UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TIARA YACHTS, INC.,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 1:22-cv-603

Honorable Robert J. Jonker

Magistrate Judge Ray Kent

PLAINTIFF'S MOTION FOR LEAVE TO FILE AMENDED COMPLAINT

Plaintiff, Tiara Yachts, Inc., through its attorneys, Varnum LLP, pursuant to Fed. R. Civ. P. 15(a)(2) and 59(e), moves this Court for leave to file an amended complaint. In support of this Motion, Plaintiff submits and incorporates by reference the accompanying brief.

Accordingly, Plaintiff respectfully requests that the Court enter an Order granting Plaintiff leave to file an amended complaint.

Pursuant to L. Civ. R. 7.1(d), Plaintiff's counsel sought concurrence in the relief requested in this motion from counsel for Defendant Blue Cross Blue Shield of Michigan ("BCBSM") via e-

mail on March 27, 2023. BCBSM's counsel opposed the requested relief

Respectfully submitted,

VARNUM LLP
Attorneys for Tiara Yachts, Inc.

Dated: March 27, 2023

By: /s/ *Chloe N. Cunningham*

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I. INTRODUCTION

The Sixth Circuit has held that "where a more carefully drafted complaint might state a claim, a plaintiff must be given at least one chance to amend the complaint before the district court dismisses the action with prejudice." *See U.S. ex rel. Bledsoe v. Community Health Sys., Inc.*, 342 F.3d 634, 644 (6th Cir. 2003). Here, the Court dismissed Plaintiff Tiara Yachts' Complaint because, in the Court's view, Tiara Yachts did not bring its Complaint on behalf of its self-funded health Plan and, rather, sought relief for its own benefit under matters of contract. The Court also held the Complaint failed to satisfy the *Twombly*/*Iqbal* pleading standard. Tiara Yachts respectfully disagrees with the Court's holding, but because Tiara Yachts can cure any purported pleading defects identified by the Court, this Court should grant Tiara Yachts leave to amend its Complaint under Federal Rules of Civil Procedure 15(a)(2) and 59(e). Tiara Yachts' Proposed Amended Complaint is attached as **Exhibit 1**.

II. BACKGROUND

Tiara Yachts filed this suit against Defendant Blue Cross Blue Shield of Michigan ("BCBSM"), alleging that BCBSM breached its fiduciary duties under the Employee Retirement Income Security Act of 1974 ("ERISA") and engaged in ERISA-prohibited transactions when it administered Tiara Yachts' self-funded health care Plan. ECF No. 1, PageID.18-21.

Instead of responding to Tiara Yachts' allegations, BCBSM filed a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6). ECF No. 12. This motion largely attacked the sufficiency of Tiara Yachts' factual allegations. For example, BCBSM argued that Tiara Yachts had failed to allege facts establishing that BCBSM acted as a fiduciary, ECF No. 12, PageID.121-123, 130-132; that Tiara Yachts had established only a "mere possibility" that BCBSM engaged in improper conduct, *id*., PageID.123; that the Complaint did not "allege facts"

establishing "a breach of any particular duty," *id*., PageID.124; that Plaintiff had only alleged "errors," which did not amount to an ERISA claim, *id*.; that the Complaint lacked necessary "factual allegations," *id*., PageID.125; that "nowhere does Tiara Yachts allege facts that BCBSM actually failed to maintain its data in an appropriate matter—let alone plead any facts suggesting that BCBSM committed a breach of its ERISA duties in this regard," *id*., PageID.125-126; that Tiara Yachts raised only "hypotheticals," *id*., PageID.126;, that "the Complaint fails to allege any facts establishing that BCBSM actually retained any savings in connection with Tiara Yachts," *id*.; that the Complaint "does not allege any overpayment BCBSM knowingly made in connection with the Tiara Yachts Plan," *id*., PageID.128; and that there is no "allegation of any transaction in which BCBSM supposedly recouped and retained improper payments in connections with Tiara Yachts' Plan through [a] allegedly fraudulent scheme," *id*., PageID.129.

Tiara Yachts opposed BCBSM's motion to dismiss, pointing out the factual allegations in its Complaint that established BCBSM's fiduciary status, fiduciary duties, and breach of such duties. ECF No. 16, PageID.197-211. BCBSM filed a reply, ECF No. 18, and this Court held a hearing on the motion to dismiss, ECF No. 20. At the hearing, Tiara Yachts' counsel offered to file an amended complaint if the Court was inclined to find any alleged pleading deficiencies. ECF No. 22, PageID.444 ("If there is some doubt . . . and you want me to plead something, I am happy to do that[.]").

The Court did not take counsel up on his offer. Instead, it granted BCBSM's motion to dismiss and simultaneously entered judgment in favor of BCBSM and against Tiara Yachts. ECF Nos. 23 and 24. Relying on the plausibility-pleading standards articulated in *Bell Atlantic Corporation v. Twombly*, 550 U.S. 544 (2007) and *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), the Court held that Tiara Yachts had not pleaded plausible claims for ERISA breach-of-fiduciary-duty

or prohibited-transactions. ECF No. 23, PageID.476 ("The Court thus determines that Tiara Yachts has not stated a *Twombly*-plausible claim that BCBSM acted as a fiduciary with respect to the claims processing complaints at issue here."); PageID.477 ("[T]he Complaint is sparse on alleged facts that would make up a fiduciary duty and breach . . . [p]rinciples of *Twombly* and *Iqbal* require more for a viable fiduciary duty claim."); PageID.478; ("The Complaint . . . does not allege, even at a broad level, that there were data deficiencies in the claims processed by BCBSM . . . [t]his is not enough to pass muster under *Twombly* and *Iqbal*."); PageID.480 ("There is no assertion within the Complaint that [BCBSM abused the Shared Savings Program in relation to] Tiara Yachts, or that claims processing and data deficiencies were tied in any way to the Shared Savings Program. This does not survive Rule 9, nor does it survive Rule 8."). Based on the Court's ruling that Tiara Yachts had not pleaded sufficient factual allegations, it dismissed Plaintiff's claims with prejudice.[1]

Tiara Yachts respectfully disagrees with the Court's ruling that its Complaint lacked sufficient factual allegations to establish plausible claims against BCBSM. Accordingly, concurrent with this motion, Tiara Yachts has filed a motion for reconsideration of the merits of the Court's order and opinion granting BCBSM's motion to dismiss. For the reasons contained in the brief supporting that motion, the Court should reconsider its decision, reverse course, and deny BCBSM's motion. But, in the alternative, Tiara Yachts also filed the instant motion to amend because, at the very least, the Court should allow it to amend its Complaint to cure the alleged pleading deficiencies.

[1] The Court's judgment is silent as to its prejudicial effect, ECF No. 24, PageID.484, so its dismissal of Plaintiff's claims is "presumed to be with prejudice." *Sublett v. Howard*, No. 19-6094, 2020 WL 5793101, at *4 (6th Cir. June 25, 2020) (unpublished cases attached at **Exhibit 2**).

III. ARGUMENT

A. STANDARD

Due to this case's current procedural posture, Tiara Yachts seeks to amend its Complaint through a combination of Rules 15(a)(2) and 56(e). Under Rule 15(a)(2), "a party may amend its pleading . . . with the court's leave" and "[t]he court should freely give leave when justice so requires." This preference for allowing amendment "reinforces the principle that cases should be tried on their merits rather than the technicalities of pleadings." *Tefft v. Seward*, 689 F.2d 637, 639 (6th Cir. 1982).

However, because this motion comes "after an adverse judgment," there is no longer a "permissive amendment policy." *Leisure Caviar, LLC, v. U.S. Fish & Wildlife Srv.*, 616 F.3d 612, 616 (6th Cir. 2010). Instead, Tiara Yachts must also "meet the requirements for reopening a case established by Rules 59 or 60."[2] *Id.* Even with these additional requirements, however, "[w]hen a motion to dismiss is granted . . . the usual practice is to grant plaintiffs leave to amend the complaint." *PR Diamonds, Inc. v. Chandler*, 364 F.3d 671, 698 (6th Cir. 2004), *abrogated in part on other grounds by Frank v. Dana Corp*., 646 F.3d 954, 961 (6th Cir. 2011)).

Where, as here, the plaintiff files a timely post-judgment motion to amend, "the Rule 15 and Rule 59 inquiries turn on the same factors." *Morse v. McWhorter*, 290 F.3d 795, 799 (6th Cir. 2002). The Court must ask if "there is undue delay, bad faith or dilatory motive on the part of the movant, repeated failures to cure deficiencies by amendments previously allowed, undue prejudice

[2] Rule 59(e) allows a court to alter or amend a judgment based on "(1) a clear error of law; (2) newly discovered evidence; (3) an intervening change in controlling law; or (4) a need to prevent manifest injustice." *Id*. at 615. Tiara Yachts' simultaneously filed Rule 59 motion explains why the Court's decision was legally erroneous but, for the purposes of this motion, dismissal with prejudice but without leave to amend would result in a manifest injustice because Tiara Yachts will be deprived of its Sixth Circuit-required "one chance" to amend. *See Southwell v. Summit View of Farragut, LLC*, 494 F. App'x 508, 513 (6th Cir. 2014) (citing *Bledsoe*, 342 F.3d at 644)).

to the opposing party by virtue of allowance of the amendment, futility of the amendment, etc." *Id*. at 800 (quoting *Foman v. Davis*, 371 U.S. 178, 182 (1962)). Because judgment has been entered, the Court must also consider "the finality of judgments and the expeditious termination of litigation," and Tiara Yacht's "explanation for failing to seek leave to amend prior to the entry of judgment." *Id*. Assigning weight to these factors and ultimately deciding the post-judgment motion to amend is left to the Court's "considerable discretion." *Leisure Caviar*, 616 F.3d at 615.

B. THE POST-JUDGMENT AMENDMENT FACTORS FAVOR GRANTING PLAINTIFF'S MOTION TO AMEND.

As an initial matter, Tiara Yachts notes that the Sixth Circuit has held that "where a more carefully drafted complaint might state a claim, a plaintiff **must** be given at least one chance to amend the complaint before the district court dismisses the action with prejudice." *Bledsoe*, 342 F.3d at 644 (emphasis added). Tiara Yachts has not received its "one chance" to amend; this alone requires the Court to grant this motion. *See also Southwell*, 494 F. App'x at 513; *Willingham v. Kneeland Indus., Inc.*, 415 F.2d 755, 756 (6th Cir. 1969) (reversing post-judgment denial of leave to amend when the tendered amended complaint did "not contain those infirmities that were . . . complained of in the original complaint"); Wright & Miller, Federal Practice and Procedure § 1483 (3d ed.) ("Ideally, **if it is at all possible that the party against whom a dismissal is directed can correct the defect in the pleading or state a claim for relief**, the court should dismiss with leave to amend.") (emphasis added).

Turning to the traditional post-judgment amendment factors, there has been no undue delay in filing this motion to amend. Tiara Yachts has been diligently working on its Amended Complaint and has filed this motion to amend within the timeframe required for post-judgment motions. *See* Fed. R. Civ. P. 56(e). To the extent that the Court is concerned that Tiara Yachts did not move to amend *before* judgment, Tiara Yachts notes that its counsel offered to amend the

Complaint at the hearing on Defendant's motion to dismiss. ECF No. 44, PageID.444 ("If there is some doubt . . . and you want me to plead something, I am happy to do that[.]").

Tiara Yachts' willingness to amend pre-judgment also shows a lack of bad faith or dilatory motive. Tiara Yachts had no intent to "use the court as a sounding board to discover holes in [its] argument, then reopen the case by amending [its] complaint to take account of the court's decision." *Leisure Caviar*, 616 F.3d at 616. Although Tiara Yachts' position was (and is) that its Complaint's factual allegations survive *Twombly*/*Iqbal* scrutiny and easily state a claim on behalf of its Plan under ERISA, Tiara Yachts would have been perfectly happy to address any "doubt" that the Court had regarding these issues. ECF No. 44, PageID.444. Tiara Yachts' express willingness to amend weighs against dismissing its complaint with prejudice. *Cf. Woldeab v. Dekalb County Board of Education*, 885 F.3d 1289, 1291 (11th Cir. 2018) ("[A] district court need not grant leave to amend when . . . *the district court has a clear indication that the plaintiff does not want to amend his complaint*[.]" (emphasis added)).

There have not been any repeated failures to cure deficiencies by amendments previously allowed. Indeed, there have been no amendments previously allowed. Tiara Yachts seeks only "its one chance to amend the complaint before the district court dismisses the action with prejudice." *Bledsoe*, 342 F.3d at 644.

BCBSM will suffer no undue prejudice if Tiara Yachts is allowed to amend its Complaint. The key word here is "undue." A defendant's need to expend "additional time, effort, or money" to defend against a revived action is not undue prejudice. *See United States ex rel Raffington v. Bon Secours Health Sys., Inc*., 567 F. Supp.3d 429, 438 (S.D.N.Y. 2021); *see also Foreback v. J.C. Expediting*, Case No. 13-10185, 2013 WL 12181764, at *2 (E.D. Mich. Oct. 15, 2013) (recognizing that, although amendment will "cause the Defendants to incur additional

expense . . . this prejudice does not constitute 'undue prejudice'" especially because the requested amendment was "necessary for this Court to fairly and fully adjudicate this matter"). Nor is the "inconvenience" that an amended complaint would cause a defendant considered "undue." *See Morse*, 290 F.3d 795, 801.

Rather, undue prejudice exists when an amended pleading raises "the prospect of duplicative discovery," or would require a defendant to "substantially revise [a] present defense strategy because" the amended complaint "add[s] new substantive claims or overhauls plaintiffs' theory of the case[.]" *Id*. The Court dismissed this case in its infancy, so there is no prospect of duplicative discovery, and Tiara Yachts' Proposed Amended Complaint does not add any new substantive claims or overhaul its theory of the case. The Amended Complaint "merely attempts to remedy the defects identified by the [Court]," which necessarily can cause no undue prejudice at this stage of litigation. *Id*.

Further, Plaintiff's Amended Complaint would not be futile because it specifically remedies the pleading defects that the Court believed existed in Plaintiff's Complaint. For example, the Amended Complaint more explicitly states that this action is brought by Tiara Yachts on behalf of and for the benefit of its Plan. The Amended Complaint spells out even more clearly the facts that compel the conclusion that BCBSM owed fiduciary duties to Tiara Yachts' Plan under ERISA. The Amended Complaint also adds in additional allegations, beyond those already contained in the original Complaint, describing how BCBSM breached the duties it owed to Tiara Yachts' Plan. And the Amended Complaint more fully explains how BCBSM's breaches harmed Tiara Yachts' Plan. In short, the Proposed Amended Complaint cures the pleading-sufficiency defects that the Court believed existed.

