(19.32)	(129.20)	(0.010)	0.0103	(211.7)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	8,396.29	2,614.88	483.73	3,098.618	0.304	0.095	1797.0
SD	14,579.69	4,781.73	609.50	4,938.139	0.460	0.294	1,021.8
Observations	130,263	130,263	130,263	130,263	130,263	130,263	130,263
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

003301

003301

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. We windsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003301

Appendix Table 11: The Impact of the Entry of TeamHealth on Hospital Charges, Payments, and Activity
Same-State Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
TeamHealth Entry	112.10	-109.47	13.23	-96.24	-0.008**	-0.008***	507.3***
	(179.33)	(78.38)	(12.81)	(84.41)	(0.004)	0.0026	(188.0)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6248.05	2435.69	426.91	2862.60	0.280	0.082	1984.0
SD	12156.69	4832.48	573.76	4983.91	0.449	0.274	1563.2
Observations	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144	2,118,144
Control	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State	Hospitals in Same State

003302
003302

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13b). Each observation is a patient episode. The control group includes hospitals in the same states as the treated hospitals. We windsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003302

Appendix Table 12: The Impact of the Entry of TeamHealth on Hospital Charges, Payments, and Activity
Propensity Score Match Control Group

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Facility Charge	Insurer Payment	Patient Cost Sharing	Total Payment	Imaging	Admission to Hospital	Episode Count
TeamHealth Entry	-153.30	-276.64**	-8.50	-285.14**	-0.008	-0.010	340.8*
	(270.94)	(109.79)	(32.65)	(132.72)	(0.010)	0.0068	(181.8)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	7,396.29	2,546.26	425.88	2,972.141	0.304	0.083	2,587.3
SD	12,920.69	4,871.93	558.87	5,045.284	0.460	0.275	1458.9
Observations	132,549	132,549	132,549	132,549	132,549	132,549	132,549
Control	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match	Propensity Score Match

003303
003303

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13b). Each observation is a patient episode. The control groups are composed of hospitals matched to treated hospitals using propensity scores calculated using entry as predicted by a treated hospital's beds, technology, and non-profit/for-profit status. We windsorized the top and bottom percentile of hospital and physician payments. Imaging is an indicator variable capturing whether a patient had an imaging study performed during an ED visit. Admissions to hospital is an indicator variable that captures whether a patient was admitted to the hospital after an ED visit. Each regression includes controls for patient age, gender, race, and Charlson score. Standard errors are clustered around hospitals. Means and standard deviation are drawn from the analytic sample population underlying the regression. All dollar amounts are inflation adjusted into 2015 dollars.

003303

Appendix Table 13: Hospital Characteristics Associated with EmCare and TeamHealth

	(1)	(2)	(3)	(4)
	EmCare	EmCare	TeamHealth	TeamHealth
For-profit	0.1063***	0.1206***	0.011	0.011
	(0.013)	(0.012)	(0.010)	(0.009)
Government	0.0464***	0.0440***	0.005	0.002
	(0.015)	(0.014)	(0.011)	(0.010)
Teaching Hospital	-0.007	-0.008	-0.017	-0.016
	(0.019)	(0.019)	(0.014)	(0.014)
Hospital Beds	0.003	0.000	0.004	0.0108*
	(0.009)	(0.008)	(0.007)	(0.006)
Technologies	0.006	-0.001	-0.008	-0.011
	(0.019)	(0.018)	(0.013)	(0.013)
Hospital HHI	0.0187*	0.0184**	0.001	0.0138**
	(0.011)	(0.008)	(0.008)	(0.006)
Proportion Medicare	0.014	0.001	0.014	0.0245**
	(0.017)	(0.016)	(0.012)	(0.012)
Proportion Medicaid	0.004	-0.003	0.005	0.007
	(0.008)	(0.008)	(0.006)	(0.006)
ED Physicians per Capita	11.510	-0.0433***	-22.9726***	-0.0197**
	(9.167)	(0.011)	(6.637)	(0.008)
Physicians per Capita	-14.979	-0.004	29.3776***	0.0506***
	(13.582)	(0.023)	(9.833)	(0.017)
Physician HHI	0.016	0.011	-0.008	-0.003
	(0.020)	(0.016)	(0.014)	(0.012)
Insurer HHI	0.021	-0.008	0.002	-0.0148*
	(0.019)	(0.011)	(0.014)	(0.008)
Household Income	0.0893**	0.0951***	0.0517*	-0.025
	(0.042)	(0.030)	(0.030)	(0.021)
Gini Coefficient	-0.1182**	0.0697***	0.026	0.028
	(0.052)	(0.026)	(0.038)	(0.019)
HRR FE	Yes	No	Yes	No
Mean	0.0581	0.0581	0.0285	0.0285
SD	0.2340	0.2340	0.1663	0.1663
Observations	3,345	3,345	3,345	3,345

Notes: * p<0.10, ** p<0.05, *** p<0.01. Each observation is a hospital. The table presents a logit regression of an indicator for EmCare or TeamHealth hospitals on the hospital characteristics in the table. Means and standard deviation are drawn from the analytic sample population underlying the regression.

003304

003304

003304

Appendix Table 14: Comparison of Entry Hospital Characteristics

	EmCare Hospitals	EmCare Entry Hospitals	P-value from two-sided t-test	TeamHealth Hospitals	TeamHealth Entry Hospitals	P-value from two-sided t-test
Hospital Characteristics						
For-profit	0.55	0.57	0.87	0.29	0.30	0.96
Non-profit	0.27	0.21	0.65	0.57	0.70	0.45
Government	0.18	0.21	0.76	0.13	0.00	0.22
Teaching	0.04	0.00	0.44	0.04	0.00	0.54
Hospital Beds	173.97	266.50	0.03	197.63	227.40	0.50
Technologies	43.10	57.79	0.06	47.79	54.80	0.45
Hospital HHI	0.57	0.58	0.98	0.59	0.66	0.48
Proportion Medicare	48.31	43.58	0.12	51.42	44.43	0.03
Proportion Medicaid	18.97	24.18	0.15	20.15	18.14	0.48
ED Physicians per Capita (per 10,000)	0.65	0.61	0.58	0.70	1.06	0.00
Physicians per Capita (per 10,000)	21.64	19.01	0.06	22.82	25.52	0.09
Physician HHI	0.41	0.59	0.02	0.41	0.65	0.13
Insurer HHI	0.36	0.35	0.75	0.35	0.40	0.31
Household Income	38,146.20	35,404.44	0.22	36,849.58	38,080.67	0.59
Gini Coefficient	0.34	0.34	0.61	0.33	0.31	0.19

Notes: The table compares characteristics of identified EmCare and TeamHealth hospitals to characteristics of hospitals where we have entry. Hospitals with entry are excluded from identified TeamHealth and EmCare hospitals. The p-value is reported from a two-sided t-test comparing the difference in means between hospitals and hospitals with entry.

003305

003305

003305

Appendix Table 15: The Impact of Entry on Historical Patient Spending and Charlson Scores

	EmCare				TeamHealth			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	6 month historical spending	12 month historical spending	6 month Charlson	12 month Charlson	6 month historical spending	12 month historical spending	6 month Charlson	12 month Charlson
Firm Entry	916.02***	1306.16***	0.033***	0.036***	-336.35**	-783.08**	0.004	0.006
	(253.83)	(425.64)	(0.010)	(0.012)	(166.74)	(305.09)	(0.005)	(0.005)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	6,247.15	11,476.89	0.326	0.449	6,266.03	11,512.46	0.326	0.450
SD	1,7201.02	27,910.51	0.919	1.056	17,236.61	27,971.30	0.919	1.056
Observations	8,418,226	7,056,427	8,418,226	7,056,427	8,661,796	7,256,251	8,661,796	7,256,251
Control	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals	All Hospitals

003306
003306

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equations (13a) and (13b). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare or TeamHealth. We windsorized the top percentile of 6 and 12 month historical spending. Standard errors are clustered around hospitals.

003306

Appendix Table 16: The Impact of the Entry of EmCare on Coding Severity from Physician Visits, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity	CPT Severity
EmCare Entry	0.151***	0.149***	0.148***	0.148***	0.156***	0.142***	0.152***	0.153***
	(0.031)	(0.030)	(0.030)	(0.030)	(0.033)	(0.030)	(0.030)	(0.031)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.347	0.347	0.347	0.326	0.445	0.297	0.319	0.424
SD	0.476	0.476	0.476	0.469	0.497	0.457	0.466	0.494
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No Controls	Patient Characteristics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We windsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6,7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

Appendix Table 17: The Impact of the Entry of EmCare on Facility Payments, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment	Facility Payment
EmCare Entry	316.63**	309.57***	294.58***	204.95**	742.32**	215.42**	228.37**	428.78***
	(124.89)	(115.77)	(113.64)	(82.50)	(356.38)	(106.80)	(109.11)	(160.14)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	2,744.27	2,744.27	2,744.27	2,417.80	4,303.16	2,353.30	2,355.26	3,524.26
SD	5,034.47	5,034.47	5,034.47	4,418.88	7,084.79	4,492.45	4,350.98	6,001.00
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No Controls	Patient Characteristics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We windsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6,7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

003308
003308
003308

Appendix Table 18: The Impact of the Entry of EmCare on the Frequency of Imaging, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Imaging	Imaging	Imaging	Imaging	Imaging	Imaging	Imaging	Imaging
EmCare Entry	0.016***	0.014***	0.014***	0.013**	0.028***	0.014**	0.017**	0.012**
	(0.005)	(0.005)	(0.005)	(0.006)	(0.009)	(0.007)	(0.008)	(0.005)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.278	0.278	0.278	0.268	0.324	0.254	0.261	0.319
SD	0.448	0.448	0.448	0.443	0.468	0.435	0.439	0.466
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No Controls	Patient Characteristics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We windsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6,7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

003309
003309
003309

Appendix Table 19: The Impact of the Entry of EmCare on the Frequency of Admissions, Robustness Checks

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions	Admissions
EmCare Entry	0.022***	0.022***	0.021***	0.014***	0.053***	0.011*	0.016***	0.035***
	(0.007)	(0.006)	(0.006)	(0.005)	(0.019)	(0.006)	(0.005)	(0.010)
Hospital FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Month FE	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mean	0.090	0.090	0.090	0.071	0.181	0.066	0.070	0.134
SD	0.286	0.286	0.286	0.257	0.385	0.248	0.256	0.341
Observations	8,418,226	8,418,226	8,418,226	6,960,514	1,457,712	2,806,097	2,806,055	2,806,074
Controls	No Controls	Patient Characteristics	Patient and Charlson	Charlson Score of 0	Non-zero Charlson Score	Lowest third of the historical spending distribution	Middle third of the historical spending distribution	Upper third of the historical spending distribution

Notes: * p<0.10, ** p<0.05, *** p<0.01. This table presents least-squares estimates of Equation (13a). Each observation is a patient episode. The control group in all regressions is all hospitals in the US exclusive of those that outsourced their ED services to EmCare. We windsorized the top and bottom percentile of facility payments. Standard errors are clustered around hospitals. In columns 6,7, and 8 historical spending is split into thirds where each column contains the sample of patients from the bottom, middle, and upper third of spending.

003310
003310
003310

Appendix Table 20: ED Episodes and Annual Spending

	Emergency Episodes	Total Facility Spending	Total Physician Spending	Percent ASO	Share of Episodes at in-network hospitals
2011	61,331	$148,222,782	$19,125,875	87.6%	97.9%
2012	69,404	$170,582,628	$22,812,526	89.2%	99.0%
2013	67,317	$182,161,431	$22,551,581	91.5%	99.6%
2014	65,388	$187,074,086	$21,531,723	92.1%	99.8%
2015	60,496	$184,594,280	$21,197,031	90.4%	99.8%
Total	323,936	$872,635,207	$107,218,736	90.2%	99.2%

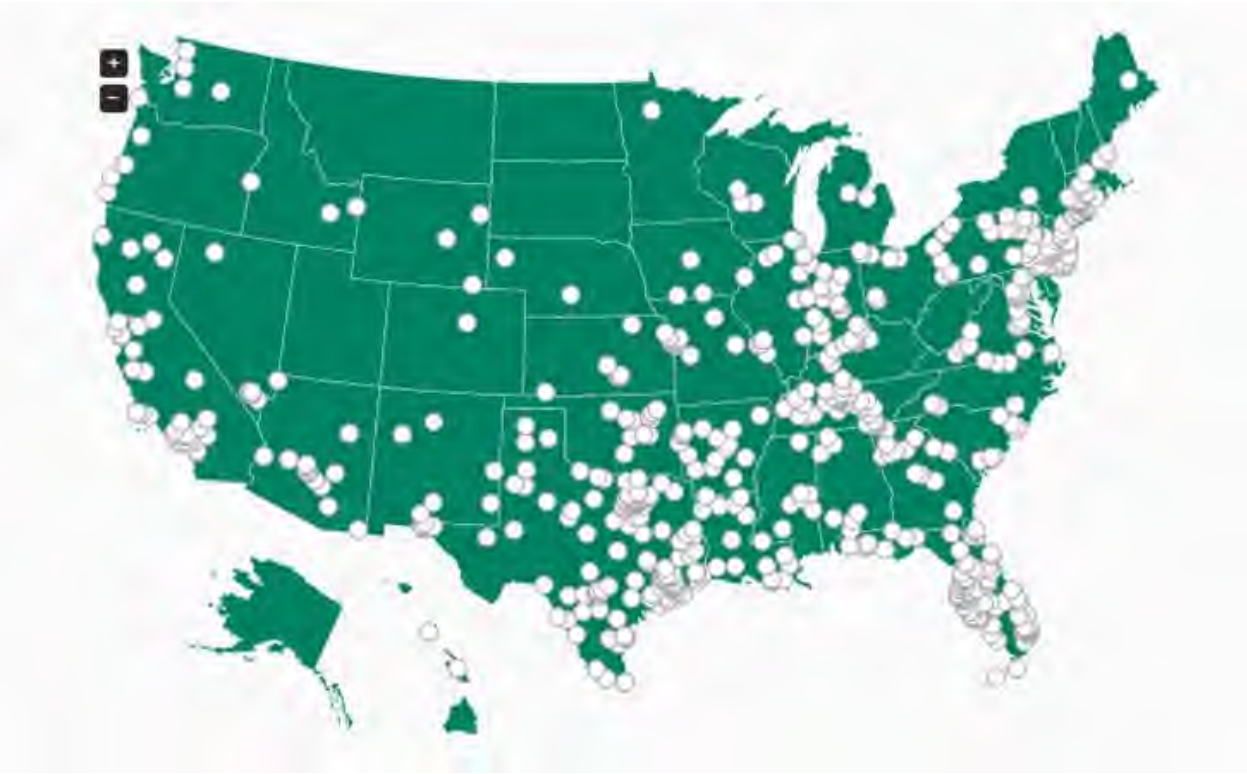
Notes: The table shows summary statistics for our data in New York State. Only episodes that occur in an in-network hospital are included. There are a small percentage of episodes (> 0.5%) that are missing a label for ASO or fully-insured.

003311

003311

003311

Appendix Figure 1A: Map of EmCare Locations



003312

003312

Notes: This map was taken from the webpage of EmCare's parent company Envision Healthcare (https://www.evhc.net/vision/emcare). The underlying HTML source code from the web page contains the latitude and longitude coordinates of each white point displayed. We calculate each coordinate pair's distance to AHA-registered hospital coordinates, and keep hospitals that are within only a 30-mile radius from an AHA-registered hospital. If there are multiple hospitals within a 30-mile radius, we keep only the nearest facility and define it as the identified hospital. We further cross-validate our findings with hospitals from EmCare's job listings found on their website. Our final list includes hospitals that are identified using mapping locations that are cross-validated with job hiring posts.

003312

Appendix Figure 1B: Map of TeamHealth Locations

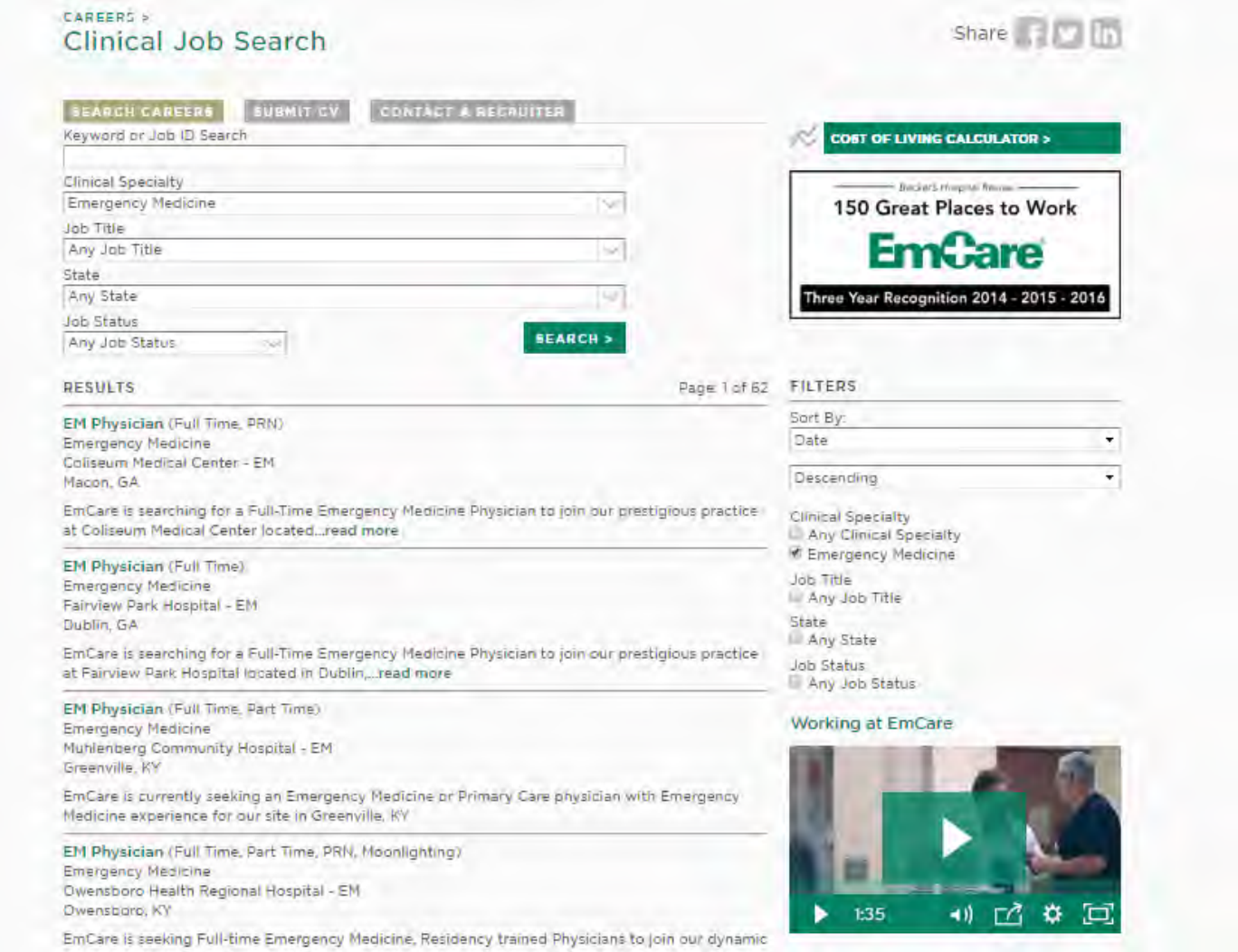
003313

003313

Notes: This is a map from a 2009 Morgan Stanley report on TeamHealth. To determine the hospital locations shown on this map, we used georeferencing in ArcGIS. Georeferencing takes an image or scanned photo without spatial reference information and aligns it to a map with a known coordinate system. In our case, we used a map of the United States (obtained here: https://www.census.gov/geo/maps-data/data/cbf/cbf_state.html), and linked control points from the US map to the map of TeamHealth's locations. To link control points, the location of two identical points on each map are identified (for example, the southern tip of Florida). With several control points defined, the TeamHealth map is then warped and transformed to overlay directly onto the known US map. With the map in place, we mark the center of each blue dot as a hospital location. Because the map now has a defined coordinate system, we are able to obtain the latitude and longitude from these markers. We subsequently calculate each coordinate pair's distance to AHA-identified hospital coordinates, and keep hospitals that are within only a 30-mile radius from an AHA-identified hospital. If there are multiple hospitals within a 30-mile radius, we keep only the nearest facility and define it as the identified hospital. We cross-validate our mapping with hospitals from TeamHealth's job listings page on their website. Our final list of hospitals only includes hospitals that are both identified from the map and appear in job listings.

003313

Appendix Figure 2: Example of EmCare Job Listing



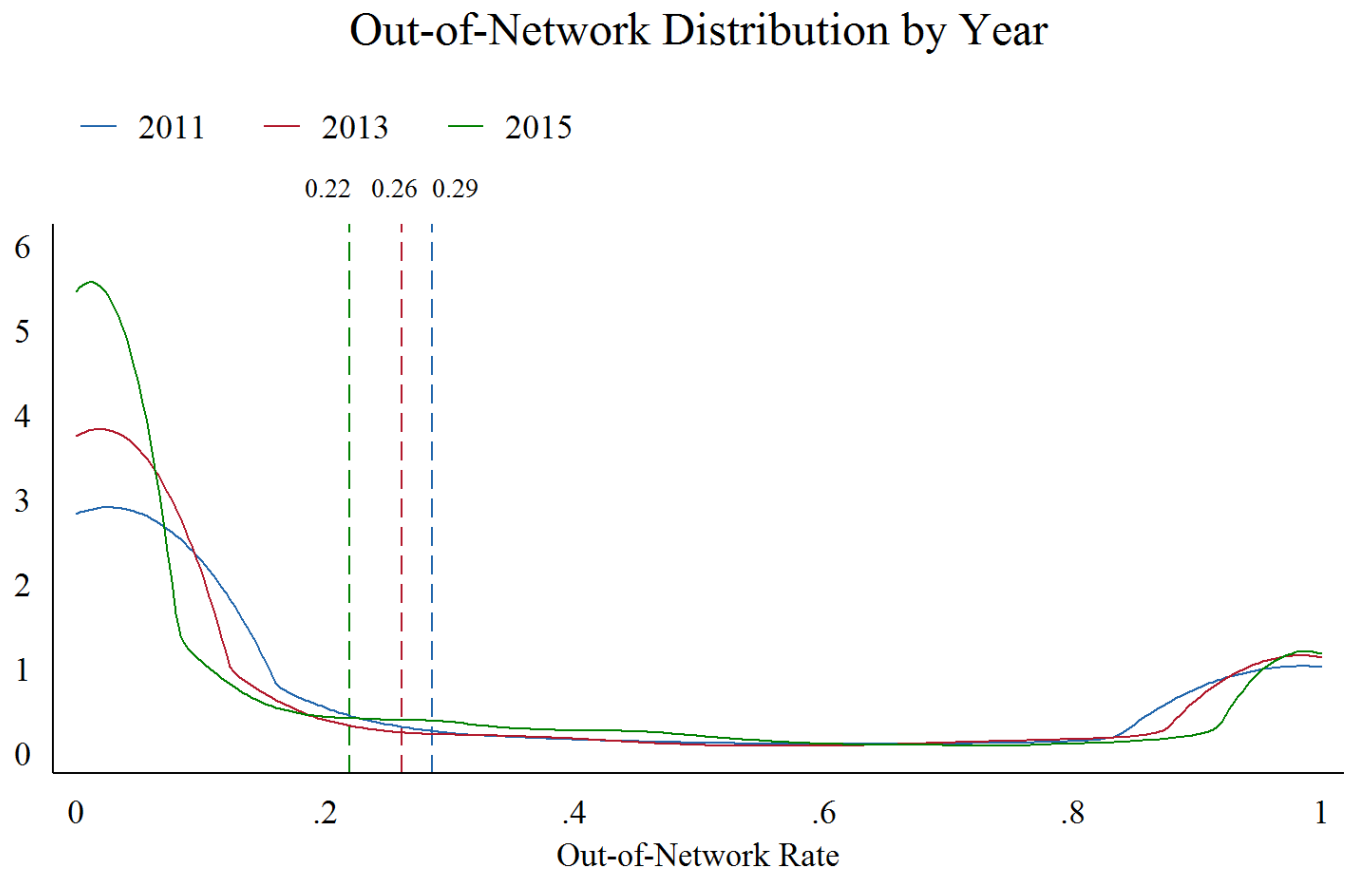
003314

003314

Notes: This screen grab is taken from EmCare's job hiring page. (https://www.emcare.com/careers/clinical-job-search).

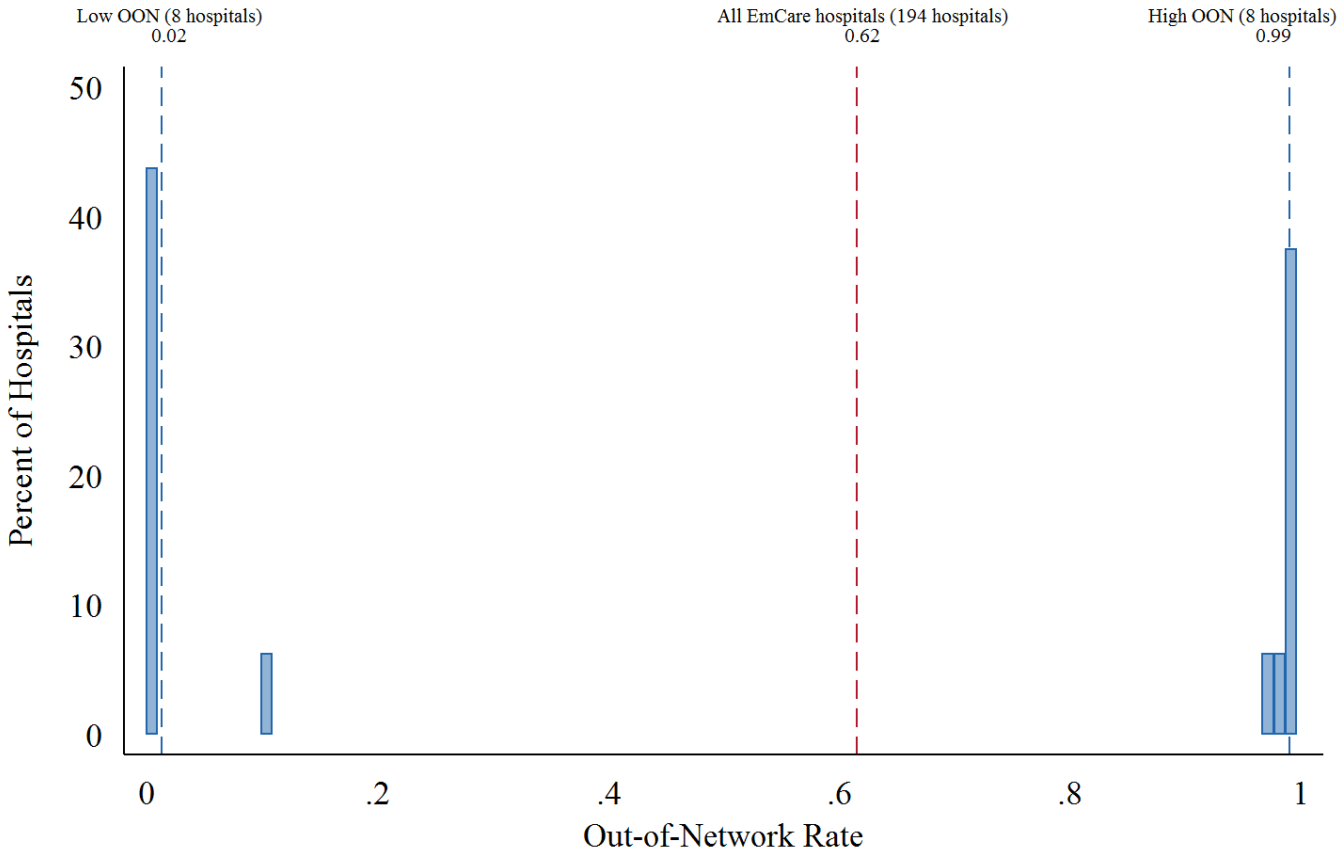
003314

Appendix Figure 3: The Distribution of Hospital Out-of-Network Rates, 2011, 2013, and 2015



Notes: The figure shows the distribution of hospital out-of-network rates in years 2011, 2013, and 2015. There are 3,345 hospitals that appear in each year of the data.

Appendix Figure 4A: The Distribution of Out-of-Network Rates at Hospitals where EmCare Enters, 2011



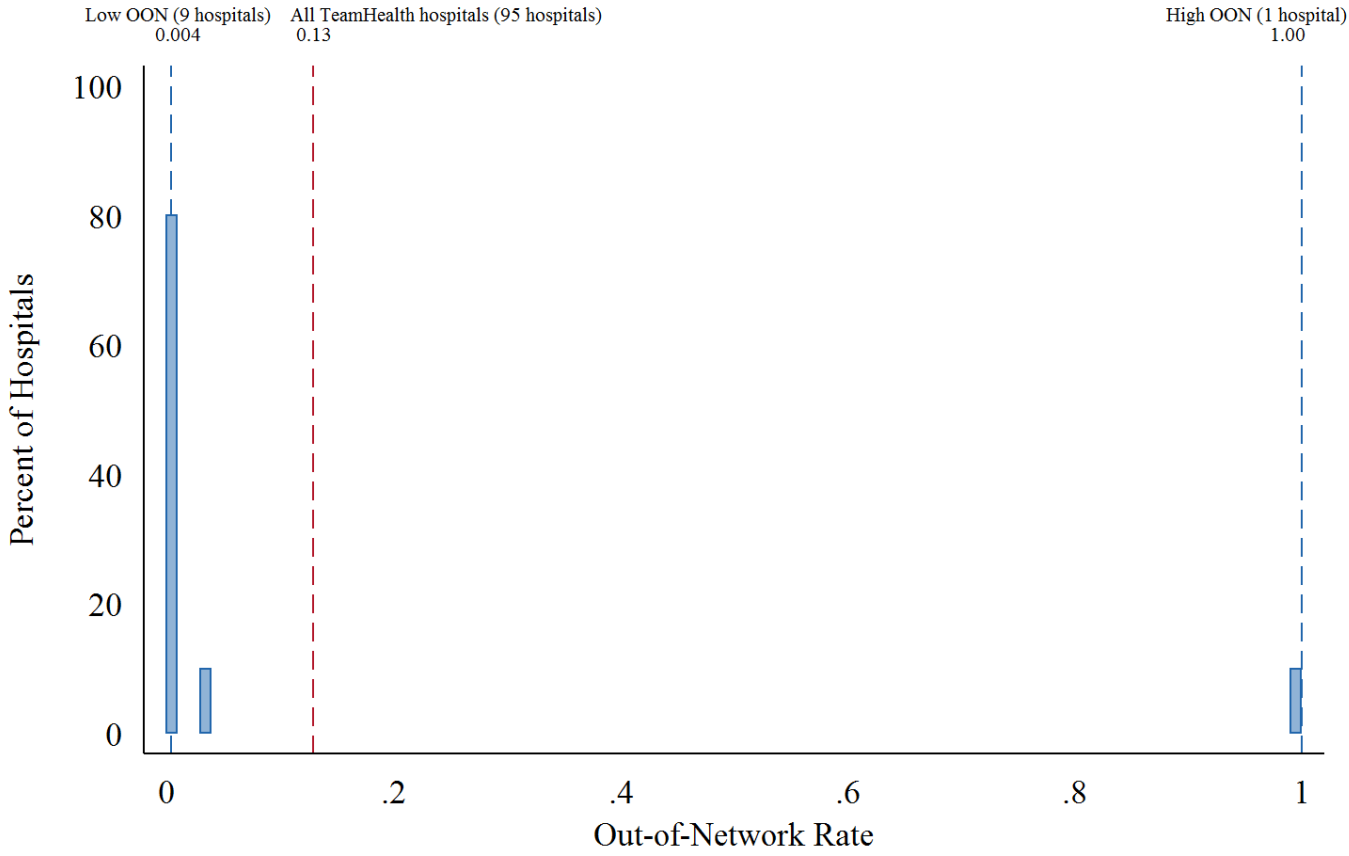
003316

003316

Notes: The figure shows a histogram of out-of-network rates for hospitals prior to EmCare entry in 2011. There are a total of 16 EmCare entry hospitals. Each bar shows the percent of hospitals falling into a given out-of-network rate. The red vertical line is the average of all EmCare hospitals from 2011-2015.

003316

Appendix Figure 4B: The Distribution of Out-of-Network Rates at Hospitals Where TeamHealth Enters, 2011



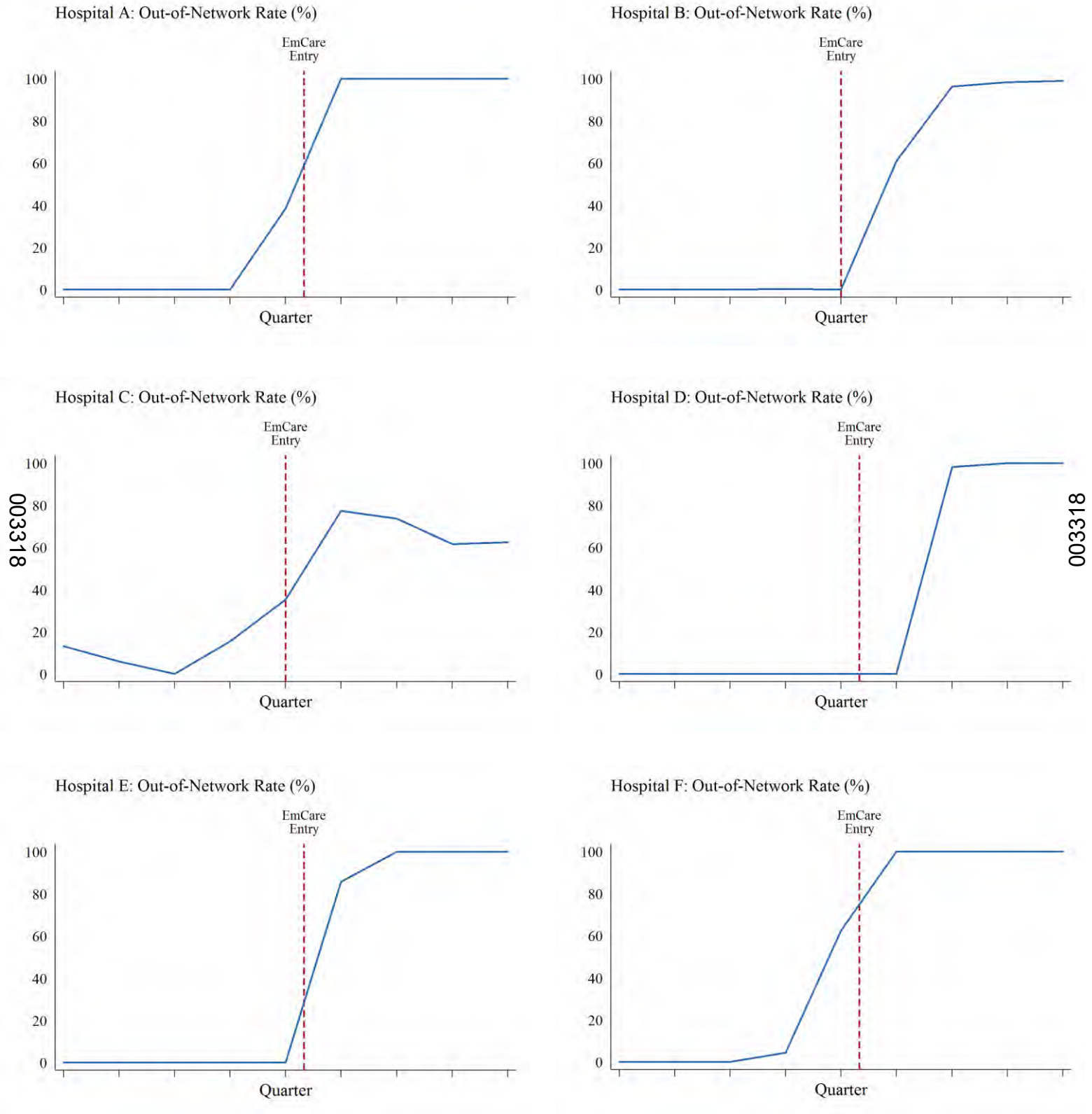
003317

003317

Notes: The figure shows a histogram of out-of-network rates for hospitals prior to TeamHealth entry in 2011. There are a total of 10 TeamHealth entry hospitals. Each bar shows the percent of hospitals falling into a given out-of-network rate. The red vertical line is the average of all TeamHealth hospitals from 2011-2015.