The factors specific to post-judgment amendments also favor granting Plaintiff's motion. Although there is an interest in the finality of judgments, this Court prefers to "resolve disputes on their merits." *See, e.g, Heritage Guitar, Inc. v. Gibson Brands, Inc.*, Case No. 1:20-cv-229, 2022 WL 17828960, at *4 (W.D. Mich. Dec 21, 2022); *see also Tefft*, 698 F.2d at 639 ("[C]ases should be tried on their merits rather than the technicalities of pleadings."). A resolution of the merits of Tiara Yachts' claims is particularly important: BCBSM administers many self-funded health care plans as a fiduciary under ERISA, and the merits of Tiara Yachts' claims may have important consequences for other companies on whose behalf BCBSM acts. And although there is also an interest "in expeditious termination of litigation," the Court must balance this interest against the purpose of Rule 59(e), which is "to allow the district court to . . . spar[e] the parties and appellate courts the burden of unnecessary appellate proceedings." *Howard v. United States*, 533 F.3d 472, 475 (6th Cir. 2008). In the interest of judicial economy, the Court should allow Tiara Yachts to correct all pleading defects it believed existed now, rather than later. *See Courtright v. City of Battle Creek*, Case No. 1:14-cv-1297-RJJ, 2015 WL 13173470, at *4 (W.D. Mich. Aug. 20, 2015) (recognizing that, if a complaint is insufficiently pleaded, the Court of Appeals will "return the case with instructions that the plaintiff be permitted an opportunity to amend to meet any deficiencies identified".)

Finally, Tiara Yachts' explanation for failing to seek leave to amend prior to the entry of judgment is simple: it believes its Complaint easily survives *Twombly*/*Iqbal* scrutiny and, in any event, did not expect this Court to dismiss its Complaint without affording it the opportunity to amend. *See* ECF No. 44, PageID.444 ("If there is some doubt . . . and you want me to plead something, I am happy to do that[.]"); *see also Bledsoe*, 342 F.3d at 645 (reversing a district court's

dismissal of a complaint with prejudice where plaintiff lacked "sufficient notice" that the court would dismiss based on pleading deficiencies).

IV. CONCLUSION

Denying Tiara Yachts any opportunity to amend its Complaint now would be inconsistent with Sixth Circuit case law, waste judicial and party resources, cause a manifest injustice by denying Tiara Yachts its day in court, and allow BCBSM to escape the consequences of its actions due to a technicality. Accordingly—if the Court denies Tiara Yachts' concurrently filed motion for reconsideration—Tiara Yachts respectfully requests that the Court grant its motion for leave to amend under Federal Rules of Civil Procedure 15(a)(2) and 59(e) and allow it to file its Proposed Amended Complaint.

Respectfully submitted,

VARNUM LLP
Attorneys for Tiara Yachts, Inc.

Dated: March 27, 2023

By: /s/ *Aaron M. Phelps*

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CERTIFICATE OF COMPLIANCE

Pursuant to L. Civ. R. 7.2(b)(i), I hereby certify that this document complies with L. Civ. R. 7.2(b)(ii) because this document, generated using Microsoft Word 2010, contains 2734 words.

/s/ Chloe N. Cunningham
Chloe N. Cunningham (P83094)

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UNITED STATES DISTRICT COURT
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INDEX OF EXHIBITS TO BRIEF IN SUPPORT OF PLAINTIFF'S MOTION FOR LEAVE TO FILE AMENDED COMPLAINT

Exhibit	Description
1	Proposed Amended Complaint
2	Unpublished Cases

EXHIBIT 1

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TIARA YACHTS, INC., AS PLAN SPONSOR FOR THE TIARA YACHTS, INC. HEALTH AND WELFARE BENEFIT PLAN,

Plaintiff,

v.

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

Case No. 1:22-cv-603

Honorable Robert J. Jonker

Magistrate Judge Ray Kent

FIRST AMENDED COMPLAINT

Plaintiff, Tiara Yachts, Inc., formerly S2 Yachts, Inc. ("Tiara Yachts"), in its capacity as Plan Sponsor on behalf of the Tiara Yachts Health and Welfare Benefit Plan (hereafter referred to as the "Plan"), by and through its counsel, Varnum LLP, hereby states for its Complaint against Defendant Blue Cross Blue Shield of Michigan ("BCBSM") as follows:

NATURE OF ACTION

1. Tiara Yachts is in the business of designing and manufacturing boats. Tiara Yachts sponsors a self-funded health insurance Plan to cover the health care needs of its employees and their dependents. Because Tiara Yachts is in the business of boating, not healthcare, it hired BCBSM, a proclaimed expert in claims processing, to serve as the Plan's claims processing administrator. This arrangement is governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1001, *et seq.,* and the terms of the Plan.

2. Throughout its relationship with BCBSM, Tiara Yachts sent millions of dollars to a BCBSM-owned and controlled bank account to cover the Plan's health care claims that were

processed and paid by BCBSM. As discussed below, and as will be established at trial, hundreds of thousands, if not millions, of those dollars were unnecessarily spent because BCBSM failed to adequately detect and prevent the payment of health care claims involving fraud, waste, and abuse.

3. Tiara Yachts recently discovered that BCBSM is aware of flaws in its claims processing system that caused it to overpay claims with assets of the Plan. Instead of fixing its claims processing system failures, BCBSM concealed them from Tiara Yachts for reasons that advance BCBSM's own interests. BCBSM continues to conceal its misconduct, in part, by maintaining exclusive control of claims data and other information related to the Plan, which is necessary to comprehensively identify all improper payments and other wrongdoing.

4. BCBSM's mismanagement of Plan Assets clearly constitutes a breach of BCBSM's fiduciary duty of care under ERISA. Tiara Yachts brings this suit, in its capacity as Plan Sponsor on behalf of the Plan, to recover the misappropriated funds and obtain all other relief to which it is entitled.

PARTIES, JURISDICTION AND VENUE

5. Tiara Yachts is a Michigan corporation, with its principal location in Holland, Michigan.

6. BCBSM is a Michigan non-profit health care corporation organized under the Nonprofit Health Care Corporation Reform Act, MCL 550.1101, *et seq.*

7. Section 1132(a)(2) authorizes fiduciaries, like Tiara Yachts as the Plan Sponsor, to bring a civil suit for the relief specified in § 1109(a). 29 U.S.C. § 1132(a)(2). Section 1109, in turn, makes a fiduciary who breaches a fiduciary duty "personally liable to make good to such plan any losses to the plan resulting from each such breach." 29 U.S.C. § 1109(a).

8. This Court has subject matter jurisdiction pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132 because Plaintiff's representative claims arise under ERISA.

9. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) because BCBSM resides in the Western District of Michigan and a substantial part of the events or omissions giving rise to the claim occurred in the Western District of Michigan. Venue is also proper pursuant to 29 U.S.C. § 1132(e)(2).

GENERAL ALLEGATIONS

10. Tiara Yachts hereby incorporates by reference the allegations contained in the preceding paragraphs.

11. Tiara Yachts, formally S2 Yachts, Inc., is in the business of designing and manufacturing boats.

12. Tiara Yachts offers health care benefits through the Plan. Rather than buy health insurance to cover employee health care claims under the Plan, during the relevant time period Tiara Yachts opted to self-insure. As such, Tiara Yachts served as the Plan Sponsor and paid the actual employee health care costs covered by the Plan, up to a large threshold. Tiara Yachts bought "stop loss" insurance to cover claims that exceeded that threshold.

13. Years ago, BCBSM began providing administrative services to Tiara Yachts and Tiara Yachts' self-funded welfare benefits Plan.

14. A self-funded arrangement is one in which the company (Tiara Yachts in this case) self-insures the health care claims of its employees instead of buying an insurance policy. Generally speaking, for every dollar of claims incurred by an employee, the self-funded entity pays that dollar. In order to self-fund, the company contracts with a third-party administrator ("TPA") to process and pay the claims in exchange for a disclosed fee.

A. TIARA YACHTS HIRED BCBSM TO SERVE AS THE PLAN'S ADMINISTRATOR.

15. Because Tiara Yachts has no experience or expertise administering a health care plan, or in processing, evaluating, and approving or denying health care claims, Tiara Yachts retained BCBSM to perform those functions for the Plan.

16. In exchange, BCBSM charged a monthly administrative fee.

17. BCBSM's administrative fee included a host of services, including but not limited to claims processing, check writing, case management, anti-fraud services, and cost containment.

18. BCBSM was to perform its administrative services in accordance with the Plan's terms and benefits.

19. BCBSM and Tiara Yachts first executed an Administrative Services Contract ("ASC") on January 1, 2006. They renewed the ASC annually, until Tiara Yachts terminated the relationship effective the end of 2018.

20. The ASC delegates to BCBSM certain Plan administration responsibilities and discretionary authority that Tiara Yachts would otherwise retain, including but not limited to interpreting Plan terms, calculating benefits, and using Plan assets to pay for health care services.

21. As the TPA, BCBSM was responsible for determining whether a claim should be approved or denied in accordance with the Plan terms and benefits. From the outset of BCBSM's role as TPA for the Plan, and for the duration of BCBSM's service in that capacity, Tiara Yachts delegated to BCBSM the responsibility for reviewing health care claims submitted to the Plan and determining whether such health care claims should be approved or denied.

22. Tiara Yachts also delegated to BCBSM the responsibility for paying health care claims from Plan assets. From the outset of BCBSM's role as a TPA, and for the duration of

BCBSM's service in that role, once BCBSM approved a claim for payment BCBSM was responsible for paying that health care claim on behalf of the Plan.

23. Although Tiara Yachts funded the Plan, it was BCBSM that exercised discretion to determine which claims to pay and how much to pay.

24. All paid claims were paid using assets belonging to the Plan.

25. Thus, BCBSM would exercise discretion to process and pay claims on behalf of the Plan using Plan assets.

26. Tiara Yachts pre-funded a BCBSM-owned and -controlled bank account, on a periodic basis, from which BCBSM drew money to pay claims, as BCBSM determined in its sole discretion.

27. The prepayments sent to BCBSM's bank account were "Plan Assets" as defined by ERISA. *See* Findings of Fact & Conclusions of Law in *Hi-Lex Controls, Inc. v. BCBSM*, No. 11-cv-12557, 2013 WL 3773364 (E.D. Mich. July 17, 2013), and *aff'd sub nom*. *Hi-Lex Controls, Inc. v. BCBSM*, 751 F.3d 740 (6th Cir. 2014), (the "*Hi-Lex* FFCL") at ¶¶ 5, 6, & 180; *Hi-Lex,* 751 F.3d at 745-46.

28. BCBSM had complete authority and control over the bank account and the Plan assets sent to it by Tiara Yachts.

29. BCBSM (a) exercised discretionary authority and control with respect to management of the Plan; (b) exercised authority and control with respect to management and disposition of Plan assets; or (c) had discretionary authority and responsibility in the administration of the Plan. *Hi-Lex* FFCL, at ¶¶ 180-82; *Hi-Lex*, 751 F.3d at 744-47.

30. BCBSM functioned as a fiduciary in its administration of the Plan. *See* 751 F.3d at 747 ("common law supports the conclusion that BCBSM was holding the funds wired by Hi–

Lex 'in trust' for the purpose of paying plan beneficiaries' health claims and administrative costs. Accordingly, the district court did not err in finding that BCBSM held plan assets of the Hi–Lex Health Plan and, in doing so, functioned as an ERISA fiduciary").

31. In short, BCBSM had discretionary authority and control over the management and administration of the Plan by virtue of its authority to approve and deny health care claims. BCBSM also exercised its discretionary authority over the processes, systems, and procedures it employed to process the Plan's claims. Furthermore, BCBSM had authority and control regarding management of Plan assets by virtue of directing and controlling Plan assets for the payment of health care claims BCBSM approved. Thus, under ERISA, BCBSM was a fiduciary to the Plan from the outset and for the duration of its service in that role.

B. CLAIMS ASSOCIATED WITH OUT-OF-STATE PROVIDERS.

32. BCBSM was responsible for administering the Plan with respect to claims submitted by out-of-state providers.

33. BCBSM is an independent licensee of the Blue Cross and Blue Shield Association ("Association").

34. The Association is a national federation compromised of 38 independently licensed, community-based, and locally operated Blue Cross Blue Shield Companies. These companies are colloquially known as "The Blues."

35. BCBSM and other Blues participate in the BlueCard Program. The BlueCard Program is a national program that enables members of one Blue Plan to obtain health care service benefits while traveling or living in another Blue Plan's service area (the "Host Blue").

36. The BlueCard Program links participating health care providers with the independent Blue Plans operating throughout the world through a single electronic network for claims processing and reimbursement.

37. This program allows BCBSM to instantly transfer and receive claim and member-eligibility information between the Blues when processing out-of-state claims.

38. BCBSM remains responsible for fulfilling BCBSM's contractual obligations when members access covered health care services within the geographic area served by a Host Blue.

39. What is supposed to be paid regarding claims submitted by participating providers is based on the negotiated price made available to BCBSM by the Host Blue.

40. BCBSM charged the Plan host fees for claims processed through the BlueCard Program, including but not limited to fees and compensation BCBSM pays to the Host Blues, the Association, and other vendors, an additional administrative service fee, and, if applicable, a network access fee.

C. BCBSM'S PRACTICE OF PAYING IMPROPER CLAIMS COMES TO LIGHT.

41. Dennis Wegner was a senior account manager at BCBSM. He worked at BCBSM for 18 years, serving many customers, and is now credited for bringing BCBSM's prolific mismanagement of customers' assets to light.

42. While serving as an account manager, Dennis Wegner was alerted by a BCBSM customer about a significant medical claim the customer received that exceeded $250,000.

43. Dennis Wegner investigated the customer's complaint and discovered that BCBSM was overpaying for routine medical testing.

44. In that particular customer's case, BCBSM had overpaid more than $600,000 within a two-year period.

45. Dennis Wegner brought the issue to BCBSM's attention, and to Dennis Wegner's surprise BCBSM's management confirmed that BCBSM's payment of improper claims was known to happen in the BCBSM billing system, but BCBSM had done nothing to stop it from happening.

46. Alarmed that BCBSM's payment of improper claims may not be isolated to one customer, Dennis Wegner researched claims and billings for two other BCBSM customers and found similar overpayments, totaling $125,000 in one case and $75,000 in another case.

47. Again, Dennis Wegner brought his concerns about overpayments to BCBSM's attention, but was told to cease researching the issue, to "stand down," and to refrain from alerting any BCBSM customers of improper payments made by BCBSM.

48. The improper charges were known by many key employees and executives within BCBSM, including Rod Begosa, David Malik, Lori Shannon, Gary Gavin, Ken Dallafior, Carol Gawronski, Robert Hopper, Dianne Malmgren, Nadiya Delaney, Kimberly Jones-Schneider, Teresa Henry, Pamela A. Braund, Sandra Fester, Aaron Friedkin, Jason M. Hover, Michael McKay Jr., Paul E. Ragos, Robert Rizzo, Diane VanEck, and Jeffrey Connolly. Yet no one at BCBSM took any action to stop the payment of improper claims.

49. After Dennis Wegner sounded the alarm, BCBSM's executives held a meeting to discuss the issue and afterwards sent a recap revealing troubling details. 9/14/2017 BCBSM Email Chain, **Exhibit A**.

50. BCBSM knew that the majority, if not all, of self-funded, non-auto customers on its NASCO platform, including Tiara Yachts and the Plan, were impacted by this systems flaw. *Id.*

51. BCBSM maintained lists of customers that were affected by this problem. *See e.g.*, *id.*, with 2017 List of Customers Impacted by Flip Logic, **Exhibit B**. Tiara Yachts is one of customers impacted by this issue.

52. BCBSM attributed this problem to an intentional design in its programming called "flip logic." Ex. A, 9/14/2017 BCBSM Email Chain.

53. BCBSM implemented flip logic in 1997. Under the logic, when a claim is submitted associated with a non-participating provider, BCBSM's system "flips" the non-participating provider's status and processes the claim at charge. 9/19/2017 BCBSM Email Chain, **Exhibit C**.

54. Thus, by using the flip logic, BCBSM allowed "providers [to] bill and get fully reimbursed for highly inflated cost of services." Ex. A, 9/14/2017 BCBSM Email Chain. Essentially, BCBSM would pay whatever was charged for a service, regardless of whether the claim was proper under the plan terms or other applicable reimbursement guidelines and policies. *Id.*

55. To be clear, this problem was not isolated to claims associated with laboratory services. The improper payments were not only associated with laboratories, but also with, for example, hospitals, x-rays, and office visits. Any provider could take advantage of BCBSM's flawed payment practices.

56. BCBSM knew that this "ha[d] been an issue within the company for a number of years." Ex. C, 9/19/2017 BCBSM Email Chain. But, "[i]n the absence of controls in the system logic that would flag suspicious claim activity, claims continue to be processed as '*pay sub at charge*,' often many times over and above the customary amount for such services." *Id.*

57. Compounding the issue, BCBSM identified at least 201 customers that had "elected to pay at the Host-allowed rate for non-par claims." Ex. C, 9/19/2017 BCBSM Email Chain, *with* Ex. B, 2017 List of Customers Impacted by Flip Logic. Tiara Yachts is amongst this group of impacted customers.

58. Thus, according to the Plan, BCBSM should have been paying out-of-state, non-par claims at a lower rate set by the applicable Host Blue plan, yet it failed to process such claims according to such benefit selection. BCBSM knew this, stating "'Flipping' logic is in direct contradiction with the group-elected benefit." Ex. C, 9/19/2017 BCBSM Email Chain.

59. In 2016 alone, "BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those [flip] charges was $30.5M and resulted in a payment amount of $26.7M." Had BCBSM applied the Host plan pricing as it was required to do, "the total allowed amount for these claims would have been $7.1M; a potential savings of $23.0M in benefit costs." *Id.* (emphasis added).

60. It gets worse. BCBSM expressly recognized that it had a "fiduciary responsibility to [its] ASC customers" and that its "lack of control over the issue [would be] viewed as a failure to fulfill this responsibility." *Id.*

61. However, instead of accepting responsibility as fiduciary for a flawed logic that it created over four decades ago and failed to correct, BCBSM worked to conceal the issue.

62. BCBSM acknowledged that its "customers may not be fully aware of the implications of the 'flipping' system logic," and took active steps to conceal the problem from Tiara Yachts and its other self-funded customers within the impacted category. Ex. A, 9/14/2017 BCBSM Email Chain.

63. BCBSM was worried that a "Provider pursuing [a] member for [a] large balance may cause a spike in member inquires and groups' dissatisfaction." *Id.* Thus, BCBSM would temporarily assume liability for any inconspicuous overcharges that resulted from the flip logic, to keep its mismanagement of customers' plans hidden. *Id.*

64. Some BCBSM employees suggested that BCBSM "make a global change to discontinue the logic and pay at Host allowed." *Id.* Essentially, the suggestion was to process claims in compliance with customers' selected benefit plans—what BCBSM should have been doing all along. Additionally, the BCBSM employees suggested making impacted customers "aware, educated, and their concurrence be documented." *Id.* These suggestions were ignored if not outright rejected.

65. BCBSM continued to conceal its misconduct from Plaintiff, and on November 14, 2018, BCBSM terminated Dennis Wegner's employment after he refused to cease investigating and pressing the issue.

66. On February 5, 2019, Dennis Wegner filed a lawsuit against BCBSM, alleging violations of the Michigan Whistleblowers' Protection Act and Michigan Bullard-Plawecki Employee Right-to-Know-Act. *See Dennis Wegner v. BCBSM*, No 19-001808-CD (Wayne Cnty. Cir. Ct.), attached as **Exhibit D**.

D. COMAU, ANOTHER ONE OF BCBSM'S SELF-FUNDED CUSTOMERS, FILES SUIT AND FURTHER EXPOSES BCBSM'S FAILURE TO PROTECT AGAINST CLAIMS INVOLVING FRAUD, WASTE, AND ABUSE.

67. After Dennis Wegner blew the whistle of BCBSM's mismanagement, another one of BCBSM's self-funded customers on the NASCO system, Comau, caught wind of BCBSM's misfeasance and sued BCBSM under ERISA alleging mismanagement of plan assets.

68. In discovery, BCBSM produced a portion of Comau's claims data, which Comau's expert analyzed to assess the scope and nature of improper claims paid by BCBSM using plan assets.

69. Comau's expert identified over $9 million in claims reimbursed by BCBSM involving fraud, waste, and abuse. These claims suffered from a variety of issues, including duplicative payments, unbundling, upcoding or wrong code, medically unlikely services, and non-adherence to payment guidelines. A copy of the expert report is attached as **Exhibit E**.

70. Common errors associated with BCBSM's NASCO claims processing system include, for example: unbundling, upcoding, medically unlikely claims, non-adherence to payment guidelines, and BCBSM's flip logic. *Id.*

71. **Unbundling.** Unbundling is when a health care service provider uses the billing codes for two or more separate procedures when the procedures were actually performed together and only one code should be paid. Within the health care industry, procedure-to-procedure ("PTP") edits are used to identify various types of unbundling. These edits work by defining pairs of Healthcare Common Procedure Coding System ("HCPCS") and Current Procedural Terminology ("CPT") codes that should not be reported together on a claim for a variety of reasons, such as a provider performing several laboratory tests for a patient that are commonly grouped as a panel and fall under a single billing code. The provider may try to increase their reimbursement by submitting claim codes for each individual test in the panel. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported. As the Plan administrator tasked with responsibility of processing claims, BCBSM should not allow and pay unbundled claims.

72. **Medically Unlikely Edits (MUE).** An MUE for a code is the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service. In other words, MUEs represent an upper limit that unquestionably requires further documentation to support. These edits are designed to limit fraud and/or coding errors. As the Plan administrator tasked with responsibility of processing claims, BCBSM should not allow and pay claims that exceed the maximum number of units allowed.

73. **Upcoding.** Upcoding occurs when health care providers submit inaccurate billing codes to insurance companies in order to receive inflated reimbursements. As the Plan administrator, BCBSM should not allow and pay upcoded claims.

74. **Non-Adherence to Payment Guidelines.** Payment guidelines are established to determine the appropriate reimbursement amounts when processing a claim. In general, Payment Guidelines dictate the reimbursement methodology used to determine the maximum allowable for any given service and provider type. As the Plan administrator, BCBSM must adhere to payment guidelines when processing and paying claims.

75. The aforementioned improper payments are non-exclusive examples of claims involving fraud, waste, and abuse, that BCBSM regularly makes when processing claims for non-auto NASCO customers, and also made when processing claims for Tiara Yachts Plan on the identical platform. This Complaint is intended to cover all further improper payments and misuses of Plan assets discovered hereafter once Plaintiff has the opportunity to analyze the complete set of data relating to claims BCBSM paid using Plan assets.

76. The *Comau* litigation was resolved when the time came to depose BCBSM's employees. For the two and one-half years, BCBSM had refused to allow Comau to depose any of BCBSM's witnesses. Things took a turn in the summer of 2022, when Comau obtained leave

and filed its Second Amended Complaint and the court compelled BCBSM to produce current and former employees for depositions.

77. Less than a week after Comau filed its Second Amended Complaint, and shortly before the first BCBSM employees were to be deposed, the case settled.

E. BCBSM CAPITALIZES ON ITS PAYMENT OF CLAIMS INVOLVING FRAUD, WASTE, AND ABUSE.

78. Around the time BCBSM's practice of reimbursing claims at charge was being called into question by Dennis Wegner, BCBSM created a program which financially rewarded BCBSM for paying claims involving fraud, waste, and abuse.

79. Effective January 1, 2018, BCBSM implemented a package of Payment Integrity Services for all of its self-funded customers using a shared savings arrangement (collectively called the shared savings program ("SSP")). SSP Internal Memo, **Exhibit F**.

80. The SSP includes four primary services: a pre-pay forensic bill review, advanced payment analytics, subrogation, and credit balance recovery. *Id.*

81. "Pre-pay Forensic Bill Review provides a review of high cost inpatient claims to detect and resolve billing errors *after* adjudication, but prior to payment." These services are performed by a third-party vendor called Equian. *Id.*

82. Equian reviews "all claims meeting [a] $25,000 threshold that are inpatient and are paid as outliers to current diagnostic edit process, OR are paid under a percent charge reimbursement methodology. This includes both in and out-of-state claims, and Par and Non-par providers." *Id.*

83. Subrogation generally "involves the detection and recovery of 3rd-party liability claims where a 3rd party is accountable for the expense." *Id.*

84. Credit Balance Recovery entails the detection and recovery of credit balances on hospital patient accounting systems due to ASC customers, such as Tiara Yachts. *Id.*

85. Last, Advanced Payment Analytics works to identify "claim overpayments not previously detected and recover the overpayment from providers after payment is rendered." These services are performed by a third-party vendor called Cotiviti. *Id.*

86. Prior to implementing Advanced Payment Analytics, BCBSM purportedly performed several post-pay claim review services, included as part of its administrative services fee. These included data mining for provider billing errors, coordination of benefits, and overpayment identification. Cotiviti differs from these services in that it offers a "2nd pass" review for improper payments. *Id.*

87. BCBSM's engagement with Cotiviti was not new. BCBSM had previously engaged Cotiviti to provide improper payment detection services for BCBSM's own fully insured book of business, and had realized savings of $12–15 million per year. BCBSM, however, did not engage Cotiviti for its self-insured groups until 2018. *Id.*

88. The SSP came with a catch. For any improper payments detected and recovered in connection with these programs, *but only as they applied to BCBSM's self-funded customers*, BCBSM would retain 30 percent of the avoided or recovered payment. BCBSM marketed its compensation as "administrative compensation." *Id.*

89. BCBSM also made it mandatory for its self-insured customers to participate and automatically opted all self-funded customers into the program. *Id.*

90. Cotiviti's review in particular would apply retroactively to improper payments extending back to January 1, 2016. *Id.*

91. In effect, for any improper payments Cotiviti detected and recovered—including the improper payments BCBSM knew existed as a result of its flip logic and beyond—BCBSM would take a 30 percent cut.

92. Essentially, BCBSM employed a program that would allow it to profit on its own mismanagement of Plan assets. The more claims involving fraud, waste, and abuse BCBSM paid using Plan assets on the front end, the more money BCBSM would make on the back end. Unfortunately, this came at the expense of the plans of BCBSM's self-insured customers, including the Plan.

93. As an ERISA fiduciary, BCBSM must avoid any conflicts of interest concerning the manner in which it performs its fiduciary duty. The SSP creates an impermissible conflict of interest.

F. BCBSM Further Conceals Its Misconduct By Gatekeeping Information Necessary To Identify Improper Charges.

94. BCBSM has designed a system in which it pays claims involving fraud, waste, and abuse, later corrects the claim charge to what it should have been in the first place, at its discretion, and then collects a recovery fee for "catching" the error.

95. BCBSM impedes its self-funded customers, including Tiara Yachts', ability to evaluate whether BCBSM is properly paying claims by significantly limiting access to each customers' claims data and other documents that set forth the guidelines and rules for claims processing and pricing.

96. Claims data is incredibly in-depth electronic information gathered from medical bills or claims submitted to BCBSM. For example, claims data identifies who rendered a service, the rendering provider(s) specialty(ies) and credentials, what service(s) was performed, what amount was billed for the service, what amount BCBSM allowed to be paid out of what was

charged, who BCBSM paid, when and where the service was provided, the patient's identity and age, and diagnoses.

97. Claims data also shows the line-item detail associated with each claim. For example, when a provider submits a claim for orthopedic surgery, the claim will have each associated cost and service broken down by service line showing the total the provider charged, the amount BCBSM allowed, and what was ultimately paid.

98. Claims data is essential to identifying improper claims and payments.

99. Throughout the parties' relationship, BCBSM maintained exclusive control and access to the claims data relating to claims BCBSM paid using Plan assets. Plaintiff never had and still does not have access to the *complete* claims data relating to claims paid using Plan assets.

100. The very limited set of claims data Plaintiff does possess is so deficient it is incapable of being meaningfully analyzed. For example, the data does not contain line-item detail, information regarding the provider who rendered a service or procedure, or even the amount charged by the provider or facility.

101. BCBSM's exclusive control and access to claims data is yet another tool BCBSM utilizes to conceal its misconduct.

102. The data relating to claims BCBSM paid using Plan assets should reflect all information necessary to ascertain whether a claim was properly processed and/or paid. To the extent it does not, BCBSM's failure to collect and/or maintain such data would itself be a breach of fiduciary duty.

103. Such data deficiencies include, for example: missing provider information, missing payee information, rolled-up financials, financials that do not reconcile, claims showing as rejected

but still paid, fields compromised by BCBSM's flip logic, or even claims that are altogether missing.

104. **Missing Provider Information.** An NPI is a unique government ID number issued to medical professionals and businesses and is required to be used in health care transactions by the Health Insurance Portability and Accountability Act ("HIPAA"). Claims without provider information, such as an NPI, are incapable of being analyzed for the identification of improper payments. BCBSM requires an NPI on every claim prior to reimbursement. *See, e.g.*, BCBSM Provider Manual[1] ("If NPI is missing or illegible, claim will be rejected."). It is the responsibility of BCBSM, as the Plan fiduciary, to provide industry standard oversight, such as confirming that the health care service provider is a covered entity as described within the plan document.

105. **Missing Payee Information.** Claims missing payee information fail to disclose where or to whom plan funds were spent. As the fiduciary, BCBSM was responsible for tracking to whom and where Plan assets are distributed.

106. **Rolled-Up Financial Details.** Claims should reflect a line-by-line detail of each claim's associated costs and reimbursements. For example, each item within a claim should have itemized details regarding the amounts billed and paid. A consolidation, or "roll-up", of a claim's line-by-line detail makes it impossible to verify whether a claim was properly made and/or paid.

107. **Claim Financials Do Not Add Up.** The maximum reimbursement for health care service is determined by the contracted rate applicable to each service billed. The maximum reimbursement is paid by the Plan after member liability (deductible, co-insurance, and co-pays) has been applied. Thus, the combination of plan paid amount and member liability should

[1]https://www.bcbsm.com/content/dam/public/Providers/Documents/help/medicare-plus-blue-ppo-manual.pdf.

represent maximum reimbursement to a network health care provider. When this combination does not reconcile with BCBSM's allowable amount (also called the approved amount), the claim financials do not add up and this raises fiduciary concerns.