003317

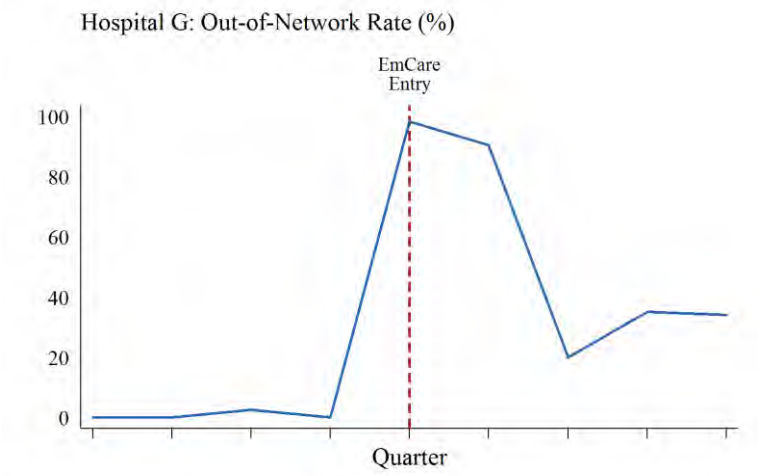
Appendix Figure 5: Out-of-Network Rates at Hospitals Where EmCare Entered

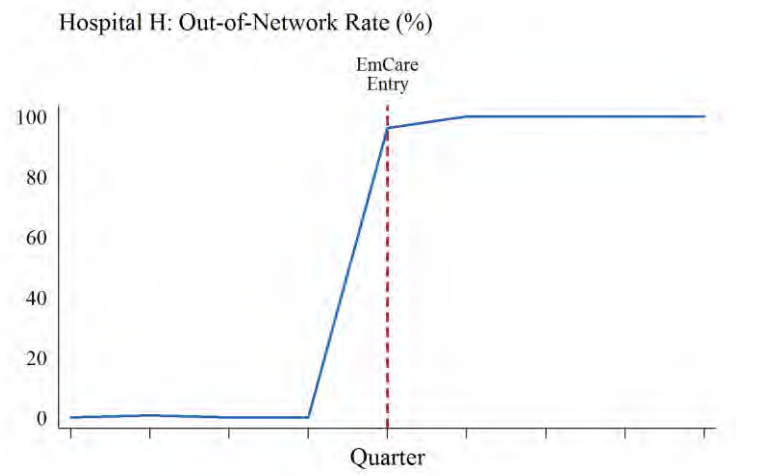


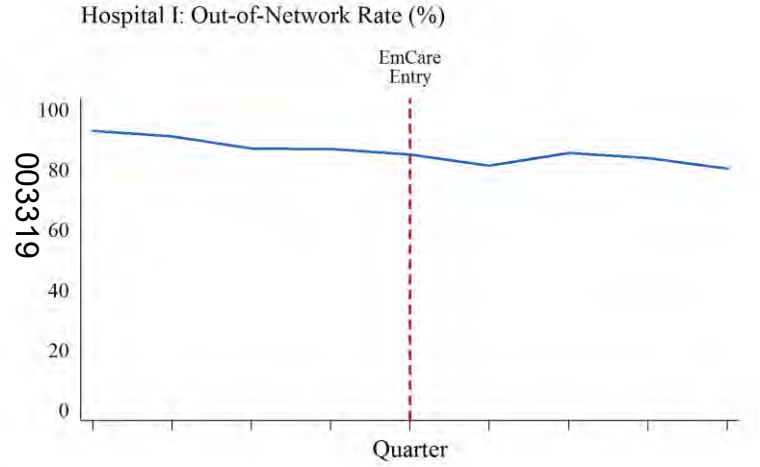
003318

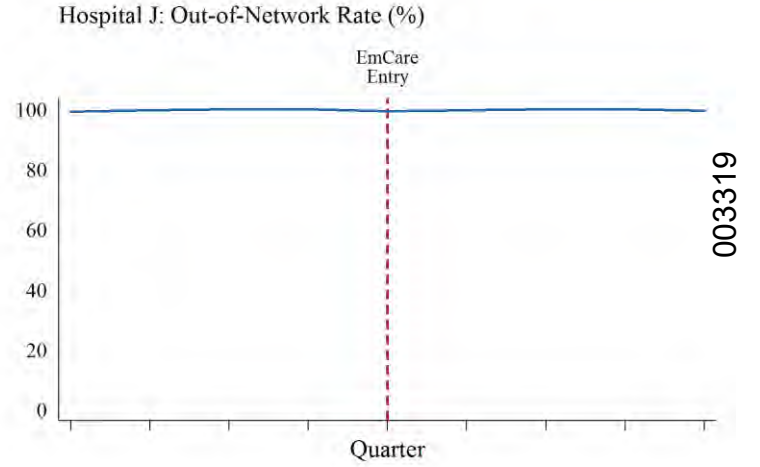
003318

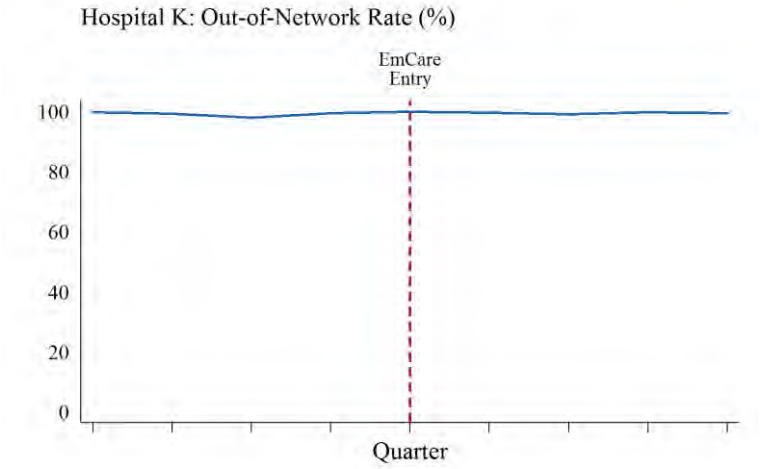
003318

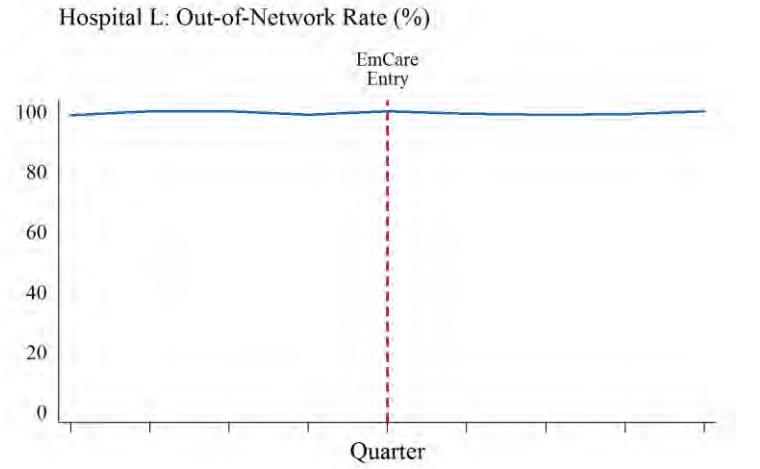








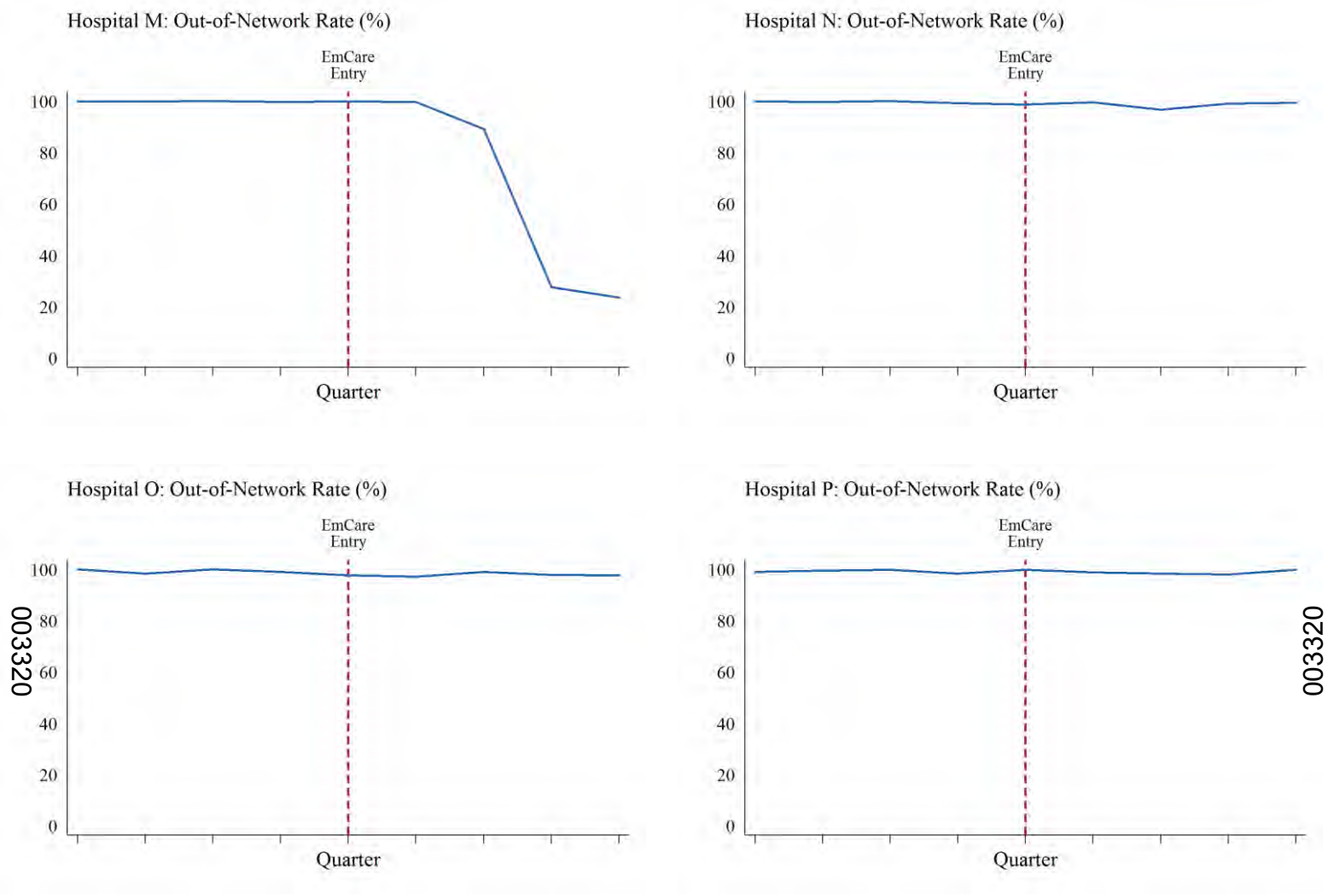




003319

003319

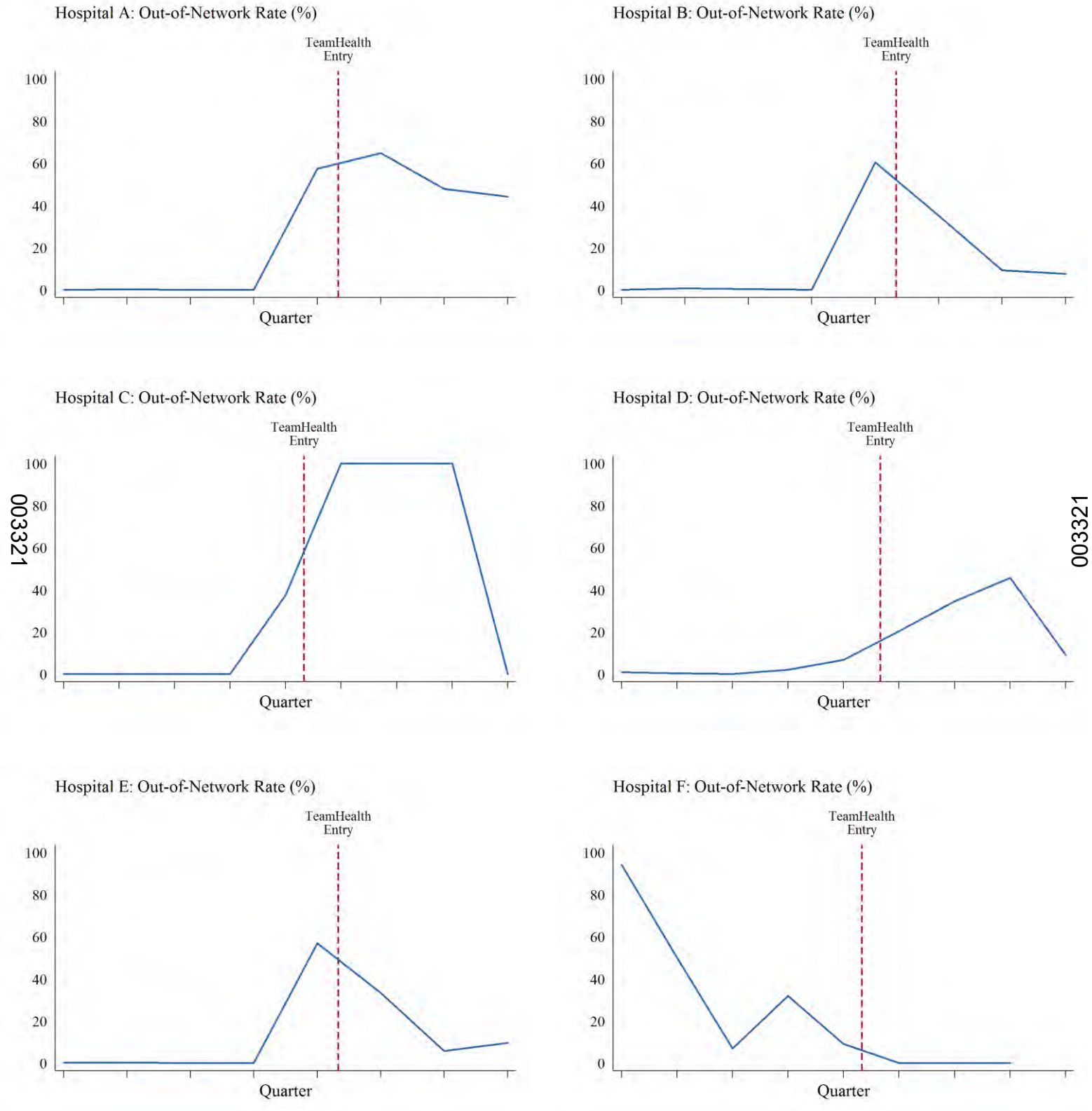
003319



Notes: This figure plots the average quarterly out-of-network rates at hospitals where EmCare entered. We present data from the four quarters before and the four quarters after EmCare took over the management of each hospital's ED.

003320
003320
003320

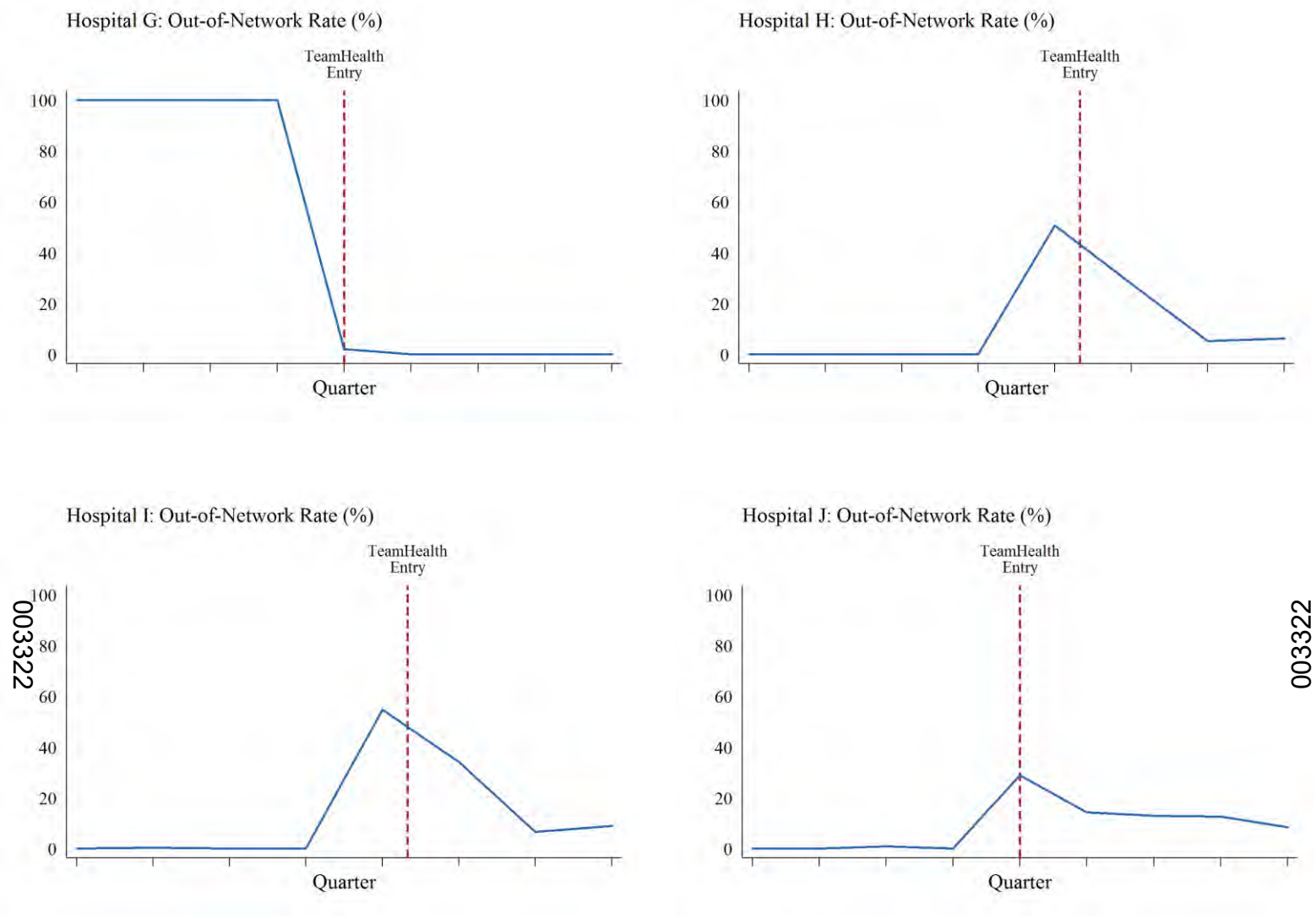
Appendix Figure 6: Out-of-Network Rates at Hospitals Where TeamHealth Entered



003321

003321

003321



003322

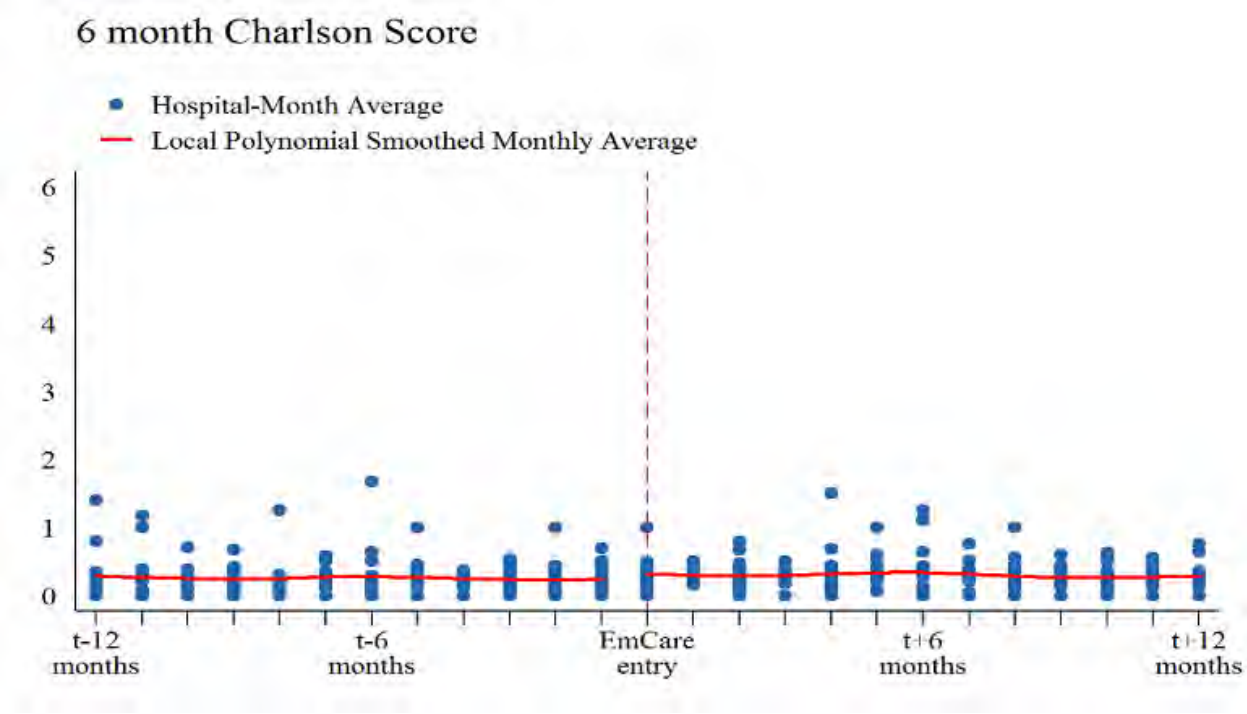
003322

Notes: This figure plots the average quarterly out-of-network rates at hospitals where TeamHealth entered. We present data from the four quarters before and the four quarters after TeamHealth took over the management of each hospital's ED.

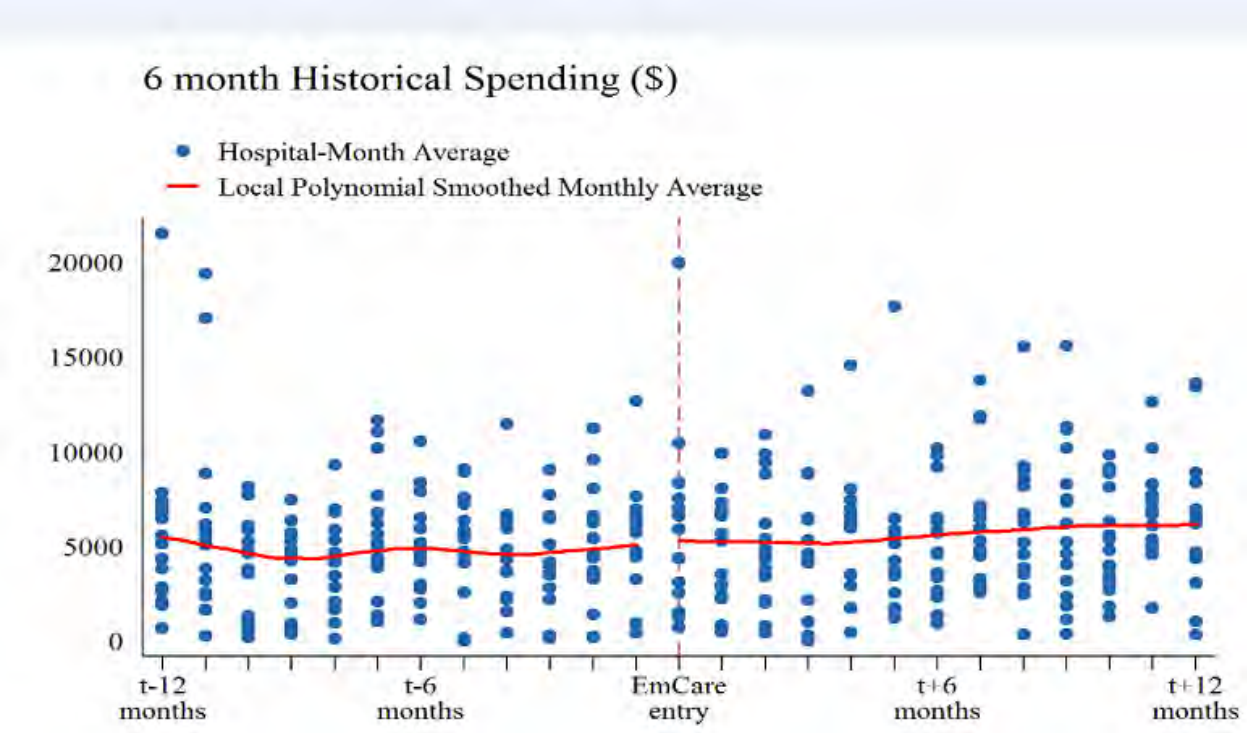
003322

Appendix Figure 7: EmCare and TeamHealth Entry on Patient Characteristics

Panel A: EmCare Entry on Hospitals' Averate Charlson Score of Patients

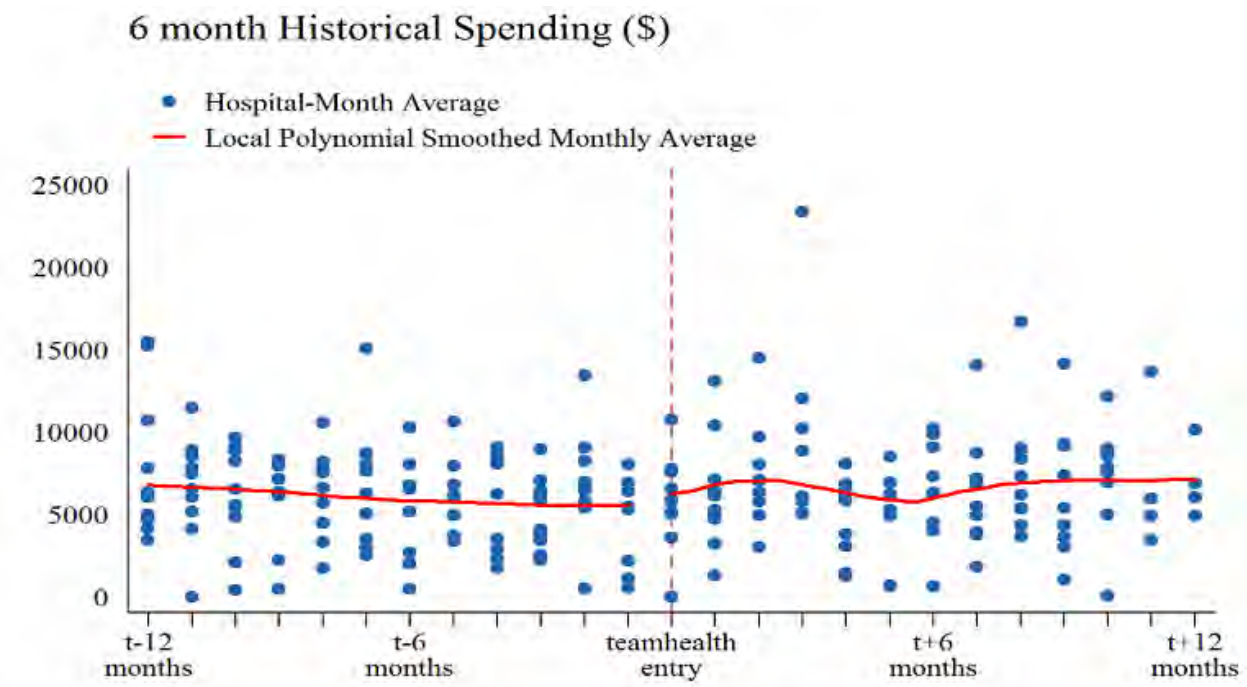


Panel B: EmCare Entry on Hospitals' Average Patient 6-Month Spending



Panel C: TeamHealth Entry on Hospitals' Average Charlson Score of Patients

Panel D: TeamHealth Entry on Hospitals' Patients 6-Month Spending History



Notes: The panels plot the monthly average by hospital from 12 months before to 12 months after EmCare or TeamHealth entered the hospital.

EXHIBIT 20

003325

003325

EXHIBIT 20

How Rich Investors, Not Doctors, Profit From Marking Up ER Bills

TeamHealth, a medical staffing firm owned by private-equity giant Blackstone, charges multiples more than the cost of ER care. All the money left over after covering costs goes to the company, not the doctors who treated the patients.

by Isaac Arnsdorf, June 12, 2020, 6 a.m. EDT

Photo Illustration: Lisa Larson-Walker/ProPublica; Source: iStock/Getty Images Plus, Dana Neely/Stone/Getty Images

ProPublica is a nonprofit newsroom that investigates abuses of power. Sign up to receive our biggest stories as soon as they're published.

In 2017, TeamHealth, the nation's largest staffing firm for ER doctors, sued a small insurance company in Texas over a few million dollars of disputed bills.

Over 2 1/2 years of litigation, the case has provided a rare look inside TeamHealth's own operations at a time when the company, owned by private-equity giant Blackstone, is under scrutiny for soaking patients with surprise medical bills and cutting doctors' pay amid the coronavirus pandemic.

Hundreds of pages of tax returns, depositions and other filings in state court in Houston show how TeamHealth marks up medical bills in order to

003326 003326

boost profits for investors. (Some of the court records were marked confidential but were available for download on the public docket; they were subsequently sealed.)

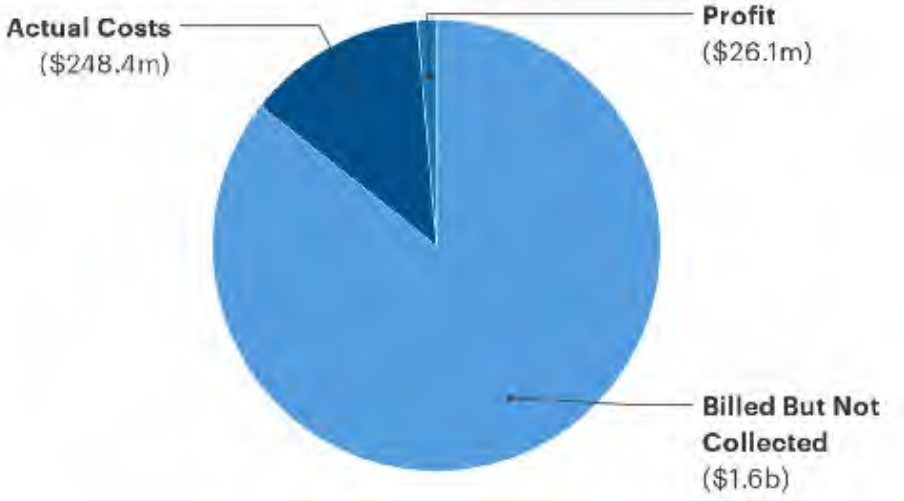
TeamHealth declined to provide an interview with any of its executives. In a statement for this story, the company says it's fighting for doctors against insurance companies that are trying to underpay: "We work hard to negotiate with insurance companies on behalf of patients even as they unilaterally cancel contracts and attempt to drive physician compensation downward."

But the Texas court records contradict TeamHealth's claims that the point of its aggressive pricing is to protect doctors' pay. In fact, none of the additional money that TeamHealth wrings out of a bill goes back to the doctor who treated the patient.

Instead, the court records show, all the profit goes to TeamHealth.

Anatomy of an ER Bill

Two TeamHealth affiliates in Texas billed 7.7 times more than their actual costs of paying for clinicians and support services. The bulk of the charges were discounted or written off. About 10% of the money actually collected went to corporate profits.



Source: Tax returns filed in Texas state court (Isaac Arnsdorf/ProPublica)

"These companies put a white coat on and cloak themselves in the goodwill we rightly have toward medical professionals, but in practice, they behave like almost any other private equity-backed firm: Their desire is to make profit," said Zack Cooper, a Yale professor of health policy and economics who has researched TeamHealth's billing practices and isn't involved in the Texas lawsuit.

"In the market for emergency medicine, where patients can't choose where they go in advance of care, there's a real opportunity to take advantage of patients, and I think we're seeing that that's almost precisely what

TeamHealth is doing, and it's wildly lucrative for the firm itself and its private equity investors."

Some of TeamHealth's own physicians say they're uncomfortable with the company's business practices.

"As an emergency medicine physician, I have absolutely no idea to whom or how much is billed in my name. I have no idea what is collected in my name," said a doctor working for TeamHealth who isn't involved in the Texas lawsuit and spoke to ProPublica on the condition of anonymity because the company prohibits its doctors from speaking publicly without permission.

"This is not what I signed up for and this isn't what most other ER docs signed up for. I went into medicine to lessen suffering, but as I understand more clearly my role as an employee of TeamHealth, I realize that I'm unintentionally worsening some patients' suffering."

Most ER doctors aren't employees of the hospital where they work. Historically they belonged to doctors' practice groups. In recent years, wealthy private investors have bought out those practice groups and consolidated them into massive nationwide staffing firms like TeamHealth and its largest competitor, KKR-owned Envision Healthcare.

These takeovers have affected patients, too, because the groups have gotten into payment disputes with their insurers. As a result, patients can receive huge medical bills even when they pick a hospital within their insurance plan's network, because the individual doctor working for a contractor like TeamHealth could be out of network. This practice, known as surprise billing, caught the attention of lawmakers who have spent months working on legislation.

TeamHealth said surprise bills are "rare and unintended," but with millions of patients, it has happened tens of thousands of times. The company has called surprise billing a "source of contracting negotiating leverage" to demand higher payments from insurers.

"Underneath this are patients who may well be charged outrageous amounts of money, but that's just not a core consideration," said Joshua Sharfstein, a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health. "The situation a lot of patients feel like they're in is they're collateral in this financial tug of war."

TeamHealth and Envision Healthcare have poured millions into political ads attacking surprise billing legislation. The companies have said they want to settle out-of-network bills through arbitration instead of using average local rates, as some lawmakers have proposed.

As an alternative to going after patients themselves, TeamHealth said it sues insurers to demand higher payments for out-of-network charges. The company has filed 38 such lawsuits since 2018.

In the Texas case, two TeamHealth affiliates that provide doctors and nurses to emergency rooms in the Houston and El Paso areas sued a small insurance company called Molina Healthcare. TeamHealth identified almost 5,000 out-of-network claims in 2016 and 2017 for which it billed $6.6 million and Molina paid $760,000. TeamHealth sent a letter demanding that Molina pay $2.3 million. Molina's lawyers viewed this as an admission that the original bill was far higher than even TeamHealth thought was fair.

The actual costs of medical services are not a factor in setting TeamHealth's prices, according to the deposition of Kent Bristow, a TeamHealth executive in charge of revenue. At some locations, TeamHealth's prices were higher than those of 95% of other providers and eight or nine times more than what Medicare would pay, according to Bristow's deposition.

Most of the two TeamHealth affiliates' charges were never actually collected, according to their tax returns and a deposition of the accountant who prepared them. For the years 2016 and 2017, the two affiliates billed a combined $1.9 billion, the tax returns show. But $1.1 billion, or 58%, was discounted according to negotiated deals with insurers. An additional $528 million was written off as bad debt that would never get repaid. So the combined revenue that the two affiliates actually received across the two years was $274.5 million, or about 14% of the amount initially billed, according to the tax returns.

The amount that TeamHealth charges doesn't determine how much TeamHealth pays its doctors who perform those services, the company's chief financial officer, David Jones, said in an October 2019 deposition. Instead, the doctors are paid a base compensation plus an incentive tied to how much work they do (which is not the same as the price billed for their services). For the two TeamHealth affiliates in the Molina case in 2016 and 2017, the company paid doctors a total of $170.5 million, or 62% of the net revenue, according to the tax returns. Other health care providers such as nurse practitioners and scribes received another $48.4 million.

The administrative services that TeamHealth provides — such as billing, printing and malpractice insurance — added up to $29.5 million, according to the tax returns.

After covering all those expenses, the amount of money left over — commonly called profit — was $26.1 million, about 10% of the two affiliates' net revenue in 2016 and 2017. (The accounting method that TeamHealth uses for its tax returns is different from how it prepares

financial statements regulated by the Securities and Exchange Commission. Under the latter method, the tax returns note a total of $36.8 million for the two affiliates in 2016 and 2017. Because of these accounting variations, it's impossible to compare the figures on the TeamHealth affiliates' tax returns to profits reported by publicly traded health care companies.)

The TeamHealth executive in charge of the two affiliates said he assumed the profit would be shared with the doctors who did the work. "It would most likely go back to the providers," the executive, Lance Williams, said in a deposition. Under further questioning, he admitted, "Yeah, I'm not sure."

In fact, the entire leftover $26.1 million went to TeamHealth's "management fee." The management fee is not a fixed rate but rather everything that remains after covering costs, regardless of the amount, according to the CFO's deposition. "If the revenues exceed the expenses, that is essentially the management fee," Jones said.

In other words, out of the $1.6 billion that was originally billed but not collected, any additional dollar that TeamHealth managed to recover would be passed through to the corporate parent. The doctors would not see it.

Jones said doctors benefit from increasing collections because their incentive-based pay is adjusted over time. In addition, Bristow said the management fee is not the same as profit because there may be additional expenses at the corporate level.

"The economic benefits created by these practices, any profit, if you will, ultimately flows up to the TeamHealth entity," Ron Luke, a health economics expert hired by Molina, said in a deposition.

To establish this business model, TeamHealth had to find a way to deal with long-standing state laws that were specifically designed to protect the medical profession from becoming beholden to profit motives. These laws, known as the corporate practice of medicine doctrine, require doctors to work for themselves or other doctors, not lay people or corporations like TeamHealth. Court records in the Molina case show how TeamHealth's lawyers use shell entities to avoid directly employing doctors.

"TeamHealth monetizes this process by unilaterally setting charges and then billing patients and payors for those amounts and retaining all of the profits of the enterprise," Robert McNamara, a former president of the American Academy of Emergency Medicine, wrote in a memo as an expert witness against TeamHealth in the lawsuit. "The fees generated, billed, and retained by TeamHealth reflect the type of overt commercialization of

the medical profession that the prohibition on the [corporate practice of medicine] is designed to prevent."

TeamHealth said its business arrangements comply with all laws and no court or agency has ever found otherwise. "TeamHealth's clinicians are supported by a world-class operating team that provides them with comprehensive practice management services that allow our clinicians to focus on the practice of medicine," the company said. Envision Healthcare also said it follows all local, state and federal laws and regulations.

State laws against the corporate practice of medicine date as far back as the 19th century, as doctors strove to distinguish themselves from quacks and snake oil salesmen. According to the American Medical Association, the laws are meant to prevent profit motives from influencing medical judgments — a recognition that corporations' devotion to shareholder value shouldn't mix with doctors' Hippocratic oath.

Another way to think about it is: Practicing medicine requires a license, and only a real human being can possibly have the education, training and character qualifications that licensing boards require.

Courts have scrutinized these arrangements for decades. No judge has ever ruled that TeamHealth or Envision Healthcare specifically violate state licensing rules. But such allegations have repeatedly cropped up in lawsuits involving the companies, some of which settled favorably to the other side, according to McNamara, who was consulted on many of the cases.

003331

TeamHealth and Envision have themselves acknowledged that they operate on questionable legal ground. During periods when the companies were publicly traded, their investor disclosures highlighted the controversy surrounding their compliance with state licensing regimes. TeamHealth and Envision said they believed their business models were legal but recognized that prosecutors, regulators and judges could conclude otherwise. TeamHealth specifically cited "laws prohibiting general business corporations, such as us, from practicing medicine."

"While we believe that our operations and arrangements comply substantially with existing applicable laws relating to the corporate practice of medicine and fee splitting, we cannot assure you that our existing contractual arrangements, including restrictive covenant agreements with physicians, professional corporations and hospitals, will not be successfully challenged in certain states as unenforceable or as constituting the unlicensed practice of medicine or prohibited fee splitting," the company said in its 2015 annual report. "In this event, we could be subject to adverse judicial or administrative interpretations or to civil or criminal penalties, our contracts could be found to be legally

003331

invalid and unenforceable or we could be required to restructure our contractual arrangements with our affiliated provider groups."

TeamHealth says the laws are outdated and unnecessary — as one of the company's senior lawyers called it in a deposition, "this arcane law we call the corporate practice of medicine that nobody needs."

Not all states have such laws. In Florida, for instance, TeamHealth employs doctors directly. In states that have laws against the corporate practice of medicine, TeamHealth has a workaround depending on the specific requirements in that state. Here's how it works for the affiliates involved in the Molina litigation, just two out of hundreds of equivalent arrangements around the country.

Doctors working for TeamHealth are technically independent contractors to a "professional association," or P.A. In order to comply with Texas law, the professional association is owned by a licensed physician. The professional association then contracts with TeamHealth subsidiaries to provide administrative services — such as billing, payroll and malpractice insurance — in exchange for payment.

These professional associations, however, are hardly independent. They're "owned" by an executive at TeamHealth, and the company has the power to remove and replace him at any time. For the two professional associations involved in the Molina case, when a new executive took over as "owner" in 2019, he said in a deposition that he couldn't remember how he "bought" the entities or if he ever paid anyone the $2 nominal price of their shares.

"Everything about your right to own, operate, and manage ACS and EST [the two professional associations] is dependent upon you staying in the good graces of the TeamHealth organization, correct?" Molina's lawyer asked in the deposition.

"Correct," the owner/executive, Lance Williams, said.

"And if you were fired for any reason, you would lose ownership of ACS and EST, lose the right to manage ACS and EST, correct?"

"Correct."

Williams also said there's no "black and white" separation between clinical and financial issues.

In sum, the contract between TeamHealth and the professional associations gives investors more control of the business than doctors, according to Chuck Pine, a financial investigator who specializes in examining shell companies to determine the real beneficial owners. Pine isn't involved in the Molina litigation.

Molina's lawyers called the arrangement "a sham to permit TeamHealth to unlawfully practice medicine by allowing it to in effect employ physicians in violation of state law."

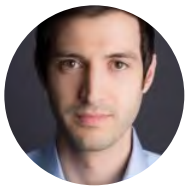
TeamHealth countered that whether or not Molina's claims are right, they aren't enforceable through private litigation; only the state's attorney general could prosecute a corporation for practicing medicine without a license.

The judge rejected Molina's claims in an order that didn't explain her rationale. Other parts of the case are still pending.

TeamHealth has used the same argument to defeat other lawsuits. It puts opponents in a Catch-22: State licensing boards have no control over a corporation that might be practicing medicine without a license because the boards don't license corporations. The boards could theoretically punish the "owners" of the professional associations, but those doctors are not always licensed in the same state as the practice, and TeamHealth could always replace them with someone else.

The Texas attorney general's office didn't respond to requests for comment. McNamara said he's brought several cases to the attention of various state attorneys general, to no avail.

Filed under: Health Care



Isaac Arnsdorf

Isaac Arnsdorf is a reporter at ProPublica covering national politics.

Isaac.Arnsdorf@propublica.org Isaac Arnsdorf

@iarnsdorf 202-886-9568 Signal: 203-464-1409

EXHIBIT 21

003334

003334

EXHIBIT 21

SDIS
PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **HEALTH CARE PROVIDERS' SECOND SUPPLEMENT TO NRCP 16.1 INITIAL DISCLOSURES**[1]

[1] The Health Care Providers made initial disclosures in federal court while awaiting remand.

003335

003335

Pursuant to **Rule 16.1 of the Nevada Rules of Civil Procedure ("NRCP")**, Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") (collectively, "Plaintiffs" or "Health Care Providers")[2], hereby supplement their initial disclosures **(in bold)** as follows:

I. INDIVIDUALS LIKELY TO HAVE DISCOVERABLE INFORMATION.

1. Based on information to date, Plaintiffs identify the individuals listed below as likely to have discoverable information under **NRCP** 26(b).

Name	Contact Information	General Subject Matter
Kent Bristow	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendant's[3] underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Paula Dearolf	265 Brookview Centre Way Suite 400 Knoxville, TN 37919 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally

[2] Although Team Physicians and Ruby Crest did not make the previous disclosures, they join in these disclosures as their initial disclosures in this matter.

[3] UnitedHealth Group, Inc., United Healthcare Insurance Company, United Health Care Services Inc., d/b/a Unitedhealthcare, UMR, Inc., d/b/a United Medical Resources, Oxford Health Plans, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc. and Health Plan of Nevada, Inc. shall collectively be referred to herein as "Defendants."

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003336

Name	Contact Information	General Subject Matter
		reduce payments due to Plaintiffs; and Plaintiffs' damages.
Greg Dosedel	c/o D. Lee Roberts, Jr. Colby L. Balkenbush **Brittany Llewellyn** Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
David Greenberg	1643 NW 136th Ave. Building H, Suite 100 Sunrise, FL 33323 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; Defendants' conduct in its negotiations with Plaintiffs; and Data iSight's representations made to Plaintiffs with respect to the amount to be paid for covered emergency medicine services provided by Plaintiffs to Defendants' insureds.
John Haben	c/o D. Lee Roberts, Jr. Colby L. Balkenbush **Brittany Llewellyn** Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003337

Name	Contact Information	General Subject Matter
		reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Rena Harris	8511 Fallbrook Ave. Suite 120 West Hills, CA 91304 This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Jacy Jefferson	c/o D. Lee Roberts, Jr. Colby L. Balkenbush **Brittany Llewellyn** Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Custodian of Records for National Care Network, LLC	211 E. 7th Street, Suite 620 Austin, TX 78701	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and the method for determining the payment made by Defendants to Plaintiffs.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003338

Name	Contact Information	General Subject Matter
Angie Nierman	c/o D. Lee Roberts, Jr. Colby L. Balkenbush **Brittany Llewellyn** Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Dan Rosenthal	c/o D. Lee Roberts, Jr. Colby L. Balkenbush **Brittany Llewellyn** Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Dan Schumacher	c/o D. Lee Roberts, Jr. Colby L. Balkenbush **Brittany Llewellyn** Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC 6385 South Rainbow Blvd. Suite 400 Las Vegas, NV 89118	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.
Jennifer Shrader	265 Brookview Centre Way, Suite 400 Knoxville, TN 37919	This witness is expected to have knowledge relating to the facts and circumstances surrounding the claims and defenses in this litigation, particularly

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003339

Name	Contact Information	General Subject Matter
	This witness may only be contacted through counsel of record: Pat Lundvall Kristen T. Gallagher. McDonald Carano LLP 2300 W. Sahara Ave., Suite 1200 Las Vegas, NV 89102	Defendants' underpayment of covered emergency medicine services provided by Plaintiffs to Defendants' insureds; the course of conduct that existed between Plaintiffs and Defendants prior to Defendants' decision to unilaterally reduce payments due to Plaintiffs; Plaintiffs' damages; and Defendants' conduct in its negotiations with Plaintiffs.

2. Any and all persons and entities identified by Defendants regarding this matter. **Plaintiffs reserve** the right to call any witness identified by any party in this matter.