108. **Rejected Claims that Report as Paid.** Claims that are rejected should be denied with no payable amount. If rejected claims showing a paid amount were in actually paid, these claims are a fiduciary violation and would be considered improper payments.

109. **Systematic Pricing Failure of Out-of-Network Claims – Flip Logic.** Due to BCBSM's flip logic, many claims may be labeled as in-network in the data and allowed at 100 percent, when in fact they were out-of-network and should have been reduced according to elected Plan benefits.

110. **Missing Claims Data.** Claims data should reconcile with the financial transactions BCBSM reported to Plaintiff. A gap between the paid amounts in the claims data and financial reports, means that either claims data is missing or Plaintiff was overcharged.

G. BCBSM'S PRACTICE OF KNOWINGLY PAYING IMPROPER CLAIMS IS INCONSISTENT WITH INDUSTRY STANDARDS, INCONSISTENT WITH HOW BCBSM HOLDS ITSELF OUT TO THE PUBLIC, AND INCONSISTENT WITH REPRESENTATIONS IT MADE TO TIARA YACHTS.

111. As BCBSM is well aware, health care claims involving fraud, waste, and abuse have been and remain a significant issue in the health care industry.

112. BCBSM acknowledges the scope of the problem on its website: "The National Heath Care Anti-Fraud Association estimates conservatively that health care fraud costs the nation about $68 billion annually — about 3 percent of the nation's $2.26 trillion in health care spending. Other estimates range as high as 10 percent of annual health care expenditure, or $230 billion."

113. Health care claims involving fraud, waste, and abuse appear in many guises. Far too often, health care providers, pharmacies, and other medical professionals submit inflated, improper, unnecessary, or erroneous medical claims to health care plans.

114. Such claims can take a myriad of forms, and it is incumbent on the claim administrator (in this case, BCBSM) to take appropriate measures to ensure that Plan assets are not diminished by the payment of claims that should not be paid.

115. Such measures would include either denying such claims outright or, when appropriate, denying the claim pending receipt of additional material establishing that the claims should be approved.

116. Among the many markers for health care claims that should not be approved because of concerns of fraud, waste, and abuse would be treatment that does not appear to be medically necessary in light of the reported health issue or CPT codes presented; repetitive dosages or treatment that cannot be justified or that exceed the standard of care; and costs the clearly exceed what would be typical or reasonable for the treatment at issue.

117. In short, there are numerous fundamental discrepancies that arise among submitted health care claims that demand further review by the TPA and, unless additional information can be provided verifying the claim, rejection of the claim due to indicia of fraud, waste, and abuse.

118. BCBSM was obligated as TPA to employ adequate policies, procedures and/or safeguards to detect and reject health care claims submitted to the Plan involving fraud, waste, and abuse, but BCBSM did not do so.

119. BCBSM's practice of paying improper claims is contrary to standards and norms in the health insurance industry, contrary to how BCBSM markets itself to the public, and is contrary to representations it makes to customers, including Tiara Yachts and the Plan.

120. BCBSM represents that its "claims processing practices consistently deliver industry-leading outcomes with respect to claim payments, and average above 99% accuracy." Payment Integrity Presentation, **Exhibit G**.

121. BCBSM says that it "takes actions to ensure health claims are submitted, and paid accurately, proactively and correctly, by the responsible party, for eligible members, according to medical, benefit and reimbursement policies and contractual term. Not in error or duplicate and free of wasteful or abusive practices." *Id.*

122. Indeed, BCBSM charges its customers for its investigation, detection, and recovery of improper claims.

123. BCBSM's practice of knowingly paying improper claims is entirely inconsistent with such representations, and with industry standards.

124. Likewise, BCBSM's payment of claims that lack basic information, such as the provider's identity and qualifications that is essential to avoiding improper payments, is inconsistent with industry standards and BCBSM's own policies.

125. Tiara Yachts never imagined, nor had reason to imagine based on BCBSM's own representations, that BCBSM knowingly paid improper claims, knew of flaws in its system affecting the Plan and Plan assets, and failed to disclose and correct these flaws.

126. The limited reporting information BCBSM provided to Tiara Yachts as sponsor of the Plan contained no information about BCBSM's practice of paying Providers' improper claims or its flawed systems.

127. Based on BCBSM's own representations – that BCBSM is as an industry expert in fraud prevention – and the fact that information BCBSM provided Tiara Yachts contained no information about its practice of paying improper claims, Tiara Yachts trusted and believed that

BCBSM was acting in the best interests of the Plan. As explained above, Tiara Yachts was sadly mistaken.

128. BCBSM, as a fiduciary to the Plan, had a duty to disclose all material facts related to its claims processing, including all Plan assets that had been mis-mismanaged. BCBSM failed to do so.

H. TIARA YACHTS PLAN HAS BEEN DAMAGED BY BCBSM'S CONDUCT.

129. The Plan suffered hundreds of thousands, if not millions, of dollars in losses as a consequence of BCBSM's improper payment of claims involving fraud, waste, and abuse.

130. These losses took the form of money Plaintiff contributed on behalf of the Plan that would not have been needed, and could have been used for other or additional Plan benefits, had BCBSM exercised its discretion over the processing and payment of claims on behalf of the Plan properly.

131. BCBSM's misfeasance resulted in hundreds of thousands, if not millions, of dollars wasted in Plan assets. Accordingly, Tiara Yachts, in its capacity as the Plan Sponsor on behalf of the Plan, brings this action against BCBSM seeking reimbursement of any and all losses the Plan has suffered as a result of BCBSM's conduct, as well as for recovery of attorneys' fees, costs, and expenses.

COUNT I
Breach of Fiduciary Duty – ERISA

132. Plaintiff hereby incorporates by reference the allegations contained in the preceding paragraphs.

133. At all times relevant, BCBSM was a fiduciary pursuant to 29 U.S.C. § 1002(21)(A) with respect to the Tiara Yachts Plan because (a) it exercised discretionary authority and control over management of the Plan; (b) it exercised authority and control over management and

disposition of the Plan's assets; or (c) it had discretionary authority and responsibility in the administration of the Plan.

134. As a fiduciary, BCBSM was required, among other things, to discharge its duties solely in the interest of the employees and beneficiaries of the Plan, preserve Plan assets, fully disclose its actions, avoid making false or misleading statements, avoid conflicts of interest, and abide by any statutory obligations or restrictions imposed on it. BCBSM also held a duty to act in accordance with the documents and instruments governing the Plan.

135. Because BCBSM was supposed to be an expert in evaluating health care claims, Tiara Yachts as Plan Sponsor relied on BCBSM to evaluate the millions of claims made over the years to the Plan. Thus, as the purported expert in health claims administration, BCBSM alone made the decision whether to use Plan assets to pay each of the claims at issue in this action.

136. Tiara Yachts has standing as a fiduciary of the Plan to pursue this action against BCBSM for BCBSM's breach of fiduciary duties.

137. BCBSM breached its fiduciary duties in numerous ways, including, but not limited to:

(a) Knowingly using Tiara Yachts Plan assets to pay claims impacted by BCBSM's systems flip logic, fully aware such flip logic had been flawed for decades and was causing the Tiara Yachts Plan to overpay for benefits;

(b) Failing to implement or correct controls in its systems logic that would flag suspicious claim activity, when BCBSM knew that its systems logic was flawed and causing claims to be processed at charges in contradiction with Tiara Yachts' elected Plan benefits;

(c) Concealing from, and otherwise failing to disclose to Tiara Yachts, the full implications of and flaws associated with its systems logic and the overpayments BCBSM made as a result;

(d) Misleading and deceiving Tiara Yachts by implementing a Shared Savings Program when it knew Plan assets were being used to overpay for benefits, allowing BCBSM to capitalize on its own misconduct and mismanagement, which was a clear conflict of interest;

(e) Using its considerable discretionary authority to advance interests other than those of the Tiara Yachts Plan or its participants/beneficiaries;

(f) Failing to implement and exercise sufficient quality control and oversight of BCBSM's claims processing systems and discretionary review of claims pre- and post-payment;

(g) Consistently paying claims suffering from a range of coding and billing issues, including but not limited to unbundling, upcoding, medically unlikely services, and reimbursing claims in non-adherence to its own and/or industry standard reimbursement guidelines;

(h) Failing to implement industry standard claims processing edits to prevent Plan assets from being used to pay improper charges;

(i) Concealing from, and otherwise failing to disclose to Tiara Yachts, as sponsor of the Plan, the payment of improper claims;

(j) Concealing from, and otherwise failing to disclose to Tiara Yachts, as sponsor of the Plan, all documents and information that govern BCBSM's methodology for determining covered charges under the Plan and amounts to be paid to providers, affording

BCBSM complete discretionary control and preventing Tiara Yachts from verifying whether reimbursements made by BCBSM using its Plan assets were calculated and made in accordance with the Plan's terms, operative pricing rates, rules, policies, and contracts;

(k) Paying claims lacking standard information necessary to properly adjudicate claims in accordance with industry standards and BCBSM's own policies and procedures, or otherwise failing to maintain claims data necessary to identify and recover incorrectly paid amounts and identify the full scope of BCBSM's misconduct and mismanagement;

(l) Failing to exercise the care, skill, prudence, and diligence under the circumstances that a prudent fiduciary acting in a like capacity and familiar with such matters would use in paying for health care claims, and otherwise administering Tiara Yachts' ERISA-governed Plan.

138. BCBSM's breach of its fiduciary duty has proximately caused substantial damages to the Tiara Yachts Plan.

COUNT II
Engaging in Prohibited Transactions

139. Plaintiff hereby incorporates by reference the allegations contained in the preceding paragraphs.

140. At all times relevant, and with respect to the actions described above, BCBSM was an ERISA fiduciary. Therefore, under 29 U.S.C. § 1106, BCBSM was prohibited from dealing with the assets of the Tiara Yachts Plan in its own interest or for its own account.

141. As described above, BCBSM instituted a mandatory Shared Savings Program whereby it was paid 30 percent of certain recoveries.

142. Whether Tiara Yachts agreed to pay 30 percent is immaterial, because the amount of the "recoveries" were in the unilateral control of BCBSM.

143. The more improper claims BCBSM failed to detect on the front end, the higher the recoveries on the back end, and the more it got paid.

144. By instituting a system that allowed it to unilaterally control the amount of its own compensation, BCBSM dealt with Tiara Yachts Plan assets in its own interest and for its own account in violation of Section 1106.

PRAYER FOR RELIEF

Plaintiff respectfully requests that this Court enter judgment in its favor, on behalf of the Plan, and against BCBSM as follows:

A. Order BCBSM to provide a full and complete accounting of all payments and uses of the Tiara Yachts Plan assets;

B. Order BCBSM to provide a full and complete accounting of all monies taken or charged by BCBSM to Tiara Yachts as sponsor of its Plan;

C. Declare that BCBSM breached its fiduciary duty owed to Tiara Yachts and the Plan and otherwise violated federal law by (1) mismanaging the Tiara Yachts Plan assets; (2) not exercising the care, skill, prudence, and diligence under the circumstances that a prudent fiduciary acting in a like capacity and familiar with the such matters would use in paying for health care claims, or otherwise administering Tiara Yachts Plan; (3) not making decisions, regarding Plan assets, with an eye single to the interests of Tiara Yachts Plan participants and beneficiaries; (4) concealing and failing to implement or correct controls in its claims processing system known to cause Tiara Yachts to overpay for elected benefits; (5) using its considerable discretionary authority to advance interests other than those of Tiara Yachts Plan or its members; (6) failing to disclose its mistakes, overpayments, improper payments or other mismanagement of Plan assets;

(7) capitalizing on its own mismanagement and misconduct, at the expense of Tiara Yachts Plan; (8) failing to implement and exercise sufficient quality control and oversight of claims progressing, review, and payment; (9) consistently reimbursing improper claims causing Tiara Yachts plan to overpay for benefits; (10) failing to implement standard claims processing edits to avoid overcharges to Tiara Yachts Plan; (11) concealing from Tiara Yachts all documents and information necessary to verify whether reimbursements made by BCBSM with Tiara Yachts Plan assets were calculated and made in accordance with the Plan's terms, operative pricing rates, rules, policies, and controls; and (12) paying claims lacking information necessary to properly adjudicate and reimburse claims in accordance with industry standards and BCBSM's own policies and procedures, or otherwise failing to maintain claims data necessary to identify and recover overpaid amounts and/or identify the full scope of BCBSM's misconduct or mismanagement;

D. Awarding restitution to Tiara Yachts, on behalf of its Plan, for all improper misuses of Tiara Yachts Plan assets;

E. Awarding restitution to Tiara Yachts, on behalf of its Plan, for all administrative compensation collected by BCBSM under its Shared Savings Program;

F. Awarding monetary damages, costs, interest, disgorgement of BCBSM's profits, and attorneys' fees (including statutory attorneys' fees under ERISA) to Tiara Yachts, on behalf of its Plan, to the fullest extent of the law; and

G. Awarding all other relief to which Tiara Yachts, on behalf of its Plan, may be entitled.

Respectfully submitted,

VARNUM LLP
Attorneys for Plaintiff

Dated: _____, 2023

By: */s/ Aaron M. Phelps*

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EXHIBIT A

Message

From: Gawronski, Carol [CGawronski@bcbsm.com]
Sent: 9/14/2017 11:41:58 AM
To: Hopper, Robert [RHopper@bcbsm.com]
CC: Malmgren, Dianne [DMalmgren@bcbsm.com]; Delaney, Nadiya [NDelaney@bcbsm.com]
Subject: FW: 9-7-17 Meeting Notes - Action Item follow up

Redacted - Attorney Work Product

From: Malmgren, Dianne
Sent: Wednesday, September 13, 2017 4:30 PM
To: Hopper, Robert <RHopper@bcbsm.com>
Cc: Shannon, Lori <LShannon2@bcbsm.com>; Wegner, Dennis <DWegner@BCBSM.com>; Malik, David R. <DMalik@bcbsm.com>; Jones-Schneider, Kimberly <KJonesl@bcbsm.com>; Begosa, Rod <RBegosa@BCBSM.com>; Gawronski, Carol <CGawronski@bcbsm.com>; Delaney, Nadiya <NDelaney@bcbsm.com>; Henry, Teresa <TMHenry@bcbsm.com>
Subject: RE: 9-7-17 Meeting Notes - Action Item follow up

Team — Attached is the list of non-auto NASCO classic groups that are affected. CFI expects to be able to provide more detail per group by next week.

Dianne Malmgren, Manager
Benefit Admin - Sales Support
Phone: 313-448-5299
Cell: 248-921-3101
Fax: 866-582-4027

From: Hopper, Robert
Sent: Tuesday, September 12, 2017 12:49 PM
To: Begosa, Rod <RBegosa@BCBSM.com>; Malmgren, Dianne <DMalmgren@bcbsm.com>; Gawronski, Carol <CGawronski@bcbsm.com>
Cc: Shannon, Lori <LShannon2@bcbsm.com>; Wegner, Dennis <DWegner@BCBSM.com>; Malik, David R. <DMalik@bcbsm.com>• Jones-Schneider, Kimberly <KJonesl@bcbsm.com>
Subject: RE: UTC Labs

Rod

As far as the "attention it deserves commentary," I need to be clear that this is not an instance where people are not paying attention to the issue. I empathize with David's sentiment in that we need to be able to determine the root cause and work to rectify which is why the cross functional stakeholders are being pulled together. In fact, a lot of people met late last week to try to get to the bottom of what this is and how we might be able to solve it. Have you been able to ascertain from the customer that they understand the ramifications of the switch in processing and its impacts to increasing member liability? Please review the below so that you can be aware of what is happening behind the scenes.

Meeting recap is below:

Attended: Jones-Schneider, Kimberly; Gawronski, Carol; Malmgren, Dianne; Montagano Roegner, Michele; Nagy, Karol; Hopper, Robert; Ozdarski, Paul; Beauregard, Maureen Ellen; Collins, Marianne; Harrison, Larry; Boillat, Erik L; Henry, Teresa; Welch, Paul; Byrd, Bruce; Delaney, Nadiya

Notes:
Who is impacted?
BlueCard transactions initiated by non-par provider for all customer groups on NASCO Classic with exception of Auto. MOS processing **is** not impacted at large, unless group made a request for exception processing by means of MOS mod/rider. MOS default logic is to pay Host allowed.

HOW partie:; are impacted?
Majority of non-Auto groups on NASCO Classic are following logic created some time back to flip the par status on the claim and process at charge when a referring provider information is submitted. This is done without checking whether providers are participating, as we do not currently have the capability to do so for out state providers. Although this logic was implemented with intention to hold member harmless in situations of no choice or limited provider availability, overtime dynamic shifted and BCBSM is observing abusive provider practices.

By allowing reimbursement at charge, providers bill and get fully reimbursed for highly inflated cost of services. In most scenarios, member is not aware or consented to referral being made out of network (for example labs).
It has been suggested that group customers may not be fully aware of the implications of the "flipping" system logic, as its intent has changed over time.
As reimbursement at charge in most case by far exceeds allowed amount, it became lucrative for providers to de-par.

What has been suggested?
1. It is workgroup's suggestion to make a global change to discontinue the logic and pay at Host allowed, but allow group customers to opt out on the individual basis, ensuring they fully understand possible consequences, including BCBSM limitation in preventing abusive provider behavior.

IllTo clarify: is there any exceptions to the suggestion above? I think, I heard somebody saying that flip logic will continue in situations of emergency or facility stay (no choice). Please address!!!

2. Impacted group customers should be made aware, educated and their concurrence be documented.
3. Provider outreach to curtail the behavior.

Business Readiness/What we need answers for?
For customer communication:
- prepare a list of impacted customers by name — D. Malmgren and T. Henry
- prepare a scrip for account management team to follow in their conversation with groups - TBD
- 1 year data comparison for each impacted group of non-par pay sub BlueCard claims paid vs host allowed. This will inform the group's decision maker of the magnitude of the issue and support our suggestion for the change — P. Ozdarski and K. Nagy
- ensure that the appropriate executive team is briefed and aligned to the above recommendation (this issue will be included on the Global Issues workgroup agenda)— R. Hopper

For provider communication:
- need to engage provider relations to understand how we educate the provider community and if there is a way to enforce the desired behaviors thru shifting financial responsibility — N. Delaney

What risks do we need to address?
- We have fiduciary responsibility to our ASC customers. Our lack of control over the issue was viewed as failure to fulfill this responsibility and a settlement was requested =example).
- It is unclear what our group customers currently understand in term of rules for processing BlueCard non-par claims. Demonstrating effects of the "flip" logic may cause groups to question their original consent to it.

- The source of the consent also came into question. We need to be able to demonstrate that consent was provided by the group's decision maker at that time, and not by any other party example).
- As the change takes effect, we need to ensure that member is held harmless. Provider pursuing member for large balance may cause a spike in member inquires and groups' dissatisfaction.

N

From: Begosa, Rod
Sent: Tuesday, September 12, 2017 12:36 PM
To: Malmgren, Dianne <DMalmgren@bcbsm.com>; Gawronski, Carol <CGawronski@bcbsm.com>; Hopper, Robert <RHopper@bcbsm.com>
Cc: Shannon, Lori <LShannon2@bcbsm.com>; Wegner, Dennis <DWegner@BCBSM.com>; Malik, David R. <DMalik@bcbsm.com>; Jones-Schneider, Kimberly <KJonesl@bcbsm.com>
Subject: FW: UTC Labs
Importance: High

Team:

It appears we have evidence that the Pay charge for non-par provider referral claims (labs) is not isolated to We need to verify and discuss whether this is a global issue.

Carol, in the interim, can we place claims on stop for looth ?

Thanks.

Rod

From: Malik, David R.
Sent: Tuesday, September 12, 2017 11:50 AM
To: Begosa, Rod <RBe osa BCBSM.com>
Subject: FW: UTC Labs
Importance: High

Rod,
This clearly needs to get elevated to receive the attention it deserves!...

David R. Malik
Regional Manager - Key Accounts I Health Plan Business
Blue Cross Blue Shield & Blue Care Network of Michigan
600 E. Lafayette Blvd., Detroit, MI 48226-2998 I Mail Code 517H
Desk: (313) 448-2335 Mobile: (313) 550-9170

From: Wegner, Dennis
Sent: Tuesday, September 12, 2017 11:24 AM
To: Malik, David R. <DMalik@bcbsm.com>
Subject: UTC Labs

David,

I found something interesting with When I applied the report filters to I found a claim for the same provider—UTC labs. We are paying 100 percent of charge for all labs, just like The total paid is $126,000 for one member for 2017.

111111111had a similar issue, but with a different provider. The total paid for their outpatient labs is around $62k.

I wanted to bring this to your attention and the potential impact for other customers.

Dennis J. Wegner
Account Manager, Key & Large Group Business
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd, Detroit MI 48226 I Mail Code 517D I 313.448.8095 Direct I 586.839.8621 Cell I 866.264.4050 Fax
dwegner@bcbsrn.com

EXHIBIT B

	A	B	C	D	E	F
1	Group	Group_Number	Account Manager			
2	[redacted]	[redacted]	Jensen, Kollin R.			
3	[redacted]	[redacted]	Squires, Mark			
4	[redacted]	[redacted]	Riden, Nathan			
5	[redacted]	[redacted]	Kelly, Stephanie			
6	[redacted]	[redacted]	Kelly, Stephanie			
7	[redacted]	[redacted]				
8	[redacted]	[redacted]	Marvin, Dawn			
9	[redacted]	[redacted]	Barry, Dree			
10	[redacted]	[redacted]	Johnson, Jennifer R.			
11	[redacted]	[redacted]	Figurski, Ryan			
12	[redacted]	[redacted]	Nosakowski, Jennifer			
13	[redacted]	[redacted]	Nosakowski, Jennifer			
14	[redacted]	[redacted]	Nosakowski, Jennifer			
15	[redacted]	[redacted]	Parenteau, Karen A.			
16	[redacted]	[redacted]	Nunnally, Jennifer			
17	[redacted]	[redacted]	Parenteau, Karen A.			
18	[redacted]	[redacted]	Kish, Kimberly			
19	[redacted]	[redacted]	Kish, Kimberly			
20	[redacted]	[redacted]	Kish, Kimberly			
21	[redacted]	[redacted]	Felton, Deborah M.			
22	[redacted]	[redacted]	Huntoon, Jason			
23	[redacted]	[redacted]	Huntoon, Jason			

	A	B	C	D	E	F
24	[redacted]		Nosakowski, Jennifer			
25			Kabongo, Jacques			
26			Parenteau, Karen A.			
27			Moore, Tani			
28			Navarra, Jonathan			
29			Hahka, John			
30			Squires, Mark			
31			Landin, Jennifer			
32			Linville, Sarah L.			
33			Gray, Daga			
34						
35			Kisiel, Gina			
36			Felton, Deborah M.			
37			Kolen, Denise			
38			Parenteau, Karen A.			
39			Whitley, Ryan D.			
40			Bickley, Kim			
41			Khoury, Michael			
42	Comau LLC	71587	Wegner, Dennis			
43	[redacted]		Notter, Josondra B.			
44			Kolen, Denise			
45			Karim, Derrick			
46			Donovan, Randy			
47			Doebel, Sherri K.			
48			Moore, Yvonne			

	A	B	C	D	E	F
49	[redacted]	[redacted]	Bengel, Ashley S.			
50			Morrone, Lynsi A.			
51			Huntoon, Jason			
52			Bengel, Ashley S.			
53			Squires, Mark			
54			Squires, Mark			
55			Donovan, Randy			
56			Khoury, Michael			
57			Nosakowski, Jennifer			
58			Karim, Derrick			
59			Moore, Tani			
60			Smith, Daniel J.			
61			Delaney, Brandon			
62			Huntoon, Jason			
63			Notter, Josondra B.			
64			Johnson, Jennifer R.			
65			Kelly, Stephanie			
66			Kelly, Stephanie			
67			Crandall, Steve			
68			Bengel, Ashley S.			
69			Harvey, Lynne			
70			Beachnau, Kevin			
71			Jurmu, Brad			

	A	B	C	D	E	F
72	[redacted]		Briggs, Whitney W.			
73			Donovan, Randy			
74			Squires, Mark			
75			Schnelker, Deborah L.			
76			Felton, Deborah M.			
77			Riden, Nathan			
78			Nosakowski, Jennifer			
79			Karim, Derrick			
80			Khoury, Michael			
81			Kelly, Stephanie			
82			Khoury, Michael			
83			Squires, Mark			
84			Linville, Sarah L.			
85			Linville, Sarah L.			
86			Town, Timothy S.			
87			Bouman, Joan			
88			Notter, Josondra B.			
89			Linville, Sarah L.			
90			Khoury, Michael			
91			Jensen, Kollin R.			
92			Gray, Daga			
93			Hagood, Rebecca			
94			Kabongo, Jacques			

	A	B	C	D	E	F
95	[redacted]		Lanfear, Vincine R.			
96			Briggs, Whitney W.			
97			Linville, Sarah L.			
98			Huntoon, Jason			
99			Middleton, Julie Smith			
100			Kiszka, Mark			
101			Landin, Jennifer			
102			Jensen, Kollin R.			
103			Coon, Philip			
104			Karim, Derrick			
105			Kik, Julie			
106			Huntoon, Jason			
107			Kisiel, Gina			
108			Kisiel, Gina			
109			Nosakowski, Jennifer			
110			Nunnally, Jennifer			
111			Moore, Yvonne			
112			Felton, Deborah M.			
113			Huntoon, Jason			
114			Hahka, John			
115			Kisiel, Gina			
116			Parenteau, Karen A.			
117			Kabongo, Jacques			
118			Delaney, Brandon			
119			Roberts, Andrea			
120			Nunnally, Jennifer			

	A	B	C	D	E	F
121	[redacted]	[redacted]	Nunnally, Jennifer			
122			Wegner, Dennis			
123			Stine, Dawn E.			
124			Figurski, Ryan			
125			Dye, Frank			
126			Hughes, Veronique			
127			Martin, Rachele A.			
128			Zdyrski, Gregory			
129			Kelly, Stephanie			
130			Khoury, Michael			
131			Moore, Tani			
132			Wegner, Dennis			
133			Saputo-Abarca, Rachel			
134			Erhart, Brandon			
135			Kabongo, Jacques			
136			Whitley, Ryan D.			
137			Kolen, Denise			
138			Coon, Philip			
139			Hagood, Rebecca			
140			Huntoon, Jason			
141			Karim, Derrick			
142			Jensen, Kollin R.			
143			Kolen, Denise			

	A	B	C	D	E	F
144	[redacted]		Briggs, Whitney W.			
145			Johnson, Jennifer R.			
146			Hahka, John			
147			Marvin, Dawn			
148			Harvey, Lynne			
149			Notter, Josondra B.			
150			Notter, Josondra B.			
151			Nunnally, Jennifer			
152			Barry, Dree			
153			Hahka, John			
154			Khoury, Michael			
155			Khoury, Michael			
156			Kolen, Denise			
157						
158			Bouman, Joan			
159			Briggs, Whitney W.			
160			Wegner, Dennis			
161			Bouman, Joan			
162			Marvin, Dawn			
163			Dye, Frank			
164			Moore, Yvonne			
165			Tyler, Shelby L.			
166						
167			Nakfoor, Jacqueline E.			
168			Jensen, Kollin R.			

	A	B	C	D	E	F
169	[redacted]		Hagood, Rebecca			
170			Martin, Rachele A.			
171			Beachnau, Kevin			
172			Linville, Sarah L.			
173			Martin, Rachele A.			
174			Zakarias, Wendy R.			
175			Navarra, Jonathan			
176			Nosakowski, Jennifer			
177			Coon, Philip			
178			Johnson, Jennifer R.			
179			White, Gretchen			
180			Middleton, Julie Smith			
181			Lanfear, Vincine R.			
182			Johnson, Jennifer R.			
183			Linville, Sarah L.			
184			Gray, Daga			
185			Wegner, Dennis			
186			Doebel, Sherri K.			
187						
188			Kish, Kimberly			
189			Mutch, Paula			
190			Landin, Jennifer			
191			Newble, Crystal			
192			Doebel, Sherri K.			
193			Beachnau, Kevin			

	A	B	C	D	E	F
194	[redacted]		Kelly, Stephanie			
195			Crandall, Steve			
196			Donovan, Randy			
197			Squires, Mark			
198			Navarra, Jonathan			
199			Kolen, Denise			
200			Fox, Amy			
201			Kolen, Denise			
202			Doebel, Sherri K.			

EXHIBIT C

Message

From: Hopper, Robert [RHopper@bcbsm.com]
Sent: 9/19/2017 9:56:30 **PM**
To: Braund, Pamela A. [PBraund@bcbsm.com]; Hopper, Robert [RHopper@bcbsm.com]; Fester, Sandra [SFester@BCBSM.com]; Friedkin, Aaron [AFriedkin@bcbsm.corn]; Gavin, Gary [GGavin@bcbsm.com]; Hover, Jason M. [JHover@bcbsm.com]; McKay Jr., Michael [MMcKay@bcbsm.com]; Ragos, Paul E. [PRagos@bcbsm.com]; Rizzo, Robert [RRizzo@bcbsm.com]; Shannon, Lori [LShannon2@bcbsm.com]; VanEck, Diane [DVanEck@BCBSM.com]; Connolly, Jeffrey [JConnolly@bcbsm.com]
Subject: Non Par Pay Sub Blue Card Claims

Importance: High

All —

Tomorrow morning, we have a meeting at 7 AM, of which the below is one of the topics for your awareness and our collective discussion and alignment on the way forward. The issue of "Non Par Pay Sub Blue Card Claims" has been an issue within the company for a number of years, but its impact and the manner in which we have coded our systems plus a lack of controls surrounding abusive billing practices has recently come to light within a couple of our ASC customers as you will note below. A digest of the issue follows, below. I am also attaching a list of 201 ASC customers we suspect are impacted by the system logic conflict currently in play. We currently do not understand the full extent of potential financial impact. However, a proposal is on the table for our review and discussion in stemming go-forward impact (below). I need to call out that Carol Gawronski and her team as well as our partners in, CFI, Claims Ops and IT are rallying around this to help us drive to the right outcome.