II. DOCUMENTS.

1. Plaintiffs disclose the following documents[4] in support of its claims, defenses, and denials asserted in the **First Amended** Complaint:

Bates Start	Bates End	Document Description
FESM00001	FESM00003	July 2, 2019 letter re Provider Dispute Reconsideration/Appeal for the Physician Practices to United Healthcare Services in Atlanta, GA
FESM00004	FESM00004	Exhibit 1 to July 2, 2019 letter re Provider Dispute Reconsideration/Appeal for Physician Practices to United Healthcare Services in Atlanta, GA - CONFIDENTIAL
FESM00005	FESM00007	July 2, 2019 letter re Provider Dispute Reconsideration/Appeal for the Physician Practices to United Healthcare Insurance Company in Salt Lake City, UT
FESM00008	FESM00008	Exhibit 1 to July 2, 2019 letter re Provider Dispute Reconsideration/Appeal for Physician Practices to United Healthcare Insurance Company in Salt Lake City, UT- CONFIDENTIAL
FESM00009	FESM00009	Spreadsheet of United Healthcare NV ED Claims July 1, 2017-April 30, 2019 – Claims Allowed in Full- CONFIDENTIAL
FESM00010	FESM00010	Spreadsheet of United Healthcare NV ED Claims July 1, 2017-April 30, 2019 – WRAP Network Claims- CONFIDENTIAL
FESM00011	FESM00011	Spreadsheet of United Healthcare NV ED Claims July 1, 2017-April 30, 2019 – Litigation Claims- CONFIDENTIAL

[4] Documents bates-labeled FESM00001-FESM00341 (other than those withheld as confidential) were previously produced in Fremont's Response to Defendants' First Set of Requests for Production of Documents to Fremont dated July 29, 2019.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003340

Bates Start	Bates End	Document Description
FESM00012	FESM00018	March 19, 2019 letter re UHG Surprise Billing Chairmen Letter
FESM00019	FESM00104	Health Plan of Nevada, Inc. – Medicaid/Nevada Check-up Consulting Provider Agreement
FESM00105	FESM00107	Health Plan of Nevada, Inc. Consulting Provider Amendment
FESM00108	FESM00108	March 1, 2019 letter re Health Plan of Nevada and Fremont Emergency Services Termination Confirmation
FESM00109	FESM00117	September 10, 2018 letter re Request to Renegotiate or Terminate Intention
FESM00118	FESM00120	Sierra Health & Life Insurance Company, Inc. Amendment to Individual/Group Provider Agreement
FESM00121	FESM00200	Sierra Health & Life Insurance Company, Inc. Individual/Group Provider Agreement
FESM00201	FESM00203	Sierra Health & Life Insurance Company, Inc. Amendment to Individual/Group Provider Agreement
FESM00204	FESM00219	Sierra Health & Life Insurance Company, Inc. Individual/Group Provider Agreement
FESM00220	FESM00220	March 1, 2019 letter re Sierra Healthcare Options (Sierra Health and Life) and Fremont Emergency Services Termination Confirmation
FESM00221	FESM00223	Amendment to Medical Group Participation Agreement MGA Commercial Rate Increase
FESM00224	FESM00224	June 30, 2017 letter re United Healthcare and Fremont Emergency Services Termination Notification
FESM00225	FESM00255	December 19, 2014 letter re Executed Participation Agreement/Notice of Effective Date
FESM00256	FESM00256	March 9, 2017 letter
FESM00257	FESM00287	December 19, 2014 letter re Executed Participation Agreement/Notice of Effective Date
FESM00288	FESM00334	Complaint filed in Middle District of Pennsylvania against United Healthcare
FESM00256	FESM00341	Information on Payment of Out-of-Network Benefits
FESM00342	**FESM00342**	**Spreadsheet of United Healthcare NV ED Claims July 1, 2017-January 31, 2020 – Claims Allowed in Full-CONFIDENTIAL**
FESM00343	**FESM00343**	**Spreadsheet of United Healthcare NV ED Claims July 1, 2017- January 31, 2020 – WRAP Network Claims-CONFIDENTIAL**
FESM00344	**FESM00344**	**Spreadsheet of United Healthcare NV ED Claims July 1, 2017-January 31, 2020 – Litigation Claims-CONFIDENTIAL**
FESM00345	**FESM00349**	**Letter dated July 9, 2019 from Angie Nierman to Kent Bristow**
FESM00350	**FESM00352**	**Letter dated July 9, 2019 from Chris Parillo to Kent Bristow**
FESM00353	**FESM00355**	**Letter dated July 9, 2019 from Chris Parillo to Jennifer Shrader**

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003341

003341

In addition, the Health Care Providers further disclose the following documents: FESM00356-FESM01381.

2. All documents or other evidence identified in any pleadings or papers filed by any party in this matter or during discovery.

III. <u>DAMAGES COMPUTATION</u>.

Plaintiffs provide the following calculation of damages:

Plaintiffs seek damages described in the **First Amended** Complaint. Specifically, Plaintiffs' damages for its claims for relief are to be determined as (i) the difference between the lesser of (a) amounts Plaintiffs charged **for the specified emergency medicine services provided to Defendants' members** and (b) the reasonable value or usual and customary rate for its professional emergency medicine services and the amount Defendants unilaterally allowed as payable for the claims at issue in the litigation plus (ii) the Plaintiffs' loss of use of those funds. In addition, Plaintiffs seek damages based on the statutory penalties for late-paid and partially paid claims as set forth in the Nevada Insurance Code under its claim for violation of Nevada's prompt pay statutes. Plaintiffs also seek to recover treble damages and all profits derived from Defendants' knowing and willful violation of Nevada's consumer fraud and deceptive trade practices statutes. **Finally, Plaintiffs seek damages based on its eighth claim for relief for violation of NRS 207.350 *et seq.* Under NRS 207.470, Plaintiffs are entitled to recover three times the actual damages it has sustained, its attorneys' fees incurred in trial and appellate courts and its costs of investigation and litigation reasonably incurred.**

The reasonable value of and/or usual and customary rate for Plaintiffs' emergency medicine services in the marketplace will be determined by the finder of fact at trial. Plaintiffs will continue to gather information concerning those calculations and their total amount of damages, which will also be the subject of expert testimony. Plaintiffs' damages continue to accrue and will be amended, adjusted and supplemented as necessary during the course of this litigation as additional claims are adjudicated and paid by Defendants. Plaintiffs also seek punitive damages, attorneys' fees, costs and interest under each of the claims asserted in this action. Plaintiffs seek equitable relief for which a calculation of damages is not required by the Nevada Rules of Civil Procedure; however, Plaintiffs

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003342

003342

seek special damages under this claim.

Subject to the foregoing, Plaintiffs **have** provide**d** Defendants with a spreadsheet providing the details for each of the claims at issue in this litigation regarding the services provided, the billed charges for the services provided and the amount Defendants adjudicated as payable, among other information. For the claims with dates of services through **January 31, 2020**, the difference between the Plaintiffs' billed charges and the amounts allowed by Defendants as payable is approximately **$20,998,329** prior to any calculation of interest due thereon.

IV. INSURANCE AGREEMENTS.

Plaintiffs are not currently aware of any relevant insurance agreements.

Plaintiffs' investigation and discovery concerning this case is continuing, and, if additional information is obtained after the date of these disclosures, Plaintiffs will supplement these disclosures.

DATED this 1st day of June, 2020.

McDONALD CARANO LLP

By: /s/ *Amanda M. Perach*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com
Attorneys for Plaintiffs

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003343

003343

003343

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 1st day of June, 2020, I caused a true and correct copy of the foregoing **HEALTH CARE PROVIDERS' SECOND SUPPLEMENT TO NRCP 16.1 INITIAL DISCLOSURES** to be served to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

D. Lee Roberts, Jr.
Colby L. Balkenbush
Brittany Llewellyn
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
lroberts@wwhgd.corn
cbalkenbush@wwhgd.corn
bllewellyn@wwhgdcorn

Attorneys for Defendants

/s/ Marianne Carter
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003344

003344

EXHIBIT 22

003345

EXHIBIT 22

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
MARSHALL DIVISION

UNITED STATES OF AMERICA, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	
STATE OF CONNECTICUT, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	
STATE OF FLORIDA, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	
STATE OF GEORGIA, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	
STATE OF INDIANA, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	Civil Action No. 2:16-CV-00432-JRG
STATE OF LOUISIANA, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	**PLAINTIFF'S FIRST AMENDED COMPLAINT FOR DAMAGES UNDER THE FEDERAL FALSE CLAIMS ACT AND VARIOUS STATE FALSE CLAIMS ACTS AND DEMAND FOR JURY TRIAL**
COMMONWEALTH OF MASSACHUSETTS, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	
STATE OF TENNESSEE, *ex rel.* Caleb Hernandez & Jason Whaley, Relators, AND	§	
STATE OF TEXAS, *ex rel.* Caleb Hernandez & Jason Whaley, Relators,	§	
Plaintiffs,	§	
v.	§	
TEAM HEALTH HOLDINGS INC., TEAM FINANCE, L.L.C., TEAM HEALTH INC., & AMERITEAM SERVICES, L.L.C.,	§	
Defendants.	§	

PLAINTIFFS' FIRST AMENDED COMPLAINT

Relators CALEB S. HERNANDEZ, D.O. and JASON W. WHALEY, PA-C, (collectively "Relators" or individually "Relator") in the above-styled action bring this suit on behalf of the United States of America (the "United States") and the States of Connecticut, Florida, Georgia, Indiana, Louisiana, Tennessee, and Texas, and the Commonwealth of Massachusetts (collectively hereinafter the "Plaintiff States") against Defendants TEAM HEALTH HOLDINGS, INC., TEAM FINANCE, L.L.C., TEAM HEALTH, INC., and AMERITEAM SERVICES, L.L.C. (collectively hereinafter "Defendants" or "TeamHealth"). Relators bring this action pursuant to the *qui tam* provisions of the Federal False Claims Act, 31 U.S.C. § 3729 *et. seq*. ("FCA"), and analogous state laws.[1]

I. INTRODUCTION

1. TeamHealth is an emergency room management company that operates hospital emergency departments across the nation. TeamHealth provides staffing, operation, and billing services to emergency departments as an outside contractor, promising to increase efficiency and profitability in exchange for a share of the emergency departments' earnings. TeamHealth emergency departments frequently render healthcare services to beneficiaries of public healthcare programs administered by the Centers for Medicare and Medicaid Services ("CMS")[2] and the Plaintiff States. This case is about two fraudulent schemes (the "Schemes") that TeamHealth has used for years to obtain grossly overpaid reimbursements from these public healthcare programs.

003347

[1] Connecticut False Claims Act, Conn. Gen. Stat. §§ 4-274 *et. seq.*; Florida False Claims Act, Fl. Stat. §§ 68.081 *et. seq.*; Georgia False Medicaid Claims Act, Ga. Code Ann. §§ 49-4-168 *et. seq.*; Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code §§ 5-11-5.7-1 *et. seq.*; Louisiana Medical Assistance Programs Integrity Law, La. Rev. Stat. Ann. §§ 46:437.1 *et seq.*; Massachusetts False Claims Act, Mass. Gen. Laws Ch. 12 §§ 5B *et. seq.*; Tennessee Medicaid False Claims Act, Tenn. Code §§ 71-5-181 *et. seq.*; and the Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code §§ 36.002 *et. seq.*

[2] The Centers for Medicare & Medicaid Services ("CMS") is a federal agency within the United States Department of Health and Human Services ("HHS") that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program ("CHIP"), and health insurance portability standards. CMS oversees the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

2. **The first Scheme is the "Mid-Level Scheme."** Under the Mid-Level Scheme, TeamHealth overbills for services provided by "mid-level" practitioners. The term "mid-level" refers to non-physician healthcare providers, such as Physician Assistants ("PAs") and Nurse Practitioners ("NPs"). Under CMS rules, a mid-level's services are reimbursed at 85% of the standard physician rate, while services rendered by a physician are reimbursed at 100% of the standard physician rate. These rates and percentages are set by CMS, and the Plaintiff States have largely, if not entirely, adopted these same rates and percentages for reimbursement.

3. The appropriate rate payable for service rendered to a CMS beneficiary is automatically triggered by the National Provider Identifier ("NPI") submitted with the claim for reimbursement. Services rendered by a mid-level should be submitted under the mid-level's NPI, triggering the 85% rate. Services rendered by a physician should be submitted under the physician's NPI, triggering the 100% rate. However, as outlined in ¶¶ 2-6, herein, and stated with more particularity in §§ V-IV, *infra* (principally § V.B), TeamHealth—*through its billing policies, procedures, and protocols* (which include training and guidelines)*, and through its coordinated operation and influence over its subsidiaries and affiliated professional entities*—systematically submits claims for mid-level services under various physicians' NPIs (*as assigning charts to a physician by a midlevel is usually based on shift assignments and how shifts overlap*), triggering the 100% rate when in fact the 85% rate applied. TeamHealth does this intentionally and has done so for years.

4. Through its billing policies and practices, TeamHealth attempts to cover up the Mid-Level Scheme by characterizing mid-level services as "split/shared." Under CMS rules, "split/shared" services occur when both a mid-level and a physician treat the same patient during the same visit, such that the services are split or shared between a mid-level and a physician. When this

happens, the mid-level's services may be billed under the physicians' NPI at 100% of the physician rate.[3] However, true split/shared visits are exceedingly rare at TeamHealth facilities—they almost *never* occur. This is because TeamHealth requires mid-levels to treat patients alone, maximizing mid-levels' efficiency and profitability. To cover this up, TeamHealth requires[4] its healthcare providers to falsify medical records to reflect a split/shared visit when none actually occurred.

5. TeamHealth accomplishes this cover-up in two ways. First, TeamHealth requires its mid-levels to indicate on medical records that a physician was involved in each patient encounter, when in fact a physician never saw the patient. Second, TeamHealth requires on-duty physicians to sign mid-level medical records, again suggesting that the physician treated the patient. The result is a medical record that appears to indicate that a split/shared visit occurred. TeamHealth then sends these falsified medical records to a coding and billing employee who "relies" on the falsified record to submit claims for reimbursement under the physician's NPI. This results in the mid-level's services being reimbursed at 100% of the physician rate.

6. TeamHealth employs this Scheme through its billing policies and practices to bill federal and state governments for millions of dollars for the services concerned. Through the Scheme, TeamHealth has fraudulently obtained tens of millions of dollars every year since it began employing the Mid-Level Scheme nationwide in or around 2002 (the year the 85% regulation was established).

7. **The second Scheme is the "Critical Care Scheme."** This Scheme is a classic upcoding scheme. Under the Critical Care Scheme, TeamHealth bills CMS for "critical care"—the

[3] CMS calls such joint treatment "Split" or "Shared" visits. *See* MEDICARE CLAIMS PROCESSING MANUAL, Chapter 12 - Physicians/Nonphysician Practitioners, at § 30.6.1 (2018), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf (last visited Sept. 24, 2018).

[4] As used throughout this Complaint whenever referencing what TeamHealth "requires," the term "require" means that TeamHealth has made the issue concerned a protocol, business practice, policy, procedure, matter of training and/or something that can be, and is, used to threaten employment if there they do not comply.

highest level of emergency treatment—when in fact critical care services were not rendered and/or were not medically necessary, thereby submitting false claims through fraudulent billing.[5] Because of the heightened skill and decision-making critical care requires, CMS reimburses providers for critical care services at a significantly higher rate than ordinary emergency services. To capitalize on this up-charge, TeamHealth requires its providers to (1) meet stated critical care quotas each month; (2) falsify critical care on patient medical records when the care they provided did not meet CMS critical care requirements; and/or (3) perform and chart critical care services when those services were not medically necessary. Again "relying" on falsified medical records, TeamHealth coding and billing employees submit claims for reimbursement for the critical care services reflected in the patient chart.

8. TeamHealth employs this Scheme through its billing policies and practices to bill federal and state governments for millions of dollars for the services concerned. Through the Scheme, TeamHealth has fraudulently obtained multiple millions of dollars through the Critical Care Scheme *each year* since at least 2008 (when the critical care regulations were last updated).

9. Both of TeamHealth's Schemes clearly violate CMS's and the Plaintiff States' billing regulations and guidelines. TeamHealth perpetrates both Schemes on a nationwide basis. Additionally, both Schemes defraud CMS and the Plaintiff States of tens of millions of dollars each year, with the exact amount being known only to private accounting of the TeamHealth defendants. In this action, Relators seek damages, civil penalties, and other remedies under the FCA and analogous laws of the Plaintiff States arising from TeamHealth's two fraudulent Schemes.

[5] Critical care is a heightened level of treatment necessary when a patient has a high probability of imminent or life threatening deterioration that requires healthcare providers to exercise a higher degree of medical decision-making and devote longer periods of time to that patient's treatment. *See* MEDICARE CLAIMS PROCESSING MANUAL, Chapter 12 - Physicians/Nonphysician Practitioners, at § 30.6.12 (2018).

II. PARTIES

A. THE RELATORS

10. Relator CALEB S. HERNANDEZ, D.O., is a citizen of the United States of America and is a resident of the State of New York. Since becoming a licensed physician, Dr. Hernandez has been employed as an emergency physician in numerous emergency departments in Arizona, Colorado, Kansas, Missouri, and the Caribbean. He brings this *qui tam* action based upon direct and unique information he obtained during his employment at the following hospital emergency departments managed and/or operated by TeamHealth: the North Colorado Medical Center in Greely, Colorado (from 2011 to 2015); Sterling Regional Medical Center in Sterling, Colorado (from 2013 to 2015); and Juan Luis Phillipe Hospital in St. Croix, United States Virgin Islands (in 2010). Through his work as an emergency physician at these TeamHealth emergency departments, and through his work for TeamHealth as an independent contractor, Dr. Hernandez has acquired direct personal knowledge of and non-public information about TeamHealth's fraudulent billing for reimbursement from federal and state healthcare payers.

11. Relator JASON W. WHALEY, PA-C, is a citizen of the United States of America and is a resident of the State of Colorado. Mr. Whaley holds active PA licenses in Colorado and Wyoming and inactive licenses in California, Nebraska and Alaska. He brings this *qui tam* action based upon direct and unique information obtained during his employment at the emergency department at North Colorado Medical Center, located in Greeley, Colorado (from 2011 to 2013), which was and is operated and/or managed by TeamHealth. Through his work as a PA at this TeamHealth emergency department, and through his work for TeamHealth as an independent contractor, Mr. Whaley has acquired direct personal knowledge of and non-public information about TeamHealth's fraudulent billing for reimbursement from federal and state healthcare payers.

B. DEFENDANTS

12. Defendants are a system of affiliated entities operating as and collectively referred to herein as "TeamHealth." TeamHealth is a national healthcare practice management company that is one of the largest suppliers of outsourced physician staffing and administrative services to hospitals in the United States. TeamHealth operates in at least forty-seven states and employs at least 13,000 healthcare professionals.

13. Defendant, TEAM HEALTH HOLDINGS, INC., is a corporation that is organized under the laws of Delaware and has its principal place of business in Knoxville, Tennessee. Team Health Holdings, Inc. was acquired in 2017 in a $6.1 Billion take-private deal.[6] Team Health Holdings, Inc. professes to be a holding company that conducts no operations, with no employees, Further, Team Health Holdings, Inc. claims its only material asset(s) to be its membership interests in Team Finance, L.L.C.

14. Defendant, TEAM FINANCE, L.L.C. is a subsidiary of Team Health Holdings, Inc. that is organized under the laws of Delaware. Because Team Finance, L.L.C. takes the citizenship of its member, Team Health Holdings, Inc., it is likewise a citizen of the States of Delaware and Tennessee.

15. Defendant, TEAM HEALTH, INC., is a subsidiary of Defendant Team Health Holdings, Inc., and does business under the name of "TEAMHEALTH." Team Health, Inc. is a Delaware corporation with its principle place of business at 265 Brookview Centre Way, Suite 400, Knoxville, Tennessee. Although—as of October of 2014—it has claimed to be a holding company

[6] On February 6, 2017, Team Health Holdings, Inc. announced the successful completion of its acquisition by funds affiliated with Blackstone, a global asset manager, and certain other investors, including Caisse de dépôt et placement du Québec ("CDPQ"), the Public Sector Pension Investment Board ("PSP Investments"), and the National Pension Service of Korea ("NPS") for $43.50 per share in cash, valued at approximately $6.1 billion. TeamHealth announced the transaction on October 31, 2016, and received approval from TeamHealth's stockholders on January 11, 2017. As a result of the transaction, TeamHealth is now a privately held company.

that conducts no operations and has no employees, Team Health, Inc., alone or through its subsidiaries, has carried out operations and employed employees within the TeamHealth system.[7]

16. Defendant, AMERITEAM SERVICES, L.L.C., is Tennessee Limited Liability Company and is an administrative and support services subsidiary of Defendant Team Health Holdings, Inc., which employs officers and other TeamHealth affiliated representatives, including those who are members of the referenced departments, committees and TeamHealth's purported [FCA] Compliance Advisory Group. Its principal place of business and mailing address is 265 BROOKVIEW CENTRE WAY, STE 400 KNOXVILLE, TN 37919-4052 USA—the same address as the other TeamHealth defendants. It does business under the name of "TEAMHEALTH." It was created in Tennessee in October 2014 and reportedly has one member, Tennessee Parent, Inc., which Blackstone created to facilitate the take-private deal.

III. VENUE, CONDITIONS PRECEDENT, AND JURISDICTIONAL ALLEGATIONS

17. This Court has jurisdiction over this action under 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1331 and 1345 because this civil action arises under the laws of the United States.

18. Relators bring this action under the FCA, 31 U.S.C. § 3729 *et. seq.*, to recover treble damages, civil penalties, and costs of suit, including reasonable attorneys' fees and expenses. Relators have authority to bring this action and their claims on behalf of the United States pursuant to 31 U.S.C. §§ 3730(b) and 3730(e)(4), and Relators have satisfied all conditions precedent to their

[7] The fact that Team Health Holdings, Inc. purportedly has no employees indicates that its own corporate functions, are significantly shared, coordinated and/or dependent upon its subsidiaries and/or the personnel operating those subsidiaries, through which Team Health Holdings, Inc. has extended its FCA policies and procedures to all of its subsidiaries and affiliated professional entities. As such, Team Health Holdings, Inc. is used as a cloak or disguise to escape corporate liability. Team Health Holdings, Inc. is so organized and controlled, and its affairs are so conducted, as to make it an instrumentality or adjunct of TEAM HEALTH, INC. and the personnel operating TEAM HEALTH, INC. (before October of 2014) and AMERITEAM SERVICE, L.L.C. and the personnel and entities operating AMERITEAM SERVICES, L.L.C. (after October of 2014) for purposes of the FCA and for purposes of the fraudulent schemes complained of herein. The nature of AMERITEAM SERVICES, L.L.C., as provided in ¶ 16, *infra*, also indicates that the operational structure of TeamHealth serves to shield the proceeds of the fraudulent schemes concerned.

participation as Relators. Pursuant to 31 U.S.C. § 3730(e)(4)(A), the allegations contained herein have not been publicly disclosed as defined by the FCA, or alternatively, Relators qualify as "original sources" within the meaning of 31 U.S.C. § 3730(e)(4)(A) and (B). Pursuant to 31 U.S.C. 3730(e)(4)(B), Relators have voluntarily provided in writing to the Attorney General of the United States and the United States Attorney's Office for the Eastern District of Texas, prior to filing this complaint, substantially all material evidence and information in Realtors' possession upon which these allegations are based. In accordance with 31 U.S.C. § 3730(b)(2), Relators served the United States pursuant to Federal Rule of Civil Procedure 4 prior to filing this complaint.

19. This Court has jurisdiction over Relators' state law claims pursuant to 31 U.S.C. § 3732, as those claims arise from the same transaction or occurrence as Relators' claim under § 3729. Additionally, this Court has supplemental jurisdiction over Relators' state law claims pursuant to 28 U.S.C. §1367(a), as those claims form part of the same case or controversy under Article III of the United States Constitution as relators' claim under the federal FCA. Relators have complied with all state law procedural requirements, including service upon the appropriate state Attorneys General prior to filing this action.

20. This Court may exercise personal jurisdiction over TeamHealth because TeamHealth transacts business within the State of Texas, in accordance with the Texas Long Arm Statute, Tex. Civ. Prac. & Rem. Code §§ 17.041-17.042. Moreover, TeamHealth purposefully directs its services at the State of Texas, thereby purposefully availing itself of the privilege of conducting business within Texas and invoking the benefits and protections of its laws. This action arises out of that conduct. This Court's exercise of jurisdiction over the Defendant does not offend traditional notions of fair play and substantial justice.

21. Venue is proper in the Eastern District of Texas pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)–(c). TeamHealth can be found in, resides in, and/or transacts business in this judicial District. Additionally, one or more of the Defendants committed acts proscribed by 31 U.S.C. § 3729 in this judicial District. Specifically, during the relevant time period, TeamHealth has transacted business with and/or on behalf of at least the following hospital emergency departments located within the Eastern District of Texas: (1) the Christus St. Mary Hospital in Port Arthur, Texas; (2) the Longview Regional Hospital in Longview, Texas; and (3) Methodist Urgent Care in The Colony, Texas.

IV. LEGAL AND REGULATORY FRAMEWORK

The Medicare Program and Federal Administration

22. Medicare[8] provides "nearly every American 65 years of age and older a broad program of health insurance designed to assist the nation's elderly to meet hospital, medical, and other health costs."[9] Medicare is funded in part by taxpayer revenue. In 2015, Medicare spending totaled $646.2 billion and accounted for 20% of the total healthcare spending in the United States.[10] Unfortunately, "[f]raud and systematic overcharging are estimated at roughly $60 billion, or 10 percent, of Medicare's costs every year."[11]

[8] Medicare is the popular name for the Health Insurance for the Aged and Disabled Act, which is title XVIII of the Social Security Act. Medicare is a federally funded program administered by CMS. CMS is part of the Department of Health and Human Services ("DHHS").

[9] CMS, MEDICARE GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT MANUAL, pub. 100-01, Ch. 1 § 10 (2015), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c01.pdf (hereinafter "MEDICARE GENERAL INFORMATION MANUAL").

[10] NHE FACT SHEET, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html (last visited Aug. 10, 2017).

[11] Reed Abelson & Eric Lichtblau, *Pervasive Medicare Fraud Proves Hard to Stop*, N.Y. TIMES, Aug. 15, 2014, http://www.nytimes.com/2014/08/16/business/uncovering-health-care-fraud-proves-elusive.html.

23. Medicare is comprised of three primary insurance programs—Medicare Parts A, B, and D—that cover different types of healthcare needs.[12] Medicare Part A (Hospital Insurance) covers institutional care such as inpatient hospital care, nursing services, drugs and biologicals necessary during an inpatient stay, and other diagnostic or therapeutic services.[13] Medicare Part B (Supplementary Medical Insurance) covers non-institutional care such as physician services, medical equipment and supplies, and services performed by qualified mid-levels under the supervision of a physician.[14] Medicare Part D (Drug Coverage) covers the cost of prescription drugs.[15]

24. Under Medicare's programs, the federal government reimburses healthcare providers for their labor and medical decision-making on a fee-for-service basis according to predetermined fee schedules, including the Medicare Physician Fee Schedule ("MPFS"), which establishes annual rates for more than 10,000 services provided by physicians and other healthcare professionals.[16] The MPFS-established rates correspond to specific codes associated with each medical procedure or service provided. The American Medical Association publishes these codes, called Current Procedural Terminology ("CPT") codes, annually.

[12] Medicare also includes Medicare Part C (also called Medicare Advantage), which is not a separate benefit, but a program whereby private companies approved by Medicare provide coverage under Medicare Part A and Part B. *See* HOW DO MEDICARE ADVANTAGE PLANS WORK?," https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/how-medicare-advantage-plans-work.html (last visited Mar. 10, 2016).

[13] CMS, MEDICARE BENEFIT POLICY MANUAL, pub. 100-02, Ch. 1, Table of Contents (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf (hereinafter "MEDICARE BENEFIT POLICY MANUAL").

[14] MEDICARE GENERAL INFORMATION MANUAL at Ch. 1 § 10.3. Medicare Part B also covers emergency department services. *See* MEDICARE.GOV, EMERGENCY DEPARTMENT SERVICES, https://www.medicare.gov/coverage/emergency-dept-services.html (last visited Mar. 10, 2016).

[15] MEDICARE.GOV, DRUG COVERAGE (PART D), https://www.medicare.gov/part-d/ (last visited Mar. 29, 2016).

[16] *See* CMS, HOW TO USE THE SEARCHABLE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) at 1 (Apr. 2014), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/How_to_MPFS_Booklet_ICN901344.pdf. CMS also has fee schedules for ambulance services, clinical laboratory services, and durable medical equipment, prosthetics, orthotics and supplies. FEE SCHEDULES – GENERAL INFORMATION, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html?redirect=/feeschedulegeninfo (last visited Mar. 10, 2016).

25. The process by which healthcare providers submit claims for and receive reimbursement involves several steps and various entities. First, physicians and mid-levels must clearly and sufficiently document patient encounters in their medical charts. To ensure clear and complete documentation, CMS has developed specific documentation guidelines that it requires healthcare providers to use—the 1995 Documentation Guidelines for Evaluation and Management Services and 1997 Document Guidelines for Evaluation and Management Services.[17] Evaluation and Management ("E/M") documentation is the process of documenting medical decision-making and care during a patient encounter so that coders can translate services into the five-digit CPT codes as CMS requires for billing purposes.[18]

26. In addition to selecting the appropriate CPT codes, the coder must submit the provider's National Provider Identifier ("NPI") and Provider Transaction Access Number ("PTAN") for billing. The NPI identifies the individual healthcare provider that performed the services to be reimbursed. The PTAN identifies the practice group or company for whom the provider works.

27. CMS reimburses different types of healthcare providers at different rates. For example, as discussed in detail below, CMS typically reimburses mid-levels at 85% of the full physician rate under federal statute and CMS regulations. As such, the coder must assign the appropriate provider's NPI to avoid improper billing, as the NPI triggers the billing rate for any particular E/M service. Once a coder assigns the appropriate CPT codes and NPI to a medical record, healthcare providers submit claims to a fiscal intermediary called a Medicare Administrative Contractor ("MAC") based on their geographical location. The MAC then processes the claims and reimburses the provider according to Medicare's fee schedule. MACs are typically private insurance

[17] Providers may use either the 1995 or the 1997 Guidelines, but not a combination of the two.

[18] *See* CMS, EVALUATION AND MANAGEMENT SERVICES GUIDE at 3-5 (November 2014), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf.

companies that the federal government has contracted to process Medicare claims. MACs are responsible for the majority of enforcement efforts when it comes to Medicare claims. For its part, CMS "manually reviews just three million of the estimated 1.2 billion claims it receives each year"—or 0.25% of all claims submitted.[19] Thus, over 99% of submitted claims evade CMS review.

The Medicaid Program and State Administration

28. The Medicaid Program ("Medicaid") is a Health Insurance Program administered by federal and state agencies. Both state and federal taxpayer revenue fund the Medicaid program. The United States Health and Human Services Department ("HHS") oversees the administration of the program. Medicaid assists participating states in providing medical services, durable medical equipment, and prescription drugs to financially-needy individuals that qualify for Medicaid.

29. While the federal government sets basic guidelines and pays between 50% and 80% of the cost of Medicaid (depending on the state's per capita income), each state itself administers the program, decides provider qualifications, and reimburses providers for their services.

30. Under Title XIX of the Social Security Act, each state must establish an agency to administer its Medicaid program according to federal guidelines. The following table provides the Plaintiff States' Medicaid administrative agency and designated program name:

State	Department	Medicaid Program Name
Connecticut	Department of Social Services	Husky Health
Florida	Agency for Health Care Administration	Florida Medicaid
Georgia	Department of Community Health	Georgia Medicaid
Indiana	Office of Medicaid Policy and Planning	Indiana Health Coverage Programs
Louisiana	Department of Health	Healthy Louisiana

[19] Reed Abelson & Eric Lichtblau, *Pervasive Medicare Fraud Proves Hard to Stop*, N.Y. TIMES, Aug. 15, 2014, http://www.nytimes.com/2014/08/16/business/uncovering-health-care-fraud-proves-elusive.html.

Massachusetts	Department of Health and Human Services	MassHealth
Tennessee	Division of Health Care Finance and Administration	TennCare
Texas	Health and Human Services Commission	Texas Medicaid

The False Claims Act

31. The False Claims Act ("FCA"), 31 U.S.C. §§ 3729 *et. seq*, provides, in pertinent part, that any person who

> (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; [or]
>
> ***
>
> (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,
> is liable to the United States Government [for statutory damages and such penalties as are allowed by law].

31 U.S.C. § 3729(a)(l), (7) (2006), amended by 31 U.S.C. § 3729(a)(l)(A), (G). The False Claims Act further provides that "knowing" and "knowingly"

> (A) mean that a person, with respect to information--
> (i) has actual knowledge of the information;
> (ii) acts in deliberate ignorance of the truth or falsity of the information; or
> (iii) acts in reckless disregard of the truth or falsity of the information; and
> (B) require no proof of specific intent to defraud.

31 U.S.C. § 3729(b) (2006), amended by 31 U.S.C. § 3729(b)(l). Violations of the kind described herein—the upcoding of mid-level services and improper billing of critical care—are material to the government's decision to reimburse for those services.

V. FACTUAL ALLEGATIONS

32. Relators allege two fraudulent Schemes through which TeamHealth unlawfully pads its pockets with federal and state funds.

33. In subsection A, Relators provide a detailed background on TeamHealth's business practices. TeamHealth's corporate culture—which is outlined in subsection A, *infra*—facilitates and

fuels the Schemes; those TeamHealth providers who further the Schemes reap rewards, while those TeamHealth providers who challenge the fraud face threats and disciplinary action.

34. In subsection B, Relators provide a detailed description of TeamHealth's Mid-Level Scheme through which TeamHealth submits false claims to CMS to receive reimbursement for mid-level E/M services at the full physician rate.

35. In Subsection C, Relators provide a detailed description of TeamHealth's Critical Care Scheme through which TeamHealth submits false claims to CMS for critical care services that were not provided or were not medically necessary.

A. BACKGROUND

36. TeamHealth is among the nation's largest and most profitable physician practice management companies ("PPMs"). PPMS provide management and human-resources services to hospitals and, in particular, to emergency departments. For decades, the healthcare industry has blamed PPMs, and TeamHealth specifically, for ushering in the era of corporate practice of emergency medicine—one where companies like TeamHealth promote profits over patient welfare. TeamHealth has been at the top of the PPM industry since its inception in the 1970s and is a poster child for this profits-based approach to emergency medicine. When healthcare companies prioritize profits over patient care, reimbursement fraud is the likely result. This is precisely the case with TeamHealth.

37. PPMs emerged as a cottage industry in the late 1960s and early 1970s. They grew astronomically as "it became widely appreciated that 'there was gold in them there hills' of emergency services."[20] In the 1990s, as competition escalated, the largest PPMs, including

[20] Brian J. Zink, M.D., ANYONE, ANYTHING, ANYTIME: A HISTORY OF EMERGENCY MEDICINE, 246 (Mosby, Inc. 2006).

TeamHealth, went to Wall Street to either merge with or become publicly traded companies. An industry historian describes this evolution as follows:

> At a time when all of medicine was becoming more business-oriented, emergency medicine evolved into the most fertile field for corporate growth, profits, and exploitation. The entrepreneurs were clever about keeping a step ahead of government regulations and the health care marketplace in building their empires.[21]

38. Indeed, TeamHealth has systematically employed clever, albeit unlawful, strategies to become a national revenue leader in the multi-billion-dollar healthcare management industry. TeamHealth generates the vast majority of its revenue by billing third-party payers, such as CMS or private insurers, for the services its healthcare providers provide. In 2015 alone, TeamHealth reported a total net revenue of $6 billion, with over 50% of that revenue coming from public-payer reimbursements: 25.4% paid by Medicare and 31.5% paid by Medicaid.

39. TeamHealth's business model is based not on quality of care but on reducing emergency department costs and increasing their revenues. TeamHealth promises to improve their clients' bottom lines in three primary ways: (1) treat and bill more patients by increasing patient "flow"; (2) cut costs by employing mid-level providers in place of more costly physicians; and (3) capture more revenue through TeamHealth's proprietary coding and billing practices.

40. First, an integral part of TeamHealth's business model is moving patients through the emergency department as quickly as possible—*i.e.*, increasing "flow." TeamHealth uses a variety of administrative or procedural techniques it adopted from the manufacturing industry, including floor management. TeamHealth primarily utilizes floor management techniques called "split-flow" modeling and the "zone" modeling, which segregating physicians and mid-levels into different areas of the emergency room. These floor-management models enable TeamHealth to increase revenue by:

[21] *Id.* at 256.

(1) creating more bed space to increase the volume of patients treated, and (2) using lower cost staffing, *i.e.*, mid-levels, to treat more patients.

41. Second, TeamHealth's business model seeks to reduce costs by relying heavily on mid-level service providers, such as PAs and NPs, in place of physicians. TeamHealth compensates these mid-levels at a lower rate than physicians. Using mid-levels instead of physicians to treat patients reduces TeamHealth's operating costs. TeamHealth derives significant revenue by submitting claims to CMS for reimbursement for mid-level services. And, as described herein (particularly in § V.B, *infra*), TeamHealth has crafted a fraudulent Scheme to obtain reimbursement from CMS for mid-level services at the full physician rate. Thus, TeamHealth maximizes its revenue by relying heavily on lower-paid mid-levels to provide care, while collecting reimbursements from CMS at the full physician rate.

42. Finally, TeamHealth's business model relies on the implementation of national, standardized billing and coding practices aimed at capturing as much revenue as possible from third-party payers like CMS. TeamHealth contracts with hospitals to provide TeamHealth's standardized coding and billing services and performs many of these services at off-site locations across the United States. Coding is the process by which a coder translates a patient's medical record into billable services identified by CPT codes, which TeamHealth then submits to CMS (or private insurers) for reimbursement.

43. TeamHealth's corporate culture and business model facilitates and encourages fraudulent behavior in its emergency departments. As former TeamHealth employees, Relators have witnessed first-hand several unlawful practices that TeamHealth utilizes to fraudulently increase billing to and reimbursement from CMS. Through their personal knowledge, experience, and investigation, Relators have uncovered the two unlawful Schemes described herein—Schemes that

TeamHealth systematically and purposely uses to submit false claims to CMS and state payors. In simple terms, TeamHealth carries out both Schemes by requiring healthcare providers to falsify electronic medical records ("EMRs" or "medical charts"), which TeamHealth coders then use to support up-coding and overbilling of emergency services. Thus, TeamHealth uses the Schemes to bill for services that were not in fact provided or medically necessary.

B. THE MID-LEVEL SCHEME

Summary

44. Through its first Scheme—the Mid-Level Scheme—TeamHealth fraudulently overbills for mid-level services by submitting claims to CMS for E/M services performed by a mid-level under a physician's NPI. Though CMS rules only allow for reimbursement of mid-level services at 85% of the standard physician rate, by submitting claims for mid-level E/M services under a physician's NPI, TeamHealth improperly obtains 100% of the physician rate. Essentially, TeamHealth falsely indicates to CMS that a physicians performed the services at issue, when in fact a mid-level performed them. This is akin to a law firm billing clients for legal services performed by an associate at senior partner rates. This is clear fraud.

45. As way to partially cover up the Mid-Level Scheme, TeamHealth falsifies underlying medical charts to invoke the CMS split/shared visit exception. That is, TeamHealth requires its mid-levels and physicians to indicate in mid-level medical charts that both a mid-level *and* a physician provided care. A true split/shared visit occurs when both a physician and a Mid-Level treat the same patient on the same day.[22] When a true split/shared visit occurs, CMS will allows the mid-level's services to be submitted under the physician's NPI, such that the mid-level's services will be reimbursed at 100% of the physician rate. This is because, when a physician and mid-level treat a

[22] *See* Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, at § 30.6.1 (2018), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf (last visited Sept. 24, 2018).

patient together, the mid-level's services are an extension of the physician's services. This exception rewards facilities and healthcare providers for providing extra attention to patients when necessary. However, split/shared visits are rarely necessary and therefore almost *never* actually occur at TeamHealth emergency rooms. Nonetheless, TeamHealth requires its healthcare providers to falsify medical charts to reflect a split/shared visit when, in reality, a physician never even saw the mid-level's patient. This presumably provides TeamHealth with at least some cover (in the unlikely event of an audit) when it submits claims for mid-level services under the physician's NPI.

46. TeamHealth has employed this practice since 2002 (the year the 85% regulation was established) at every emergency department TeamHealth manages across the nation. TeamHealth's Mid-Level Scheme clearly violates CMS billing regulations and guidelines. TeamHealth perpetrates the Scheme on a nationwide basis and, through it, defrauds CMS of tens of millions of dollars each year, in direct relationship to the millions of dollars it bills federally-funded healthcare programs for the referenced services.

CMS Reimbursement of Mid-Level Services and the Shared Visit Exception

47. Mid-level healthcare professionals—PAs and NPs—work under the general supervision of physicians but have attained a higher level of education or training than nurses. Accordingly, they are commonly referred to as mid-levels. A qualified mid-level is permitted by law to provide services without his or her supervising physician being physically present or reviewing each patient seen by the mid-level.[23] As such, Congress and CMS have developed specific regulations and requirements that must be met in order for services provided solely by mid-levels to

[23] *See* Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants, Medicare Learning Network (2016), available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf (last visited Sept. 24, 2018).

be reimbursed. The billing rates for services provided by mid-levels differ based on the healthcare setting in which the services were provided and the supervising physician's level of involvement. According to Medicare, typical mid-level services shall be billed at 85% of the physician billing rate for E/M services.[24] *See* 42 U.S.C. § 1395l(a)(1)(O). The 85% rate is triggered when the claim for a mid-level's services is submitted under the mid-level's NPI. To determine the allowable fee for a service provided by a mid-level—and properly submitted under the Mid-Level's NPI—Medicare will select the proper amount based on the physician fee schedule and discount that amount by 15% to reach the appropriate 85% mid-level billing rate.