Background

In 1997 processing logic was implemented for non-par claims that would *flip* the par status on the claim and process at charge when referring provider information is submitted on the claim. It was assumed that the referring provider is most likely par and thus will be referrin

ntly have the capability for providers outside of Michigan.

Issue(s)

1. Recent review of benefit design documents confirmed that the majority of non-Auto groups on NASCO Classic platform (201 in total) have elected to pay at the Host-allowed rate for non-par claims, with the exception of a "no-choice" situation (services performed by hospital-based providers where the member has no ability to select a provider). "Flipping" logic is in direct contradiction with the group-elected benefit.
2. In the past few years, the dynamic shifted and BCBSM is observing abusive provider billing practices. In the absence of controls in the system logic that would flag suspicious claim activity, claims continue to be processed as *"pay sub at charge,"* often many times over and above the customary amount for such services. The account is the latest group to raise a concern on lab fees (urinalysis) in excess of $300K for one of their members in one year.

In 2016, BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those charges was $30.5M and resulted in a payment amount of $26.7M. With the application of the Host plan pricing, the total allowed amount for these claims would have been $7.1M; a potential savings of $23.OM in benefit costs.

Who Is Impacted?

- BlueCard transactions initiated by non-par providers for 201 customer groups on NASCO Classic with exception of Auto.

- MOS processing is not impacted at large, unless a group made a request for exception processing by means of MOS mod/rider. MOS default logic is to pay "Host allowed."

By allowing reimbursement "at charges," providers bill and get fully reimbursed for highly inflated costs of services. In most scenarios, the member is not aware or consented to a referral being made out of network (for example labs). It has been suggested that group customers may not be fully aware of the implications of the "flipping" system logic. As reimbursement "at charges" in most case by far exceeds the Host plan allowed amount, it became lucrative for providers to de-par to circumvent host plan cost controls.

What Has Been Suggested?

1. **Short Term Solution:** Make a global change to discontinue the logic and pay at Host allowed, except for global selection - no choice services. Also allow group customers to opt out on the individual basis, ensuring they fully understand possible consequences, including BCBSM limitation in preventing abusive provider behavior.

2. **Long Term Solution:** implement SBP 18642 BlueCard Non-par Payment that would introduce a robust select criteria for if/when they wish to pay at charge in benefits (currently undergoing feasibility review and estimation). A key business requirement is that the necessary controls are put in place to curtail potential provider fraud and abuse in addition to leveraging host plan allowed amounts.

3. In counsel with the OGC,1 **Redacted - Attorney-Client Privilege** **Redacted - Attorney-Client Privilege**

4. Provider outreach to curtail the behavior,

5. Member outreach for education.

Business Readiness/What We Need Answers For

- Ensure that the appropriate executive team is briefed and aligned to the above recommendation (this issue will be included on the Global Issues workgroup agenda) - R. Hopper
- Prepare a script for the account management team to follow in their conversation with groups - **TBD**
- 1-year data comparison for each impacted group of non-par pay sub BlueCard claims paid vs host allowed. This will inform the group's decision maker of the magnitude of the issue and support our suggestion for the change - P. Ozdarski and K. Nagy (Claims Ops)
- Need to engage provider relations to understand how we educate the provider community and if there is a way to enforce the desired behaviors thru shifting financial responsibility - N. Delaney

What Risks Do We Need To Address?

- We have fiduciary responsibility to our ASC customers. Our lack of control over the issue was viewed as failure to fulfill this responsibility and a settlement was requested (_example).
- It is unclear what our **group** customers currently understand in term of rules for processing BlueCard non-par claims. Demonstrating effects of the "flip" logic may cause groups to question their original consent to it.
- As the change takes effect, we need to ensure that member is fully aware of the possible balanced-billing as member liability could likely increase. Providers pursuing members for large balances may cause a spike in member inquires and groups' dissatisfaction.

R.crb-

Rob Hopper
Director, Group Customer Activation
Group Customer Advocate and Performance

Health Plan Business
Blue Cross Blue Shield of Michigan
Office: 313.448.2339
Mobile: 586.863.6002
Download our mobile app

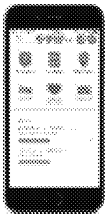

EXHIBIT D

STATE OF MICHIGAN

IN THE WAYNE COUNTY CIRCUIT COURT

DENNIS WEGNER,

Plaintiff

Case No. 2019 - - CD
Hon.

-vs-

BLUE CROSS BLUE SHIELD OF MICHIGAN,

Defendant.

/

AMANDA J. SHELTON (P67770)
MARY K. DEON (P63019)
Shelton & Deon Law Group
612 East 4th Street
Royal Oak, MI 48067
(248) 494-7444
Attorneys for Plaintiff

/

There is no other pending or resolved civil action arising out of the transaction or occurrence alleged in the complaint.

VERIFIED COMPLAINT

Plaintiff DENNIS WEGNER, by his attorneys, Shelton & Deon Law Group, asserts the following complaint against Defendant BLUE CROSS BLUE SHIELD OF MICHIGAN:

Jurisdiction and Parties

1. This is an action for violation of the Michigan Whistleblowers' Protection Act, MCL 15.361 et seq.

2. Plaintiff Dennis Wegner is a resident of Macomb County.

3. Defendant Blue Cross Blue Shield of Michigan is a Michigan corporation doing business in Wayne County, Michigan.

4. The events giving rise to this cause of action occurred in Wayne County, Michigan.

5. The amount in controversy exceeds $25,000, exclusive of interest, costs, and attorney fees.

Background Facts

6. Plaintiff was an account manager with Defendant corporation for the past 18 years. Plaintiff managed insurance accounts for a number of companies.

7. During his employment a customer alerted Defendant regarding a significant medical claim in excess of $250,000.

8. Plaintiff researched the complaint and discovered that a medical provider was taking advantage of Defendant's claims processing system and overcharging significantly for routine medical testing.

9. By way of example, the medical provider was billing between $5,000 - $15,000 for routine urinalysis that actually costs $10.00 or less.

10. Defendant paid the total amounts billed by the medical provider and charged the customer the amounts billed.

11. Shocked to learn that this customer was being overbilled, Plaintiff conducted additional research and discovered a pattern with other medical providers and over a two-year period Defendant paid over $600,000 for over-charged procedures.

12. Upon bringing Plaintiff to Defendant's attention and with the customer's knowledge of the overbilling, Defendant ultimately did reimburse that customer for the total amount of overbilling, an amount in excess of $600,000.00 for that one customer.

13. Plaintiff was concerned that other customers had been likewise overbilled and forced to pay excess medical fees as a result of Defendant's failure to appropriately oversee the claims.

14. Plaintiff began researching claims and billings for two of his other customers and found similar issues totaling $125,000 and $75,000.

15. When Plaintiff brought this to Defendant's attention he was specifically told to cease researching into the issues, to "stand down" and that he was not to alert the other two customers of the fraudulent charges.

16. Plaintiff believes that the fraudulent overcharging was widespread and would have cost the Defendant significant funds to correct and reimburse all of Defendant's customers who had unwittingly been forced to pay grossly inflated and fraudulent charges.

17. Defendant was aware of Plaintiff's knowledge and concerns regarding the legality of Defendant's actions and specifically threatened Plaintiff that he was to stand down and not inform other customers of the fraudulent charges they were unwittingly required to pay.

18. Plaintiff began researching various state agencies, including the Michigan Department of Insurance and Financial Services, about the problem of fraudulent insurance billing.

19. Plaintiff expressed to Defendant's supervisor his opposition to what he believed were unlawful insurance practices of Defendant corporation.

20. After Plaintiff raised questions or complained, his treatment and his relations with the management of Defendant corporation changed for the worse.

21. On November 14, 2018, Defendant terminated Plaintiff's employment.

Count I:
Violation of Michigan Whistleblowers' Protection Act

22. Plaintiff incorporates by reference paragraphs 1 through 21.

23. At all material times, Plaintiff was an employee, and Defendant was his employer, covered by and within the meaning of the Whistleblowers' Protection Act, MCL 15.361 et seq.

24. Defendant violated the Whistleblowers' Protection Act when it discriminated against Plaintiff as described regarding the terms, benefits, conditions, and privileges of his employment because he was on the verge of reporting a violation or suspected violation of a law, regulation, or rule of the State of Michigan and opposed practices made illegal by the laws, regulations, or rules of the State of Michigan.

25. The actions of Defendant were intentional.

26. As a direct and proximate result of Defendant's unlawful actions against Plaintiff as described, Plaintiff has sustained injuries and damages, including, but not limited to, loss of earnings; loss of career opportunities; mental and emotional distress; loss

of reputation and esteem in the community; and loss of the ordinary pleasures of everyday life, including the opportunity to pursue gainful occupation of choice.

Count II:
Michigan Bullard-Plawecki Employee Right -to -Know-Act

26. Plaintiff incorporates by reference paragraphs 1 through 25.

27. Pursuant to the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501 Plaintiff is entitled to a copy of any information contained in his personnel record.

28. Plaintiff requested his employee file pursuant to the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501 on November 29, 2018.

28. At no time since Plaintiff's request on November 29, 2018, Defendant did not provide Plaintiff an opportunity to review his personnel record.

29. At no time since Plaintiff's request on November 29, 2018, Defendant did not mail Plaintiff his personnel record.

30. Defendant willfully and knowingly violated the Bullard Plawecki Employee Right-to-Know-Act MCL 423.501.

WHEREFORE, Plaintiff requests that this court enter judgment against Defendant as follows:

a. statutory damages in whatever amount he is found to be entitled;

b. compensatory damages in whatever amount he is found to be entitled;

c. exemplary damages in whatever amount he is found to be entitled

d. judgment for lost wages, past and future, in whatever amount he is found to be entitled

e. an award for the value of lost fringe and pension benefits, past and future

f. an award of interest, costs, and reasonable attorney fees

g. whatever other equitable relief appears appropriate at the time of final judgment

DEMAND FOR JURY TRIAL

Plaintiff hereby demands trial by jury in the above-captioned cause.

Respectfully submitted,

Dated: February 5, 2019

Shelton & Deon Law Group
MARY K. DEON (P63019)
AMANDA J. SHELTON (P67770)
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Royal Oak, MI 48067
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VERIFICATION

I, DENNIS WEGNER, state under oath that the factual statements contained in the Verified Complaint are true and correct to the best of my knowledge, information and belief.

Dennis J. Wegner

Dennis Wegner

Subscribed and sworn to before me
this 4 day of February, 2019.

NOTARY PUBLIC
Acting in the County of Oakland

MARY K. DEON
NOTARY PUBLIC - STATE OF MICHIGAN
COUNTY OF OAKLAND
My Commission Expires Feb. 12, 2019
Acting in the County of Oakland

EXHIBIT E

Because Healthcare Costs Too Much Already

JANUARY 19, 2021

Table of Contents

The following data files will be provided separate from this report:

a. Sample of claim errors (revised 01/13/2022)
b. Out Of Network analysis (previously provided 8/2021)
c. Daniel Crowell analysis (previously provided 8/2021)
d. Flip Logic Data file (claims allowed at 100% of billed)

REPORT SUMMARY

Varnum LLP engaged ClaimInformatics ("CI") to perform a review of services of electronic health care claims paid data on behalf of Comau LLC ("Comau"), a self-funded health plan administered by Blue Cross Blue Shield of Michigan ("BCBS Michigan").

CI received detailed claim file(s) from Varnum Law totaling $113,721,072.70 in aggregate paid medical plan expenditures processed and administered by BCBS Michigan, a Third Party Administrator.[1] CI reviewed claims that BCBSM paid over a period of twelve (12) years from January 1st, 2008 through January 8th, 2021 (the "Reviewed Period"). The Reviewed Period of paid claims encompassed claims incurred by members between March 13th, 2005 through January 7th, 2021. Comau terminated its relationship with BCBS Michigan effective December 31st, 2019.

Overview of all claims (paid and rejected) produced by BCBS Michigan:

- # Claims 462,746
- # Records (line items) 1,169,989
- Aggregate Billed $309,796,977.80
- Aggregate Approved $121,416,158.44
- Aggregate Paid $113,721,072.70

Data was scrubbed to remove duplicate records resulting from re-processed transactions (i.e. claims that are reprocessed produce replicate records; the replicate records are removed so that only the final version of a claim is subject to review) as well as claims with extensive missing data points. **With those records eliminated, the data set was left with 363,693 claims totaling an aggregate $109 million in paid claims.**

During our review process, CI identified significant data issues that limit a comprehensive review of the data and raises fiduciary oversight concerns.

This report covers the process CI followed to assist with determining fiduciary concerns associated with plan administration for the time period under review. The table below summarizes findings that are detailed within. To be clear, these findings do not represent a final or comprehensive analysis, given the missing data and various data deficiencies detailed within.

Category	Fiduciary Concerns	Page(s) In Report
Financials do not add up	$56,664,842	28
No Payee Information	$25,456,645	13&21
Claims lines rolled up	$18,196,589	24
Improper Payments	$8,015,388	7
Missing claims data (Quarterly Report vs. Raw Data)	$3,330,682	3 & 4
No Provider Information	$2,793,358	6 &19
Out of Network Facility>Medicare Rate	$1,432,564	12
Rejected Claim Lines	$1,179,751	6
Out of Network Professional>Medicare Rate	$409,383	12
Out of Network Pricing Failure "Flip Logic"	$9,122,450	8

[1] After CI's initial analysis, BCBS Michigan produced $2.7 million in additional claims data in November 2021. This supplemental claims data is under review and is yet to be incorporated into the present report.

PART I: SIGNIFICANT DATA ISSUES

The claims data file provided by BCBS Michigan has significant flaws that include missing and/or inaccurate information (i.e. missing claims data, inaccurate allowed amounts, inaccurate billed amounts, missing payee, missing line item allowable, CPT Codes, etc.). Often these flaws are not found in isolation. For example, a claim may be missing multiple key data fields such as the identity of the provider, what services were rendered, and what BCBSM paid for such services. Missing and/or inaccurate data points are problematic standing alone, however, the presence of multiple missing and/or inaccurate data points on a claim compounds the problem. Moreover, the data provided by BCBSM not only suffers from missing and/or inaccurate information, but is also not representative of all claims BCBSM paid on behalf of Comau for the Reviewed Period as a substantial portion of claims remain unaccounted for. All of these problems severely impact the ability to perform fiduciary oversight and review; in other words, BCBSM's failure to maintain accurate data allows BCBSM to prevent its customers, like Comau, from ensuring that BCBSM is fulfilling its fiduciary duties.

As a preliminary note, Billing & financial data must comply to The Department of Health and Human Services (DHHS) created the Administrative Simplification rules that apply to all providers covered under HIPAA. One of the four types of standards required to make electronic communications more efficient include Code sets for clinical diagnoses and procedures. These standards are sometimes called electronic data interchange, or EDI, standards. These same standards apply to all commercial payers (health plans), health care providers and clearinghouses who use electronic exchange of health care information, such as electronic claims submission. The regulations require all HIPAA-covered entities and their Business Associates to adopt these standards for transactions involving the electronic exchange of health care data to ensure payment integrity. Covered entities include providers, health plans and clearinghouses. They are all required to comply with the HIPAA transaction sets, which includes code sets for diagnoses and procedures. All payers, including Medicare, Medicaid, MA, and commercial plans, must use CPT codes, HCPCS, ICD-10 codes, National Drug Codes and Codes on Dental Procedures and Nomenclature.

Determination of what is covered, allowed and paid is highly dependent on these standard HIPAA transactions and code sets. This is important, as we know the detail must be submitted in order for BCBS Michigan to make a benefit determination. As with all other covered entities subject to HIPAA standard transactions, BCBS Michigan is also required to comply with the HIPAA transaction sets, and in fact this information is required in order for benefit determination to be made. The combination of both billing and payment information should provide the 5 W's (Who, What, When, Where, Why).

The following section outlines key data issues pertaining to the claims data provided by BCBSM. This is not an exhaustive list.

1. Missing Claims Data

Confirmed by Daniel Crowell's Analysis. CI confirmed that claims data is missing, at least some of which is in BCBSM's possession. Missing data was discovered when CI compared Daniel Crowell (BCBS Michigan expert)'s data file with the raw data file submitted to Comau. CI identified claims that BCBS Michigan made available to Daniel Crowell that were not provided to Comau. (*see* Daniel Crowell Review, page 14).

Confirmed by Quarterly Settlement Reports. To better ascertain the scope of missing claims data, CI compared BCBS Michigan's Quarterly Settlement Reports with medical claims data. The key data points used in this analysis were restricted to medical claims (professional and hospital claims) associated from each Quarterly Settlement Report. At the time of review, only a portion (22) of Quarterly Settlement Reports were available—those reporting the amount of claims paid from January 1, 2008 through June 30, 2014. Thus, this review was only performed on 42% of the claims data (66 months out of 156 months of raw data) that was segregated and matched up (based on payment date) to the 22 Quarterly Settlement Reports.

This analysis revealed a significant gap in total paid claims of $3.3 Million, as outlined below. Meaning, one can reasonably conclude that either claims data has been withheld from Comau or Comau has been overcharged as the data does not support the financial transactions reported in the Quarterly Settlement Reports.

Gap in total paid claims of $3.3 Million (see **Appendix B** for details)

Quarterly Settlement Report (amount charged to client):	$54,899,565 (22 Quarters only)
Medical Claims Data:	$51,568,882
GAP (missing data or client overcharged):	**$3,330,682**

BCBS Michigan's Crawford "Expert Rebuttal Report" acknowledged that some data was withheld.[2] Crawford reports that $2.7 Million in paid claims data was not provided to Comau. A separate file representing the $2.7 Million has been submitted and is referred to as "Additional BCBSM Claims Data" (provided by BCBS Michigan in November 2021). As of the present, a review of such data is in process; CI has only validated the total aggregate paid amount which reflects what Crawford reported ($2.7 Million). The Crawford Rebuttal Report did not compare the medical claims data to the quarterly reports—it simply compared annual and quarterly reports and did not substantiate why there is a significant gap between the claims data and the Quarterly Settlement Reports.

In summary, CI was able to evaluate 66 months out of 156 months of raw data, and in those 66 months alone, CI found an unexplained $3.3 Million shortfall. This figure is likely much larger given the 90 months currently excluded from this evaluation. Assuming that the 66 months CI was able to evaluate are representative of the larger data set, then there is likely a total ~$7.8 Million gap. Even after accounting for the $2.7 Million in newly provided data from BCBS Michigan, there may still be over $5 Million in unexplained payments across the full 156 months. This reaffirms the need for complete access to Comau's claims data.

2. Missing Provider Information

CI identified **8,851 claims**, representing a **total aggregate paid of $3,006,692**, that did not list a National Provider Identifier (NPI) number. The NPI is a 10-digit unique identifier that represents health care providers in HIPAA standard transactions. As described within BCBS Michigan's corporate website[3], HIPAA requires the adoption and use of the standard unique identifier for health care providers. It is the responsibility of the plan fiduciary to provide industry standard oversight, such as confirming that the healthcare service provider is a covered entity as described within the plan document.

Without the NPI number, CI is extremely limited in the coding edits it is able to run. Each provider's unique NPI number is used to identify their Taxonomy code, a key data point that describes the provider's classification and specialty. This information is used to inform reimbursement and benefit access, and thus is necessary to identify inappropriate and fraudulent billings (e.g. an allergist should not be billing for a cardiac heart surgery). Thus, it is impossible for CI to validate 8,851 records with no NPI number, representing a total aggregate spend of $3,006,692. Notably, $1.3 Million of which was also paid to unknown entities (i.e. no payee information).

CI requested missing provider information, and in response BCBS Michigan asserted such information was unavailable due to claims stemming from out-of-state "Host" plans. The Crawford Expert Rebuttal Report stated, "The majority of claims noted in the CI Report as lacking a provider name or biller name are BlueCard Home claims. These are claims processed and paid to the provider by the 'host' platform, not BCBSM, and BCBSM then reimburses the host through a transaction clearing system."[4] A review of the data invalidated BCBS Michigan's explanation.

CI analyzed the 8,851 claims missing NPI numbers and found that 3,626 of the claims were processed under the Home plan and not the Host plan. (see **Appendix A** for details). This directly conflicts with both statements of BCBS Michigan and Crawford expert. In summary, there is no reasonable explanation as to why the NPI number was not provided for

[2] Crawford Expert Rebuttal Report Page 10
[3] https://www.BCBS Michigan.com/providers/help/faqs/national-provider-identifier-faq/what-is-npi.html
[4] Crawford Expert Rebuttal Report page 44

8,851 claims.

Claims missing provider information had to be removed from review, because CI is unable to run baseline coding edits as the taxonomy field provided is null and therefore requires the NPI field element. Further, regardless of plan (Home or Host) or processing system (Legacy or NASCO), this is a mandatory field required for claim adjudication.

3. Missing Payee Information

CI identified **30,091 claims,** representing a **total aggregate paid of $25,456,645** that had no payee indicator. The payee indicator identifies the entity that BCBS Michigan reimbursed for a claim (i.e. the Member or Provider).

In response to a request for payee information, BCBS Michigan initially asserted that PAYEE information was provided on all claims. This assertion blanently conflicts with the data, which shows the payee field as "NULL" for the 30,091 claims. Below is a snapshot of the claim samples provided to BCBS Michigan that clearly illustrates payee information is NULL:

Claim #	Provider	Total Billed	Total Paid	Payee
[redacted]	William Beaumont Hospital Royal Oak	$15,866.67	$12,238.92	Null
[redacted]	Botsford Hospital	$22,184.00	$12,232.65	Null
[redacted]	Providence Park Hospital Novi	$12,576.25	$12,200.20	Null
[redacted]	St Joseph Mercy Hospital Ann Arbor	$19,571.28	$12,158.58	Null
[redacted]	St Joseph Mercy	$8,356.00	$12,081.60	Null
[redacted]	Henry Ford Hospital	$46,977.46	$12,070.12	Null
[redacted]	St John Macomb Oakland Hospital - Macomb Center	$24,178.58	$12,060.97	Null
[redacted]	St Joseph Mercy Hospital Livingston	$87,748.15	$12,009.38	Null
[redacted]	St Joseph Mercy Hospital Livingston	$90,255.15	$12,009.38	Null
[redacted]	St Joseph Mercy Hospital Livingston	$89,643.15	$12,009.38	Null

The Crawford Expert Rebuttal then further asserted:

- "*Payments for all in-network services are required to be made to the provider*, per the provider participating agreements. Therefore, the provider is the payee for in-network claims when the provider name or biller name is available in the BCBS Michigan Claims Data.
- "Because all of the payments in question are for facility claims, the identity of the payee is readily known *if the name of the provider or biller is available*."

CI reviewed all in network claims where the payee indicator was present within the claims data. CI captured 440,881 claims that were processed as a "in-network" in order to validate both statements of BCBS Michigan and Crawford. Claims that had a network indicator of "Y" were captured by CI as an in-network provider claim. Meaning, these claims are supposed to represent providers whom have a network agreement with a BCBS plan (regardless of what state the Health Care Service provider resides).

The following chart represents the in-network service claims breakdown that includes the Payee Indicator (Provider, Subscriber and No Payee Indicator-null) and financials associated.

Payee	In Network Indicator	Claim Count	Total Allowed	Total Paid
Provider	Y	410,342	$104,380,714.34	$83,005,715.57
Subscriber	Y	1,072	$443,566.39	$288,185.65
NULL	Y	29,467	$8,455,106.74	$24,896,843.38
	Total	440,881	$113,279,387.47	$108,190,744.60

In summary, the attestation of both BCBS Michigan and Crawford conflicts with the data as shown above because there are 1,072 claims that were "in-network" and paid to the subscriber/member. The concern is reasonable, as both statements conflict with the claims data and of the 30,091 claims that have no payee indicator, 29,467 were in-network and it remains a mystery as to whether $24 Million in plan assets were paid to the provider or the subscriber or other entity.

Additional review of recently produced documents revealed a systemic design in the BCBS Michigan processing system known as **"FLIP LOGIC."** This **FLIP LOGIC** (see page 9, #7 for more detail) pertains to out of network claims that are flipped to an in network status of which the billed charges are allowed at 100%. The PAYEE field becomes more relative to this review and may explain why subscribers were paid directly for claims marked as in network. Meaning, these claims paid to the subscriber and deemed as in-network in the claims data were actually out-of-network.

In the early days of the data review for this case, CI mentioned that the billed charges did not seem to be accurate, as CI identified $8.1 Million in paid claims were the claim has a "Y" network indicator and billed charges were allowed at 100%. Meaning, CI identified $**8.1 Million in paid claims that were:**

- Designated as in network
- Billed Charge was equal to Approved Amount.
- No reduction occurred and billed charge were allowed at 100%

Claims processed through BCBS Michigan's FLIP LOGIC were thus processed in contradiction to Comau's elected plan benefits. Further analysis and information is necessary to quantify

4. Claims Missing Line-Item Financial Details (Roll-up Financials)

CI identified **4,711 Facility claims**, representing a **total aggregate paid of $18,196,589** where line-item financial detail was not provided, impacting 38% of all facility[5] type claim payments. This data issue creates significantly limits the ability to identify egregious provider payments as the missing line item financials was withheld.

As illustrated in the claim sample below, a roll up of both Billed and Paid amounts makes it impossible to determine the line item allowed amount that is relative to each service code billed and therefore the approved amount cannot be determined.

[5] **Facility billing** is insurance billing (form UB04 is used in billing facility type claims) for hospitals, inpatient or outpatient clinics, and other offices such as ambulatory surgery centers. This insurance billing is not the same as billing for a regular doctor or specialist. **Professional billing** is the type of billing used in individual physicians' practices. Professional billing is completed on the CMS-1500 Forms. Providers are the individuals rendering a service, and may submit a claim through a facility or professional.

OUTPATIENT HOSPITAL PROCEDURE
Example of Roll up & Financials do not add up

Line	CPT	Billed	Approved Amount	Deductible	Copay	Coinsurance	Paid
1	85730	$61,202.00	$10.89	$0.00	$0.00	$0.00	$40,650.04
2	33249	$0.00	$1,930.00	$0.00	$0.00	$0.00	$0.00
3	86510	$0.00	$11.42	$0.00	$0.00	$0.00	$0.00
4	93641	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
5	71090	$0.00	$186.43	$0.00	$0.00	$0.00	$0.00
6	71010	$0.00	$34.52	$0.00	$0.00	$0.00	$0.00
		$61,202.00	$2,173.26	$0.00	$0.00	$0.00	$40,650.04

In the above sample claim, the healthcare service provider billed 6 service lines. Both the "billed" and "paid" fields are rolled up into line 1, while lines 2 through 6 are blank. The data does not reflect the billing transaction, as each service line must have an associated billed amount. The "billed" field reflects the charged amount and the "approved amount" (also called the allowed amount) should reflect the maximum allowed for each service. The approved amount for in network provider claims should represent the contracted rate and for out of network provider claims it should represent the usual customary and reasonable allowance (UCR). Meaning, the approved amount represents the maximum allowable per service and the paid field should represent the amount that was reimbursed (i.e. paid by plan assets).

It is impossible to determine egregious pricing or perform any claim editing when the data is masked due to this roll up scenario. For example, in looking at this claim it is impossible to tell what Comau paid for servce Line 2. Comau could have paid the approved amount of $1,930 or Comau could have $30,000. The problem is, it is impossible to tell.

Additionally, the fact that the approved field is also problematic (as discussed below) compounds the issue.

5. Claim Financials That Do Not Add Up

CI identified **238,331 claims**, representing a **total aggregate paid of $56,664,842** had inaccurate financials within a claim that do not add up. Approximately 65.5% (238,331) of all claims (363,693) under review have a financial issue specific to the approved amount (aka: allowable amount). The approved amount should reflect the correct contract allowance for network providers and for out of network claims it determines the usual customary and reasonable (UCR) allowance applied to each service level.

The sample claim in the immediately preceeding section ("Outpatient Hospital Procedure") also illustrates this issue with respect to approved amounts. In that sample, the total aggregate approved amount of $2,173 is inaccurate as the paid amount was $40,650. Here, the paid amount exceeds the approved amount by $38,476, hence the approved amount reported for each line item of the claim is inaccurate. In fact, BCBS Michigan expert rebuttal report statement recognize that this field is problematic: "It should also be noted that the total payments from the BCBSM Claims Data are not intended to always equal the full approved amounts on a claim-by-claim basis. Sometimes this is true, but other times there are factors outside of the data that allow the approved amounts to not equal the total payments."

Claim Type	# Claims	Approved/Allowed	Member Liability	*Calculated Payable* *Allowed (minus) Member Deductible, Copay & Coinsurance*	Paid Amount (within data)
Facility	229,220	$39,486,365.49	$3,251,716.10	*$36,234,649.39*	$ 33,443,749.70
Professional	9,111	$8,925,729.81	$978,002.32	*$7,947,727.49*	$ 23,221,092.71
	238,331	$48,412,095.30	$4,229,718.42	*$44,182,376.88*	$ 56,664,842.41

In summary, the approved amount is a key field used to determine how a service line was processed. After, an approved amount is established, then the patient's liability is calculated which ultimately determines how much the plan should pay and what the member should pay. The responses from BCBS Michigan do not address why 65.5% of all claims have an approved amount that does not reconcile with the financial detail. BCBS Michigan's explanation that this is a "legacy system issue" does not support why a significant portion of claims do not add up. Further research into this field will be required to better understand this data anomaly and its impact.