48. Through its Mid-Level Scheme, TeamHealth wholly ignores federal regulations and requirements governing mid-level reimbursement rates by submitting mid-level services under physicians' NPIs. As a national provider of Medicare and Medicaid services, TeamHealth cannot deny its knowledge of and familiarity with these important rules. TeamHealth has knowledge of the falsity of the claims it submits under this Scheme—whether by actual knowledge, deliberate ignorance, or reckless disregard.

49. When TeamHealth submits a mid-level claim under a physician's NPI, CMS presumes the services were performed by a physician rather than a mid-level and, thus, reimburses the claims based on full physician fee schedule without any discount.

50. CMS provides an exception to the 85% rule in the emergency department context. That exception—the split/shared visit exception—permits providers to bill mid-level services at 100% of the physician rate ***if and only if*** the mid-level performs services in conjunction with a

[24] The Medicare statute specifically states, "with respect to services described in 1861(s)(2)(K) [42 USCS § 1395x(s)(2)(K)] (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 [42 USCS § 1395w-4], or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery[.]" 42 U.S.C. § 1395l(a)(1)(O).

supervising physician, such that both the mid-level and the physician treat the same patient on the same day and work in the same patient medical chart. In such a scenario, CMS considers the services to be split or shared between both practitioners and, thus, *all* services—including the mid-level's—may be submitted under the physician's NPI. This is because the physician will have either directly supervised the mid-level or, in the very least, reviewed the mid-level's notations in the patient's chart prior to the patient being discharged, ensuring appropriate care.

51. Importantly, a split/shared visit requires that both the physician and the mid-level provided a substantive portion of the visit face-to-face with the patient. Simply put, both the physician and the mid-level must lay eyes on the patient and directly treat the patient. To be properly billed under the physician's NPI, a mid-level's split/shared services must be supported by documentation from both the physician and the mid-level. A physician's signature alone on a Mid-Level's chart is *not* sufficient to justify billing the mid-level services at the physician rate.[25]

52. Because of this documentation requirement, TeamHealth frequently attempts to cover up its Mid-Level Scheme by requiring mid-levels to indicate physician involvement in their medical charts—even when no such involvement occurred. This is often accomplished through an "attestation" in which the mid-level clicks a box in the EMR indicating he or she was supervised by a physician. TeamHealth then requires its on-duty physicians to sign mid-level charts at the end of the shift and, many times, to attest to supervising the mid-level. TeamHealth simply divides and randomly assigns mid-level charts to on-duty physicians and requires physicians to sign the charts assigned to them.

53. Typically, by the time a physician signs mid-level charts at the end of their shift, the patients who were treated by the mid-level have already been discharged from the emergency

[25] *See* CMS, Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors 4 (April 2013), www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908625.pdf.

department. In some cases, physicians may be assigned mid-level charts for patients seen by mid-levels in the *prior* shift when the signatory physician was not even on-site.

54. After the physician signs a mid-level chart, the result is a patient medical record that appears to indicate a split/shared visit occurred when in fact the mid-level treated the patient alone. In the case of an audit by CMS, TeamHeath hopes these charts will provide plausible deniability. However, a closer review of the chart will quickly reveal that the physician did not provide any face-to-face treatment of the patient, which is fatal to split/share claim.

Segregation of Physicians and Mid-Levels

55. In TeamHealth facilities, patients are assigned to either a physician or a mid-level depending on the severity of the patient's condition or injury. However, in TeamHealth facilities, physicians and mid-levels are housed in different areas of the emergency department. As such, direct interaction between physicians and mid-levels is exceedingly rare, and it is equally rare for a patient to see both a physician *and* a mid-level. This is intentional, as it prevents overlap and maximizes the number of patients each individual healthcare provider is able to treat. TeamHealth intentionally coordinates its physicians, mid-levels, and billing throughout the Scheme and thereby profits from the results. Under TeamHealth's floor-management models, it is extremely rare that mid-levels and physicians ever see the same patient or even discuss a patient's diagnosis or treatment plan.

56. This is important because, under the Mid-Level Scheme, TeamHealth submits claims for reimbursement related to mid-level services under a physician's NPI, but it is *highly unlikely* that the physician whose NPI was used ever saw or talked to the mid-level that actually performed the services being billed.

The Mid-Level Scheme: EMR Falsification

57. During or immediately following treatment, the mid-level will create and complete an EMR (electronic medical chart) for the patient, documenting all of the elements of treatment, which will be used for billing later. These elements include a detailed or comprehensive medical history, physical examination, identification of medicines administered, tests ordered, images ordered, and a description of the medical decision making required. There are several industry-standard software programs used to create and complete EMRs, and such software is implemented in all of TeamHealth's emergency departments.

58. After the mid-level completes the patient visit and fills out the EMR, TeamHealth requires mid-levels to indicate that he or she was supervised by a physician during the patient's treatment—even though physicians and mid-levels typically do not interact at all. TeamHealth strongly encourages healthcare providers to create macros—autocomplete functions with pre-prepared text indicating supervision—for their attestation and, in many cases, provides healthcare providers with the language that should be used in such macros. At the end of the mid-level's shift, every chart he or she created will indicate physician supervision, when in reality no physician involvement occurred whatsoever.

59. After the mid-level finalizes and signs the EMR, TeamHealth requires physicians to "countersign" mid-level charts or EMRs. The mid-level EMRs are typically sent to the physicians via email or through the EMR software's internal messaging system (which contains inboxes for each healthcare provider in the emergency department). In the rare circumstance that paper charts are used at a particular TeamHealth-managed facility, the mid-level paper charts will be randomly divided and distributed to on-duty physicians for counter-signature.

60. TeamHealth tells its employees that physician countersignatures are required for the mid-level services to be billed and reimbursed. That is, TeamHealth's explanation to its employees is that mid-levels' services cannot be billed *at all* without a physician signature. This is wrong. There is no such CMS requirement. Mid-level services that are reflected in an EMR can be billed *under the mid-levels' NPI* without a physician signature—triggering the appropriate 85% billing rate.[26] But, TeamHealth takes advantage of the system and its employees by requiring physician signature (for no legitimate billing reason) and then submitting mid-level claims under a physician NPI.

61. For their part, physicians have no option to disagree with the care or documentation provided by the mid-level. The physicians are not actually present to supervise the mid-level. Given TeamHealth's protocols, it is common that the patient has already left the facility by the time the physician reviews and signs the mid-level patient's chart. The signing physician has no option to change the plan of care—her only options are (1) to sign the chart and continuing working at TeamHealth, or (2) refuse to sign the chart and risk her employment (as explained below).

62. Whatever the case, the following is certainly true: Every emergency physician is *required* to sign and approve some amount of mid-level charts or EMRs at the end of each shift. TeamHealth has no good reason for doing this other than to commit fraud. In the vast majority of cases, it would have been physically impossible for the physician to have actually supervised the mid-level during the shift, let alone interacted with the mid-level or the patient.

The Mid-Level Scheme: Evidence of Fraud

63. The physical impossibility of physician involvement is corroborated by the statements of a former TeamHealth coder, **Confidential Witness No. 1 ("CW1")**. CW1 was

[26] *See* Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants, Medicare Learning Network (2016), available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf (last visited Sept. 24, 2018).

employed by TeamHealth as an Emergency Department Coder from February 2012 until August 2013 in Jacksonville, Florida. CW1 received patient charts directly from TeamHealth-managed hospitals and translated the physician services in the charts into codes, which were then submitted for billing. CW1 explained that, at TeamHealth, a physician signature on a patient's chart meant that the physician supervised the PA, was physically present during the patient encounter, saw the patient and the treatment provided with his or her own eyes, and agreed with the mid-level's diagnosis and treatment plan. However, in reviewing patient charts, CW1 discovered on several occasions that, due to the timing of physician signatures on the charts, physicians would have had to have been in two or more places at one time to have actually seen the patient as indicated by the physician's signature.

64. Nonetheless, TeamHealth administrators adamantly insist that physicians countersign outstanding charts, often sending threatening emails to physicians requesting countersignatures. These TeamHealth administrators also repeatedly press mid-levels to list a supervising physician on all patient charts, regardless of whether the physician had any involvement with the patient or any interaction with the mid-level regarding the patient.

65. When a mid-level submits a chart to TeamHealth's coding department without a physician's signature, the chart is sent back to the mid-level by a TeamHealth documentation specialist with a note to add a supervising physician. CW1 explained that the most common reason a chart would be returned to a hospital for further documentation was a missing physician signature. TeamHealth ensures charts are submitted as instructed through threats of suspension and withholding compensation. When a physician fails or refuses to countersign Mid-Level charts, TeamHealth threatens that the physician will lose his or her privileges, be pay-docked, or even fired.

66. Once the physician-signed charts (or EMRs) are completed and sent to the billing department, coding and billing specialists working for TeamHealth then reduce the falsified charts to

CPT codes for E/M services and select the *physician's* NPI for billing purposes, despite the fact that the physician performed no services at all. Based on information and belief, coding and billing specialists working for TeamHealth are trained or told that, when a physician has signed and/or attested to a mid-level chart, that means the physician's NPI should be use for billing purposes. With this training, the chosen CPT codes (which are usually entered into an electronic database program for ease of processing) are then submitted to CMS through a MAC under the physician's NPI, such that the claims are reimbursed at the full physician rate instead of the proper 85% rate. Thus, TeamHealth systematically submits false claims to CMS.

67. Under CMS practices, claims for mid-level and physician E/M services are "pass through" claims for billing purposes. This means there is little or no front-end review or auditing of these charges—the MAC pays them automatically. In essence, the reimbursement system for the E/M services at issue here is an honor system.

68. Moreover, CMS does not require underlying EMRs to be submitted along with requests for reimbursement for E/M services. This means that CMS cannot perform a medical chart or EMR review to determine where TeamHeath's claims are accurate. As such, these claims go unnoticed by CMS and are automatically paid. TeamHealth takes advantage of this "pass-through" honor system.

69. A former TeamHealth employee, **Confidential Witness No. 2 ("CW2")**, corroborates the nature and prevalence of TeamHealth's Mid-Level Scheme. CW2 was employed as an Accounts Receivable Specialist at TeamHealth's corporate headquarters in Lewisville, Tennessee from October 2013 to January 2015. While a TeamHealth employee, CW2 dealt with Medicare billing on behalf of TeamHealth in numerous states, including North Carolina, Pennsylvania, New York, South Carolina, Texas, California and Michigan. CW2 was responsible for denials and appeals

for emergency department professional billings at TeamHealth-managed hospitals—*i.e.*, the type of claim at issue here.

70. CW2 commonly reviewed electronic and paper CSM claims submissions. When Medicare denied a claim, CW2 would personally review the underlying EMR in search of the reason for the claim denial. When reviewing EMRs and claims forms, CW2 often observed mid-level signatures on the charts, indicating that mid-levels were involved in the treatment of the patient. However, even when a mid-level had signed a patient's chart, ***only a physician's name and NPI were transferred to the claims form and submitted to CMS***. In other words, TeamHealth submitted the NPI of the physician in order to claim reimbursement for the Mid-Level's services at the full 100% physician rate, as if each patient encounter were a shared visit.

71. **Confidential Witness No. 3 ("CW3")** worked at TeamHealth's Knoxville, TN facility in 2010 and 2011 as Billing Operations Analyst. CW3 was responsible for analyzing reimbursement claim denials and fielding customer billing complaints. CW3 explained that she regularly received calls from patients complaining that a physician's name appeared on their bill when they had not been treated by a physician at all. CW3 would then access the patient's underlying medical record to determine if a physician's signature was present. However, CW3 could not confirm from the chart whether the physician actually treated the patient. TeamHealth instructs its billing professionals that a physician's name is required on billing and claims documents, even if the physician did not see or treat the patient. Billing professionals like CW3 relay this misinformation to complaining customers, presumably to appease them. However, TeamHealth bills emergency room claims under physician NPIs.

72. TeamHealth knowingly submits false claims to CMS for mid-level services under physicians' NPIs for reimbursement at the full physician rate. TeamHealth perpetrates its Scheme by

coordinating the actions of its employees—and their implementation of its billing policies and procedures—throughout all Team Health Holdings, Inc. subsidiaries. It secures its unlawful profits in holding companies that do not have employees.

73. TeamHealth systematically perpetrates the Mid-Level Scheme nationwide and extends to and through all TeamHealth subsidiaries and affiliated entities. It is operated, administered, and supported throughout all of the Team Health Holdings. Inc. subsidiaries and affiliated entities through the subsidiaries TEAM HEALTH, INC. and AMERITEAM SERVICES, L.L.C. and their subsidiaries. Relators observed the exact same policies regarding Mid-Level charting and physician countersignatures at every TeamHealth emergency department that employed them. The uniform nature of the Mid-Level Scheme is also corroborated by former TeamHealth employees, including CW1 and CW2.

74. TeamHealth's Mid-Level Scheme violates CMS regulations governing reimbursement for E/M services performed by mid-levels and thus the FCA. TeamHealth systematically perpetrates this fraudulent scheme on a nationwide basis.

C. TEAMHEALTH'S CRITICAL CARE SCHEME

Summary

75. TeamHealth's second Scheme—the Critical Care Scheme—is classic upcoding. TeamHealth fraudulently bill CMS for critical care services which were either not provided or not medically necessary. TeamHealth requires its healthcare providers to manipulate medical charts to support billing for ordinary emergency services at the higher "critical care" rate. Critical care is a heightened level of emergency treatment necessary when a patient has a severe medical condition (usually, an imminently life-threatening condition) that requires healthcare providers to exercise a higher degree of medical decision-making and devote undivided attention to that patient's

treatment.[27] CMS reimburses providers for critical care services at a much higher rate than ordinary emergency services. Thus, TeamHealth views critical care reimbursement as a lucrative opportunity.

76. TeamHealth imposes unrealistic critical care quotas—typically 6% of patient encounters or more—on healthcare providers and threatens to pay-dock, suspend, or terminate those providers who fail to meet such quotas. Of course, TeamHealth and its employees have no control over the severity of the injuries and illnesses that their patients present with. True critical care situations should account for approximately 1% or less of emergency cases. Thus, to meet the quotas, TeamHealth trains providers to falsify medical charts to indicate that critical care is required when, in fact, only ordinary emergency treatment is required. TeamHealth then uses the falsified medical charts to submit claims to CMS at the higher critical care rate.

77. TeamHealth has been upcoding for critical care since at least 2008 (when the critical care regulations were last updated) at every emergency department TeamHealth manages across the nation. This Critical Care Scheme too accounts for millions of dollars in overpayment by CMS to TeamHealth every year.

78. Under the Critical Care Scheme, TeamHealth requires physicians to falsify medical charts to show that critical care was performed when it was not required and submits claims to CMS for reimbursement at the higher critical care rate based on the falsified charts. TeamHealth sets monthly or quarterly quotas for critical care that must be met by healthcare providers at each of its facilities. TeamHealth openly discusses with its employees the fact that these critical care quotas are in place to drive revenue.

79. As with the Mid-Level Scheme, TeamHealth forces healthcare providers to comply with its critical care policies by threatening pay reduction, privilege suspension, and even firing.

[27] *See* Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, at § 30.6.12 (2018), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf (last visited Sept. 24, 2018).

However, healthcare providers have no control over the amount of true critical care that will be required in any given time period. Thus, to meet the quotas, TeamHealth encourages its healthcare providers to document critical care for patients who only required ordinary (*i.e.*, non-critical) emergency care. TeamHealth's Critical Care Scheme violates CMS regulations and the FCA.

CMS Reimbursement of Critical Care Services

80. Like the Mid-Level Scheme, the Critical Care Scheme begins when a patient enters a TeamHealth-operated emergency department. During or immediately after the administration of medical care, the provider completes the EMR (electronic medical record) like any other patient encounter, notating the required elements—*i.e.*, a detailed or comprehensive medical history, physical examination, identification of medicines administered, tests ordered, images ordered and a description of the medical decision making required. The EMR will indicate to the coder the level of care provided.

81. CMS divides emergency medical treatment into five levels of care based on severity of the condition(s) presented. Level 1 represents the lowest severity condition, and Level 5 represents the highest severity condition. The higher the severity level, the higher the reimbursement rate CMS will pay. Specifically, according to the CMS Physician Fee Schedule, a Level 1 patient encounter is reimbursed at $21.60, a Level 5 at $176.04, and Levels 2, 3, and 4 at amounts in between.[28] These reimbursement rates are flat payments and are *not* based on the amount of time the provider spends with the patient. Thus, a Level 1 encounter will be reimbursed at $21.60 whether it lasts 10 minutes or 2 hours.

82. However, there is a level of care above Level 5: "critical care." Critical care is the level of treatment and decision-making required by the highest severity conditions and can generally

[28] The reimbursement rates quoted above and listed below were obtained using CMS's Physician Fee Schedule Lookup Tool for 2015B at the National Payment Amount (available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html?redirect=/pfslookup/).

be described as that level of care required by imminently life-threatening emergency conditions. Specifically, CMS defines "critical care" as "physician(s) medical care for a critically ill or critically injured patient," whose "critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." MEDICARE CLAIMS PROCESSING MANUAL at Ch. 12, § 30.6.12(A) (emphasis added).

83. True critical care conditions are rare and typically account for approximately 1% of all emergency department visits, with the overwhelming majority of critical patients ultimately being admitted to critical care units within the hospital.[29] According to CMS, "[c]ritical care involves high complexity decision making to assess, manipulate, and support vital system functions(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition." *Id.* at § 30.6.12(A). Further, all critical care services must be *medically necessary* and reasonable. *Id.* at § 30.6.12(B) (emphasis added).

84. Due to its complex nature, CMS reimburses critical care at a higher rate than ordinary emergency care. Also, unlike Levels 1 through 5, critical care billing is based on the amount of time the physician spends treating the critical patient such that the more time a physician administers critical care, the more reimbursement money the emergency department will receive. The chart below shows the 2018 National Payment billing rates for Level 1 through critical care:

CPT Code	**2018 Medicare Reimbursement Amount (National Payment Amount)**
99281 (ED Level 1)	$21.60
99282 (ED Level 2)	$42.12
99283 (ED Level 3)	$63.00
99284 (ED Level 4)	$119.52
99285 (ED Level 5)	$176.04

[29] *See* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756824/. ("Between 2001 and 2009, annual visits by critically ill patients to U.S. EDs increased by 79% from 1.2 to 2.2 million. The proportion of ED visits resulting in admission to a critical care bed increased by 75% from 0.9% to 1.6%."). *See also* https://www.cdc.gov/nchs/fastats/emergency-department.htm.

99291 (Critical Care, 1st 30-74 min)	$226.80
99292 (Critical Care, subsequent 30 min)	$113.55

The Critical Care Scheme: EMR Falsification

85. According to TeamHealth, critical care provides a lucrative opportunity to increase reimbursement revenues. Indeed, the first 30 minutes of critical care alone provide a minimum of $50 in additional revenue over and above an hours-long Level 5 encounter.

86. Thus, TeamHealth sets minimum quotas for critical care billing that it expects healthcare providers to meet—typically 6% of all patient encounters. TeamHealth administrators circulate communications to employees of TeamHealth-managed emergency departments, indicating that TeamHealth physicians should be billing critical care in the 6-12% range. These administrators further encourage TeamHealth providers to bill critical care time and to capitalize on opportunities to improve critical care billing. TeamHealth's quotas do not jive with the national critical care admission rate of approximately 1%.

87. To be reimbursed for critical care, a physician must properly record his or her critical care treatment in the EMR. To qualify for critical care billing, the treating physician must specifically document in the EMR that he or she performed "critical care" (using those words) and notate the amount of time (typically in minutes) such critical care was administered.

88. In order to meet TeamHealth's unrealistic critical care quotas, TeamHealth requires physicians to provide this documentation for encounters in which critical care treatment was not necessary and to capitalize by maximizing every possible minute of critical care billing.

89. Healthcare providers working for TeamHealth are desensitized to this over-charting and upcoding because TeamHealth constantly hammers them with training that contradicts the medical education that providers received during medical school or residency. During such training, TeamHealth redefines what constitutes critical care for its healthcare providers. In addition,

TeamHealth publicly calls out healthcare providers who fail to document critical care in situations where TeamHealth claims they should.

90. TeamHealth's training (or re-training) sessions are often conducted by non-physician coders. Further, TeamHealth coding specialists also regularly send "feedback" to healthcare providers, attaching specific patient charts and instructing them on what additional information should have been included so that a chart can meet the higher-revenue critical care billing requirements. TeamHealth has designed a uniform policy that encourages healthcare providers to memorize those medical conditions that, according to TeamHealth, will require critical care every time. TeamHealth systematically perpetrates this one-size-fits-all Critical Care Scheme nationwide, rather than relying on trained healthcare professionals to provide the level of care they believe to be most appropriate. TeamHealth emergency departments even have "critical care committees" that meet periodically to monitor critical care billing levels and brainstorm about how to increase those billing levels.

91. Evidencing this one-size-fits all approach to critical care charting, TeamHealth physicians typically use uniform critical care language in their EMR charts, such that the charts are merely rubber stamped with inexact statements such as "Performed critical care for 30-74 minutes." This language simply parrots the CMS critical care requirements so that TeamHealth can "check the box" for critical care billing. Indeed, often times, TeamHealth EMRs contain literal boxes next to this type of formulaic language that a treating physician will click or check. Each such click means more money for TeamHealth.

92. TeamHealth uses the falsified medical records to upcode for nonexistent or unnecessary critical care. With knowledge of the falsity of the medical records, TeamHealth

knowingly submits false claims for reimbursement to CMS and state agencies for the reimbursement at the higher critical care rates.

93. Relators observed the same policies with respect to critical care at every TeamHealth emergency department they have worked in. At every TeamHealth-managed facility the Relators worked at, healthcare providers were encouraged and/or required to increase the amount of critical care they performed and were consistently told that critical-care billing was a priority.

94. Importantly, as with the charges for mid-level billing, TeamHealth is able to disguise these fraudulent claims in plain sight because a critical care claim is a "pass through" claim for billing purposes, meaning there is no front-end auditing of these charges. The absence of the risk of auditing emboldens TeamHealth to encourage the submission of fraudulent claims for reimbursement of critical care services with impunity. And, even if TeamHealth is required to submit underlying EMRs (such as, in accordance with an ad hoc audit or probationary period implemented by a MAC), the EMRs will theoretically evidence the provision of critical care, when in fact critical care was not required or medically necessary.

95. It is evident that the Critical Care Scheme is a company-wide policy. National and regional TeamHealth administrators often send emails to TeamHealth physicians and Mid-Levels instructing and reminding them of TeamHealth's critical care policy.

VI. CAUSES OF ACTION

Count One
Violation of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A)

96. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

97. The FCA, 31 U.S.C. § 3729(a)(1)(A) imposes liability upon those who knowingly present or cause to be presented false claims for payment or approval to the United States government.

98. When submission of such false claims are discovered by private citizens, the FCA allows those citizens to bring an action on behalf of the United States against the perpetrators. 31 U.S.C. § 3730(b)(1).

99. Through their conduct, Defendants have knowingly submitted, or caused to be submitted, false claims for payment, as set forth above, in violation of 31 U.S.C. § 3729(a)(1).

100. Specifically, as alleged herein, Defendants have submitted false claims for reimbursement for evaluation and management ("E/M") services performed solely by non-physician practitioners (mid-levels) in TeamHealth emergency departments as if they were performed by or in conjunction with a physician. TeamHealth fraudulently overbills for mid-level services by submitting claims to CMS for E/M services performed by a mid-level under a physician's NPI. Though CMS rules only allow for reimbursement of mid-level services at 85% of the standard physician rate, by submitting claims for mid-level E/M services under a physician's NPI, TeamHealth improperly obtains 100% of the physician rate.

101. Further, as alleged herein, Defendants have submitted false claims for reimbursement for un-necessary or non-existent "critical care. TeamHealth requires its providers to (1) meet stated arbitrary critical care quotas each month; (2) falsify critical care on patient medical records when the care they provided did not meet CMS critical care requirements; and/or (3) perform and chart critical care services when those services were not required, medically necessary, or otherwise proper for reimbursement. Again "relying" on falsified medical records, TeamHealth coding and billing

employees submit claims for reimbursement for the critical care services reflected in the patient chart.

102. Relators have brought this action pursuant to 31 U.S.C. § 3730(b)(1) and provided a Disclosure Statement to the United States in compliance with § 3730(b)(2).

103. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., CMS would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

104. By reason of Defendants' actions, the United States has incurred and continues to incur damages.

Count Two
Violation of the Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(B))

105. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

106. Section 3729(a)(1)(B) of the FCA imposes liability upon those who make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim to the United States government. *See* 31 U.S.C. § 3729(a)(1)(B).

107. Through their conduct, Defendants have made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, as set forth above, in violation of 31 U.S.C. § 3729(a)(1)(B).

108. Specifically, as alleged herein, Defendants have submitted false claims for reimbursement for evaluation and management ("E/M") services performed solely by non-physician practitioners (mid-levels) in TeamHealth emergency departments as if they were performed by or in conjunction with a physician. TeamHealth fraudulently overbills for mid-level services by submitting claims to CMS for E/M services performed by a mid-level under a physician's NPI. Though CMS

rules only allow for reimbursement of mid-level services at 85% of the standard physician rate, by submitting claims for mid-level E/M services under a physician's NPI, TeamHealth improperly obtains 100% of the physician rate.

109. Further, as alleged herein, Defendants have submitted false claims for reimbursement for un-necessary or non-existent "critical care. TeamHealth requires its providers to (1) meet stated arbitrary critical care quotas each month; (2) falsify critical care on patient medical records when the care they provided did not meet CMS critical care requirements; and/or (3) perform and chart critical care services when those services were not required, medically necessary, or otherwise proper for reimbursement. Again "relying" on falsified medical records, TeamHealth coding and billing employees submit claims for reimbursement for the critical care services reflected in the patient chart.

110. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., CMS would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

111. By reason of Defendants' actions, the United States has incurred and continues to incur damages.

Count Three
Violation of the Connecticut False Claims Act,
CONN. GEN. STAT. § 4-274 *et seq.*

112. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

113. Similar to Medicare, the Connecticut Medicaid rules reimburse services provided by NPs at a rate below the physician's rate. Specifically, Connecticut reimburses for the services of NPs at a rate of ninety percent (90%) of the department's fees for physician procedure codes. *See* Conn.

Agencies Regs. § 17b-262-617. Also similar to Medicare, Connecticut Medicaid rules and regulations provide for reimbursement of services provided by PAs at a rate below the physician's rate. Specifically, Connecticut Medicaid reimburses for services rendered by a PA at ninety percent (90%) of the physician department's fees for physician procedure codes. *See* Conn. Agencies Regs. § 17b-262-347; *see also* Connecticut Medical Assistance Program, Policy Transmittal 2013-19, PB 2013-40 (July 2013).

114. Like Medicare, the Connecticut Medicaid rules also reimburse for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care. *See, e.g.*, Connecticut Medical Assistance Program Enhanced Fee Schedule, at 32 (March 30, 2016).[30]

115. The Connecticut False Claims Act imposes liability upon those who knowingly present, or cause to be presented, false or fraudulent claims for payment or approval under a state-administered health or human services program. Conn. Gen. Stat. §§ 4-274, 4-275. Additionally, it imposes liability upon those who knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim under a state-administered health or human services program. *Id.*

116. Through their conduct, Defendants have knowingly presented or caused to be presented, false or fraudulent claims for reimbursement, as set forth above, to the Connecticut Medicaid program in violation of Connecticut General Statute § 4-275.

117. Through their conduct, Defendants have additionally knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, as set forth above, in violation of Connecticut General Statute § 4-275.

[30] The Connecticut Medical Assistance Program Enhanced Fee Schedule is available online at https://www.ctdssmap.com/CTPortal/Portals/0/StaticContent/Publications/Fee_Schedule_Instructions.pdf.

118. Relators bring this action in accordance with the civil action provision in Connecticut General Statute § 4-277 and have served a copy of this Complaint and written disclosure of substantially all material evidence and information on the Connecticut Attorney General as provided thereunder.

119. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

120. By reason of Defendants' actions, the State of Connecticut has incurred and continues to incur damages.

Count Four
Violation of the Florida False Claims Act,
FL. STAT. § 68.081 *et seq.*

121. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

122. Florida statutes enable the Agency for Health Care Administration to establish the maximum allowable fee for providers through Medicaid rules, policy manuals and handbooks. Fl. Stat. §§ 409.901(2), 409.908. Similar to Medicare, the Florida Agency rules allow for reimbursement for PA services and NP services at a rate below the physician rate, specifically at eighty percent (80%) of the physician rate. Florida Medicaid Practitioner Services Coverage and Limitations Handbook (April 2014), Ch. 3, § 3-6.

123. Also, like Medicare, the Florida Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary,

or non-critical, levels of care. *See, e.g.*, Florida Medicaid Practitioner Fee Schedule (January 1, 2016).[31]

124. The Florida False Claims Act imposes liability upon those who knowingly present or cause to be presented a false or fraudulent claim for payment or approval and those who knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim. Fl. Stat. § 68.082(2).

125. Through their conduct, Defendants have knowingly presented or caused to be presented false or fraudulent claims for approval, as set forth above, to the Florida Medicaid system in violation of Florida Statute § 68.082(2).

126. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, as set forth above, in violation of Florida Statute § 68.082(2).

127. Relators bring this action in accordance with the civil action provision in Florida Statute § 68.083(2) and have complied with all requirements therein.

128. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

129. By reason of Defendants' aforementioned actions, the State of Florida has incurred and continues to incur damages.

Count Five
Violation of the Georgia State False Medicaid Claims Act,
GA. CODE § 49-4-168

[31] The Florida Medicaid Practitioner Fee Schedule is available online at http://portal.flmmis.com/FLPublic/Portals/0/StaticContent/Public/FEE%20SCHEDULES/2016-01-01_Practitioner_Fee_Schedule_v1-2.pdf.

130. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

131. Similar to Medicare, Georgia Medicaid rules limit reimbursement for services provided by a Physician Assistant to no more than 90% of the maximum allowable amount paid to a physician. *See* Georgia Department of Community Health, Division of Medicaid, Policies and Procedures for Physician Services Handbook Ch. 1001.

132. Also, like Medicare, the Georgia Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care. *See, e.g.*, Georgia Department of Community Health, Georgia Medicaid Management Information System, Schedule of Maximum Allowable Physician Payments (April 2016).[32]

133. The Georgia State False Medicaid Claims Act imposes liability upon those who knowingly present or cause to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval and those who knowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim to the Georgia Medicaid program. Ga. Code § 49-4-168.

134. Through their conduct, Defendants have knowingly presented or caused to be presented to the Georgia Medicaid program false or fraudulent claims for payment or approval, as set forth above, in violation of Georgia Code § 49-4-168.

[32] The Georgia Medicaid Practitioner Fee Schedule for April 2016 is available online at https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FEE%20SCHEDULES/Schedule%20of%20%20Maximum%20%20Allowable%20Payments%20Physician%20April%202016%2014-03-2016%20213423.pdf.

135. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to the Georgia Medicaid program, as set forth above, in violation of Georgia Code § 49-4-168.

136. Relators assert this claim in accordance with the civil action provision in Georgia Code § 49-4-168.2 and have complied with all requirements therein.

137. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

138. By reason of the Defendants' actions, the State of Georgia has incurred and continues to incur damages.

Count Six
Violation of the Indiana Medicaid
False Claims and Whistleblower Protection Act,
IND. CODE § 5-11-5.7-1 *et seq.*

139. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

140. Similar to Medicare, the Indiana Medicaid rules allow for reimbursement of services provided by NPs at a rate below the physician's rate, specifically at seventy-five percent (75%) of the physician rate on file. Indiana Health Coverage Programs BR 200422 (June 1, 2004).

141. Also, like Medicare, the Indiana Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care.[33]

[33] The Indiana Health Coverage Programs allows the most recent Fee Schedules to be downloaded at the following URL: http://provider.indianamedicaid.com/ihcp/Publications/MaxFee/fee_home.asp.

142. The Indiana Medicaid False Claims and Whistleblower Protection Act imposes liability upon those who knowingly present, or cause to be presented, a false claim to the State of Indiana for payment or approval and those who make, use, or cause to be made or used, a false record or statement that is material to a false or fraudulent claim. Ind. Code § 5-11-5.7-2.

143. Through their conduct, Defendants have knowingly presented, or caused to be presented, false claims to the State of Indiana for payment or approval, as set forth above, in violation of Indiana Code § 5-11-5.7-2.

144. Through their conduct, Defendants have also made, used, or caused to be made or used, false records or statements that are material to false or fraudulent claims submitted to the State of Indiana for payment or approval, as set forth above, in violation of Indiana Code § 5-11-5.7-2.

145. Relators assert this claim in accordance with the civil action provision in Indiana Code § 5-11-5.7-4 and have complied with all requirements therein.

146. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., CMS would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

147. By reason of Defendants' actions, the State of Indiana has incurred and continues to incur damages.

Count Seven
Violation of the Louisiana Medical Assistance Programs Integrity Law,
LA. REV. STAT. § 46:437.1 *et seq.*

148. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

149. Similar to Medicare, Louisiana Medicaid rules allow for reimbursement of services provided by NPs and PAs at a rate below the physician rate, specifically at eighty percent (80%) of

the fee for physician services. Louisiana Medicaid Professional Services Fee Schedule, Report No. RF-0-76 (Jan. 1, 2016).

150. Also, like Medicare, the Louisiana Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care. *See* Louisiana Medicaid Program, *Professional Services Provider Manual*, Ch. 5, Sect. 5.1.[34]

151. The Louisiana Medical Assistance Programs Integrity Law imposes liability upon those who knowingly present or cause to be presented a false or fraudulent claim and those who knowingly engage in misrepresentation or make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim to the State's medical assistance programs. La. Rev. Stat. § 46:438.3.

152. Through their conduct, Defendants have knowingly presented, or caused to be presented, false or fraudulent claims to the State of Louisiana, as set forth above, in violation of Louisiana Revised Statute § 46:438.3.

153. Through their conduct, Defendants have also knowingly engaged in misrepresentation and/or made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to the Louisiana medical assistance programs, as set forth above, in violation of Louisiana Revised Statute § 46:438.3.

154. Relators bring this action in accordance with the civil action *qui tam* provision in Louisiana Revised Statute §§ 46:439.1 – 46:439.4 and have complied with all requirements therein.

[34] The Louisiana Medicaid Program enables the most recent Professional Services Fee Schedules to be downloaded at the following URL: http://www.lamedicaid.com/provweb1/fee_schedules/ProfServ_FS.htm.

155. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

156. By reason of Defendants' actions, the State of Louisiana has incurred and continues to incur damages.

Count Eight
Violation of the Massachusetts False Claims Act,
MASS. GEN. LAWS CH. 12 § 5B *et seq*.

157. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

158. Similar to Medicare, Massachusetts Medicaid rules allow for reimbursement for services provided by Mid-Levels at a rate below the physician's rate, specifically at eighty-five percent (85%) of the physician fee on file. 101 Code Mass. Regs. § 317.03(4) (2013).

159. Also, like Medicare, the Massachusetts Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care. *See* 101 Code Mass. Regs. § 317.04(4) (Fee Schedule).

160. The Massachusetts False Claims Act imposes liability upon those who knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval and those who knowingly make, use or cause to be made or used a false record or statement material to a false or fraudulent claim. Mass. Gen. Laws Ann. 12 § 5B.

161. Through their conduct, Defendants have knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval to the Commonwealth of Massachusetts, as set forth above, in violation of Massachusetts General Law 12 § 5B.

162. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted to the Commonwealth of Massachusetts, as set forth above, in violation of Massachusetts General Law 12 § 5B.

163. Relators bring this action in accordance with the civil action *qui tam* provision in Massachusetts General Law 12 § 5C and have complied with all requirements therein.

164. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

165. By reason of Defendants' actions, the Commonwealth of Massachusetts has incurred and continues to incur damages.

Count Nine
Violation of the Tennessee Medicaid False Claims Act,
TENN. CODE ANN. § 71-5-181 *et seq*.

166. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

167. Similar to Medicare, Tennessee Medicaid rules allow for reimbursement for services performed by a PA at a rate below the physician rate, specifically at no more than sixty percent (60%) of the charges provided for licensed physicians. Tenn. Code Ann. § 71-5-129.

168. Also, like Medicare, the Tennessee Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care.[35]

[35] TennCare allows the Professional Services Fee Schedules for TennCare's managed care organizations to be downloaded from the following website: https://www.tn.gov/tenncare/topic/providers-managed-care-organizations.

169. The Tennessee Medicaid False Claims Act imposes liability upon those who knowingly present, or causes to be presented, a false or fraudulent claim for payment or approval under the Medicaid program and those who knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim under the Medicaid program. Tenn. Code Ann. § 71-5-182.

170. Through their conduct, Defendants have knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval under the Tennessee Medicaid program, as set forth above, in violation of Tennessee Code § 71-5-182.

171. Through their conduct, Defendants have also knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims submitted under the Tennessee Medicaid program, as set forth above, in violation of Tennessee Code § 71-5-182.

172. Relators bring this action in accordance with the civil action *qui tam* provision in Tennessee Code § 71-5-183 and have complied with all requirements therein.

173. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

174. By reason of Defendants' actions, the State of Tennessee has incurred and continues to incur damages.

Count Ten
Violation of the Texas Medicaid Fraud Prevention Act,
TEX. HUM. RES. CODE § 36.002 *et seq.*

175. The preceding factual statements and allegations are incorporated herein by reference as if fully set forth herein.

176. Similar to Medicare, Texas Medicaid rules allow for reimbursement for services provided by a Mid-Levels at a rate below the physician rate, specifically at ninety-two percent (92%) of the reimbursement for the same professional service paid to a physician. Tex. Admin. Code tit. 1, §§ 355.8093, 355.8281.

177. Also, like Medicare, the Texas Medicaid rules allow for reimbursement for critical care services provided, under the same CPT Codes, at a higher reimbursement rate than for ordinary, or non-critical, levels of care. *See* TEXAS MEDICAID & HEALTHCARE PARTNERSHIP, *Texas Medicaid Provider Procedures Manual* (March 2016), Vol. 2, *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* § 9.2.58.6.4 ("Critical Care").[36]

178. The Texas Medicaid Fraud Prevention Act imposes liability upon those who: (1) knowingly make or cause to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized, and (2) knowingly conceal or fail to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized. Tex. Hum. Res. Code § 36.002.

179. Through their conduct, Defendants have (1) knowingly made or caused to be made false statements or misrepresentation of material fact in order to receive payment under the Texas Medicaid program that is not authorized, and/or (2) knowingly concealed or failed to disclose information to receive payment under the Texas Medicaid program that is not authorized, as set forth above, in violation of Texas Human Resources Code § 36.002.

[36] The *Texas Medicaid Provider Procedures Manual* can be downloaded at the following URL: http://www.tmhp.com/TMHP_File_Library/Provider_Manuals/TMPPM/2016/Mar_2016%20TMPPM.pdf.

180. Relators bring this action in accordance with the civil action *qui tam* provision in Texas Human Resources Code § 36.101 and have complied with all requirements therein.

181. Defendants' fraudulent conduct described herein is material to the government's decision to reimburse Defendants for services billed (i.e., the state would not authorize reimbursements of claimed services if it was aware of Defendants' fraud).

182. By reason of Defendants' actions, the State of Texas has incurred and continues to incur damages.

VII. DEMAND FOR JURY TRIAL

183. Relators expressly demand a trial by jury.

VIII. PRAYER FOR RELIEF

WHEREFORE, Relators, on behalf of themselves, the United States and the Plaintiff States, request that this Court:

(a) Enter judgment that Defendants be ordered to cease and desist from submitting and/or causing the submission of additional false claims or otherwise violating 31 U.S.C. §§ 3729-3733;

(b) Enter judgment against each Defendant in an amount equal to three times the damages the United States has sustained as a result of each and all of Defendants' actions, as well as a civil penalty against each Defendant of $11,000 for each violation of 31 U.S.C. § 3729;

(c) Find joint and several liability against Defendants pursuant to 31 U.S.C. § 3729;

(d) Enter judgment that Defendants be ordered to cease and desist from submitting and/or causing the submission of additional false claims violating the statutes of the respective Plaintiff States as pled herein;

(e) Enter judgment against each Defendant in an amount equal to three times the damages the respective Plaintiff States have sustained as a result of each and all Defendants' actions, as well as a civil penalty against each Defendant in the maximum amount allowable under the statutes of each respective Plaintiff State for each and every false record, statement, certification and claim submitted to the respective Plaintiff States;

(f) Award Relators the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) and the relevant provisions of the statutes of each of the Plaintiff States;

(g) Award Relators all costs and expenses of this action, including court costs, expert fees, and all attorneys' fees incurred by Relators in prosecution of this action; and

(h) That the United States, the Plaintiff States and Relators be granted each other and further relief as the Court deems just and proper.

Dated: November 12, 2018

Respectfully submitted,

/s/ Michael Angelovich

Michael Angelovich, TX Bar No. 785666
mangelovich@nixlaw.com
Trey Duck, TX Bar No. 24077234
tduck@nixlaw.com
Bradley W. Beskin, TX Bar No. 24105463
bbeskin@nixlaw.com
NIX, PATTERSON LLP
3600 N. Capital of Texas Hwy.
Building B, Suite 350
Austin, TX 78746
Telephone: 512.328.5333
Facsimile: 512.328.5335

Ed Dougherty, MO#26862, *Pro Hac Vice* in Progress
edougherty@dh-law.com
DOUGHERTY & HOLLOWAY, LLC
7200 NW 86th St., Suite D

Kansas City, MO 64153
Telephone: 816.891.9990
Facsimile: 816.891.9905

CERTIFICATE OF SERVICE

I hereby certify that I filed this First Amended Complaint with the Clerk of the Court by means of the Court's ECF system, which served on the following attorneys copies of the filing:

Eric Hugh Findlay Brian Craft **Findlay Craft PC** 102 N College Avenue Suite 900 Tyler, TX 75702 903/534-1100 Fax: 903/534-1137 efindlay@findlaycraft.com bcraft@findlaycraft.com *Counsel for Defendants*	James G. Gillingham **United States Attorney's Office** Eastern District of Texas 101 E. Park Blvd, Suite 500 Plano, TX 75074 james.gillingham@usdoj.gov *Counsel for the United States*

003397

/s/ Michael Angelovich
Michael Angelovich

Counsel for Relators

003397

71

Electronically Filed
01/11/2021 8:46 AM
CLERK OF THE COURT

OST

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Brittany M. Llewellyn, Esq.
Nevada Bar No. 13527
bllewellyn@wwhgd.com
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

HEARING REQUESTED

DEFENDANTS' MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME

Defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans LLC (incorrectly named as "Oxford Health Plans, Inc."); Sierra Health and Life Insurance Company, Inc.; Sierra Health-Care Options, Inc. and Health Plan of Nevada, Inc. (collectively, "United" or "Defendants"), hereby submits the following Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on an Order Shortening Time ("Motion"). This Motion is made and based upon the papers and pleadings on file herein, the Declaration of Brittany M. Llewellyn, the following memorandum of points and authorities, and any arguments made by counsel at the time of the hearing.

Dated this 8th day of January, 2021.

/s/ Brittany M. Llewellyn

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Attorneys for Defendants

003399

DECLARATION OF BRITTANY M. LLEWELLYN IN SUPPORT OF DEFENDANTS' MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME

1. I am an attorney licensed to practice law in the State of Nevada, an attorney at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, counsel for Defendants in the above-captioned matter.

2. This Declaration is submitted in support of Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Set of Requests for Production. I have personal knowledge of the matters set forth herein and, unless otherwise stated, am competent to testify to the same if called upon to do so.

3. On June 28, 2019, United filed and served its First Set of Requests for Production of Documents to Plaintiffs (the "First Requests for Production"). A true and correct copy of the First Requests for Production is attached hereto as ***Exhibit 1***.

4. On July 29, 2019, Plaintiffs served their Responses and Objections to the First Set of Requests for Production (the "First Response"). A true and accurate copy of Plaintiffs' First Response is attached hereto as ***Exhibit 2***.

5. By letter dated January 23, 2020, Defendants outlined the various deficiencies in Plaintiffs' First Response and their document production in an attempt to resolve the disputes without Court intervention. A true and accurate copy of the January 23, 2020 deficiency letter is attached hereto as ***Exhibit 3***.

6. On June 1, 2020, Plaintiffs served Supplemental Responses and Objections to the First set of Requests for Production (the "First Supplemental Responses"). A true and accurate copy of Plaintiffs' First Supplemental Responses is attached hereto as ***Exhibit 4***.

7. On August 12, 2020, Defendants filed and served their Second Set of Requests for Production of Documents to Plaintiffs (the "Second Request for Production"). A true and correct copy of the Second Set of Requests for Production is attached hereto as ***Exhibit 5***.

8. On September 28, 2020, Plaintiffs served their Responses and Objections to the Second Set of Requests for Production (the "Second Response"). A true and accurate copy of Plaintiffs' Second Response is attached hereto as ***Exhibit 6***.

9. By letter dated October 23, 2020, Defendants outlined the various deficiencies in Plaintiffs' Second Response and their document production in an attempt to resolve the disputes without Court intervention. A true and accurate copy of the October 23, 2020, deficiency letter is attached hereto as ***Exhibit 7***.

10. By letter dated November 17, 2020, Defendants outlined the various deficiencies in Plaintiffs' Second Response and their document production in an attempt to resolve the disputes without Court intervention. A true and accurate copy of the November 17, 2020, deficiency letter is attached hereto as ***Exhibit 8***.

11. By letter dated December 4, 2020, Defendants outlined the various deficiencies in Plaintiffs' First Response and their document production in an attempt to resolve the disputes without Court intervention. A true and accurate copy of the December 4, 2020, deficiency letter is attached hereto as ***Exhibit 9***.

12. Although Plaintiffs have produced documents in response to Defendants' First and Second Sets of Requests for Production, Plaintiffs' production has been wholly insufficient. Plaintiffs have, without basis and through improper and meritless objections, categorically refused to respond to numerous of Defendants' request for production of documents that are necessary for Defendants to conduct meaningful and productive depositions, test Plaintiffs' allegations, and prepare for trial. Moreover, Plaintiffs have completely refused to produce documents describing policies, procedures, or corporate structure while demanding precisely the same type of production from United.

13. On December 11, 2020, the Parties conferred regarding certain of Plaintiffs' discovery deficiencies, including related to the categories of Defendants' document requests concerning Plaintiffs' relationship to TeamHealth and Plaintiffs' corporate structure. During the conferral, the Parties reached an impasse regarding whether such information is discoverable and relevant to Plaintiffs' claims and/or Defendants' defenses. Certain discovery deficiencies raised during the Parties' December 11, 2020, conferral are still part of ongoing discussions and are not part of this Motion.

14. On December 21, 2020, Plaintiffs filed an opposition to Defendants' Motion to

Extend Discovery Deadline and Continue Trial arguing that "United asked the Health Care Providers to produce documents relating to the corporate structure of TeamHealth Holdings, produce documents related to the Health Care Providers' costs of doing business and contracts between the Health Care Providers and the hospitals where they provide emergency services," and "Requests for corporate structure information, costs and hospital contracts – like United's earlier request for clinical records – have no relationship to the First Amended Complaint's allegations, or any viable defense." Plaintiffs' Opposition to Motion to Extend Discovery Deadlines and Continue Trial Setting on Order Shortening Time, ***Exhibit 10***, at 4.

15. Based on the statements in Plaintiffs' filing, in an email of December 30, 2020, United expressed its understanding that the Parties remained at an impasse with respect to those Defendants' document requests referenced in Plaintiffs' Opposition. A true and accurate copy of the December 30, 2020 email is attached hereto as ***Exhibit 11***. Plaintiffs did not respond to disagree with this characterization of the status of the dispute.

16. To date, Defendants have not received a Privilege Log or any other such document detailing any of the documents responsive to Defendants' requests that Plaintiffs are withholding for privilege or any other reason.

17. I hereby certify that Defendants have, in good faith, conferred or attempted to confer with the Plaintiffs in an effort to obtain the requested documents without Court intervention.

18. Despite Defendants' multiple attempts to resolve these deficiencies and improper objections in Plaintiffs' Responses without Court intervention, it was unable to do so.

19. Defendants bring the instant motion requesting that this Court enter an order compelling Plaintiffs to provide supplemental responses and produce documents responsive to United's First and Second Set of Requests for Production within ten (10) days of the date of the order.

20. United respectfully submits that good cause exists to grant the order shortening time because United has been awaiting responses to the requests at issue since September 28, 2020, and is in need of this information to prepare for party depositions. Given that fact

discovery is set to close on March 15, 2021, there are only approximately sixty (60) days remaining in the fact discovery period.

21. I declare that the foregoing is true and correct under the penalty of perjury under the laws of the state of Nevada.

DATED: January 8, 2021

/s/ Brittany M. Llewellyn

003403

003403

ORDER SHORTENING TIME

Good cause appearing, it is ordered that **DEFENDANTS' MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION** shall be heard on the 13th day of January, 2021, at 1:00 ~~a~~x.m./p.m., Department No. XXVII.

Dated this 11th day of January, 2021

Nancy L Allf

Nancy Allf, District Court Judge

BBB 0FC 3D43 0939
Nancy Allf
District Court Judge

This may be a preliminary hearing, as the time set for hearing may not allow for a thorough opposition to be filed.

Submitted by:

/s/ Brittany M. Llewellyn

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone:(702) 938-3838
Facsimile: (702) 938-3864

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Attorneys for Defendants

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Court is familiar with the basics of the dispute before it. The TeamHealth Nevada Plaintiffs ("Plaintiffs") are private-equity backed out-of-network healthcare providers who Defendants contend have grossly inflated their charges for services, improperly "up-coded," and are not entitled to anything more than what has already been paid. TeamHealth is the controlling intermediary between its affiliated entities and health plans like those administered or issued by Defendants, and it has long pursued a policy of forcing its subsidiaries to become out-of-network physicians in order to maximize profits.[1] Despite Plaintiffs' attempts to avoid their discovery obligations, including discovery with respect to TeamHealth, their claims—which allege that Defendants have underpaid health plan benefits to Plaintiffs—and Defendants' defenses require that discovery be a two-way street.

Plaintiffs hope to win this case by inundating Defendants with onerous, irrelevant, and disproportionate discovery requests, while simultaneously stonewalling almost every request Defendants serve. Their hope is that this Court will give Plaintiffs far-reaching, claim-by-claim discovery that stretches from Alaska to Florida, while at the same time restricting Defendants' discovery to arbitrary and narrow categories of information. Without any credible basis, Plaintiffs object to document requests concerning TeamHealth, which their own First Amended Complaint alleges negotiated *on Plaintiffs' behalf*, thus making TeamHealth Plaintiffs' agent for purposes of this case. Not to be overlooked, Plaintiffs continue to argue that TeamHealth's in-house counsel should be considered *Plaintiffs'* in-house counsel, an admission that TeamHealth-related discovery is probative and fair game. Plaintiffs cannot have it both ways.

By this Motion, Defendants ask that this Court order the following discovery that is both relevant and critical to this case: (1) discovery concerning Plaintiffs' corporate structure and relationship to TeamHealth (Request Nos. 61, 69, 95, 108, 132, 133, 134, 142, 143, 144, and

---

[1] *See* Complaint, *Celtic Insurance Co. v. Team Health Holdings, Inc. et. al.* at 10-14 (E.D. Tenn. 2020), attached hereto as ***Exhibit 12***.

003405

145); (2) discovery related to the Plaintiffs' costs of doing business for the at-issue emergency services (Request Nos. 68, 86, 92, 93, and 94); and (3) discovery of contracts between Plaintiffs and the hospitals where they provide emergency services (Request Nos. 126, 137, and 146).[2] Plaintiffs have made it clear that they have no intention of compromising on this discovery, as they declared in their opposition to Defendants' Motion to Extend Discovery Deadline and Continue Trial that they believe such information is not relevant.[3] While Plaintiffs' preemptive strike on this issue was procedurally improper—because no motion seeking Plaintiffs' requested relief was before the Court—as discussed *infra*, Plaintiffs are entirely wrong on the issue of discoverability and relevancy as it relates to the At-Issue Requests.

Prior to filing this Motion, Defendants filed and served two Requests for Production of Documents to Plaintiffs seeking documents necessary for Plaintiffs to substantiate their various allegations and for Defendants to establish defenses to these allegations.[4] Plaintiffs filed and served Responses to these Requests and have only produced a small subset of the documents requested. To date, Plaintiffs' responses to Defendants' Requests for Production have been insufficient: Plaintiffs have categorically refused to produce broad categories of documents, relying on meritless objections despite Defendants sending four detailed deficiency letters as part of ongoing attempts to confer regarding Defendants' Requests for Production.[5] While there are numerous outstanding deficiencies with Plaintiffs' discovery responses and production,[6]

003406

---

[2] Defendants will collectively refer to Request Nos. 61, 68, 69, 86, 92, 93, 94, 95, 108, 126, 132, 133, 134, 137, 142, 143, 144, 145, and 146 as the "At-Issue Requests."

[3] Plaintiff's Opposition to Motion to Extend Discovery Deadlines and Continue Trial Setting on Order Shortening Time, ***Exhibit 10***, at 3–4.

[4] The Defendants' First Set of Requests for Production of Documents to Plaintiffs is attached hereto as ***Exhibit 1*** and the Defendants' Second Set of Requests for Production of Documents to Plaintiffs is attached hereto as ***Exhibit 5***.

[5] Defendants' first deficiency letter, dated January 23, 2020, is attached hereto as ***Exhibit 3***, Defendants' second deficiency letter, dated October 23, 2020, is attached hereto as ***Exhibit 7***, Defendants' third deficiency letter, dated November 17, 2020, is attached hereto as ***Exhibit 8***, and Defendants' fourth deficiency letter, dated December 4, 2020, is attached hereto as ***Exhibit 9***.

[6] Nothing herein shall waive Defendants rights to seek further relief from the Court related to other discovery deficiencies identified by Defendants in their correspondence to Plaintiffs, but where the Parties are continuing to confer to try to avoid seeking intervention from the Court.

003406

Defendants are requesting that the Court compel production of the documents that Plaintiffs have failed to produce—and made clear they have no intention of producing—sought in the At-Issue Requests.[7]

II. LEGAL STANDARD

NRCP 37 provides, in relevant part, that a party seeking discovery may move for an order "compelling an answer, designation, production, or inspection" if "a party fails to produce documents or fails to respond that inspection will be permitted—or fails to permit inspection—as requested under Rule 34." NEV. R. CIV. P. 37(a)(3)(B).

In accordance with Rule 37, Defendants have made attempts to confer with Plaintiffs in an effort to obtain the documents requested under Rule 34 without court intervention. As Plaintiffs have refused to produce the requested documents sought in the At-Issue Requests, Defendants bring the instant requesting the Court to compel production of the requested documents.

III. LEGAL ARGUMENT

Plaintiffs responded to each of the At-Issue Requests in full or in part that "the Health Care Providers decline to respond to the request," citing a myriad of unsubstantiated and improper objections as the grounds for their declinations. Meanwhile, Plaintiffs have demanded the same type of documents from Defendants—such as documents describing the Defendants' corporate relationships and business relationships between Defendants and third parties that evidence the "reasonableness" of the Defendants' payments to Plaintiffs.[8] Discovery is not one-

---

[7] *See* Plaintiffs' Opp. to Motion to Extend 3–4 (stating that such requests "have no relationship to the First Amended Complaint's allegations, or any viable defense" and characterizing Defendants' requests as "unilaterally contrived" and Defendants as "slow-playing so that [they[could manufacture discovery disputes abutting the December 30 deadline").

[8] For example, Plaintiffs sought "all documents regarding the Provider charges and/or reimbursement rates that [Defendants] have paid to Participating or Non-Participating Providers from July 1, 2017, to the present in Nevada." Freemont Emergency Services (Mandavia), Ltd.'s First set of Requests for Production at 8, attached hereto as ***Exhibit 13***. Defendants responded that this request was "overbroad, unduly burdensome, and seeks irrelevant information that is not proportional to the needs of the case," but produced responsive documents on a rolling basis, most recently on November 20, 2020. *See* Defendants' Thirteenth Supplemental Responses to Fremont Emergency Services (Mandavia) Ltd.'s First Set of Requests for Production of Documents at 7, attached hereto as ***Exhibit 14***.

003407

sided.

Plaintiffs' preference to "decline to respond" to the At-Issue Requests does not supply a basis for failure to engage in good faith in discovery in this case. Plaintiffs' delayed production of documents and information responsive to the At-Issue Requests, which seek relevant and critical discovery, prejudices Defendants. Defendants respectfully request that the Court strike Plaintiffs' boilerplate objections to the At-Issue Requests and order the production of responsive documents so that Defendants are able to conduct meaningful and productive depositions, challenge Plaintiffs' allegations, and support their defenses.

A. PLAINTIFFS' BOILERPLATE OBJECTIONS SHOULD BE STRICKEN AS IMPROPER

Plaintiffs' boilerplate objections to the At-Issue Requests are improper and should be stricken. *See Partner Weekly, LLC v. Viable Mktg. Corp.*, 2014 WL 1577486, at *2 (D. Nev. Apr. 17, 2014) ("Boilerplate and generalized objections are inadequate and tantamount to no objection at all"); *EnvTech, Inc. v. Suchard*, 2013 WL 4899085, at *4 (D. Nev. Sept. 11, 2013) ("[B]boilerplate objections are disfavored, especially when a party fails to submit any evidentiary declarations supporting such declarations." (internal citations omitted)). Even if Plaintiffs are objecting to part of a request, they still needed to "specify the part and permit inspection of the rest." NEV. R. CIV. P. 34. Plaintiffs, however, avoid their obligations and raise numerous unsubstantiated, boilerplate objections without proffering any legitimate basis for doing so.

First, for Request Nos. 61, 68, 86, 92, 93, 94, and 126, Plaintiffs decline to respond on the basis that they are "**vague and ambiguous**." *See generally* ***Exhibit 6***. However, Plaintiffs failed to explain why the terms of these requests were unclear, identify the multiple interpretations, or select a reasonable interpretation of those terms. Furthermore, there can be no serious question as to the meaning of terms like "reflecting your corporate structure" (Request No. 61), "cost" (Request No. 92), and "presentations" and "proposals" (Request No. 126). ***Exhibit 6*** at 25, 42, and 57–58.

Second, Plaintiffs raise "**overly broad**" objections to Request Nos. 108 and 126, but fail to explain why these requests are overbroad or why Defendants should be satisfied with an

incomplete set of the requested documents. *See* ***Exhibit 6*** at 50 and 57–58. A party asserting an "overly broad" objection must state the objection with specificity, explaining how the objection relates to the requested documents. *See Krause v. Nevada Mut. Ins. Co.*, 2014 WL 496936, at *4–6 (D. Nev. Feb. 6, 2014), *aff'd*, 2014 WL 3592655 (D. Nev. July 21, 2014). Plaintiffs fail to do so here.

Third, Plaintiffs interpose a number of "**improper purpose**" objections to the At-Issue Requests. *See generally* ***Exhibit 6***. These objections likewise fail to provide Defendants with sufficient information to understand which documents Plaintiffs object to providing and for what specific reason.

In short, Plaintiffs' boilerplate objections should be stricken as improper. Any surface or searching review of Plaintiffs' objections reveals that Plaintiffs have simply used stock language in the hopes that the Court will not review them. Such baseless objections should not be barrier to Defendants seeking the discovery sought in the At-Issue Requests, which are relevant to Plaintiffs' claims and Defendants' defenses.[9]

B. DEFENDANTS' AT-ISSUE REQUESTS SEEK RELEVANT AND DISCOVERABLE INFORMATION DIRECTLY RELATED TO PLAINTIFFS' CLAIMS AND DEFENDANTS' DEFENSES

Plaintiffs "declined to respond" to each of Defendants' At-Issue Requests because they purportedly have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of Defendants' affirmative defenses." *See generally*

---

[9] Plaintiffs' objections to Request Nos. 61, 68, 86, 92, 93, and 94 rest on the grounds that they "potentially seek[] documents protected by the attorney-client privilege and work product doctrine and/or are otherwise confidential." ***Exhibit 6*** at 25–43. If there are any documents responsive to Defendants' Requests for Production for which Plaintiffs are asserting privilege, Defendants have yet to receive a privilege log as required by NRCP 26(b)(5). Plaintiffs' objections also ignore that Plaintiffs can designate confidential documents in accordance with the protective order on file in this case, as Plaintiffs themselves have recognized. *See* Oct. 8, 2020 Transcript of Proceedings re: Motions at 59:23–60:3 ("United also objects to . . . some of the issues with respect to trade secrets under the Nevada statute, and it's [sic] proprietary information as well as their customer information. I think . . . we're well established at this point that we have a protective order. United is not shy about identifying things that is attorneys' eyes only. So I think that provides the most protection."). Defendants have made it known to Plaintiffs that Defendants are willing to accept data that blinds or redacts identifying information for non-United payers. *See* ***Exhibit 8*** at 3.

003409

Exhibit 6. However, parties may "obtain discovery regarding any nonprivileged matter that is relevant to any party's claims or defenses and proportional to the needs of the case . . . ." NEV. R. CIV. P. 26(b)(1). Any party objecting to production on relevance grounds "has the burden of clarifying, explaining and supporting its objections." *Painters Joint Comm. v. Employee Painters Tr. Health & Welfare Fund*, 2011 WL 4573349, at *5 (D. Nev. Sept. 29, 2011), order corrected on reconsideration sub nom. *Painters Joint Comm. v. J.L. Wallco, Inc.*, 2011 WL 5854714 (D. Nev. Nov. 21, 2011); *Koninklijke Philips Elecs. N.V. v. KXD Tech., Inc.*, 2007 WL 778153, at *4 (D. Nev. Mar. 12, 2007) (To meet the burden of showing that "discovery is overly broad, unduly burdensome or not relevant," "the objecting party must specifically detail the reasons why each request is irrelevant."). To meet this burden, the objecting party "must ***specifically detail*** the reasons why each request is irrelevant." *Id.* And, "[f]or discovery purposes, relevance means only that the materials sought are reasonably calculated to lead to the discovery of admissible evidence." *See F.T.C. v. AMG Servs., Inc.*, 291 F.R.D. 544, 552, 556 (D. Nev. 2013). Plaintiffs do not meet their burden or explain why the At-Issue Requests are of "no import."

During the parties' conferrals and in Plaintiffs' submission to this Court, Plaintiffs have made the erroneous and conclusory assertion that Defendants' discovery requests "have no relationship to the First Amended Complaint's allegations, or any viable defense" as justification for refusing to comply with Defendants' legitimate At-Issue Requests. *See* Plaintiff's Opposition to Motion to Extend Discovery Deadlines and Continue Trial Setting on Order Shortening Time, ***Exhibit 10***, at 4. Plaintiffs' primary legal authority in support of this assertion is a case filed in Florida's Thirteenth Judicial District in and for Hillsborough County, *Gulf-to-Bay Anesthesia Associates, LLC. v. Unitedhealthcare of Florida, Inc. et. al.*, No. 17-CA-011207 (2017) ("*Gulf-to-Bay*"). *See id.* at 4 and Ex. 2. Despite the fact that this case is pending in Nevada state court, not Florida state court, Plaintiffs contend that a two-page October 19, 2020, omnibus discovery order sustaining an objection to the production of "ownership and acquisition information" by TeamHealth Holdings, Inc. is somehow "persuasive" on this point. *Id.*

Although the plaintiff in *Gulf-to-Bay* is also a TeamHealth-affiliated entity, its complaint

is distinguishable from the First Amended Complaint here in several critical respects—in part because the claims in *Gulf-to-Bay* were brought under Florida statutes for which Nevada has no analog. ***First***, Plaintiffs strategically fail to disclose that the pleading in *Gulf-to-Bay*, attached hereto as ***Exhibit 15***, makes no reference to national contract negotiations regarding issues, such as the establishment of a "reasonable" rate, whereas Plaintiffs put these negotiations ***squarely at issue*** in the instant case throughout their First Amended Complaint. *Cf.* ***Exhibit 15*** with First Amended Complaint ("FAC") at ¶¶ 90–109 (filed January 7, 2020). Defendants have produced documents pertaining to these negotiations, which show that TeamHealth engaged in these negotiations on behalf of Plaintiffs. Moreover, Plaintiffs have disclosed TeamHealth employees as party witnesses in this case, and have already produced emails between TeamHealth and Defendants. Yet, Plaintiffs contend that Defendants cannot take discovery on the very entity with which they negotiated, even when Plaintiffs have propounded requests about the same negotiations. Plaintiffs cannot be allowed to rely on and ask Defendants to produce communications involving TeamHealth employees when it benefits them, and then refuse to engage in discovery related to TeamHealth.

Second, Plaintiffs fail to disclose that the basis for the court's decision in *Gulf-to-Bay* was because of Florida's narrow statute governing the reimbursement of disputed commercial claims. *See Gulf-to-Bay* Order Denying Defendants' Motion to Compel Discovery Regarding Plaintiff's Internal Cost Structure at 2–3 (Dec. 1, 2020), attached hereto as ***Exhibit 16***. Nevada has no analogous statute for identifying the "reasonableness" of a reimbursement rate for commercial claims, and so discovery concerning that issue is necessary here. In short, the *Gulf-to-Bay* order is not an escape valve for Plaintiffs. *See* ***Exhibit 17***, Order on Defendants' First Mot. to Compel, *Florida Emergency Physicians v. Sunshine State Health Plan*, No. CACE19-013026 (07) (Fla. Cir. Ct. Dec. 21, 2020) (distinguishing Gulf-to-Bay on the basis that there, "defendants did not raise any unreasonable pricing claims, either by affirmative defense or counterclaim," and "the pleadings were focused solely on a statutory analysis that addresses the fair market value of the services provided") ("Florida Emergency Discovery Order").

Plaintiffs have wholly failed to meet their burden of establishing that the At-Issue

Requests are of "no import." To the contrary, the At-Issue Requests seek documents necessary for Defendants to conduct meaningful and productive depositions and challenge Plaintiffs' allegations. Moreover, Defendants have raised numerous affirmative defenses for which the documents sought by the At-Issue requests are necessary, including that Plaintiffs have not suffered any damages, their claims are subject to recoupment based on improper billing practices, and that Plaintiffs' billed charges are excessive under the applicable standards. *See* Defendants' Answer to FAC, ***Exhibit 18***, at 43–49. As noted *supra*, this was a critical distinction in the *Florida Emergency Discovery Order*. *See* ***Exhibit 17.*** Documents regarding Plaintiffs' corporate ownership's applicable top-down directives, Plaintiffs' relationship with and obligations to their facilities, and the costs associated with Plaintiffs' business are all necessary for Defendants to adequately support these defenses. As discussed *infra,* there can be no serious question that the At-issue Requests are of high import.

a. Plaintiffs' Corporate Structure (Request Nos. 61, 69, and 132)

Plaintiffs declined to respond to Defendants' Request Nos. 61, 69, and 132 seeking documents demonstrating individuals or entities with ownership, control, or governance of Plaintiffs such as TeamHealth, Plaintiffs' respective boards of directors or governing bodies, or any groups or committees charged with the task of reviewing or setting rates inform many issues, including identification of the individuals or entities who have decisional input concerning the setting of Plaintiffs' charges, and the decisions concerning whether to accept an amount below billed charges. *See* ***Exhibit 6*** at 25–29 and 60.

Whether any of these individuals or entities has a financial incentive to influence the rates or the amounts of payment that Plaintiffs would accept calls into question the objectivity of the charged amount and whether the charges were set in good faith. This is all the more relevant here as Plaintiffs appear to be contending that up to 90% of their full, unilaterally-set billed charges reflect a reasonable reimbursement rate. *See* FAC at ¶ 54 (alleging that, "a reasonable reimbursement rate for the Health Care Providers' Non-Participating Claims for emergency services is **75-90% of the Health Care Providers' billed charge**") (emphasis added).

Defendants respectfully request that the Court order Plaintiffs to produce documents

responsive to Request Nos. 61, 69, and 132.

b. Relationship Between Plaintiffs and TeamHealth (Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145)

Defendants' Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145 seek documents concerning Plaintiffs' relationship with their parent company, TeamHealth, to which Plaintiffs again responded that that these requests were of "no import," noting in Plaintiffs' response to Request No. 108 that "TeamHealth is not a party to this lawsuit and documents regarding any relationship between the Health Care Providers and TeamHealth do not have any bearing on the dispute at issue in this action." *See* ***Exhibit 6*** at 43, 50, and 60–66. Contrary to these assertions, the relationship between Plaintiffs and TeamHealth informs many issues, including identification of the entities that have decisional input concerning the setting of Defendants' charges and concerning whether to accept an amount below billed charges. TeamHealth's financial incentive to influence the rates or the amounts of payments Plaintiffs would accept calls into question the objectivity of the charged amount and whether the charges are set in good faith, or instead calculated to generate the most money possible for a private equity firm.

TeamHealth's strategy of increasing out-of-network rates as a negotiation tactic is well documented, as is Blackstone's need to increase profitability. *See Surprise! Out-of-Network Billing for Emergency Care in the United States*, Cooper, et al., December 2018; *Ill-Timed Health-Care Buyouts Bruise KKR and Blackstone*, Gottfried, Wall Street Journal, May 28, 2020, attached hereto as ***Exhibit 19***. Also documented are the high dollar figures associated with the administrative services TeamHealth purportedly provides and the management fee it charges. *See How Rich Investors, Not Doctors, Profit From Making Up ER Bills*, Armsdorf, PROPUBLICA, June 12, 2020, attached hereto as ***Exhibit 20***. Whether the fees for these services inflated Plaintiffs' billed charges for the at-issue claims is relevant to the reasonable value of the underlying medical services. Moreover, ***all*** of the party witnesses Plaintiffs have disclosed appear to be current or former TeamHealth employees. *See* Plaintiffs' Second Supplement to NRCP 16.1 disclosure of witnesses and documents, attached hereto as ***Exhibit 21***. And, Plaintiffs' pleadings and discovery to date suggests that all of the contractual negotiations at

003413

issue in this case were with TeamHealth—***not Plaintiffs***. Accordingly, Plaintiffs' contention that documents regarding TeamHealth are not relevant simply is not credible.

Defendants respectfully request that the Court order Plaintiffs to produce documents responsive to Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145.

c. Plaintiffs' Actual Costs of Doing Business (Request Nos. 68, 86, 92, 93, and 94)

Defendants Request Nos. 68, 86, 92, 93, and 94 seek documents that detail Plaintiffs' actual costs of doing business, to which Plaintiffs responded, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of United's affirmative defenses." *See* ***Exhibit 6*** at 29–43. Contrary to Plaintiffs' unsupported assertions, the costs incurred by Plaintiffs in performing emergency medical services is directly relevant to the issue of whether any payment by United was "reasonable" *vis-à-vis* the value of any services rendered, which Plaintiffs have placed squarely at issue in this case. *See* FAC ¶ 40 ("Specifically, the reimbursement claims within the scope of this action are (a) nonparticipating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) *at rates below* the billed charges and *a reasonable payment for the services rendered*, (d) as measured by the community where they were performed and by the person who provided them.") (emphasis added); *see, e.g.*, Answer to FAC, ***Exhibit 18***, at 44 ("Some or all of Plaintiffs' billed charges are excessive under the applicable standards"). Moreover, Plaintiffs' actual costs of doing business are, despite Plaintiffs' unsupported assertions to the contrary, directly relevant to several of Defendants' affirmative defenses. *See id.* at 43-48. For example, Defendants' Sixth ("Some or all of Plaintiffs' billed charges are excessive under the applicable standards"), Fourteenth (Plaintiffs' claims are barred, in whole or in part, to the extent they have not suffered any damages"), Eighteenth ("Plaintiffs' claims are barred, in whole or in part, to the extent that Plaintiffs have not mitigated their damages"), and Twenty-Sixth ("Plaintiffs are not entitled to relief because they have received all payments due, if any,

for the covered services they provided in accordance with the terms of their patients' health plans") affirmative defenses all concern the "reasonableness" of the Plaintiffs' services rendered, of which Plaintiffs' costs incurred providing these services are a significant factor. *Id*. at 44, 46-48.

Defendants respectfully request that the Court order Plaintiffs to produce documents responsive to Request Nos. 68, 86, 92, 93, and 94.

d. Plaintiffs' Relationships with Facilities (Request Nos. 126 and 137)

Defendants' Request Nos. 126 and 137 seek documents pertaining to presentations and/or proposals, as well as contracts and/or agreements between Plaintiffs and any facilities, to which Plaintiffs responded, among other things, that these Requests have "no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor [do they] have any bearing on or relationship to any of United's affirmative defenses." *See* ***Exhibit 6*** at 57–58 and 62. Quite the contrary: What Plaintiffs offer, charge, or accept from hospitals/facilities is relevant to the reasonable value of the services. Furthermore, if Plaintiffs offer, charge, or accept different amounts depending on the hospital or facility, then that is probative of the issue of what a reasonable payment looks like.

Similarly, Defendants' Request No. 146 seeks "All documents relating to your entitlement to render services in the facilities at which treatment for the Claims was rendered, including but not limited to licensure, privileges, and credentialing." ***Exhibit 6*** at 66–67. Plaintiffs responded, among other things, that this Request, "has no import as to the Health Care Providers' allegations of underpayment, breach of an implied-in-fact contract, and civil racketeering, among other claims, nor does it have any bearing on or relationship to any of United's affirmative defenses." *Id*. The documents sought in Request No. 146 are relevant for a number of reasons, including, for example, whether Plaintiffs were the exclusive providers, or among several providers at the facility, and what professional licensure and credentialing requirements Plaintiffs' providers needed to satisfy to render services at the facility. Whether Plaintiffs are subject to competition that could potentially drive down their rates is relevant to

whether their charges are reasonable. If, for example, they maintain a monopoly on a facility and can set rates at their discretion without regard to any competitive factors, then the rates they charge may not be reasonable. The professional licensure and credentialing of their providers is likewise informative of whether Plaintiffs' billed charges are reasonable. *Cf. United States v. TeamHealth Holdings*, Civil Action No. 2:16-cv-00432-JRG, Doc. 33 at ¶¶ 2–6 (E.D. Tex. Filed Nov. 12, 2018) (alleging that TeamHealth improperly billed for emergency room physician services when in fact the services were performed by physician assistants whose services are billed at only 85% of the standard physician rate), attached hereto as ***Exhibit 22***. Defendants respectfully request that the Court order Plaintiffs to produce documents responsive to Request Nos. 126 and 137.

IV. RELIEF REQUESTED

Defendants respectfully request that this Court grant their Motion to Compel Plaintiffs' Responses to Defendants' First and Second Request for Production in its entirety.

Dated this 8th day of January, 2021.

/s/ Brittany M. Llewellyn

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374
Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on the 8th day of January, 2021, a true and correct copy of the foregoing **DEFENDANTS' MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

Pat Lundvall, Esq.
Kristen T. Gallagher, Esq.
Amanda M. Perach, Esq.
McDonald Carano LLP
2300 W. Sahara Ave., Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com
Attorneys for Plaintiffs

/s/ Kelly L. Pierce
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

003417

WEINBERG WHEELER HUDGINS GUNN & DIAL
003417

CSERV

DISTRICT COURT
CLARK COUNTY, NEVADA

Fremont Emergency Services (Mandavia) Ltd, Plaintiff(s) vs. United Healthcare Insurance Company, Defendant(s)	CASE NO: A-19-792978-B DEPT. NO. Department 27

AUTOMATED CERTIFICATE OF SERVICE

This automated certificate of service was generated by the Eighth Judicial District Court. The foregoing Order Shortening Time was served via the court's electronic eFile system to all recipients registered for e-Service on the above entitled case as listed below:

Service Date: 1/11/2021

Audra Bonney	abonney@wwhgd.com
Cindy Bowman	cbowman@wwhgd.com
D. Lee Roberts	lroberts@wwhgd.com
Raiza Anne Torrenueva	rtorrenueva@wwhgd.com
Colby Balkenbush	cbalkenbush@wwhgd.com
Brittany Llewellyn	bllewellyn@wwhgd.com
Pat Lundvall	plundvall@mcdonaldcarano.com
Kristen Gallagher	kgallagher@mcdonaldcarano.com
Amanda Perach	aperach@mcdonaldcarano.com
Beau Nelson	bnelson@mcdonaldcarano.com

003418
003418
003418

Marianne Carter	mcarter@mcdonaldcarano.com
Karen Surowiec	ksurowiec@mcdonaldcarano.com
Flor Gonzalez-Pacheco	FGonzalez-Pacheco@wwhgd.com
Kelly Gaez	kgaez@wwhgd.com
Kimberly Kirn	kkirn@mcdonaldcarano.com
Natasha Fedder	nfedder@omm.com

003419

003419

72

Electronically Filed
1/12/2021 2:16 PM
Steven D. Grierson
CLERK OF THE COURT

OPPM
Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: XXVII

PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME

Hearing Date: January 13, 2021
Hearing Time: 1:00 p.m.

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest

003420

003420

Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") file this opposition to defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans, Inc.; Sierra Health and Life Insurance Co., Inc.; Sierra Health-Care Options, Inc.; and Health Plan of Nevada, Inc.'s (collectively, "United") Motion to Compel responses to certain requests for production of documents ("RFPs") that seek corporate structure/relationship, costing and hospital/facility contract and licensing/credentialing documents (the "Motion").

This Opposition to the Motion ("Opposition") is based upon the record in this matter, the Declaration of Kristen T. Gallagher, the points and authorities that follow, the pleadings and papers on file in this action, and any argument of counsel entertained by the Court.

POINTS AND AUTHORITIES

I. INTRODUCTION

Like its denied email protocol and request for clinical records, United's most recent Motion to compel is meant to distract and delay these proceedings by seeking information about corporate structure/relationship, irrelevant costing information and hospital contracts that have nothing to do with the Health Care Providers' First Amended Complaint which makes clear that this case involves whether United is paying the appropriate reimbursement rates for the emergency medicine services that the Health Care Providers' practitioners provide to United's members. This Court has already rejected United's multiple attempts to re-define this case into something it is not. For example, the Court has had to reject United's attempt to cast this as an ERISA case on numerous occasions and the Court has rejected United's attempt compel clinical records. With this Motion, United once again disregards this Court's Order that already set the framework for this case when United tested it by trying to compel clinical records. The Court concluded:

> The relevant inquiry in this action is the proper rate of reimbursement which is based on the amount billed by the Health Care Providers and the amount paid by United.

October 26, 2020 Order Denying Defendants' Motion To Compel Production Of Clinical Documents For The At-Issue Claims And Defenses And To Compel Plaintiff To Supplement

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003421
003421
003421

Their NRCP 16.1 Initial Disclosures On An Order Shortening Time ("Order Denying Clinical Records") at ¶ 18. Because the Health Care Providers' corporate structure, costs or contracts with hospitals where they provide services has nothing to do with the amount paid by United, the Health Care Providers respectfully request the Court deny United's Motion as none of the foregoing categories of documents are relevant and proportional to the needs of a case that involves the "rate of payment." *Id.*

II. OVERVIEW OF THE INSTANT DISPUTE

A. Facts Relevant to the Current Dispute

United's current effort to compel production of documents relating to corporate structure, actual costs of doing business and hospital/facility contracts is another effort at requiring unnecessary and irrelevant document production by the Health Care Providers. The First Amended Complaint makes it clear that this litigation concerns ***United's*** failure to allow reasonable reimbursement rates. *See, e.g.*, First Am. Compl. ¶¶ 1-2, 55; Order Denying Clinical Records at ¶ 1 ("The First Amended Complaint alleges that the Health Care Providers "seek the proper reimbursement rate, making this a 'rate-of-payment' case."). Whether the amount United reimburses the Health Care Providers for emergency services is reasonable does not depend on any corporate structure; or the costs of doing business because Nevada's unjust enrichment and quantum meruit law is informed by market value, not costs; nor do hospital/facility contracts between the Health Care Providers and those hospitals inform any of the claims or defenses in this case. As a result, United is unable to establish entitlement to these categories under NRCP 26.

The Health Care Providers served responses to the subject RFPs (Nos. 61, 69 and 132, corporate structure; Nos. 95, 108, 133, 134, 142, 143, 144, and 145, costing; and Nos. 68, 86, 92, 93, and 94, costing; and Nos. 126, 137 and 146 on September 28, 2020. On December 11, 2020, the parties engaged in a meet and confer that included the Health Care Providers' responses to RFPs. **Exhibit A**, Gallagher Decl. ¶ 3. With respect to the RFPs subject to United's Motion, the Health Care Providers further explained that they objected to the requests because corporate records, costing and hospital/facility contracts are not relevant to the First Amended Complaint's

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003422

allegations and United had not raised a legitimate related affirmative defense either. *Id.* at ¶ 4. As stated in a letter, United's counsel's proffered basis for seeking cost-related documents is "the costs incurred by Plaintiffs in performing emergency medical services is directly relevant to the issue of whether any payment by United was "reasonable" vis-à-vis the value of any services rendered, which Plaintiffs have placed squarely at issue in this case." United's Appendix to Motion, Exhibit 8 at p.8. United articulated the same reason when it sought clinical records, arguing in a position now rejected by this Court, that the Health Care Providers had to prove they performed the services for which they billed. The Court disagreed and instead ruled that the framework for this case is the proper rate of reimbursement and the "Health Care Providers do not have the burden to provide what was done clinically to establish their claims." Order Denying Clinical Records at ¶ 18.[1]

Similarly, with requests for presentations and proposals made to facilities (RFP No. 126) and hospital/facility contracts (RFP No. 137), United contends that "What Plaintiffs offer, charge or accept from hospitals/facilities is relevant to the reasonable value of the services." The former category has no relationship to the Health Providers' claims and the latter category is just a sub-category of actual costs. Neither have any bearing whether United's reimbursement rates are reasonable. United also asks for information about the Health Care Providers' licensure, privileges and credentialing (RFP No. 146) to establish the providers' entitlement to render emergency services in hospitals/facilities, claiming that such information is relevant to determine the Health Care Providers were the exclusive providers at a facility, whether they are subject to competition and whether they have a monopoly – all supposedly related to determining the reasonableness of the Health Care Providers billed charges. Motion at 18:24-19:4. This is an unsupported attempt to shift the burden to the Health Care Providers to prove something that is not at issue in this litigation. As the First Amended Complaint provides, and the Court has

[1] As this Court has had occasion to address recently, this is another of United's attempt to re-litigate the framework of this case that the Court has already decided. *See* December 23, 2020 Hearing Transcript at 51:22-24, 52:6-8 ("But this seems to be a continued pattern from your client with trying to argue matters that have already been decided without meeting and conferring…..And we're still -- I know it was removed and remanded, but we're still rearguing some of the fine points again and again, and in some cases three times.").

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003423
003423
003423

confirmed, the framework for this litigation is whether United's reimbursement rates are reasonable.

B. Relief Sought in Opposing the Motion

The Health Care Providers seek an order denying United's Motion to compel production of corporate structure/relationship, costing and hospital/facility contract and licensing/credentialing documents because none of these categories are relevant to the claims that form the First Amended Complaint.

III. LEGAL ARGUMENT

A. Legal Standard

NRCP 26(b)(1) provides:

> Parties may obtain discovery regarding any nonprivileged matter that is ***relevant to any party's claims or defenses and proportional to the needs of the case***, considering the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit.

NRCP 26(b)(1). This is the second time that United has failed to provide the Court with an analysis of the correct standard applied to the requested documents. See also, Plaintiffs' Opposition to Motion to Compel Clinical Records. A review of the relevant factors below demonstrates that United cannot meet this burden as to any of the RFPs that are subject to the Motion.

B. United's Document Requests Have No Bearing on the First Amended Complaint's Allegations or any Affirmative Defense

Without any legal basis for seeking corporate structure/relationship, costing and hospital/facility contract and licensing/credentialing documents, United nevertheless tries to burden the Health Care Providers with production of documents that will in no way support or refute either side's evidentiary burden because none of the RFPs inform whether ***United's*** reimbursement rates are reasonable. Order Denying Clinical Records at ¶ 18. Moreover, under Nevada law, the reasonable value of services concerns market value, not underlying costs.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003424

1. Corporate Structure Documents Have No Bearing on the Health Care Providers' Claims

United asks for corporate structure documents in RFP Nos. 61, 69 and 132:

> 61. Please produce all documents reflecting your corporate structure for each year from July 1, 2017 to the present.
>
> 69. Please produce all any and all articles of incorporation, amendments and governing documents for each of the Plaintiffs in effect at any time from July 1, 2017 to present.
>
> 132. All documents demonstrating the individuals or entities with ownership, control, or governance of Plaintiffs, including shareholders, owners, officers, board members, etc.

United's Appendix to Motion, Exhibit 5 at RFP Nos. 61, 69, 132. United argues that the foregoing requests also include a request to identify individuals or entities who have decisional input about how the Health Care Providers set charges. Motion at 15:18-20. A simple review of the requests demonstrates that no such requests are embodied therein because ownership, control or governance is not correlated to operational decision-making. Moreover, United admits that the Health Care Providers have disclosed such individuals on their NRCP 16.1 list of witnesses. Thus, this part of United's argument in the Motion is not related to the identified RFP Nos. 61, 69 and 132 and the information it claims it wants (information about who is making operational decisions), it already has.

Next, United contends that "whether any of these individuals or entities has a financial incentive to influence the rates or the amounts of payment that Plaintiffs would accept calls into question the objectivity of the charged amount and whether the charges were set in good faith." Motion at 15:21-23. This is an improper effort to reformulate the First Amended Complaint's allegations that provide the recognized framework for this "rate of payment" case into something else and impose an additional evidentiary burden onto the Health Care Providers to establish the propriety of billed charges that does not exist. Order Denying Clinical Records at ¶ 18 ("The relevant inquiry in this action is the proper rate of reimbursement which is based on the amount billed by the Health Care Providers and the amount paid by United.").

In a similar action, a Western District of Oklahoma court rejected an insurance company's efforts to compel corporate documents of the same nature as United's RFPs.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003425

Emergency Services of Oklahoma, PC v. Aetna Health, Inc., No. CIV-17-600-J, 2020 WL 6813218, at *2 (W.D. Okla. Nov. 19, 2020). Like the First Amended Complaint here, the *Emergency Services of Oklahoma* litigation "centers on a dispute over reimbursement rates by Defendants to Plaintiffs: this action concerns only the rate of payment to which Plaintiffs are entitled." *Id.* It is not surprising that the Oklahoma federal district court disagreed with the identical arguments made by that defendant (Aetna) and ruled that that corporate documents are not relevant to any claims or defenses (or counterclaims), rejecting the argument that such documents would "shed light on the motivations of both TeamHealth and Plaintiffs." *Id.* at *2-3. The framework there – "proper rate of reimbursement" – is identical to this case, thus *Emergency Services of Oklahoma* is instructive. The Health Care Providers respectfully request the Court sustain their objections and deny United's Motion to compel responses in connection with RFP Nos. 61, 69 and 132.

2. The Relationship Between TeamHealth and the Health Care Providers Has No Bearing on the Parties' Respective Claims or Defenses

Similar to the corporate structure documents, the next set of categories of documents United seeks to compel relates to the relationship between TeamHealth and the Health Care Providers. These "relationship" documents are in Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145:

> 95. Documents which show the relationship between Plaintiffs and Team Health from July 1, 2017 to present, including but not limited to documents showing the services provided to you by Team Health, any compensation Team Health received in connection with those services (including remuneration flowing between you and Team Health or collected reimbursement that Team Health keeps), and documents showing any Team Health ownership and/or control over you.
>
> 108. All contracts, arrangements and/or agreements between you and Team Health, Inc., that were in force anytime July 1, 2017 to the present which relate to:
>
> a) Reimbursements for emergency medical claims;
> b) Pricing for emergency medical claims;
> c) The Claims in dispute in this lawsuit;
> d) Defendants.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003426

> 133. All documents sufficient to demonstrate whether any individuals at Team Health have acquired the right to own, operate, or manage the Plaintiff entities.
>
> 134. All documents reflecting the full and complete financial relationship between You and Team Health.
>
> 142. All documents regarding TeamHealth's current employee health plan, including the benefit level, reimbursement methodology, and plan language applicable to claims for reimbursement for out-of-network services received by plan participants.
>
> 143. All data showing the allowed amounts for claims for reimbursement for out-of-network emergency medical services rendered by participants of TeamHealth employee benefit plan at any time since July 1, 2017.
>
> 144. All documents regarding TeamHealth's prior, United Healthcare administered plan, including the benefit level, reimbursement methodology, and plan language applicable to claims for reimbursement for out-of-network services received by plan participants.
>
> 145. All data showing the allowed amounts for claims for reimbursement for out-of-network emergency medical services rendered by participants of the plan identified in response to Request 143.

United's Appendix, Exhibit 5 at RFP Nos. 95, 108, 133, 134, 142, 143, 144, and 145. United's generic "relationship" description of these RFPS is not entirely forthcoming because RFP Nos. 142-145 seek information about TeamHealth's current employee health plan, as well as its former United Healthcare administered plan.

The Health Care Providers objected to each of these requests because the information is not relevant or proportional to the needs of the case given that this is a "rate of payment" case that is predicated on whether United's reimbursement rates are proper. United argues that the subject requests would end to inform "identification of the entities that have decisional input concerning the setting of Defendants' [sic] charges and concerning whether to accept an amount below billed charges" and "TeamHealth's financial incentive." Motion at 16:9-15. The *Emergency Services of Oklahoma* court rejected that defendant-insurer's request for the same type of documents because they just do not have a nexus to the asserted rate of payment claims like those that exist here. *Emergency Services of Oklahoma, PC v. Aetna Health, Inc.*, No. CIV-

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003427

17-600-J, 2020 WL 6813218, at *2 (W.D. Okla. Nov. 19, 2020) ("Neither Plaintiffs' claims nor Defendants' defenses nor counterclaim extend the relevant issues in the case to include motivations, financial benefits, or anticipated impacts of Plaintiffs' acquisition by a non-party. Nor do they encompass within the realm of relevancy contracts between Plaintiffs or TeamHealth and medical facilities.").

Here, there is nothing about United's RFP Nos. 95, 108, 133, 134, 142, 143, 144, or 145 that would support or refute the Health Care Providers' claims asserted in the First Amended Complaint, nor does United point to any affirmative defense that this information could purportedly inform. Nevertheless, United points to two articles in support of its efforts to obtain irrelevant and disproportionate discovery. Motion at 16:16-23. Essentially, United argues that financial arrangements between TeamHealth and the Health Care Providers and/or Blackstone's equity investment in TeamHealth is "relevant to the reasonable value of the underlying medical services." Motion at 16:24-25. In their opposition to United's motion to compel clinical records, the Health Care Providers had occasion to explain that the cornerstone of an evaluation of the "value of services" under Nevada law relates to market value.[2] *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381 n.3, 283 P.3d 250, 257 n. 3 (2012) (citing Restatement (Third) of Restitution and Unjust Enrichment § 49(3)(c) & cmt. f (2011); *see also Massachusetts Eye and Ear Infirmary v. QLT Phototherapeutics, Inc.*, 552 F.3d 47, n.26 ((1st Cir. 2009), *decision clarified on denial of reh'g*, 559 F.3d 1 (1st Cir. 2009) (the fair market value of a requested benefit was a well-accepted measure of unjust enrichment). Or further, a previous agreement between the parties may be a proper consideration in determining the reasonable value of services rendered. *See Flamingo Realty, Inc. v. Midwest Dev., Inc.*, 110 Nev. 984, 988–89, 879 P.2d 69, 71–72 (1994) *see also Children's Hosp. Cent. California v. Blue Cross of*

[2] "A person confers a benefit upon another if he gives to the other possession of or some other interest in money, land, chattels, or choses in action, performs services beneficial to or at the request of the other, satisfies a debt or a duty of the other, or in any way adds to the other's security or advantage." Restatement (First) of Restitution §1 cmt. b. (1937); *see also Certified Fire Prot. Inc*., 128 Nev. at 382, 283 P.3d at 257 ("'[B]enefit' in the unjust enrichment context can include 'services beneficial to or at the request of the other,' 'denotes any form of advantage,' and is not confined to retention of money or property").

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003428
003428

California, 172 Cal. Rptr. 3d 861, 872 (2014) (internal citations omitted) (the true marker of the "reasonable value" of services has been described as the "going rate" for the services or the "reasonable market value at the current market prices"); *Eagle v. Snyder*, 412 Pa. Super. 557, 604 A.2d 253 (1992) (reasonable value of medical services may be determined through expert testimony regarding the market value of the medical services provided based on the average charges in the region where the services were performed); Restatement (Third) of Restitution and Unjust Enrichment § 31 cmt. e (2011) ("Where such a contract exists, then, quantum meruit ensures the laborer receives the reasonable value, usually market price, for his services.").

The foregoing authorities demonstrate that United is just plain wrong that any "relationship" documents have anything to do with the Health Care Providers' ability to carry their evidentiary burden that ***United's*** reimbursement rates are unreasonable, nor does United point to the existence of any affirmative defense that would be impacted by these requests because the relevant inquiry is not whether the Health Care Providers' charges are reasonable. Moreover, the articles cited by United do not provide any legitimate authority for ordering discovery that does not have a relationship to the claims asserted in the First Amended Complaint. This Court has previously concluded that "[t]he relevant inquiry in this action is the proper rate of reimbursement which is based on the amount billed by the Health Care Providers and the amount paid by United." Order Denying Clinical Records at ¶ 18. None of the "relationship" requests have any connection to this framework. As such, the Health Care Providers objected to the requests and now respectfully ask the Court to sustain their objections and deny United's Motion.

3. Costs Are Not Relevant to Establishing the Reasonable Value of Services

Documents asking for the Health Care Providers' actual costs have nothing to do with whether United has properly reimbursed the Health Care Providers for emergency services, yet, United made the following broadly worded requests:

> 68. Please produce all documents which reflect or discuss the extent to which the rates you charge for emergency medical

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003429

> services, from July 1, 2017 to present, capture or reflect your actual cost of doing business.
>
> 86. Please produce all documents and communications of any type related to any cost to charge analysis performed on any emergency medical service you offer patients from July 1, 2017 to present.
>
> 92. Documents showing each and every cost incurred by you in offering emergency services to patients from July 1, 2017 to present.
>
> 93. Documents showing each and every cost incurred by you in offering the types of services reflected in the Claims from July 1, 2017 to present.
>
> 94. A copy of any cost report(s) presented by you to any federal or state agency since July 1, 2017 to present.

United's Appendix to Motion, Exhibit 5 at Request Nos. 68, 86, 92, 93, and 94. United contends that "the costs incurred by Plaintiffs in performing emergency medical services is directly relevant to the issue of whether any payment by United was "'reasonable' vis-à-vis the value of any services rendered." Motion at 17:12-14. However, Nevada law makes it clear that the reasonable value of services does not embody cost considerations, instead focusing on market value. *Certified Fire Prot. Inc.*, 128 Nev. at 381 n.3, 283 P.3d at 257 n. 3.

United also points to its sixth affirmative defense in support of its position that costs are relevant to the inquiry.[3] However, its sixth affirmative defense that [s]ome or all of Plaintiffs' billed charges are excessive under the applicable standards" has nothing to do with underlying costs to do business. Rather United's affirmative defense essentially says that United believes its rate of payment is justified, essentially the contrary argument to the Health Care Providers' allegations that United's rate of payment is improperly manipulated. United cannot overcome the fact that its reimbursement rates are what is at stake in this litigation and not the Health Care Providers' costs.

Although United tries to distinguish the *Gulf-to-Bay* case involving United affiliates and a provider under the Team Health umbrella, an order provided by United provides a persuasive

[3] Which states: "Some or all of Plaintiffs' billed charges are excessive under the applicable standards, and/or Plaintiffs have failed to identify any basis for entitlement to demand receipt of any fixed percentage of billed charges." Answer to First Am. Compl. at 44:21-23.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003430
003430

discussion as to why costs are not relevant to an inquiry about the reasonable value of services. United Appendix to Motion, Exhibit 16. The *Gulf-to-Bay* case involves a Florida statute that requires payment of the usual and customary provider charges for similar services in the community, likening it to the "fair market value." As a result, that court concluded that costs are not part of the equation under the statute. But the court went even further to discuss other asserted claims for breach of implied-in-fact-contract, quantum meruit and unjust enrichment – claims included in the First Amended Complaint in this case – and also found that internal costing has no bearing on whether the reasonable value of services provided and/or a benefit has been conferred. *Id.* at ¶ 10.[4] The *Gulf-to-Bay* discovery order is consistent with Nevada law and the cornerstone element of unjust enrichment and quantum meruit claims that look to market value, not costs. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. 371, 381 n.3, 283 P.3d 250, 257 n. 3 (2012) (citing Restatement (Third) of Restitution and Unjust Enrichment § 49(3)(c) & cmt. f (2011); *see also Massachusetts Eye and Ear Infirmary v. QLT Phototherapeutics, Inc.*, 552 F.3d 47, n.26 ((1st Cir. 2009), *decision clarified on denial of reh'g*, 559 F.3d 1 (1st Cir. 2009) (the fair market value of a requested benefit was a well-accepted measure of unjust enrichment).

Conspicuously, United fails to cite any legal authority in support of its contention that cost documents should be ordered in this case. Motion at 17:5-18:6. The Health Care Providers' position is consistent with courts that have considered and rejected arguments that cost documents are relevant in similar scenarios. For example, in *NorthBay Healthcare Group* -

[4] The Florida state court found:

> Additionally, the Florida Standard Jury Instructions provide that the determination of damages for breach of implied-in-fact contract, quantum meruit, and unjust enrichment ***is based upon the fair compensation for the services rendered and/or benefit conferred – not the costs to provide the service***. *See* Florida Standard Jury Instructions in Contract and Business Cases, § 416.7, Restatement (First) of Restitution § 1 cmt. b (1937). Plaintiff's internal cost structure is therefore irrelevant to the analysis of the value of the services conferred by the Plaintiff or the factors to be considered by the jury.

(emphasis added).

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003431

003431

Hosp. Div. v. Blue Shield of California Life & Health Ins., 342 F. Supp. 3d 980, 990 (N.D. Cal. 2018), the defendant-insurer asked a provider for documents explaining how billed charges were set and showing the providers' profitability. The court declined to compel production of such costing documents because in a quantum meruit dispute, "the reasonable and customary value of hospital services is determined by value to the recipient, not the cost to the provider" and the provider did not intend to introduce such evidence in support of the establishing the value of services. *Id.* As a result, the court denied the defendant-insurer's motion to compel documents related to costing and profitability. *Id.; see also Regents of the Univ. of California v. Glob. Excel Mgmt., Inc.*, No. SACV160714DOCEX, 2018 WL 5794508, at *19 (C.D. Cal. Jan. 10, 2018) ("under quantum meruit, the costs of the services provided are not relevant to a determination of reasonable value.").

Because United has not articulated any relevant and proportional basis to require the Health Care Providers to respond to the broadly crafted RFP Nos. 68, 86, 92, 93, and 94, they respectfully request the Court sustain their objections and deny the Motion on this issue.

4. Hospital Contracts Are Not Relevant and Proportional Either

Lastly, United asks the Court to compel documents related to hospitals where they provide emergency medicine services:

> 126. All documents relating to presentations and/or proposals you have made to the facilities where services in question were rendered regarding your emergency medical services.
>
> 137. All contracts and/or agreements between you and any hospital or facility that were in effect between July 1, 2017 to the present where the emergency medical services relating to the Claims were provided.
>
> 146. All documents relating to your entitlement to render services in the facilities at which treatment for the Claims was rendered, including but not limited to licensure, privileges, and credentialing.

United's Appendix to Motion, Exhibit 5 at RFP Nos. 126, 137 and 146. In support of RFP Nos. 126 and 127, United contends that what "Plaintiffs offer, charge or accept from hospitals/facilities is relevant to the reasonable value of services." Motion at 18:13-15. As

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003432
003432

explained herein, United's argument misses the mark in that market value (and not costs) is the relevant consideration. *Certified Fire Prot. Inc.*, 128 Nev. at 381 n.3, 283 P.3d at 257 n. 3.

In support of RFP No. 146, United contends that a request to obtain licensing and credentialing of medical providers is designed to learn whether "Plaintiffs are subject to competition that could potentially drive down their rates." Motion at 18:27-28. United provides no further explanation about how a providers' license or credential could provide any information about competition. Moreover, United's proffered reason does not inform any of the claims in the First Amended Complaint or any defenses. Again, the "relevant inquiry in this action is the proper rate of reimbursement." Order Denying Clinical Records at ¶ 18. United's attempt to compel production of professional licensure and credentialing is really an end run around the Court's Order Denying Clinical Records. The Court can infer this from United's reference to a qui tam action pending in the Eastern District of Texas that alleges TeamHealth billed physician assistants at physician status as a signal that United wants to revisit the underlying clinical records.[5] But the Court has already considered that argument and denied it. *Id.*at ¶ 2 (finding that "because this is a rate of pay case and [t]here is no counterclaim, then the [clinical] records…are [not] relevant to the Plaintiffs' complaint.") (internal quotations omitted). Like before, the Health Care Providers' credentials and licenses have no bearing on this case's reimbursement context; therefore the Court should, respectfully, deny United's Motion on this issue. *Certified Fire Prot. Inc. v. Precision Constr.*, 128 Nev. at 381 n.3, 283 P.3d at 257 n. 3.

In *Emergency Services of Oklahoma*, the Court denied a nearly identical request by a defendant-insurer for hospital/facility contracts, disagreeing that the that "[c]ontracts between Plaintiffs (or TeamHealth) and the facilities where Plaintiffs provide emergency medical services may shed light on the reasonableness of Plaintiffs' charges, any incentives Plaintiffs have to treat patients or code claims in a certain way, and Plaintiffs' market power and bargaining position

[5] TeamHealth denies that it has improperly billed provider services and is currently litigating claims that concern the sufficiency of documentation required to establish compliance with Centers for Medicare & Medicaid Services ("CMS") billing requirements for split/shared visits that involve a physician and a physician assistant or advanced practice nurse. The issues there are not analogous and do not provide United an avenue to conduct discovery that is irrelevant to the claims at issue in this action.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003433

for emergency medical services in Oklahoma." 2020 WL 6813218, at *2. This decision is instructive given the lack of any nexus between requests that really seek actual costs and tries to divert the focus of this action that is centered on the propriety of United's reimbursement rates for emergency medicine services that the Health Care Providers are required by federal and state law to provide regardless of an individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment & Labor Act ("EMTALA"), 42 U.S.C. § 1395dd; *see also* NRS 695G.170(1); 42 C.F.R. § 438.114(c)(1)(i); First Am. Compl. ¶ 18.

United has not articulated any relevant and proportional basis to require the Health Care Providers to respond to RFP Nos. 126, 137 and 146, they respectfully request the Court sustain their objections and deny the Motion.

IV. CONCLUSION

Based on the foregoing, the Health Care Providers respectfully request that the Court deny United's Motion to compel in its entirety.

DATED this 12th day of January, 2021.

McDONALD CARANO LLP

By: */s/ Kristen T. Gallagher*

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003434

003434

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that I am an employee of McDonald Carano LLP, and that on this 12th day of January, 2021, I caused a true and correct copy of the foregoing **PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME** to be served via this Court's Electronic Filing system in the above-captioned case, upon the following:

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
lroberts@wwhgd.com
cbalkenbush@wwhgd.com
bllewellyn@wwhgd.com

Natasha S. Fedder
O'MELVENY & MYERS LLP
400 South Hope Street, 18th Floor
Los Angeles, CA 90071-2899
nfedder@omm.com

Attorneys for Defendants

/s/ *Marianne Carter*
An employee of McDonald Carano LLP

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003435

003435

EXHIBIT A

003436

003436

EXHIBIT A

Pat Lundvall (NSBN 3761)
Kristen T. Gallagher (NSBN 9561)
Amanda M. Perach (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: A-19-792978-B Dept. No.: XXVII **DECLARATION OF KRISTEN T. GALLAGHER IN SUPPORT OF PLAINTIFFS' OPPOSITION TO MOTION TO COMPEL RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME** Hearing Date: January 13, 2021 Hearing Time: 1:00 p.m.

I, KRISTEN T. GALLAGHER, declare as follows:

1. I am an attorney licensed to practice law in the State of Nevada and am a partner in the law firm of McDonald Carano LLP, counsel for plaintiffs Fremont Emergency Services

003437

003437

(Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers").

2. This declaration is submitted in support of the Plaintiffs' Opposition To Motion To Compel Responses To Defendants' First And Second Requests For Production On Order Shortening Time ("Motion") and is made of my own personal knowledge, unless otherwise indicated. I am over 18 years of age, and I am competent to testify as to same.

3. On December 11, 2020, the parties engaged in a meet and confer that included the Health Care Providers' responses to RFPs.

4. With respect to the RFPs subject to United's Motion, the Health Care Providers further explained that they objected to the requests because corporate records, costing and hospital/facility contracts are not relevant to the First Amended Complaint's allegations and United had not raised a legitimate related affirmative defense either

I declare under penalty of perjury that the foregoing is true and correct.

Executed: January 12, 2021. /s/ *Kristen T. Gallagher*
Kristen T. Gallagher

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003438

003438

73

Electronically Filed
1/19/2021 10:07 AM
Steven D. Grierson
CLERK OF THE COURT

RTRAN

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA) LTD., Plaintiff(s), vs. UNITED HEALTHCARE INSURANCE COMPANY, Defendant(s).	CASE NO: A-19-792978-B DEPT. XXVII

003439

BEFORE THE HONORABLE NANCY ALLF, DISTRICT COURT JUDGE

WEDNESDAY, JANUARY 13, 2021

RECORDER'S PARTIAL TRANSCRIPT OF PROCEEDINGS
RE: MOTIONS (UNSEALED PORTION ONLY)

APPEARANCES (Attorneys appeared via Blue Jeans):

For the Plaintiff(s): PATRICIA K. LUNDVALL, ESQ.
KRISTEN T. GALLAGHER, ESQ.
AMANDA PERACH, ESQ.

For the Defendant(s): COLBY L. BALKENBUSH, ESQ.
D. LEE ROBERTS, JR., ESQ.
BRITTANY M. LLEWELLYN, ESQ.

RECORDED BY: BRYNN WHITE, COURT RECORDER
TRANSCRIBED BY: KATHERINE MCNALLY, TRANSCRIBER

003439

LAS VEGAS, NEVADA, WEDNESDAY, JANUARY 13, 2021

[Proceeding commenced at 1:01 p.m.]

[Sealed portion of proceedings not transcribed.]

THE COURT: Let me call the case of Fremont versus United.

Appearances, please.

MS. LUNDVALL: Good afternoon, Your Honor. This is Pat Lundvall, from McDonald Carano, on behalf of plaintiff.

THE COURT: Thank you.

Other plaintiffs?

MS. GALLAGHER: Good afternoon, Your Honor. Kristen Gallagher, on behalf of the plaintiff Health Care Providers.

MS. PERACH: Good afternoon, Your Honor. Amanda Perach, also appearing on behalf of the plaintiff.

THE COURT: Okay. Mr. Roberts, Mr. Balkenbush, Ms. Llewellyn, are you there?

MR. BALKENBUSH: I'm on, Your Honor. Colby Balkenbush for the defendants. And Mr. Roberts should be calling in any moment now.

THE COURT: Okay. Let's give him a moment.

Are there other defendants who wish to make appearance?

MS. LLEWELLYN: Yes, Your Honor. Brittany Llewellyn, also here on behalf of defendants.

003440

003440

003440

THE COURT: Thank you.

And will Mr. Roberts be the main spokesperson today?

MR. BALKENBUSH: Your Honor, in regard to the Special Master issue, Mr. Roberts is going to handle any discussion of that that the Court would like to have. And then I will be handling the Motion to Compel.

THE COURT: All right. So what I'm going to suggest on the Motion to Compel is that because the order shortening time was only filed two days ago, I did see that there was an opposition. I have to assume that it's preliminary. And because I've had hearings literally all day since 9:00 today, I haven't had a chance to review it. So I'm going to assume your motion is complete.

003441

I'll hear from the plaintiff with regard to what, if any, additional time they need to fully brief in opposition.

003441

Then I'll hear from you, Mr. Balkenbush, on when you can do a reply. And we'll get a hearing scheduled on that.

So plaintiff, on the Motion to Compel.

MS. GALLAGHER: Hi, Your Honor. Kristen Gallagher, on behalf of the plaintiffs, with respect to the Motion to Compel.

We are prepared to argue that today. We know it was on shortened time, but we are prepared to go forward. And if Your Honor is not inclined to hear it today, I would request respectfully, if it's within your schedule, to have a hearing either tomorrow or Friday.

THE COURT: Okay. Good enough.

003441

And so let's -- I am not prepared to go forward today, because I had added the language to the order that this would be a preliminary hearing. So --

MS. GALLAGHER: I appreciate that, Your Honor.

THE COURT: Good enough. How long then, Mr. Balkenbush, will you need to file a reply?

MR. BALKENBUSH: Your Honor, if we could have -- I'm just looking at my calendar here -- if we could have until Tuesday, the 19th, if the Court would be amenable to that, that would be sufficient time.

THE COURT: All right. So then I'll hear it on the 21st or 22nd. We can do a special setting on the 21st at 1 p.m., if everyone is available, because I can work in pieces and then read the reply at the end.

MS. GALLAGHER: That's agreeable, Your Honor. I'm available then as well.

MR. BALKENBUSH: And I'm available then as well, Your Honor.

THE COURT: All right. So it has to be by 5 p.m. on the 19th. And you should e-mail a courtesy copy to the law clerk, because we have sometimes a delay in our system as well, getting documents. And then we'll have a special setting on the 21st at 1 p.m., then, on that Motion to Compel.

Does that then resolve the issue with regard to Motion to Compel?

003442

003442

003442

MS. LUNDVALL: Just the clarify, the e-mail copy of the reply brief then would also be copied to us at the same time it goes to the law clerk?

THE COURT: That's correct.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: Any questions, anybody, on that?

All right. So I see Mr. Roberts has joined us.

Mr. Roberts, are you with us or on another call?

MR. ROBERTS: No, I am with you. I couldn't get my audio on, so I called in. So this is you that I'm talking to.

THE COURT: Okay. Very good. All right. So let's -- we'll make your appearance for the record.

And we have just disposed of the issue of the Motion to Compel on an order shortening time, since an opposition has been -- well, the opposition has been filed. But the reply deadline, we set it for next Thursday at 1 o'clock.

Are you now ready to proceed? It must be defendant's motion for the Special Master.

Mr. Roberts, are you now ready to proceed? And tell me about the three people you chose and how you chose them and why. And then I'll hear from the plaintiff.

MR. ROBERTS: We are, Your Honor. But before I do that, I did meet and confer with Ms. Lundvall before the call. And we were wondering if we could have this conversation with regard to the candidates off the record -- either off the record on the call or

003443

003443

003443

perhaps with a chambers call immediately following the hearing, just because these all are prominent, respected lawyers, and that would allow us to be frank, you know, with you.

THE COURT: Well, I think what you can do is stipulate in writing to have a sealed session. That stipulation has to comport with the rules.

MS. LUNDVALL: Your Honor, we are in agreement with the request that Mr. Roberts is making.

If my recollection serves me -- and I'm now relying upon recollection -- is that DCR 16 allows us to be able to put on the record a stipulation that would have the same effect then as a written stipulation. And so we would agree to stipulate that the record concerning the discussion of the proposed Special Master candidates then be sealed, so that it is -- it can be a candid conversation then with the Court.

THE COURT: All right. And Mr. Roberts, did you wish to respond?

MR. ROBERTS: Yes. I would agree with that, Your Honor.

THE COURT: Okay. So Brynn.

THE COURT RECORDER: Yes.

THE COURT: Tell me how you would propose to do this, so that the record is protected and those portions of the record are sealed by stipulation.

THE COURT RECORDER: Would the whole hearing need to be sealed or just those portions?

003444

003444

003444

THE COURT: Just the portion we're entering into now.

THE COURT RECORDER: Okay. So then just -- if you could mark clearly on the record when we need to seal it and unseal it. And then I can do my --

THE COURT: Well, we're going to seal it right now. And then we'll tell you when it's unsealed.

THE COURT RECORDER: Okay. Thank you.

[Sealed hearing excerpt from 1:08:45 p.m. to 1:29:33 p.m. -- not transcribed.]

THE COURT: Thank you.

So the matter of who will be appointed as the Special Master is now ready to be ruled on by the Court.

Having considered all of the applicants and having reviewed all of the materials; having heard off the record argument from both sides with regard to proceed to strengths and weaknesses of the candidates; the Court will select retired Judge Dave Wall as the Special Master in this case. I find that he has such a varied background that he will be able to put fresh eyes on to these discovery disputes; that he has served as a judge; he did criminal, civil, defense, prosecution; and then served as a very distinguished judge for a number of years. He's had great success as a mediator. He has the type of temperament that the -- even though the parties here are very professional and very courteous, it is a high-conflict case. I find that his demeanor will be -- and work ethic will be effective and beneficial for both sides.

003445

003445

003445

Was there -- were there any comments for the record or any objections that you would like to make to preserve the record? Starting first with the defendant.

MR. ROBERTS: No, Your Honor. We have no objection. Thank you, Your Honor.

THE COURT: Plaintiff?

MS. LUNDVALL: No further comments, Your Honor.

THE COURT: Okay. So is there anything else we need to do today other than stay healthy and safe until next week?

Mr. Balkenbush?

MR. BALKENBUSH: Your Honor --

MS. GALLAGHER: Your Honor, I have the --

MR. BALKENBUSH: Oh, I apologize.

THE COURT: Mr. Balkenbush.

MR. BALKENBUSH: Thank you, Your Honor. And then I think Ms. Perach had something to say after this.

Just a point of clarification. For the Motion to Compel, I thought Your Honor had said that the reply would be due by 5 p.m. on January 19th. But then right before we went off the record to discuss Special Master candidates, I thought you may have said 1 p.m. on January 19th. I just wanted to have clarifications on the deadline.

THE COURT: Five p.m. on Tuesday, the 19th. At the time it's filed, served electronically to me and to the plaintiffs.

MR. BALKENBUSH: Thank you, Your Honor.

003446

003446

003446

THE COURT: Okay.

MS. GALLAGHER: Your Honor --

THE COURT: Now, Ms. Perach, do you have something?

MS. GALLAGHER: It's Ms. Gallagher. I have one point, a housekeeping matter.

We had submitted an order with respect to the earlier December 23rd hearing on the Motion to Clarify that United has filed, and it looked like we received an auto return thinking that there had been competing orders.

United filed an objection, so no competing order. I just wanted to make sure whether or not that the Court needs an additional copy, for us to resend that, or if you do have it.

THE COURT: Yeah. What happens is that when the order sits there, I get notified if there is an objection or opposition. This one, I think I returned it before I had a chance even to review the objection to it. So send it back to the TPO. The law clerk and I will review it again, probably tomorrow afternoon because I have hearings all day tomorrow -- all morning. And I'm still not ready for all of them yet.

So you should expect a turnaround this week on that order.

MS. GALLAGHER: Thank you.

THE COURT: We'll either sign, interlineate, or schedule a telephonic.

MS. GALLAGHER: Thank you, so much. Appreciate it.

003447

003447

003447

THE COURT: Now, is there anything else left to do today?

All right. Mr. Roberts, you'll be tasked then with drafting the order for the appointment of the Special Master. I had previously made rulings with regard to the scope of the duties. And work with opposing counsel. Again, no competing orders. But if you have objections, bring that to my attention through the law clerk.

MR. ROBERTS: Thank you, Your Honor. I will do that. I'll provide a draft to Ms. Lundvall.

THE COURT: Good enough.

MS. LUNDVALL: Thank you, Your Honor.

THE COURT: Thank you, both. Stay safe. Stay healthy. See you next week.

MS. LUNDVALL: Thank you, Your Honor.

MS. GALLAGHER: Thank you, Your Honor.

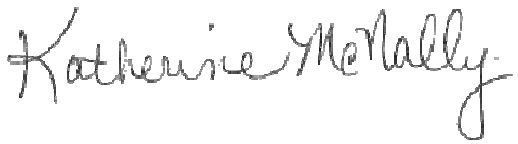
MR. BALKENBUSH: Thank you, so much.

MR. ROBERTS: Thank you.

[Proceeding concluded at 1:33 p.m.]

* * * * * * *

ATTEST: I do hereby certify that I have truly and correctly transcribed the audio/video proceedings in the above-entitled case to the best of my ability.



Katherine McNally
Independent Transcriber CERT**D-323
AZ-Accurate Transcription Service, LLC

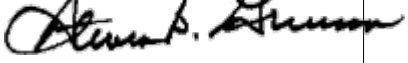
003448

003448

003448

74

Electronically Filed
1/19/2021 5:04 PM
Steven D. Grierson
CLERK OF THE COURT



RPLY

D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Brittany M. Llewellyn, Esq.
Nevada Bar No. 13527
bllewellyn@wwhgd.com
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Attorneys for Defendants

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

HEARING REQUESTED

DEFENDANTS' REPLY IN SUPPORT OF MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION

003449

003449

WEINBERG WHEELER HUDGINS GUNN & DIAL

Defendants UnitedHealth Group, Inc.; UnitedHealthcare Insurance Company; United HealthCare Services, Inc.; UMR, Inc.; Oxford Health Plans LLC (incorrectly named as "Oxford Health Plans, Inc."); Sierra Health and Life Insurance Company, Inc.; Sierra Health-Care Options, Inc. and Health Plan of Nevada, Inc. (collectively, "United" or "Defendants"), hereby submit the following Reply in Support of Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production ("Reply"). This Reply is made and based upon the papers and pleadings on file herein, the Declaration of Brittany M. Llewellyn, the following memorandum of points and authorities, and any arguments made by counsel at the time of the hearing.

Dated this 19th day of January, 2020.

/s/ Brittany M. Llewellyn

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Attorneys for Defendants

DECLARATION OF BRITTANY M. LLEWELLYN IN SUPPORT OF DEFENDANTS' REPLY IN SUPPORT OF MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION

1. I am an attorney licensed to practice law in the State of Nevada, an attorney at Weinberg, Wheeler, Hudgins, Gunn & Dial, LLC, counsel for Defendants in the above-captioned matter.

2. This Declaration is submitted in support of Defendants' Reply in Support of Motion to Compel Plaintiffs' Responses to Defendants' First and Second Set of Requests for Production. I have personal knowledge of the matters set forth herein and, unless otherwise stated, am competent to testify to the same if called upon to do so.

3. On January 7, 2020, Plaintiffs filed their First Amended Complaint. A true and correct copy of the First Amended Complaint is attached hereto as ***Exhibit 23***.

4. On September 21, 2020, Defendants filed their Motion to Compel Production of Clinical Documents for the At-Issue Claims. A true and correct copy of the Motion to Compel Production of Clinical Documents for the At-Issue Claims is attached hereto as ***Exhibit 24***.

5. On October 8, 2020, the Court held a telephonic hearing with each party. A true and correct copy of the Transcript from that proceeding is attached hereto as ***Exhibit 25***.

6. True and accurate copies of the Team Health Company or Linked-In profiles for the party witnesses disclosed in Plaintiffs' Second Supplement to their NRCP 16.1 Initial Disclosures are attached as ***Exhibit 26***.

7. On July 29, 2019, Plaintiff Fremont Emergency Services (Mandavia), Ltd. served its Objections and Answers to Defendants' First Set of Interrogatories, a true and correct copy of which is attached hereto as ***Exhibit 27***.

8. I declare that the foregoing is true and correct under the penalty of perjury under the laws of the state of Nevada.

DATED: January 19, 2021

/s/ Brittany M. Llewellyn

003451

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

The Court has characterized this as a "rate of payment" case. Oct. 8, 2020 Tr. at 30:17, attached hereto as ***Exhibit 25***. The reasonableness of the reimbursement rates for the disputed claims is not, as Plaintiffs would have it, a one-sided inquiry that evaluates only the benefit amounts that Defendants allowed under their members' benefits plans. Rather, a corresponding inquiry into the reasonableness of the billed charges is necessary because Plaintiffs have themselves put at issue the reasonableness of their charges by arguing that they should be paid a percentage of their billed charges. Defendants thus seek discovery into the basis for, and the reasonableness of, those billed charges. Plaintiffs attempt to rewrite the At-Issue Requests[1] into ones that would be covered by this Court's order denying without prejudice Defendants' motion to compel clinical records. This attempt must fail. The At-Issue Requests do not seek records to contest whether Plaintiffs in fact provided the services for which they billed, or whether those services were coded properly— *i.e.*, the discovery that was sought by the clinical records motion. Instead, the At-Issue Requests seek information regarding:

- How Plaintiffs' billed charges were set, and whether they were set objectively and in good faith (Request Nos. 61, 69, and 132);
- Whether and how TeamHealth—which Plaintiffs effectively admit is the ultimate decision maker for setting their billed charges—and TeamHealth's own financial incentives influenced Plaintiffs' billed charges (Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145);
- Plaintiffs' costs of doing business for the disputed emergency services (Request Nos. 68, 86, 92, 93, and 94); and

[1] This Reply adopts the same abbreviations and acronyms in the Defendants' Motion to Compel Plaintiffs' Responses to Defendants' First and Second Requests for Production on Order Shortening Time ("Motion" or "Mot.").

- The amounts that Plaintiffs offer, charge, or accept from hospitals/facilities, and whether Plaintiffs' billed charges for the at-issue claims are reasonable *vis-à-vis* those amounts (Request Nos. 126, 137, and 146).

The At-Issue Requests relate to Defendants' affirmative defenses that contest the reasonableness of Plaintiffs' billed charges, including whether Plaintiffs' billed charges are "excessive under the applicable standards," ***Exhibit 18*** to Motion at 44, and whether Plaintiffs have suffered any damages or mitigated those damages. *Id.* at 43-48. They also relate to Plaintiffs' own allegations, which put at issue what payment amount constitutes "a reasonable payment for the services rendered." Plaintiffs' First Amended Complaint ("FAC") ¶ 40, attached hereto as ***Exhibit 23***.

Moreover, any argument by Plaintiffs that discovery related to TeamHealth is not relevant here falls flat: (1) TeamHealth, while not a named plaintiff, currently or previously employed *every party witness* that Plaintiffs have disclosed in this matter; (2) a TeamHealth employee verified Plaintiffs' discovery responses in this matter; and (3) it does not appear that Plaintiffs disclosed or otherwise identified *any* employees of the named Plaintiffs themselves that have knowledge relating to the claims and defenses in this case. In short, Plaintiffs have baselessly drawn a line between TeamHealth and themselves for purposes of discovery. The broad and liberal rules of discovery do not permit such limitations. Without the document discovery sought by this Motion, Defendants will be severely prejudiced when trying to depose "party" witnesses and defend themselves at any trial. Defendants respectfully request that the Court grant their Motion.

III. LEGAL ARGUMENT

A. PLAINTIFFS' BOILERPLATE OBJECTIONS SHOULD BE STRICKEN AS IMPROPER

As an initial matter, Plaintiffs fail to address Defendants' argument that their boilerplate objections should be stricken. *See* Mot. at 11-12; *see generally* Plaintiffs' Opposition to Motion ("Opposition" or "Opp'n"). The Court should therefore strike all of Plaintiffs' improper boilerplate objections to the At-Issue Requests.

003453

B. THE AT-ISSUE REQUESTS SEEK RELEVANT AND DISCOVERABLE INFORMATION DIRECTLY RELATED TO PLAINTIFFS' CLAIMS AND DEFENDANTS' AFFIRMATIVE DEFENSES

Defendants have propounded relevant discovery concerning (1) Plaintiffs' corporate structure and relationship to TeamHealth (Request Nos. 61, 69, 95, 108, 132, 133, 134, 142, 143, 144, and 145); (2) Plaintiffs' costs of doing business for the at-issue emergency services (Request Nos. 68, 86, 92, 93, and 94); and (3) contracts between Plaintiffs and the hospitals where they provide emergency services (Request Nos. 126, 137, and 146). With the At-Issue Requests, Defendants seek to discover the basis for the charges that Plaintiffs billed for the disputed benefit claims, and to test the reasonableness of those billed charges. These inquiries are relevant to both Plaintiffs' claims and Defendants' affirmative defenses.

Plaintiffs have defined their claims as follows: "Specifically, the reimbursement claims within the scope of this action are (a) nonparticipating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) ***at rates below the billed charges and a reasonable payment for the services rendered***, (d) as measured by the community where they were performed and by the person who provided them." ***Exhibit 23*** ¶ 40 (emphasis added). Plaintiffs further allege that, "a ***reasonable reimbursement rate*** for the Health Care Providers' Non-Participating Claims for emergency services ***is 75-90% of the Health Care Providers' billed charge***." *Id.* ¶ 54 (emphasis added). Defendants are entitled to test Plaintiffs' contention that a "reasonable payment" for the disputed benefit claims is "75-90% of the Health Care Providers' billed charge." Plaintiffs argue that this discovery is irrelevant because "this litigation concerns ***United's*** failure to allow reasonable reimbursement rates." Opp'n at 3 (emphasis in original). In so arguing, Plaintiffs effectively ask Defendants and the Court to accept that their billed charges were reasonable. But that is not how litigation and trials work. Plaintiffs bear the burden of proving that their billed charges were reasonable, and Defendants have a due process right to contest the reasonableness of those charges. *See Children's Hosp. Cent. California v. Blue Cross of California*, 226 Cal.App.4th 1260, 1275, 172 Cal.Rptr.3d 861, 873 (2014) ("In contrast here, Hospital was required to demonstrate the reasonable value, i.e., market value, of the

poststabilization care it provided. This market value is not ascertainable from Hospital's full billed charges alone."). Plaintiffs cite no authority supporting the proposition that they are entitled to any presumption of reasonableness with respect to their billed charges.[2] Defendants, for their part, have interposed affirmative defenses that challenge and probe the reasonableness of Plaintiffs' billed charges, including that "[s]ome or all of Plaintiffs' billed charges are excessive under the applicable standards." ***Exhibit 18*** at 44.

The At-Issue Requests seek to discover the basis for and reasonableness of Plaintiffs' billed charges for the disputed claims. Defendants' requests probing Plaintiffs' corporate structure (Request Nos. 61, 69, and 132) seek to ascertain which individuals or entities have ownership, control, and/or governance of Plaintiffs, and whether any of the individuals or entities with ownership, control, or governance of Plaintiffs has a financial incentive to jack-up Plaintiffs' billed charges. *See* Mot. at 15-16. Whether TeamHealth, or any other individual or entity that has ownership, control, or governance of Plaintiffs' respective boards of directors or governing bodies, or any groups or committees charged with the task of reviewing or setting rates, has a financial incentive to habitually increase Plaintiffs' billed charges is directly related to whether Plaintiffs' unilaterally-set rates are reasonable. Indeed, Plaintiffs' own allegations suggest that reimbursement at 100% of their billed charges is ***not*** reasonable: Plaintiffs pinpoint "75-90% of the Health Care Providers' billed charge" as "a reasonable reimbursement rate." ***Exhibit 23*** ¶ 54. If 100% of billed charges is not a reasonable reimbursement rate, then discovery into the basis for the billed charges, and how those charges compare to other payment rates that Plaintiffs accept, is relevant to determining the reasonableness of their alleged damages.

Similarly, Defendants' requests regarding the relationship between Plaintiffs and TeamHealth (Request Nos. 95, 108, 133, 134, 142, 143, 144, and 145) focus on whether and how TeamHealth influences the billed charges that Plaintiffs set. *See* Mot. at 16-17. Plaintiffs have

---

[2] The Court's order denying Defendants' motion to compel clinical records without prejudice does not stand for this proposition and addressed a different issue.

003455

003455

effectively admitted TeamHealth is the ultimate decision maker regarding their billed charges. *See* Opp'n at 6 ("United argues that the foregoing requests also include a request to identify individuals or entities who have decisional input about how the Health Care Providers set charges. . . . United admits that **the Health Care Providers have disclosed such individuals** on their NRCP 16.1 list of witnesses.") (emphasis added). In fact, Plaintiffs have not identified *one party witness* who is not a current or former TeamHealth employee. *See* Mot. at 16; *see also* ***Exhibit 26*** (compiling profiles for Plaintiffs' party witnesses reflecting that each of them is a current or former TeamHealth employee); ***Exhibit 27*** at 5-7 (identifying Plaintiffs' party witnesses as a current or former TeamHealth employees). Plaintiffs cannot rely on TeamHealth witnesses to prove their case, on the one hand, and then deny Defendants discovery into TeamHealth's role in setting and influencing Plaintiffs' billed charges and/or contracted payments, on the other.[3]

The At-Issue Requests regarding the payment rates that Plaintiffs charge, offer, or accept for emergency services from facilities (Request Nos. 126 and 137), and Plaintiffs' entitlement to provide services at those facilities, including whether Plaintiffs had a monopoly at those facilities (Request No. 146) are also probative of whether the payment rates that Plaintiffs charged Defendants were reasonable. *See* Mot. at 18-19. *See also* ***Exhibit 23*** ¶ 40 (reimbursement claims within scope of action are in part "measured by the community where [the services] were performed"). Plaintiffs themselves allege that the reimbursement rates allowed on the disputed claims are below "a reasonable payment for the services rendered . . . as measured by the community where they were performed and by the person who provided them." ***Exhibit 23*** ¶ 40. The discovery that Defendants seek into Plaintiffs' relationships with facilities in the community is thus directly tied to Plaintiffs' own allegations. *See Eagle v. Snyder*, 412 Pa. Super. 557, 560, 604 A.2d 253, 254 (1992) (healthcare provider's billed charges "alone should not be the base

[3] As for At-Issue Requests regarding TeamHealth's current employee health plan, if TeamHealth reimburses for out-of-network emergency services at rates that are different from the ones Plaintiffs are demanding here, that is relevant to the issue of whether the rates to which Plaintiffs claim entitlement are reasonable.

003456

003456

upon which community standards are established" if the charges derive from a single provider because "the price is dictated under those circumstances by monopolistic forces."). To evaluate whether Plaintiffs' billed charges for the at-issue claims are reasonable *vis-à-vis* the Plaintiffs' charges pursuant to their contracts with such facilities, Defendants need to understand, for example, whether Plaintiffs have a monopoly in the relevant market that allows them to set artificially high charges for their services, whether Plaintiffs increased their charges by agreeing that providers who meet certain licensing and/or credentialing requirements would render certain services, or whether Plaintiffs offered, charged, or accepted different payment amounts depending on the hospital or facility where the service was performed. *See* Mot. at 18-19. Such discovery is further probative of whether Plaintiffs' contractual arrangements with such facilities impact their out-of-network billing practices. For example, if those contractual arrangements generate costs to Plaintiffs that they absorb and compensate for by increasing their billed charges for out-of-network services.

Defendants also seek discovery into the cost of providing the services underlying the at-issue claims to assess whether the Plaintiffs' billed charges were reasonable (Request Nos. 68, 86, 92, 93, and 94). *See Florida Emergency Physicians Kang & Assocs., M.D., Inc. v. Sunshine State Health Plan, Inc.*, CACE19-013026, Filing No. 118577916, at 4-6 (Fl. Cir. Ct. Dec. 21, 2020) (***Exhibit 17***).[4] The court in *Florida Emergency Physicians* allowed such discovery where, as here, the plaintiffs in that case (who are, just like the plaintiffs here, affiliated with TeamHealth) alleged that defendants failed to adequately reimburse plaintiffs for emergency services and sought recovery on breach of implied contract and unjust enrichment theories, among others. *Id.* at 1, 4-6. The court reasoned that, while it was "'appropriate to consider the amounts billed and the amounts accepted by providers,'" it was not "inappropriate to allow discovery into other areas," and thus the court was not precluded from "compelling . . . cost of care discovery." *Id.* at 3, 5 (quoting *Baker Cnty. Med. Servs., Inc. v. Aetna Health Mgmt., LLC*,

[4] Plaintiffs erroneously contend that United "fails to cite any legal authority in support of its contention that cost documents should be ordered in this case." Opp'n at 12.

31 So. 3d 842, 845 (Fla. 1st DCA 2010)). In so ruling, the *Florida Emergency Physicians* court distinguished the *Gulf-to-Bay* case cited by Plaintiffs on the basis that there, "defendants did not raise any unreasonable pricing claims, either by affirmative defense or counterclaim," and "the pleadings were focused solely on a statutory analysis that addresses the fair market value of the services provided." *Id.* at 5. Here, like the providers in *Florida Emergency Physicians*, Plaintiffs' actual costs of doing business are directly relevant to several of Defendants' affirmative defenses, including Defendants' Sixth ("Some or all of Plaintiffs' billed charges are excessive under the applicable standards"), Fourteenth ("Plaintiffs' claims are barred, in whole or in part, to the extent they have not suffered any damages."), Eighteenth ("Plaintiffs' claims are barred, in whole or in part, to the extent that Plaintiffs have not mitigated their damages"), and Twenty-Sixth ("Plaintiffs are not entitled to relief because they have received all payments due, if any, for the covered services they provided in accordance with the terms of their patients' health plans.") affirmative defenses. ***Exhibit 18*** at 44, 46, 48. *See* ***Exhibit 17*** at 5 ("Here, Defendants have raised at least four affirmative defenses relating to the reasonableness of Plaintiffs' charges and pricing."). Furthermore, unlike in *Gulf-to-Bay*, Plaintiffs' pleading contains no claim based on a statute that addresses compensation of out-of-network emergency services, because no such claim is available to Plaintiffs in Nevada.[5]

For these reasons, this Court should follow the reasoning of the court in *Florida Emergency Physicians* and allow discovery into Plaintiffs' costs of providing care for the disputed emergency services.

C. PLAINTIFFS FAIL TO MEET THEIR BURDEN OF SHOWING THAT DEFENDANTS' DISCOVERY REQUESTS ARE IRRELEVANT

Plaintiffs have failed to meet their burden of "clarifying, explaining, and supporting [their relevancy] objections" to the At-Issue Requests. Motion at 13 (collecting cases). As an initial matter, Plaintiffs improperly attempt to shift the focus of the reasonableness inquiry to United.

[5] A special statutory rate of payment scheme passed in the 2019 Nevada Legislative Session, but those statutory requirements did not go into effect until January 1, 2020 and the statute is not retroactively applicable to this case. *See* AB 469 at § 29(2) (2019 Nevada Legislative Session) (stating that law does not go into effect until January 1, 2020).

See Opp'n at 10 (discovery sought allegedly irrelevant to "the Health Care Providers' ability to carry their evidentiary burden that ***United's*** reimbursement rates are unreasonable") (emphasis in original), 11 ("United cannot overcome the fact that its reimbursement rates are what is at stake in this litigation and not the Health Care Providers' costs."). For the reasons stated above, the Court should reject Plaintiffs' untenable position that the reasonableness of Plaintiffs' billed charges is irrelevant in case where they seek to recover damages for Defendants' failure to pay them a percentage of those charges.

Plaintiffs also argue that their relationship with TeamHealth is wholly irrelevant to this matter. *See* Opp'n at 9-10. TeamHealth, while not a named plaintiff, currently or previously employed every party witness that Plaintiffs have disclosed in this matter. *See* ***Exhibit 26***; ***Exhibit 27*** at 5-7. Furthermore, as noted *supra* at 8, Plaintiffs have effectively admitted that TeamHealth is the ultimate decision maker behind their charges. *See* Opp'n at 6. And, a TeamHealth employee has verified interrogatory responses that Plaintiffs have submitted in this matter. *See* Plaintiff Fremont Emergency Services (Mandavia), Ltd.'s Objections and Answers to Defendants' First Set of Interrogatories at 9, attached hereto as ***Exhibit 27*** (verification signed by Kent Bristow, Senior Vice President, Revenue Management at TeamHealth). Plaintiffs have not disclosed or otherwise identified any employees of the named Plaintiffs themselves that have knowledge relating to the claims and defenses in this case. In these ways, *Plaintiffs* have plastered TeamHealth all over this case, and the Court should reject their argument that their relationship to TeamHealth "has no bearing" on their allegations or United's defenses.

Next, Plaintiffs attempt to recast Defendants' discovery requests as seeking clinical records to argue that the issues presented by this Motion have already been decided by the Court. *See, e.g.*, Opp'n at 2, 4, 14. Plaintiffs are wrong. In their motion for clinical records, Defendants sought discovery into whether Plaintiffs actually performed and properly reported the alleged medical services they reported in each of their claims forms. Defendants' Motion to Compel Production of Clinical Documents for At-Issue Claims at 8, attached hereto as ***Exhibit 24***. In other words, Defendants sought discovery into the services underlying the at-issue claims to test

003459

whether those services were properly coded, and/or were performed at all. The Court in ruling on the motion stated:

> I do see it as a rate-of-pay case. The two of you are trying completely different theories -- the defendant, of course, continues to resist the plaintiffs' grounds for its complaint. But I just don't see -- when the plaintiff bills the CPT codes, it doesn't put a burden on the defendant to make the plaintiff prove what was actually done clinically. On a rate of -- in the rate of payment type of case, it's the plaintiffs' burden to prove that the rate was wrong. So I don't see where the clinical records matter. Everything here is based upon the bills that were provided by the plaintiff.

Exhibit 25 at 50:11-21. Defendants respectfully disagree with the Court's analysis of the relevance of clinical records to Plaintiffs' allegations and burden of proof. But that disagreement notwithstanding, here, Defendants are not seeking discovery into "what was actually done clinically." Rather, Defendants seek discovery into the basis for Plaintiffs' billed charges, and the reasonableness of those billed charges. This discovery is clearly relevant to "a rate-of-pay case," even as this Court has defined the contours of relevant evidence.

The case law that Plaintiffs cite does not counsel a different result. *First*, Plaintiffs rely on several cases from jurisdictions with state statutes that address reimbursement rates for out-of-network services. *See, e.g.*, *Gulf-to-Bay* (***Exhibit 16***); *Children's Hosp. Cent. California*, 226 Cal.App.4th 1260 at 1267-68; *Emergency Servs. of Oklahoma, PC v. Aetna Health, Inc.*, 2020 WL 6813218, at *2 (W.D. Okla. Nov. 19, 2020).[6] As noted above, there is no such statute in Nevada that applies to the disputed claims. Those courts thus evaluated discovery requests in light of statutory language that has no application to this case. *See, e.g.*, *Emergency Servs. of Oklahoma*, 2020 WL 6813218, at *2.

Second, in the absence of Nevada case law addressing how to determine the reasonableness of billed charges for out-of-network emergency services, Plaintiffs attempt to impose their own definition. Plaintiffs urge this Court to apply a "market value" standard, under

[6] The discovery the defendant sought in *Emergency Servs. of Oklahoma* with respect to TeamHealth is likewise distinguishable. There, defendants sought discovery into "motivations, financial benefits, or anticipated impacts of Plaintiffs' acquisition by [TeamHealth]." 2020 WL 6813218, at *2. Here, Defendants do not seek discovery into Plaintiffs' acquisition by TeamHealth, and the *Emergency Servs. of Oklahoma*'s ruling on that issue is inapplicable.

003460

which, according to Plaintiffs, their relationship to TeamHealth, their hospital contracts, and their costs of care are irrelevant. *See* Opp'n at 9-15. As a threshold matter, none of the cases that Plaintiffs cite categorically limit the factors that the finder-of-fact may consider to determine the reasonableness of the reimbursement rates that the health insurers and health plans allowed for payment. Specifically, none of those cases foreclose consideration of information concerning the basis for, and the reasonableness of, Plaintiffs' billed charges, including information pertaining to Plaintiffs' relationship to the entity that apparently sets its billed charges, as well as information about what Plaintiffs offer, charge or accept from hospitals/facilities, and/or about Plaintiffs' costs of care. For example, the *Children's Hospital* court stated in pertinent part:

> "[A] medical care provider's billed price for particular services is not necessarily representative of either the cost of providing those services or their market value." Rather, the full billed charges reflect what the provider unilaterally says its services are worth. In a given case, the reasonable and customary amount that the health care service plan has a duty to pay "might be the bill the [medical provider] submits, or the amount the [health care service plan] chooses to pay, or some amount in between."

226 Cal.App.4th at 1275 (quoting *Howell v. Hamilton Meats & Provisions, Inc.*, 52 Cal.4th 541, 564, 129 Cal.Reptr.3d 325, 257 P.3d 1130 (2011) and *Prospect Med. Grp. Inc. v. Northridge Emergency Med. Grp.*, 45 Cal.4th 497, 504, 87 Cal.Rptr.3d 299, 198 P.3d 86 (2009)); *see Massachusetts Eye and Ear Infirmary v. QLT Phototherapeutics, Inc.*, 552 F.3d 47, 66-67 (1st Cir. 2009) (citing Massachusetts law for the proposition that, "In a case where the jury cannot estimate the value of a benefit from common knowledge, the plaintiff must present evidence of the reasonable value of the benefit in order to receive anything more than nominal damages," and further that, "the plaintiff's sole reliance on evidence of his own lost profits insufficient to sustain a claim for unjust enrichment damages."); *NorthBay Healthcare Grp. - Hosp. Div. v. Blue Shield of California Life & Health Ins.*, 342 F.Supp.3d 980, 990 (N.D. Cal. 2018) (citing California law and acknowledging that there are "many ways a plaintiff could prove reasonable value," and stating that "[a] party suing for its reasonable value 'may testify as to the value of his services,'" although "'such evidence is not required . . .'") (quoting *Children's Hosp. Cent.*

003461

California, 226 Cal.App.4th 1260, 1274).[7] The Restatement (Third) of Restitution and Unjust Enrichment, for its part, allows for damages in the amount of the market value of the benefit, and also allows for other measures of damages, including "the cost to the claimant of conferring the benefit[.]" Restatement (Third) of Restitution and Unjust Enrichment § 49(3)(b), (c).[8]

Further, Plaintiffs cite portions of case law that are limited to quantum meruit or unjust enrichment claims, and largely based on other state law. *See, e.g.*, *Certified Fire*, 128 Nev. 371 at 381 (addressing quantum meruit and unjust enrichment claims); *Flamingo Realty, Inc. v. Midwest Dev., Inc.*, 110 Nev. 984, 987, 879 P.2d 69, 71 (1994) (analyzing "*[t]he appropriate measure of damages under quantum meruit*" in dispute over real estate sale) (emphasis in original); *Massachusetts Eye and Ear Infirmary*, 552 F.3d at 66-69, 68 n.26 (citing Massachusetts law and addressing unjust enrichment damages in context of patent dispute and stating, "The fair market value of a requested benefit is a well accepted measure of unjust enrichment."); *NorthBay Healthcare Grp. - Hosp. Div.*, 342 F.Supp.3d at 990 (citing California law and addressing "the reasonable and customary value of hospital services" in "quantum meruit disputes such as this"); *Children's Hosp. Cent. California*, 226 Cal.App. 4th at 1278 (addressing determination of reasonable value in quantum meruit context, and citing California law); *Regents of the Univ. of California v. Glob. Excel Mgmt., Inc.*, 2018 WL 5794508, at *18-19 (C.D. Cal. Jan. 10, 2018) (same).[9] Plaintiffs' claims are not, however, limited to unjust

---

[7] Defendants strongly dispute that Plaintiffs have conferred any benefit on them.

[8] *Certified Fire Prot. Inc. v. Precision Constr.*, which is one of only two Nevada cases Plaintiffs cite, does not, as Plaintiffs maintain, "make[] . . . clear that the reasonable value of services does not embody cost considerations, instead focusing on market value." Opp'n at 11. The court in that case articulated general quantum meruit and unjust enrichment principles, but did not make any such holding. The footnote Plaintiffs cite merely states that the "actual value of recovery" in quantum meruit cases is "'usually the lesser of (i) market value and (ii) a price the defendant has expressed a willingness to pay.'" 128 Nev. 371, 381 n.3, 283 P.3d 250, 257-58 (2012) (quoting Restatement (Third) of Restitution and Unjust Enrichment § 31 cmt. (e) (2011)). The court did not have occasion to address the plaintiff's costs, as it found that the plaintiff "submitted no evidence of an ascertainable advantage [defendant] drew from the work it performed," and therefore agreed with the district court that the plaintiffs could not recover in either quantum meruit or unjust enrichment. *Id.* at 383.

[9] The court in *Massachusetts Eye and Ear Infirmary* analyzed the jury's damages award, not the merits of the matter. *See* 552 F.3d at 68.

003462

003462

enrichment and quantum meruit (indeed, they do not style any of their claims as "quantum meruit"). Even if Plaintiffs' case law could be read to state that the At-Issue Requests are not relevant to their unjust enrichment claim—and it cannot be—it does not demonstrate that the At-Issue Requests are irrelevant to the other causes of action that Plaintiffs have asserted in the Amended Complaint.

Lastly, Plaintiffs cite *Gulf-to-Bay* to argue that their own costs are not relevant,[10] but the court in *Florida Emergency Physicians* considered *Gulf-to-Bay* and ruled that the case on which *Gulf-to-Bay* relied, *Baker County*, "does not preclude [] compelling . . . cost of care discovery." ***Exhibit 17*** at 5. The court went on to allow discovery into those TeamHealth plaintiffs' costs of service because it was "relevant to analyze the reasonableness and fairness of rates." *Id.* at 4-6.[11] As noted *supra* at 9-10, the plaintiffs in *Florida Emergency Physicians*, like Plaintiffs here, asserted breach of implied contract and unjust enrichment claims.

In short, the non-binding case law to which Plaintiffs point does not foreclose this Court from compelling discovery concerning the basis for and the reasonableness of the billed charges—or the percentage of those charges—to which Plaintiffs claim entitlement. Indeed, as *Florida Emergency Physicians* illustrates, such discovery is routinely authorized in cases where a healthcare provider disputes the reimbursement paid by a health plan or health insurer and seeks to recover higher payments based on their billed charges or some percentage thereof. For these reasons and those set forth in Defendants' Motion, Plaintiffs have failed to carry their burden to demonstrate that the At-Issue Requests are irrelevant. Defendants respectfully request that this Court compel Plaintiffs to respond to the At-Issue Requests (Request Nos. 61, 68, 69, 86, 92, 93, 94, 95, 108, 126, 132, 133, 134, 137, 142, 143, 144, 145, and 146). Defendants

---

[10] The United entities that are defendants in the *Gulf-to-Bay* case have appealed this ruling. *See UnitedHealthcare of Florida, Inc., et al. v. Gulf-to-Bay Anesthesiology Assoc., LLC*, Case No. 2D20-3717 (Fla. 2d DCA).

[11] Plaintiffs cite *Children's Hospital* and other California case law for the proposition that, "under quantum meruit, the costs of the services provided are not relevant to a determination of reasonable value." *Children's Hosp. Cent. California*, 226 Cal.App.4th at 1275. They cite no Nevada authority for this proposition, and Defendants are aware of no such authority in Nevada.

further request that this Court compel Plaintiffs to produce a privilege log for any documents withheld on the basis of privilege.

C. RELIEF REQUESTED

Defendants respectfully request that this Court grant their Motion to Compel Plaintiffs' Responses to Defendants' First and Second Request for Production in its entirety.

Dated this 19th day of January, 2021.

/s/ Brittany M. Llewellyn

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Attorneys for Defendants

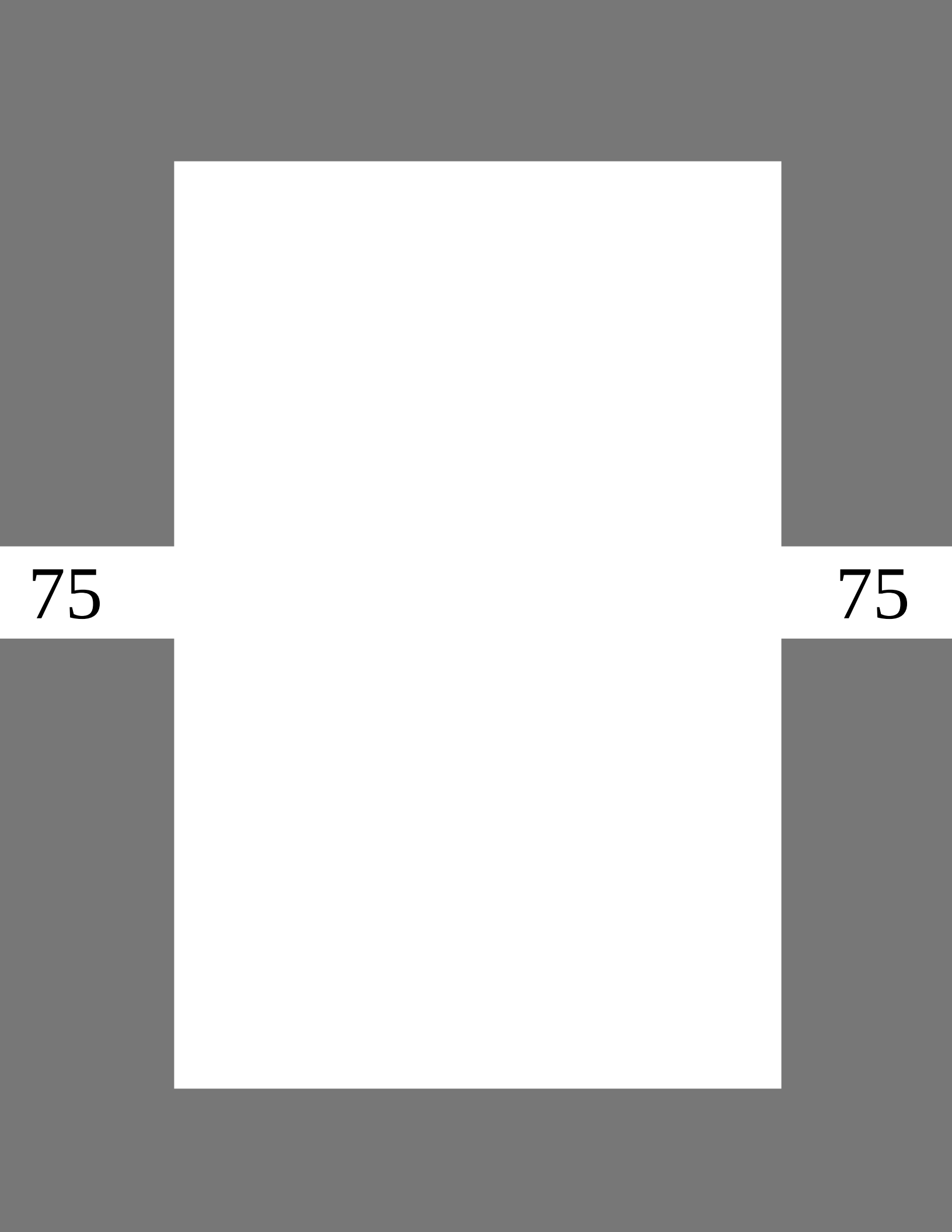
003464

CERTIFICATE OF SERVICE

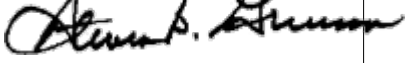
I hereby certify that on the 19th day of January, 2021, a true and correct copy of the foregoing **DEFENDANTS' REPLY IN SUPPORT OF MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

Pat Lundvall, Esq.
Kristen T. Gallagher, Esq.
Amanda M. Perach, Esq.
McDonald Carano LLP
2300 W. Sahara Ave., Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com
Attorneys for Plaintiffs

/s/ Cynthia S. Bowman
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC


75
75

Electronically Filed
1/19/2021 5:04 PM
Steven D. Grierson
CLERK OF THE COURT



APEN
D. Lee Roberts, Jr., Esq.
Nevada Bar No. 8877
lroberts@wwhgd.com
Colby L. Balkenbush, Esq.
Nevada Bar No. 13066
cbalkenbush@wwhgd.com
Brittany M. Llewellyn, Esq.
Nevada Bar No. 13527
bllewellyn@wwhgd.com
WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118
Telephone: (702) 938-3838
Facsimile: (702) 938-3864

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
nfedder@omm.com
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071
Telephone: (213) 430-6000

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
lblalack@omm.com
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006
Telephone: (202) 383-5374

Attorneys for Defendants

DISTRICT COURT

CLARK COUNTY, NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC. dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC. dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20,

Defendants.

Case No.: A-19-792978-B
Dept. No.: 27

APPENDIX TO DEFENDANTS' REPLY IN SUPPORT OF MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME

003466

003466

WEINBERG WHEELER HUDGINS GUNN & DIAL

Defendants UnitedHealthcare Insurance Company ("UHIC"), United HealthCare Services, Inc. ("UHS"), UMR, Inc. ("UMR"), Oxford Health Plans LLC (incorrectly named as "Oxford Health Plans, Inc."), Sierra Health and Life Insurance Co., Inc. ("SHL"), Sierra Health-Care Options, Inc. ("SHO"), and Health Plan of Nevada, Inc. ("HPN") (collectively, "Defendants"), by and through their attorneys of record, WEINBERG, WHEELER, HUDGINS, GUNN & DIAL, LLC and O'MELVENY & MYERS LLP, hereby submit this Appendix To Defendants' Reply In Support Of Motion To Compel Plaintiffs' Responses To Defendants' First And Second Requests For Production On Order Shortening Time.

Exhibit	Description
23.	First Amended Complaint filed 01/07/2020
24.	Defendants' Motion to Compel Production of Clinical Documents for the At-Issue Claims and Defenses and to Compel Plaintiffs to Supplement their NRCP 16.1 Initial Disclosures on an Order Shortening Time filed 09/21/2020
25.	Hearing Transcript 10/08/2020
26.	Linked-In profiles for the party witnesses disclosed in Plaintiffs' NRCP 16.1 Disclosures
27.	Fremont Emergency Services (Mandavia), Ltd.'s Objections and Answers to Defendants' First Set of Interrogatories

Dated this 19th day of January, 2021.

/s/ Brittany M. Llewellyn

D. Lee Roberts, Jr., Esq.
Colby L. Balkenbush, Esq.
Brittany M. Llewellyn, Esq.
WEINBERG, WHEELER, HUDGINS,
GUNN & DIAL, LLC
6385 South Rainbow Blvd., Suite 400
Las Vegas, Nevada 89118

Natasha S. Fedder, Esq.
Admitted Pro Hac Vice
O'Melveny & Myers LLP
400 S. Hope St., 18th Floor
Los Angeles, CA 90071

K. Lee Blalack, II, Esq.
Admitted Pro Hac Vice
O'Melveny & Myers LLP
1625 Eye St. NW
Washington, DC 20006

Attorneys for Defendants

CERTIFICATE OF SERVICE

I hereby certify that on the 19th day of January, 2021, a true and correct copy of the foregoing **APPENDIX TO DEFENDANTS' REPLY IN SUPPORT OF MOTION TO COMPEL PLAINTIFFS' RESPONSES TO DEFENDANTS' FIRST AND SECOND REQUESTS FOR PRODUCTION ON ORDER SHORTENING TIME** was electronically filed and served on counsel through the Court's electronic service system pursuant to Administrative Order 14-2 and N.E.F.C.R. 9, via the electronic mail addresses noted below, unless service by another method is stated or noted:

Pat Lundvall, Esq.
Kristen T. Gallagher, Esq.
Amanda M. Perach, Esq.
McDonald Carano LLP
2300 W. Sahara Ave., Suite 1200
Las Vegas, Nevada 89102
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com
Attorneys for Plaintiffs

/s/ Cynthia S. Bowman
An employee of WEINBERG, WHEELER, HUDGINS GUNN & DIAL, LLC

EXHIBIT 23

003469

003469

EXHIBIT 23

PAT LUNDVALL (NSBN 3761)
KRISTEN T. GALLAGHER (NSBN 9561)
AMANDA M. PERACH (NSBN 12399)
McDONALD CARANO LLP
2300 West Sahara Avenue, Suite 1200
Las Vegas, Nevada 89102
Telephone: (702) 873-4100
plundvall@mcdonaldcarano.com
kgallagher@mcdonaldcarano.com
aperach@mcdonaldcarano.com

Attorneys for Plaintiffs Fremont Emergency Services (Mandavia), Ltd., Team Physicians of Nevada-Mandavia, P.C. & Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

FREMONT EMERGENCY SERVICES (MANDAVIA), LTD., a Nevada professional corporation; TEAM PHYSICIANS OF NEVADA-MANDAVIA, P.C., a Nevada professional corporation; CRUM, STEFANKO AND JONES, LTD. dba RUBY CREST EMERGENCY MEDICINE, a Nevada professional corporation, Plaintiffs, vs. UNITEDHEALTH GROUP, INC., a Delaware corporation; UNITED HEALTHCARE INSURANCE COMPANY, a Connecticut corporation; UNITED HEALTH CARE SERVICES INC., dba UNITEDHEALTHCARE, a Minnesota corporation; UMR, INC., dba UNITED MEDICAL RESOURCES, a Delaware corporation; OXFORD HEALTH PLANS, INC., a Delaware corporation; SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC., a Nevada corporation; SIERRA HEALTH-CARE OPTIONS, INC., a Nevada corporation; HEALTH PLAN OF NEVADA, INC., a Nevada corporation; DOES 1-10; ROE ENTITIES 11-20, Defendants.	Case No.: 2:19-cv-00832-JAD-VCF **FIRST AMENDED COMPLAINT** **Jury Trial Demanded**

Plaintiffs Fremont Emergency Services (Mandavia), Ltd. ("Fremont"); Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians"); Crum, Stefanko and Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest" and collectively the "Health Care Providers") as and

for their First Amended Complaint against defendants UnitedHealth Group, Inc. ("UHG"), and its subsidiaries and/or affiliates United Healthcare Insurance Company ("UHCIC") United Health Care Services Inc. dba UnitedHealthcare ("UHC Services"); UMR, Inc. dba United Medical Resources ("UMR"); Oxford Benefit Management, Inc. ("Oxford" together with UHG, UHC Services and UMR, the "UHC Affiliates" and with UHCIC, the "UH Parties"); Sierra Health and Life Insurance Company, Inc. ("Sierra Health"); Sierra Health-Care Options, Inc. ("Sierra Options" and together with Sierra Health, the "Sierra Affiliates"); Health Plan of Nevada, Inc. ("HPN") (collectively "Defendants") hereby complain and allege as follows:

NATURE OF THIS ACTION

1. This action arises out of a dispute concerning the rate at which Defendants reimburse the Health Care Providers for the emergency medicine services they have already provided, and continue to provide, to patients covered under the health plans underwritten, operated, and/or administered by Defendants (the "Health Plans") (Health Plan beneficiaries for whom the Health Care Providers performed covered services that were not reimbursed correctly shall be referred to as "Patients" or "Members").[1] Collectively, Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their third party payment rates to defraud the Health Care Providers, to deny them reasonable payment for their services which the law requires, and to coerce or extort the Health Care Providers into contracts that only provide for manipulated rates. Defendants have reaped millions of dollars from their illegal, coercive, unfair, fraudulent conduct and will reap millions more if their conduct is not stopped.

2. Defendants have manipulated, are continuing to manipulate, and have conspired to manipulate their payment rates to defraud the Health Care Providers and deny them reasonable payment for services, which the law requires.

[1] The Health Care Providers do not assert any causes of action with respect to any Patient whose health insurance was issued under Medicare Part C (Medicare Advantage) or is provided under the Federal Employee Health Benefits Act (FEHBA). The Health Care Providers also do not assert any claims relating to Defendants' managed Medicaid business or with respect to the right to payment under any ERISA plan. Finally, the Health Care Providers do not assert claims that are dependent on the existence of an assignment of benefits ("AOB") from any of Defendants' Members. Thus, there is – and was – no basis to remove this lawsuit to federal court under federal question jurisdiction.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003471

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003472

PARTIES

3. Plaintiff Fremont Emergency Services (Mandavia), Ltd. ("Fremont") is a professional emergency medicine services group practice that staffs the emergency departments at ER at Aliante; ER at The Lakes; Mountainview Hospital; Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus; Dignity Health – St. Rose Dominican Hospitals, San Martin Campus; Dignity Health – St. Rose Dominican Hospitals, Siena Campus; Southern Hills Hospital and Medical Center; and Sunrise Hospital and Medical Center located throughout Clark County, Nevada. Fremont is part of the TeamHealth Holdings, Inc. ("TeamHealth") organization.

4. Plaintiff Team Physicians of Nevada-Mandavia, P.C. ("Team Physicians") is a professional emergency medicine services group practice that staffs the emergency department at Banner Churchill Community Hospital in Fallon, Nevada.

5. Plaintiff Crum, Stefanko And Jones, Ltd. dba Ruby Crest Emergency Medicine ("Ruby Crest") is a professional emergency medicine services group practice that staffs the emergency department at Northeastern Nevada Regional Hospital in Elko, Nevada.

6. Defendant UnitedHealth Group, Inc. ("UHG") is the largest single health carrier in the United States and is a Delaware corporation with its principal place of business in Minnesota. UHG is a publicly-traded holding company that is dependent upon monies (including dividends and administrative expense reimbursements) from its subsidiaries and affiliates which include all of the other Defendant entities named herein.

7. Defendant United HealthCare Insurance Company ("UHCIC") is a Connecticut corporation with its principal place of business in Connecticut. UHCIC is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, United HealthCare Insurance Company is a licensed Nevada health and life insurance company.

8. Defendant United HealthCare Services, Inc. dba UnitedHealthcare ("UHC Services") is a Minnesota corporation with its principal place of business in Connecticut and affiliate of UHCIC. UHC Services is responsible for administering and/or paying for certain

003472

emergency medical services at issue in the litigation. On information and belief, United HealthCare Services, Inc. is a licensed Nevada health insurance company.

9. Defendant UMR, Inc. dba United Medical Resources ("UMR") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. UMR is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, UMR is a licensed Nevada health insurance company.

10. Defendant Oxford Health Plans, Inc. ("Oxford") is a Delaware corporation with its principal place of business in Connecticut and affiliate of UHCIC. Oxford is responsible for administering and/or paying for certain emergency medical services at issue in the litigation.

11. Defendant Sierra Health and Life Insurance Company, Inc. is a Nevada corporation and affiliate of UHCIC. Sierra Health is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Health is a licensed Nevada health insurance company.

12. Defendant Sierra Health-Care Options, Inc. ("Sierra Options") is a Nevada corporation and affiliate of UHCIC. Sierra Options is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, Sierra Options is a licensed Nevada health insurance company.

13. Defendant Health Plan of Nevada, Inc. ("HPN") is a Nevada corporation and affiliate of UHCIC. HPN is responsible for administering and/or paying for certain emergency medical services at issue in the litigation. On information and belief, HPN is a licensed Nevada Health Maintenance Organization ("HMO").

14. There may be other persons or entities, whether individuals, corporations, associations, or otherwise, who are or may be legally responsible for the acts, omissions, circumstances, happenings, and/or the damages or other relief requested by this Complaint. The true names and capacities of Does 1-10 and Roes Entities 11-20 are unknown to the Health Care Providers, who sues those defendants by such fictitious names. The Health Care Providers will seek leave of this Court to amend this Complaint to insert the proper names of the defendant

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003473

Doe and Roe Entities when such names and capacities become known to the Health Care Providers.

JURISDICTION AND VENUE

15. The amount in controversy exceeds the sum of fifteen thousand dollars ($15,000.00), exclusive of interest, attorneys' fees and costs.

16. The Eighth Judicial District Court, Clark County, has subject matter jurisdiction over the matters alleged herein since only state law claims have been asserted and no diversity of citizenship exists. The Health Care Providers contest this Court's subject matter jurisdiction over the matters alleged herein and have moved to remand. *See* Motion to Remand (ECF No. 5). The Health Care Providers do not waive their continued objection to Defendants' removal based on alleged preemption under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). Venue is proper in Clark County, Nevada.

FACTS COMMON TO ALL CAUSES OF ACTION

The Health Care Providers Provide Necessary Emergency Care to Patients

17. The Health Care Providers are professional practice groups of emergency medicine physicians and healthcare providers that provides emergency medicine services 24 hours per day, 7 days per week to patients presenting to the emergency departments at hospitals and other facilities in Nevada staffed by the Health Care Providers. The Health Care Providers provide emergency department services throughout the State of Nevada.

18. The Health Care Providers and the hospitals whose emergency departments they staff are obligated by both federal and Nevada law to examine any individual visiting the emergency department and to provide stabilizing treatment to any such individual with an emergency medical condition, regardless of the individual's insurance coverage or ability to pay. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd; NRS 439B.410. The Health Care Providers fulfill this obligation for the hospitals which they staff. In this role, the Health Care Providers' physicians provide emergency medicine services to all patients, regardless of insurance coverage or ability to pay, including to Patients with insurance coverage issued, administered and/or underwritten by Defendants.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003474

19. Upon information and belief, Defendants operate as an HMO under NRS Chapter 695C, and is an insurer under NRS Chapters 679A, 689A (Individual Health Insurance), 689B (Group and Blanket Health Insurance), 689C (Health Insurance for Small Employers) and 695G (Managed Care Organization). Defendants provide, either directly or through arrangements with providers such as hospitals and the Health Care Providers, healthcare benefits to its members.

20. There is no written agreement between Defendants and the Health Care Providers for the healthcare claims at issue in this litigation; the Health Care Providers are therefore designated as a "non-participating" or "out-of-network" provider for all of the claims at issue. An implied-in-fact agreement exists between the Health Care Providers and Defendants, however.

21. Because federal and state law requires that emergency services be provided to individuals by the Health Care Providers without regard to insurance status or ability to pay, the law protects emergency service providers -- like Fremont here -- from predatory conduct by payors, including the kind of conduct in which Defendants have engaged leading to this dispute. If the law did not do so, emergency service providers would be at the mercy of such payors. the Health Care Providers would be forced to accept payment at any rate or no rate at all dictated by insurers under threat of receiving no payment, and then the Health Care Providers would be forced to transfer the financial burden of care in whole or in part onto Patients. The Health Care Providers are protected by law, which requires that for the claims at issue, the insurer must reimburse the Health Care Providers at a reasonable rate or the usual and customary rate for services they provide.

22. The Health Care Providers regularly provide emergency services to Defendants' Patients.

23. Defendants are contractually and legally responsible for ensuring that Patients receive emergency services without obtaining prior approval and without regard to the "in network" or "out-of-network" status of the emergency services provider.

24. The uhc.com website state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

> provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

25. Relevant to this action:

a. From July 1, 2017 through the present, Fremont has provided emergency medicine services to Defendants' Members as an out-of-network provider of emergency services as follows: ER at Aliante (approximately July 2017-present); ER at The Lakes (approximately July 2017-present); Mountainview Hospital (approximately July 2017-present); Dignity Health – St. Rose Dominican Hospitals, Rose de Lima Campus (approximately July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, San Martin Campus approximately (July 2017-October 2018); Dignity Health – St. Rose Dominican Hospitals, Siena Campus (approximately July 2017-October 2018); Southern Hills Hospital and Medical Center (approximately July 2017-present); and Sunrise Hospital and Medical Center (approximately July 2017-present).

b. At all times relevant hereto, Team Physicians and Ruby Crest have provided emergency medicine services to Defendants' Members as out-of-network providers of emergency services at Banner Churchill Community Hospital in Fallon, Nevada and Northeastern Nevada Regional Hospital in Elko, Nevada, respectively.

26. Defendants have generally adjudicated and paid claims with dates of service through July 31, 2019. As the claims continue to accrue, so do the Health Care Providers' damages. For each of the claims for which the Health Care Providers seek damages, Defendants have already determined the claim was covered and payable.

The Relationship Between the Health Care Providers and Defendants

27. Defendants provide health insurance to their members (*i.e.*, their insureds).

28. In exchange for premiums, fees, and/or other compensation, Defendants are responsible for paying for health care services rendered to members covered by their health plans.

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003476

29. In addition, Defendants provide services to their Members, such as building participating provider networks and negotiating rates with providers who join their networks.

30. Defendants offer a range of health insurance plans. Plans generally fall into one of two categories.

31. "Fully Funded" plans are plans in which Defendants collect premiums directly from their members (or from third parties on behalf of their members) and pay claims directly from the pool of funds created by those premiums.

32. "Employer Funded" plans are plans in which Defendants provide administrative services to their employer clients, including processing, analysis, approval, and payment of health care claims, using the funds of the claimant's employer.

33. Defendants provide coverage for emergency medical services under both types of plans.

34. Defendants are contractually and legally responsible for ensuring that their members can receive such services (a) without obtaining prior approval and (b) without regard to the "in network" or "out-of-network" status of the emergency services provider.

35. Defendants highlight such coverage in marketing their insurance products.

36. For example, on the "patient protections" section of Defendants' website, uhc.com, Defendants state:

> There are no prior authorization requirements for emergency services in a true emergency, even if the emergency services are provided by an out-of-network provider. Payment for the emergency service will follow the plan rules for network emergency coverage. This provision applies to all non-grandfathered fully insured and self-funded group health plans [Fully Funded plans], as well as group and individual health insurance issuers [Employer Funded plans].

37. Payors typically demand a lower payment rate from contracted participating providers.

38. In return, payors offer participating providers certainty and timeliness of payment, access to the payor's formal appeals and dispute resolution processes, and other benefits.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003477

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

39. For all claims at issue in this lawsuit, the Health Care Providers were non-participating providers, meaning they did not have an express contract with Defendants to accept or be bound by Defendants' reimbursement policies or in-network rates.

40. Specifically, the reimbursement claims within the scope of this action are (a) non-participating commercial claims (including for patients covered by Affordable Care Act Exchange products), (b) that were adjudicated as covered, and allowed as payable by Defendants, (c) at rates below the billed charges and a reasonable payment for the services rendered, (d) as measured by the community where they were performed and by the person who provided them. These claims are collectively referred to herein as the "Non-Participating Claims."

41. The Non-Participating Claims involve only commercial and Exchange Products operated, insured, or administered by the insurance company Defendants. They do not involve Medicare Advantage or Medicaid products.

42. Further, the Non-Participating Claims at issue do not involve coverage determinations under any health plan that may be subject to the federal Employee Retirement Income Security Act of 1974, or claims for benefits based on assignment of benefits.[2]

43. Those counts concern the *rate* of payment to which the Health Care Providers are entitled, not whether a *right* to receive payment exists.

44. Defendants bear responsibility for paying for emergency medical care provided to their members regardless of whether the treating physician is an in-network or out-of-network provider.

45. Defendants understand and expressly acknowledge that their members will seek emergency treatment from non-participating providers and that Defendants are obligated to pay for those services.

…

…

[2] The Health Care Providers understand, in any event, that Defendants do not require or rely upon assignments from their members in order to pay claims for services provided by the Health Care Providers to their members.

003478

The Reasonable Rate for Non-Participating Emergency Services is Well-Established

46. Defendants have traditionally allowed payment at 75-90% of billed charges for the Health Care Providers' emergency services.

47. Defendants have done so largely through the use of rental networks, which establish a reasonable rate for out-of-network provider services through arms-length negotiations between the rental network and providers on the one hand, and the rental network and health insurance companies on the other.

48. Rental networks act as "brokers" between non-participating providers and health insurance companies.

49. A rental network will secure a contract with a provider to discount its out-of-network charges.

50. The rental network then contracts with (or "rents" its network to) health insurance companies to allow the insurer access to the rental network and to the providers' agreed-upon discounted rates.

51. As such, rental networks' negotiated rates act as a proxy for a reasonable rate of reimbursement for out-of-network emergency services, both in the industry as a whole and for particular payors.

52. For many years, the Health Care Providers' respective contracts with a range of rental networks, including MultiPlan, have contemplated a modest discount from the Health Care Providers' billed charges for claims adjudicated through the rental network agreement.

53. In practice, nearly all of the Health Care Providers' non-participating provider claims submitted under Employer Funded plans from 2008 to 2017 were paid at between 75-90% of billed charges, including the Non-Participating Claims submitted to Defendants.

54. This longstanding history establishes that a reasonable reimbursement rate for the Health Care Providers' Non-Participating Claims for emergency services is 75-90% of the Health Care Providers' billed charge.

55. Beginning in approximately January 2019, Defendants have further slashed their reimbursement rate for Non-Participating Claims to less than 60%, and to as low as 12% of the

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003479

charges billed for professional services, rates that are well-below reasonable reimbursement rates.

56. Defendants' drastic payment cuts are entirely inconsistent with the established rate and history between the parties.

Defendants Paid the Health Care Providers Unreasonable Rates

57. Defendants arbitrarily began manipulating the rate of payment for claims submitted by the Health Care Providers. Defendants drastically reduced the rates at which they paid the Health Care Providers for emergency services for some claims, but not others. Instead of paying a usual and customary rate of the charges billed by the Health Care Providers, Defendants paid some of the claims for emergency services rendered by the Health Care Providers at far below the usual and customary rates. Yet, Defendants paid other substantially identical claims (e.g. claims billed with the same Current Procedural Terminology (CPT) Code, as maintained by American Medical Association) submitted by the Health Care Providers at higher rates and in some instances at 100% of the billed charge.

a. For example, on October 10, 2017, Defendants' Member #1, presented to the emergency department at Southern Hills Hospital and was treated by Fremont's providers. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants allowed and paid $223.00, which is just 17% of the charges billed. By contrast, on October 9, 2017, Defendants' Member #2 presented to the emergency department at St. Rose Dominican Hospitals, Siena Campus. The professional services were billed with CPT Code 99285 in the amount $1,295.00; Defendants paid $1,295.00, 100% of the charges billed.

b. By way of further example, between January 9 and 31, 2019, Defendants' Members #3, #4, #5 all presented to emergency departments staffed by Fremont's providers. In each instance the professional services were billed with CPT Code 99285 and Defendants paid nearly all or 100% of the billed charges. By contrast, on February 26, 2019, Defendants' Members #6, #7 and #8 all presented to emergency departments staffed by Fremont. In each instance the professional services were billed with CPT Code 99285 in the amount of $1,360.00 and Defendants only paid $185.00, a mere 13.6% of the billed charges in each instance.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003480

c. Further, Fremont's providers treated Member #9 on March 3, 2019. The professional services were billed at $971.00 (CPT 99284) and Defendants allowed $217.53, which is 22% of billed charges.

d. The Health Care Providers do not assert any of the foregoing claims pursuant to, or in reliance on, any assignment of benefit by Defendants' Members. Upon information and belief, Defendants do not require or rely upon assignment of benefits from their Members in order to pay claims for services provided by the Health Care Providers.

58. Defendants generally paid lower reimbursement rates for services provided to Members of their fully insured plans and authorize payment at higher reimbursement rates for services provided to Members of employer funded plans or those plans under which they provide administrator services only.

59. The Health Care Providers have continued to provide emergency medicine treatment, as required by law, to Patients covered by Defendants' plans who seek care at the emergency departments where they provide coverage.

60. Defendants bear responsibility for paying for emergency medical care provided to their Members regardless of whether the treating physician is an in-network or out-of-network provider.

61. Defendants expressly acknowledge that their Members will seek emergency treatment from non-participating providers and that they are obligated to pay for those services.

62. In emergency situations, individuals go to the nearest hospital for care, particularly if they are transported by ambulance. Patients facing an emergency situation are unlikely to have the opportunity to determine in advance which hospitals and physicians are in-network under their health plan. Defendants are obligated to reimburse the Health Care Providers at the usual and customary rate for emergency services the Health Care Providers provided to their Patients, or alternatively for the reasonable value of the services provided.

63. Defendants' Members received a wide variety of emergency services (in some instances, life-saving services) from the Health Care Providers' physicians: treatment of

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003481

conditions ranging from cardiac arrest, to broken limbs, to burns, to diabetic ketoacidosis and shock, to gastric and/or obstetrical distress.

64. As alleged herein, the Health Care Providers provided treatment on an out-of-network basis for emergency services to thousands of Patients who were Members in Defendants' Health Plans. The total underpayment amount for these related claims is in excess of $15,000.00 and continues to grow. Defendants have likewise failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of these claims.

65. Defendants paid some claims at an appropriate rate and others at a significantly reduced rate which is demonstrative of an arbitrary and selective program and motive or intent to unjustifiably reduce the overall amount Defendants pay to the Health Care Providers. Defendants implemented this program to coerce, influence and leverage business discussions with the Health Care Providers to become a participating provider at significantly reduced rates, as well as to unfairly and illegally profit from a manipulation of payment rates.

66. Defendants failed to attempt in good faith to effectuate a prompt, fair, and equitable settlement of the subject claims as legally required.

67. The Health Care Providers contested the unsatisfactory rate of payment received from Defendants in connection with the claims that are the subject of this action.

68. All conditions precedent to the institution and maintenance of this action have been performed, waived, or otherwise satisfied.

69. The Health Care Providers bring this action to compel Defendants to pay it the usual and customary rate or alternatively for the reasonable value of the professional emergency medical services for the emergency services that it provided and will continue to provide Patients and to stop Defendants from profiting from their manipulation of payment rate data.

Defendants' Prior Manipulation of Reimbursement Rates

70. Defendants have a history of manipulating their reimbursement rates for non-participating providers to maximize their own profits at the expense of others, including their own Members.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003482

71. In 2009, defendant UnitedHealth Group, Inc. was investigated by the New York Attorney General for allegedly using its wholly-owned subsidiary, Ingenix, to illegally manipulate reimbursements to non-participating providers.

72. The investigation revealed that Ingenix maintained a database of health care billing information that intentionally skewed reimbursement rates downward through faulty data collection, poor pooling procedures, and lack of audits.

73. Defendant UnitedHealth Group, Inc. ultimately paid a $50 million settlement to fund an independent nonprofit organization known as FAIR Health to operate a new database to serve as a transparent reimbursement benchmark.

74. In a press release announcing the settlement, the New York Attorney General noted that: "For the past ten years, American patients have suffered from unfair reimbursements for critical medical services due to a conflict-ridden system that has been owned, operated, and manipulated by the health insurance industry."

75. Also in 2009, for the same conduct, defendants UnitedHealth Group, Inc., United HealthCare Insurance Co., and United HealthCare Services, Inc. paid $350 million to settle class action claims alleging that they underpaid non-participating providers for services in *The American Medical Association, et al. v. United Healthcare Corp., et al.*, Civil Action No. 00-2800 (S.D.N.Y.).

76. Since its inception, FAIR Health's benchmark databases have been used by state government agencies, medical societies, and other organizations to set reimbursement for non-participating providers.

77. For example, the State of Connecticut uses FAIR Health's database to determine reimbursement for non-participating providers' emergency services under the state's consumer protection law.

78. Defendants tout the use of FAIR Health and its benchmark databases to determine non-participating, out-of-network payment amounts on its website.

79. As stated on Defendants' website (https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits) for non-participating provider claims, the relevant United

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003483

Health Group affiliate will "in many cases" pay the lower of a provider's actual billed charge or "the reasonable and customary amount," "the usual customary and reasonable amount," "the prevailing rate," or other similar terms that base payment on what health care providers in the geographic area are charging.

80. While Defendants give the appearance of remitting reimbursement to non-participating providers that meet usual and customary rates and/or the reasonable value of services based on geography that is measured from independent benchmark services such as the FAIR Health database, Defendants have found other ways to manipulate the reimbursement rate downward from a usual and customary or reasonable rate in order to maximize profits at the expense of the Health Care Providers.

81. During the relevant time, Defendants imposed significant cuts to the Health Care Providers' reimbursement rate for out-of-network claims under Defendants' fully funded plans, without rationale or justification.

82. Defendants pay claims under fully funded plans out of their own pool of funds, so every dollar that is not paid to the Health Care Providers is a dollar retained by Defendants for their own use.

83. Defendants' detrimental approach to payments for members in fully funded plans continues today, Defendants have made payments to the Health Care Providers at rates as low as 20% of billed charges.

84. Team Physicians' providers treated Member #10 on March 15, 2019 and the professional services (CPT 99285) were billed in the amount of $1,138.00, but Defendants allowed $435.20 which is just 38% of the billed charges.

85. In another example, Team Physicians' providers treated Member #11 on February 9, 2019 and the professional services (CPT 99285) were billed in the amount of $1,084.00, but Defendants allowed $609.28 which is just 56% of the billed charges.

86. Further, Fremont's providers treated Member #12 on April 17, 2019 and the professional services were billed in the amount of $1,428.00 (CPT 99285), but defendants allowed $435.20 which is 30% of the billed charges.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003484

87. Fremont also treated Member #13 on March 25, 2019 and the professional services were billed in the amount of $973.00, but defendants allowed $214.51 which is 22% of the billed charges.

88. As a result of these deep cuts in payments for services provided to Members of fully funded plans, Defendants have not paid the Health Care Providers a reasonable rate for those services since early 2019.

89. In so doing, Defendants have illegally retained those funds.

Defendants' Current Schemes

90. In 2017, Defendants also attempted to pay less than a reasonable rate on their employer funded plans, further exacerbating the financial damages to the Health Care Providers.

91. From late 2017 to 2018, over the course of multiple meetings in person, by phone, and by email correspondence, the Health Care Providers' representatives tried to negotiate with Defendants to become participating, in-network providers.

92. As part of these negotiations, the Health Care Providers' representatives met with Dan Rosenthal, President of Defendant UnitedHealth Networks, Inc., John Haben, Vice President of Defendant UnitedHealth Networks, Inc., and Greg Dosedel, Vice President of National Ancillary Contracting & Strategy at Defendant UnitedHealthCare Services, Inc.

93. Around December 2017, Mr. Rosenthal told the Health Care Providers' representatives that Defendants intended to implement a new benchmark pricing program specifically for their employer funded plans to decrease the rate at which such claims were to be paid.

94. Defendants then proposed a contractual rate for their employer funded plans that was roughly half the average reasonable rate at which Defendants have historically reimbursed providers – a drastic and unjustified discount from what Defendants have been paying the Health Care Providers on their non-participating claims in these plans, and an amount materially less than what Defendants were paying other contracted providers in the same market.

95. Defendants' proposed rate was neither reasonable nor fair.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003485

96. In May 2018, Mr. Rosenthal escalated his threats, making clear during a meeting that, if the Health Care Providers did not agree to contract for the drastically reduced rates, Defendants would implement benchmark pricing that would reduce the Health Care Providers' non-participating reimbursement by 33%.

97. Dan Schumacher, the President and Chief Operating Officer of UnitedHealthcare Inc. and part of the Office of the Chief Executive of Defendant UnitedHealth Group, Inc., said that, by April 2019, Defendants would cut the Health Care Providers' non-participating reimbursement by 50%.

98. Asked why Defendants were forcing such dramatic cuts on the Health Care Providers' reimbursement, Mr. Schumacher said simply "because we can."

99. Defendants made good on their threats and knowingly engaged in a fraudulent scheme to slash reimbursement rates paid to the Health Care Providers for non-participating claims submitted under their employer funded plans to levels at, or even below, what they had threatened in 2018.

100. Defendants falsely claim that their new rates comply with the law because they contracted with a purportedly objective and transparent third party, Data iSight, to process the Health Care Providers' claims and to determine reasonable reimbursement rates.

101. Data iSight is the trademark of an analytics service used by health plans to set payment for claims for services provided to Defendants' Members by non-participating providers. Data iSight is owned by National Care Network, LLC, a Delaware limited liability company with its principal place of business in Irving, Texas. Data iSight and National Care Network, LLC will be collectively referred to as "Data iSight." Data iSight is a wholly-owned subsidiary of MultiPlan, Inc., a New York corporation with its principal place of business in New York, NY. MultiPlan acts as a Rental Network "broker" and, in this capacity, has contracted since as early as June 1, 2016 with some of the Health Care Providers to secure reasonable rates from payors for the Health Care Providers' non-participating emergency services. The Health Care Providers have no contract with Data iSight, and the Non-

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Participating Claims identified in this action are not adjudicated pursuant to the MultiPlan agreement.

102. Since January 2019, Defendants have engaged in a scheme and conspired with Data iSight to impose arbitrary and unreasonable payment rates on the Health Care Providers under the guise of utilizing an independent, objective database purportedly created by Data iSight to dictate the rates imposed by Defendants.

103. Defendants also continued to advance this scheme on the negotiation front.

104. On July 7, 2019, Mr. Schumacher advised, in a phone call, that Defendants planned to cut the Health Care Providers' rates over three years to just 42% of the average and reasonable rate of reimbursement that the Health Care Providers had received in 2018 if the Health Care Providers did not formally contract with them at the rate dictated by Defendants.

105. Mr. Schumacher additionally advised that leadership across the Defendant entities were aware and supportive of the drastic cuts and provided no objective basis for them.

106. The next day, Angie Nierman, a Vice President of Networks at UnitedHealth Group, Inc., sent a written proposal reflecting Mr. Schumacher's stated cuts.

107. In addition to denying the Health Care Providers what is owed to them for the Non-Participating Claims, Defendants' scheme is an attempt to use their market power to reset the rate of reimbursement to unreasonably low levels.

108. As further evidence of Defendants' scheme to use their market power to the detriment of the Health Care Providers and other emergency provider groups that are part of the TeamHealth organization, in August 2019, UHG advised at least one Florida medical surgical facility (the "Florida Facility") that Defendants will not continue negotiating an in-network agreement unless the Florida Facility identifies an in-network anesthesia provider. The current out-of-network anesthesia provider is part of the TeamHealth organization. Defendants' threats to discontinue contract negotiations prompted the Florida Facility's Chief Operating Officer to send TeamHealth a "Letter of Concern" on August 14, 2019. Defendants' threats and leverage are aimed at intentionally interfering with existing contracts and with a goal of reducing TeamHealth's market participation.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003487

109. Additionally, Defendants first threatened, and then, on or about July 9, 2019, globally terminated all existing in-network contracts with medical providers that are part of the TeamHealth organization, including the Health Care Providers, in an effort to widen the scale of the scheme to deprive the Health Care Providers of reasonable reimbursement rates through its manipulation of reimbursement rate data.

Defendants' Fraudulent Schemes to Deprive the Health Care Providers of Reasonable Reimbursement Violates Nevada's Civil Racketeering Statute

110. Each Defendant, UnitedHealth Group, Inc., United Healthcare Insurance Company, United Health Care Services Inc., UMR, Inc., Oxford Benefit Management, Inc., Sierra Health and Life Insurance Company, Inc., Sierra Health-Care Options, Inc., Health Plan of Nevada, Inc. (collectively "Defendants") violated NRS 207.350 *et seq.* by committing the following crimes related to racketeering activity: NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) and that the Defendants devised, conducted, and participated in with unnamed third parties, including, but not limited to, Data iSight.

111. The Enterprise, as defined in NRS 207.380 consists of the Defendants, non-parties Data iSight and other entities that develop software used in reimbursement determinations used by the Defendants (the "Enterprise"). The participants of the Enterprise are associated, upon information and belief, by virtue of contractual agreement(s) and/or other arrangement(s) wherein they have agreed to undertake a common goal of reducing payments to the Health Care Providers for the benefit of the Enterprise. The Enterprise participants communicate routinely through telephonic and electronic means as they unilaterally impose reimbursement rates based on their manipulated "data" but which is nothing more than a transparent attempt to impose artificially reduced reimbursement rates that the Defendants threatened during business-to-business negotiations.

112. The Defendants illegally conduct the affairs of the Enterprise, and/or control the Enterprise, that includes Data iSight, through a pattern of unlawful activity.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003488

113. As part of this scheme, the Defendants prepared to, and did knowingly and unlawfully, reduce the Health Care Providers' reimbursement rates for the non-participating claims to amounts significantly below the reasonable rate for services rendered to Defendants' Members, to the detriment of the Health Care Providers and to the benefit and financial gain of Defendants and Data iSight.

114. To carry out the scheme and in furtherance of the conspiracy, Defendants and Data iSight engaged in conduct violative of NRS 207.400.

115. Since January 2019, the Enterprise worked together to manipulate and artificially lower non-participating provider reimbursement data that coincides and matches the earlier threats made by UHG in an effort to avoid paying the Health Care Providers for the usual and customary fee or rate and/or for the reasonable value of the services provided to Defendants' Members for emergency medicine services. The unilateral reduction in reimbursement rates is not founded on actual statistically sound data, and is not in line with reimbursement rates that can be found through sites such as the FAIR Health database, a recognized source for such reimbursement rates. Each time the Defendants direct payment using manipulated reimbursement rates and issue the Health Care Providers a remittance, the Defendants further their scheme or artifice to defraud Fremont because the Defendants retain the difference between the amount paid based on the artificially reduced reimbursement rate and the amount paid that should be paid based on the usual and customary fee or rate and/or the reasonable value of services provided, to the detriment of the Health Care Providers who have already performed the services being billed. Further, the Health Care Providers' representatives have contacted Data iSight and have been informed that acceptable reimbursement rates are actually influenced and/or determined by Defendants, not Data iSight.

116. As a result of the scheme, Defendants have injured the Health Care Providers in their business or property by a pattern of unlawful activity by reason of their violation of NRS 207.400(1)(a)- (d), (1)(f), (1)(i)-(j). *See* NRS 207.470.

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

Defendants' and Data iSight's Activities Constitute Racketeering Activity

117. Defendants and Data iSight committed, and continue to commit, crimes related to racketeering pursuant to NRS 207.360 that have the same or similar pattern, intents, results, accomplices, victims or methods of commission or are otherwise interrelated by distinguishing characteristics and are not isolated incidents in violation of NRS 207.360(28) (obtaining possession of money or property valued at $650 or more), NRS 207.360(35) (any violation of NRS 205.377), and NRS 207.360(36) (involuntary servitude) such that they have engaged in racketeering activity as defined by NRS 207.400 and which poses a continued threat of unlawful activity such that they constitute a criminal syndicate under NRS 207.370.

118. Defendants and Data iSight have knowingly, wrongfully, and unlawfully reduced payment to the Health Care Providers for the emergency services that the Health Care Providers provided to Defendants' Members, for the financial gain of the Defendants and Data iSight.

119. The racketeering activity has happened on more than two occasions that have happened within five years of each other. In fact, the Defendants have processed and submitted a substantial number of artificially reduced payments to the Health Care Providers since January 2019 in furtherance of Defendants' unlawful conduct.

120. As a direct and proximate result of those activities, the Health Care Providers have suffered millions of dollars in discrete and direct financial loss that stem from the Defendants' knowing retention of payment that is founded on a scheme to manipulate payment rates and payment data to their benefit.

The Enterprise and Scheme

121. The Enterprise is comprised of Defendants and third-party entities, to include Data iSight, that developed software used in reimbursement determinations by Defendants.

122. Defendants and Data iSight agreed to, and do, manipulate reimbursement rates and control allowed payments to the Health Care Providers through acts of the Enterprise.

123. The Defendants and Data iSight conceal their scheme by hiding behind written agreements and/or other arrangements, and false statements.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003490

124. Since at least January 1, 2019, the Defendants, by virtue of their engagement and use of Data iSight, have falsely claimed to provide transparent, objective, and geographically-adjusted determinations of reimbursement rates.

125. In reality, Data iSight is used as a cover for Defendants to justify paying reimbursement to the Health Care Providers at rates that are far less than the reasonable payment rate that the Health Care Providers have historically received and are entitled to under the law. The reimbursement rates purportedly collected and employed by Data iSight are nothing more than an instrumentality for the Defendants' unilateral decision to stop paying the Health Care Providers the usual and customary fee and/or the reasonable value of the services provided.

126. This scheme is concealed through the use of false statements on Data iSight's website and in Defendants' and Data iSight's communications with providers, including the Health Care Providers' representatives.

127. The Enterprise's scheme, as described below, was, and continues to be, accomplished through written agreements, association, and sharing of information between Defendants and Data iSight.

The Enterprise's False Statements: Transparency

128. By the end of June 2019, an increasingly significant amount of non-participating claims submitted to Defendants were being processed for payment by Data iSight.

129. The Data iSight website claims to offer "Transparency for You, the Provider," and that the "website makes the process for determining appropriate payment transparent to [providers]. . . so all parties involved in the billing and payment process have a clear understanding of how the reduction was calculated."

130. Contrary to these claims, however, the Enterprise, through Data iSight, uses layers of obfuscation to hide and avoid providing the basis or method it uses to derive its purportedly "appropriate" rates.

131. This concealment was designed by the Enterprise to, and does, prevent the Health Care Providers from receiving a reasonable payment for the services it provides.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003491

132. For claims whose reimbursement is determined by Data iSight, non-participating providers receive a Provider Remittance Advice form ("Remittance") from Defendants with "IS" or "1J" in the "Remark/Notes" column.

133. Over the past six months, an ever-increasing number of non-participating claims have been processed by Data iSight with drastically reduced payment amounts.

134. Yet Defendants and Data iSight do not state, on the face of the Remittance, or anywhere else, any reason for the dramatic cut.

135. Instead, the Remittances contain a note to call a toll-free number if there are questions about the claim.

136. In July 2019, a representative of Team Physicians contacted Data iSight via that number to discuss three separate claims with CPT Code 99285 (emergency department visit, problem of highest severity) which had been billed at $1,084.00, but for which Data iSight had allowed two claims at $435.20 (40% of billed charges) and one at $609.28 (56% of billed charges). After Team Physicians' representative spoke with Data iSight's intake representative, a Data iSight representative, Kimberly (Last Name Unknown) ("LNU") ("Kimberly"), called back and she asked if Team Physicians wanted a proposal for one of the inquired-upon claims. Team Physicians' representative indicated that he was interested in learning more and asked what reimbursement rate would be offered. Kimberly stated, "I have to look at a couple of things and decide." Thereafter, Kimberly sent the Team Physicians' representative a proposed Letter of Agreement (prepared July 31, 2019) (ICN: 48218522) offering to increase the allowed amount from $609.28 to $758.80 – increasing the amount to 70% of billed charges instead of 56% – as payment in full and an agreement not to balance bill Defendants' Member or Member's family. All it took was one call and a request for a more reasonable payment and almost immediately Defendant United Healthcare Services increased the amount it would pay, although still not to the level that the Health Care Providers consider to be reasonable.

137. Medical providers that are part of the TeamHealth organization have experienced this same trend across the country with Data iSight. In one instance, in July 2019, a representative of another provider, Emergency Group of Arizona Professional Corporation (the

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003492

"AZ Provider"), contacted Data iSight via that number to discuss a claim with CPT Code 99284 (emergency department visit, problem of high severity) which had been billed at $1,190.00, but for which Data iSight had allowed and paid $295.28, just 24.8% of billed charges.

138. After the AZ Provider's representative spoke with Data iSight's intake representative, a Data iSight representative, Michele Ware ("Ware"), called back and claimed the billed charges were paid based on a percentage of the Medicare fee schedule. The AZ Provider's representative challenged the reasonableness of the $295.28 payment. After learning that the AZ Provider had not yet billed Defendants' Member for the difference, Ware stated "ok – so you're willing negotiate" and offered to pay 80% of billed charges. In response, the AZ Provider's representative asked for payment of 85% of billed charges – $1,011.50 – to which Ware promptly agreed. Immediately thereafter, Ware sent a written agreement for the AZ Provider's representative to review and sign, confirming payment of $1,011.50 as payment in full and an agreement not to balance bill Defendants Services' Member or Member's family.

139. In another instance, when asked to provide the basis for the dramatic cut in payment for the claims, a Data iSight representative by the name of Phina LNU, did not and could not explain how the amount was derived or how it was determined that a cut was appropriate at all. The representative could only say that the payments on the claims represented a certain percentage of the Medicare fee schedule; she could not explain how Data iSight had arrived at that payment for either of the two claims, or why it allowed a different amount for each claim.

140. Instead, the representative simply stated that the rates were developed by Data iSight and Defendants. When the Health Care Providers' representative continued to pursue the issue and spoke with a Data iSight supervisor, James LNU, to inquire as to the basis for these determinations, James LNU responded that "it is just an amount that is recommended and sent over to United [HealthCare]." When James LNU was expressly challenged on Data iSight's false claim that it is transparent with providers, he responded with silence.

141. Further attempts to understand Data iSight and obtain information about the basis for its reimbursement rate-setting from Data iSight executives have also been futile.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003493

142. Data iSight and the Defendants know that the rates that Data iSight have allowed for the Health Care Providers' claims in 2019 are unreasonable and are not, in fact, based on objective, reliable data designed to arrive at a reasonable reimbursement rate.

143. Defendants know this because when a provider challenges the payment, Data iSight and Defendants are authorized to revise the allowed amount back up to a reasonable rate, but only if the Health Care Providers persist long enough in the process.

144. This process to contest the unreasonable payment takes weeks to conclude for the Health Care Providers and is impracticable to follow for every claim – a fact that Defendants and Data iSight understand.

145. For example, as evidence of this fraudulent practice, the Health Care Providers' representatives contested the allowed amounts on the claim discussed above in paragraph 136.

146. Eventually, Data iSight, offered to allow payment of at least one claim at 70% of the billed charges.

147. Absent providers taking the time to chase every claim, Data iSight and Defendants are able to get away with paying a rate that they know is not based on objective data and is far below the reasonable one.

148. Moreover, the Enterprise's scheme of refusing to reimburse at reasonable rates unless and until the Health Care Providers challenge its determinations continually harms the Health Care Providers, in that, even if they eventually receive reasonable reimbursement upon contesting the rate, this scheme burdens them with excessive administrative time and expense and deprives the Health Care Providers of their right to prompt payment.

The Enterprise's False Statements: Representations that Payment Rates Are "Defensible and Market Tested"

149. The Enterprise's claim to "transparency" is not its only fraudulent representation.

150. The Enterprise, through Data iSight, also falsely represents, on Data iSight's website, to set reimbursement rates in a "defensible, market tested" way.

151. Claims processed by Data iSight contain the following note:

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003494

> MEMBER: THIS SERVICE WAS RENDERED BY AN OUT-OF-NETWORK PROVIDER AND PROCESSED USING YOUR NETWORK BENEFITS. IF YOU'RE ASKED TO PAY MORE THAN THE DEDUCTIBLE, COPAY AND COINSURANCE AMOUNTS SHOWN, PLEASE CALL DATA ISIGHT AT 866-835- 4022 OR VISIT DATAISIGHT.COM. THEY WILL WORK WITH THE PROVIDER ON YOUR BEHALF. **PROVIDER: THIS SERVICE HAS BEEN REIMBURSED USING DATA ISIGHT WHICH UTILIZES COST DATA IF AVAILABLE (FACILITIES) OR PAID DATA (PROFESSIONALS).** PLEASE DO NOT BILL THE PATIENT ABOVE THE AMOUNT OF DEDUCTIBLE, COPAY AND COINSURANCE APPLIED TO THIS SERVICE. IF YOU HAVE QUESTIONS ABOUT THE REIMBURSEMENT CONTACT DATA ISIGHT.

(emphasis added).

152. This note is intended to, and does, mislead the Health Care Providers to believe that the reimbursement calculations are tied to external, objective data.

153. Further, in its provider portal, Data iSight describes its "methodology" for reimbursement determinations as "calculated using paid claims data from millions of claims . . . . The Data iSight reimbursement calculation is based upon standard relative value units where applicable for each CPT/HCPCS code, multiplied by a conversion factor."

154. Data iSight's parent company, MultiPlan, similarly describes Data iSight's process as using "cost- and reimbursement-based methodologies" and notes that it has been "[v]alidated by statisticians as effective and fair."

155. These statements are false.

156. Data iSight's rates are not data-driven: they match the rate threatened by Defendants in 2018 and are whatever Defendants want, and direct Data iSight, to allow.

157. For example, the Health Care Providers submitted claims for Members but received reimbursement in very different allowed amounts:

a. Member #14 was treated on May 9, 2019. Fremont billed Defendants $973.00 for procedure code 99284, and Defendants allowed $875.70 through MultiPlan, which is approximately 90% of billed charges – a reasonable rate, in line with the reasonable rate paid by Defendants to Fremont for non-participating provider services.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003495

b. But, for Member #15, who was treated on May 24, 2019, Defendants, through Data iSight, allowed only $295.28 for billed charges of $1,019.00, which is only 29% of the billed charges.

c. Further, at just one site, Defendants allowed and paid Team Physicians at varying amounts for the same procedure code (99285) (Members ##16a-16e):

i. Date of Service ("DOS"): January 4, 2019; Charge $1084.00; Allowed $609.28 (56% of Charge and reimbursed using Data iSight);

ii. DOS: January 15, 2019; Charge $1084.00; Allowed $294.60 (27% of Charge);

iii. DOS: January 24, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight);

iv. DOS: January 29, 2019; Charge $1084.00; Allowed $328.39 (30% of Charge); and

v. DOS: February 7, 2019; Charge $1084.00; Allowed $435.20 (40% of Charge and reimbursed using Data iSight).

158. This lock-step reduction, consistent with Defendants' 2018 threats to drastically reduce rates even further if the Health Care Providers failed to agree to their proposed contractual rates, spans a significant number of the Health Care Providers' claims for payment for services to Defendants' Members.

159. From the above examples, it is clear that Data iSight is not using any externally-validated methodology to establish a reasonable reimbursement rate, as its rates are not consistent, defensible, or reasonable.

160. Rather, Defendants, in complicity with Data iSight, increasingly reimburse the Health Care Providers at entirely unreasonable rates, in retaliation for the Health Care Providers' objections to their reimbursement scheme, and completely contrary to their false assertions designed to mislead the Health Care Providers and similar providers into believing that they will receive payment at reasonable rates.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003496

161. This reimbursement is dictated by Defendants, to the financial detriment of the Health Care Providers.

The Enterprise's False Statements: Geographic Adjustment

162. In addition to false statements regarding transparency and its methodologies, the Enterprise furthered the scheme by using false statements promising geographic adjustments to allowed rates.

163. Indeed, on its provider portal, Data iSight falsely claims that "[a]ll reimbursements are adjusted based on your geographic location and the prevailing labor costs for your area."

164. Data iSight's parent company, MultiPlan, further falsely states on its website that:

> For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as full payment for services. Claims are first edited, and then priced using widely-recognized, AMA created Relative Value Units (RVU), to take the value and work effort into account [and] CMS Geographic Practice Cost Index, to adjust for regional differences . . . [then] Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

165. Contrary to those statements, however, claims from providers in different geographic locations show that Data iSight does not adjust for geographic differences but instead, works with Defendants to cut uniformly out-of-network provider payments across geographic locations.

166. For example, Member WY was treated in Wyoming on January 21, 2019. The provider billed Defendants $779 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

167. Four days later, on January 25, 2019, Member AZ in Arizona and billed Defendants $1,212.00 for CPT Code 99284 and Defendants, via Data iSight, allowed exactly $413.39.

…

…

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003497

168. On the same date, Member NH was treated on the other side of the country in New Hampshire. The provider billed Defendants $1,047 for procedure 99284, and Defendants, via Data iSight, again allowed $413.39.

169. On February 8, 2019, Member OK was treated in Oklahoma. The provider billed Defendants $990 for procedure code 99284, and Defendants, via Data iSight, allowed $413.39.

170. Two days later, Members KS and NM were treated in Kansas and New Mexico, respectively. The providers billed Defendants $778.00 and $895.00, respectively, for procedure code 99284, but for both of these claims, Defendants, via Data iSight, allowed exactly $413.39.

171. One month later, Member CA was treated in California and Member NV was treated in Nevada. The CA provider billed Defendants $937.00 for procedure code 99284. Defendants, via Data iSight, yet again allowed exactly $413.39. A Health Care Provider billed Defendants $763.00 for procedure code 99284 and, via Data iSight, Defendants again allowed exactly $413.39.

172. Two months later, on May 20, 2019, a provider treated Member PA in Pennsylvania and billed Defendants $1,094 for procedure code 99284, and Defendants, via Data iSight, allowed exactly $413.39.

Patient	Location	Date of Service	Billed Amount	CPT Code	Allowed Amount – "DataiSight™ Reprice"
WY	Wyoming	1/21/19	$779 .00	99284	$413.39
AZ	Arizona	1/25/19	$1,212.00	99284	$413.39
NH	New Hampshire	1/25/19	$1047.00	99284	$413.39
OK	Oklahoma	2/8/19	$990.00	99284	$413.39
KS	Kansas	2/10/19	$778.00	99284	$413.39
NM	New Mexico	2/10/19	$895.00	99284	$413.39
CA	California	3/25/19	$937.00	99284	$413.39
NV	Nevada	3/30/19	$763.00	99284	$413.39
PA	Pennsylvania	5/20/19	$1,094.00	99284	$413.39

173. Defendants falsely claim on their website to "frequently use" the 80th percentile of the FAIR Health Benchmark databases "to calculate how much to pay for out-of-network services."

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003498

174. The 80th percentile of FAIR Health Benchmark databases clearly shows that reimbursement for the above non-participating provider charges, when actually based on a geographically-adjusted basis, would not only vary widely, but also all be higher than the allowed $413.39:

Location	CPT Code	80th Percentile of Fair Health Benchmark
Wyoming	99284	$1,105.00
New Hampshire	99284	$753.00
Oklahoma	99284	$1,076.00
Kansas	99284	$997.00
New Mexico	99284	$1,353.00
California	99284	$795.00
Pennsylvania	99284	$859.00
Arizona	99284	$1,265.00
Nevada	99284	$927.00

The Enterprise's Predicate Acts

175. To perpetuate the scheme and conceal it from the Health Care Providers, in or around 2018, Defendants and Data iSight entered into written agreements with each other that are consistent with Data iSight's agreements with similar health insurance companies.

176. Under those contracts, Data iSight would handle claims determinations for services rendered to Defendants' Members under pre-agreed thresholds set by Defendants.

177. By no later than 2019, Defendants and Data iSight then coordinated and effectuated the posting of false statements on websites and the communication of false statements to providers, including the Health Care Providers, in furtherance of the scheme.

178. These statements include Data iSight and its parent company posting that it would provide a transparent, defensible, market-based, and geographically-adjusted claims adjudication and payment process for providers.

179. Data iSight communicated to the Health Care Providers' representatives by phone and by email in June 2019 that, contrary to its website's claims to transparency, Data iSight could not provide a basis for its unreasonably low allowed amount, mustering only that "it is just an amount that is recommended and sent over to United [HealthCare]."

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003499

180. Finally, after weeks of pressure, Data iSight informed the Health Care Providers' representative by phone that it would, after all, allow payment on the contested claims at a reasonable rate: 85% of billed charges.

181. In short, the Enterprise perpetuated its scheme by communicating threats regarding reimbursement cuts to the Health Care Providers in late 2017 and 2018.

182. Then, after making good on those threats, the Enterprise communicated false and misleading information to the Health Care Providers and falsely denied that it had information requested by the Health Care Providers about the basis for the drastically-cut and unreasonable reimbursement rates that Defendants sought to impose.

183. In addition, since at least January 1, 2019, the Enterprise has furthered this scheme by communicating payment amounts and making reimbursement payments to the Health Care Providers at rates that were far below usual and customary rates and/or reasonable rates for the services provided.

184. For example, Defendants sent Fremont, a Remittance for emergency services provided to Members under multiple procedure codes, including the following for CPT Codes 99284 and 99285:

d. Member #17 was treated on May 14, 2019 at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

e. Member #18 was treated on May 18, 2019, at a billed charge of $1,428.00 (CPT Code 99285), for which Defendants, via Data iSight, allowed $435.20.

f. Yet, Member #19 was treated on March 25, 2019, at a billed charge of $973.00 (CPT Code 99285), for which Defendants, via MultiPlan, allowed $875.00 which is 90% of billed charges. This a reasonable rate, in line with the reasonable rates historically paid by Defendants to Fremont for non-participating provider services.

g. Further, for professional services provided by Team Physicians between January and June 2019, Defendants allowed and approved payments ranging from $294.60 (27% of billed charges in the amount of $1,084.00) up to 100%, or $1,084.00.

McDONALD CARANO
2300 WEST SAHARA AVENUE, SUITE 1200 • LAS VEGAS, NEVADA 89102
PHONE 702.873.4100 • FAX 702.873.9966

003500