6. Rejected Claim Lines That Report As Paid

CI identified **1,180 claims**, representing a **total aggregate paid of $1,179,751** that were supposed to be denied with no payable amount. The claim status "R" indicator reflects claims that are rejected (aka: denied). CI identified 35,583 claims had an "R" claim status, of those claims 1,180 show a paid amount, representing a total aggregate paid of $1,179,751. Based on BCBS Michigan's data dictionary, an "R" claim status means that the claim line was rejected, therefore the paid amount should be $0.00. Of those claims labeled "R," 1,180 claims show a paid amount. Indicating that $1,179,751 in claims were paid despite being coded as rejected. If actually paid, these claims are a fiduciary violation and would be considered **improper payments** (**in addition to those outlined in Part II below**). BCBS Michigan should confirm why any amount would be listed in the paid field for claim lines that were rejected. No reasonable explanation has been provided BCBS Michigan.

7. Systemic Pricing Failure of Out of Network Claims "FLIP LOGIC"

CI identified **14,473 claims**, representing the **total aggregate billed amount of $9.1 Million** of which billed charges were allowed at 100%. This anomaly was brought to BCBS Michigan's attention in the early stages of CI's review, as a significant portion of claims (14,135 claims) were labeled as in-network, but Billed Charges were allowed at 100%.

The following was BCBS Michigan's response to this data anomaly:

> *"There are a variety of reasons why the Total Billed may mirror the Allowed Amount on a claim. Some providers charge BCBSM exactly the amount they know they will get paid. Additionally, some small hospitals have a contracted rate of 100% of charges. Finally, some claims are paid at the lesser of BCBSM's allowed amount or the provider's charged amount, and sometimes the provider's charged amount is less than BCBSM's allowed amount."*

Months after CI issued its first intial report, BCBS Michigan produced a host of documents in late November 2021, that detailed a system wide pricing failure specific to out of network claims. Further review of BCBS Michigan's internal communications revealed that BCBS Michigan knowingly changed the network status of out-of-network claims to in-network status of which the system was designed to then allow 100% of the billed charge across ALL service lines. Meaning, claims were masked to appear to be in-network and allowed at 100%, when in fact they were out-of-network and should have been reduced to the average in network rate per Comau's elected plan benefits. In addition, it is our understanding that these same claims were processed as in-network and therefore benefits were administered at the in-network benefit level versus the out-of-network benefit level (higher deductible and coinsurance was bypassed), a violation of the plan.

Below is a snip it of BCBS Internal Email communication[6] dated September 12th, 2017:

> In 1997 processing logic was implemented for non-par claims that would ***FLIP*** **the par status on the claim and process at charge when referring provider information is submitted on the claim.** It was assumed that the referring provider is most likely par and thus will be referring the member within the network. This is done without checking whether providers are participating, as we do not currently have the capability of providers outside of Michigan.
>
> 1. Recent Review of benefit design documents confirmed that the majority of non-Auto groups on NASCO classic (201 in total) have elected to pay at the Host-allowed rate for non-par claims, with the exception of "no-choice" situation (services performed by hospital-based providers where the member has no ability to select a provider**). "Flipping" logic** is in direct contradiction with the group-elected benefit.
>
> 2. In the past few years, the dynamic shifted and BCBSM is observing abusive provider billing practices. In the absence of controls in the system logic that would flag suspicious claim activity, claims continue to be processed as "pay sub at charge", often many times over and above the customary amount for such services. The [redacted] account is the latest group to raise a concern on lab fees (urinalysis) in excess of $300K for one of their members in one year.
>
> In 2016, BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those charges was $30.5M and resulted in a payment amount of $26.7M. With the application of the Host Plan Pricing, the total allowed amount for these claims would have been $7.1M; a potential savings of $23.M in benefit costs.

The FLIP LOGIC referred to in the aforementioned BCBS Michigan internal email, supports the fact that BCBS Michigan knowingly processed out-of-network claims in direct contradiction of the group elected benefit of which the processing system was deliberately designed to allow 100% of billed charges. In fact, according to this email, in 2016 BCBSM processed 30,000 non-par claims at charge when Host pricing was available. This systemic pricing failure resulted in an estimated $23 M in overcharge/loss savings for 2016 alone. At this time, the true calculated loss to Comau is unknown, as this calculation would require access to Host Pricing, which BCBSM has not provided. While the specific amount of **improper payments** BCBSM made as a result of its FLIP LOGIC is unknown, it is known that Comau was affected by this issue.

The fact that out-of-network claims are masked and appear to be in-network in the data makes it problematic in segregating what claims were truly in network versus out of network. CI extracted ALL claims where ALL service lines within a claim had billed and approved amounts match and there appeared to be -0- reduction.

The below chart represents the total number of claims processed at 100% of Billed Charge.

Network Status - Payee	Sum of Claim count	Billed	Allowed
In Network	**14,135**	**$8,996,300**	**$8,996,300**
NULL-no payee information	301	$155,249	$155,249
Paid To Provider	13,597	$8,710,544	$8,710,544
Paid to Subscriber	237	$130,506	$130,506
Out of Network	**338**	**$126,150**	**$126,150**
NULL-no payee information	2	$1,607	$1,607

[6] BCBS-Comau00029305

Paid To Provider	211	$79,620	$79,620
Paid to Subscriber	125	$44,923	$44,923
Grand Total	**14,473**	**$9,122,450**	**$9,122,450**

As illustrated in the above chart, **14,145 claims**, representing a **total aggregate Billed of $8,996,300** were assigned as participating in-network provider claims of which the total of billed charges were allowed at 100%. Within this $8.9 M, is a mix of non-participating (out-of-network) & participating (in-network) provider claims. Provider claims that are truly out-of-network are found throughout claims labeled as participating (in-network) that are actually "out of network." CI points to two (2) discovery documents labeled "Out of State Non Par Data 2016-2019" (BCBS Comau-00027428 & 00027429).

The below chart illustrates a sample of claims subjected to FLIP LOGIC that were identified in the document labeled BCBS COMAU-00027429, this validates that these claims are in fact out-of-network and show up as in-network.

Claim #	Date Incurred	Total Billed	Total Allowed	National Average (for all services)	% of National Avg.
[redacted]	[redacted]2018	$6,400	$6,400	$3,600	178%
[redacted]	[redacted]2018	$1,500	$1,500	$51.01	2,941%
[redacted]	[redacted]2017	$18,500	$16,500*	$4,450	371%
[redacted]	[redacted]2015	$2,638	$2,638	$196	1,345%

*$2,000 diff. represents service line denied in whole. 100% of billed allowed across all other service lines

In summary, BCBS Michigan knew that the processing system was set up to process claims inaccurately and that Comau was affected by this flawed system design. **This issue requires extensive review to further validate the direct impact to Comau and its members of this systemic pricing failure.** CI has not yet had time to completely evaluate as filing this supplemental report due to BCBSM's belated production of the documents. CI may supplement this report if needed and when CI's analysis is complete.

PART 2: IMPROPER PAYMENTS

$8.0 Million captured in improper payments

After CI scrubbed and removed claims with key data issues, we then commenced the electronic analysis to provide an overcharge analysis that identifies improper payments and pricing disparities for the plan and members. The information contained herein represents the analysis of primarily professional claims (non facility). Data limitations specific to the roll-up of financials limited the analysis of hospital/facility type claims.

The quality of data and key field parameters ultimately determine the efficacy of reported financials and findings. Claims not impacted by data limitations were reviewed and CI identified more than **$8.0 Million** in improper charges; more than **$7.3 Million** of plan payments and **$710K** of member liability.

To be clear, this is not an exhaustive list of improper payments. **Improper payments resulting from BCBSM's flip logic system design, claims that were rejected and paid nonetheless, and more, are also considered improper payments. Additional analysis and information is necessary to quantify these additional improper payments.**

Summary of improper charges by error type:

Error Type	Plan Liability	Member Liability	Total
Unbundling/Incidental/Mutually Exclusive	$2,332,918	$248,652	$2,581,570
Episode of Care (Upcoding/Wrong Code)	$4,460,900	$423,839	$4,884,739
Medically Unlikely	$393,715	$25,778	$419,493
Non-Adherence to Payment Guidelines	$117,279	$12,307	$129,586
Grand Total	$7,304,812	$710,576	$8,015,388

(note: CI has removed all Duplicate payments originally reported due to high adjustment rates)

The $8.0 Million does not represent a sampling, nor does this represent an extrapolation; these represent actual overcharges to Comau and its members. Further, given these results came from an electronic review, they by no means represent the entire universe of overcharges, especially considering BCBSM's data deficiencies.

PROCESS OVERVIEW

CI first reviews data to identify claim adjustments, voids, plus no pays and removes original records that have been re-adjudicated; this process reduces the false positives and provides a review of final processed transactions.

RAW Data File total(s) were as follows:

- # Claims 462,746
- # Records (line items) 1,169,989
- Aggregate Billed $309,796,977.80
- Aggregate Approved $121,416,158.44
- Aggregate Paid $113,721,072.70

The following describes CI's process of cleaning/" scrubbing" the data and the hierarchy and sequence of applying a claim ignore status. So that we do not replicate financials for claims that may fall into multiple ignore steps, we developed a hierarchy sequence to ensure accurate financial reporting.

Step 1 - Exclude Replicated Records
CI identifies claims that have been re-adjudicated and removes duplicate records to capture the final actual payments. There are 4 main types of claim adjustments: Credit, Debit, No Pay or Void.

52,215 Claims removed from review- These claims were either paid and completely backed out or re-adjudicated.

Table representing aggregate total(s) for replicated records removed from review:

Claim Count	Claim line Count	Sum Billed	Sum Approved	Sum Paid
643	5,410	-$6,158,220.60	-$303,501.70	-$2,339,600.66
646	5,434	$6,165,079.41	$304,217.03	$2,340,250.40
50,926	134,567	$11,297,617.14	$4,388,800.37	-$470,168.74

Step 2 - Exclude Claims Rejected with R claim status
CI identified all claims where all claims' lines within were assigned an "R" claim status where "R" represents "Rejected."

35,583 Claims were removed from review – 35,583 claims had an "R" status. Of those labeled "R", 1,180 claims with an aggregate total of $1,179,751 were paid anyway. If actually paid, these claims are a fiduciary violation. Comau should confirm why any amount would be listed in the paid field for claim lines that were rejected.

Aggregate total(s) for claims with a "R" Rejected claim status removed from review:

Claim Count	Claim line Count	Sum Billed	Sum Approved	Sum Paid
35,583	76,278	$26,618,372	$7,182,304	$1,179,751

Step 3 - Exclude Claims with NO provider information
CI identified 10,602 claims where no or highly limited provider information was provided. Of the 10,602 claims, 1,722 were ignored under step 1 & 2; therefore, the remaining 8,880 were removed under step 3.

8,880 Claims removed from review- 8,880 claims, with an aggregate paid total of $2,793,358 were paid without provider information. If actually paid, these claims are also a fiduciary violation.

Aggregate total(s) for claims with no provider information removed from review:

Claim Count	Claim line Count	Sum Billed	Sum Approved	Sum Paid

8,880	21,751	$7,305,818	$2,511,522	$2,793,358

Step 4 - Exclude Claims where -0- amount was paid

CI identified all claims where sum paid was -0-

1,593 Claims removed from review

Aggregate total(s) for claims where sum paid was -0- removed from review:

Claim Count	Claim Line Count	Sum Billed	Sum Approved	Sum Paid
1,593	3,610	$577,354	$347,157	$0.00

Step 5 - Assignment of Ignore Status Code

CI assigns an internal ignore code so that claims do not run through the core processing engine that captures improper payments. Once this step is finalized, the data runs through a series of edit concepts that are applicable to BCBS Michigan's policy and procedures. Claims are captured and improper payments for the plan and members are calculated.

Final total(s) after data has been scrubbed:

	Raw Data	Post Scrubbed Data
#Claims	462,746	363,693
# Records/Lines	1,169,989	914,866
Total Aggregate Billed	$309,796,977.80	$ 262,111,944.07
Total Aggregate Approved	$121,416,158.44	$ 106,404,966.73
Total Aggregate Paid	$113,721,072.70	$ 109,486,648.13

For this analysis, 462,746 claims paid from January 1st, 2008 through January 8th, 2021 with a value of $113 million paid were loaded into the ClaimInformatics' ClaimIntelligence™ platform. The data was scrubbed, and CI excluded 99,053 claims totaling $4.2 million in paid claims (adjusted, denied, pended and other).

INFORMATIONAL FINIDNGS

Due to significant data limitations discussed above that impact review of hospital/facility UB04 claim types (missing provider information and line-item detail, in particular), CI's analysis centered primarily around **professional claims data**. CI can identify improper payments due, in part, to non-compliance with standard claim edit policies. Billing and coding edits are based on guidelines from established industry sources such as the American Medical Association (AMA), medical specialty professional societies, and the Centers for Medicare and Medicaid Services (CMS). Claim payment determinations are also based on coding terminology and methodologies that are based on accepted industry standards, including Healthcare Common Procedure Coding System (HCPCS) manual, the Current Procedural Terminology (CPT) codebook, the International Statistical Classification of Diseases and Related Health (ICD) manual and the National Uniform Billing Code (NUBC).

Data total(s) post scrub:

	Total Paid Dollars	% of Total Claim $	Total Claim Count
Professional Claims (HCFA)	$47,565,972	43%	313,689
Hospital/Facility (UB04)	$61,920,675	57%	50,004
Total	**$109,486,647**	**100%**	**363,693**

$8.0 Million in Improper Payments

CI reviewed claims not impacted by data limitations as set forth in Part I and identified **$8.0 Million** in improper payments; **$7.3 Million** in plan payments and **$710K** of member liability.

CI grouped findings into four primary categories. Given the significant amount of missing data and data deficiencies, these categories by no means represent the entire scope of improper payments made by BCBS Michigan.

Error Type	Plan Liability	Member Liability	Total
Unbundling/Incidental/Mutually Exclusive	$2,332,918	$248,652	$2,581,570
Episode of Care (Upcoding/Wrong Code)	$4,460,900	$423,839	$4,884,739
Medically Unlikely	$393,715	$25,778	$419,493
Non-Adherence to Payment Guidelines	$117,279	$12,307	$129,586
Grand Total	$7,304,812	$710,576	$8,015,388

CI's Claim Intelligence Platform is configured to deploy specific coding and payment guidelines utilized by BCBS Michigan. The system configuration is in alignment with BCBS Michigan's national tables that are used to identify code unbundling, incidental procedures, and procedures that are mutually exclusive.

The findings highlight abusive unbundling of services, unpoding, MUEs, and non-adherence to standard payment guidelines. However, as previously stated, a majority of claim errors are specific to professional claims, as data issues were more prevalent with facility claims, limiting their reliability. The estimated error rate for professional claims exceeds **18%** (meaning, BCBSM improperly paid an estimate 18% of professional claims)**.** The quality of data and key field parameters ultimately determine the efficacy of reported financials and findings.

The **18%** estimated error rate is extremely high and does not include the portion of missing claims data provided by BCBS Michigan in November 2021 after CI reported missing data concerns. It is safe to assume that the additional $2.7 Million in paid claims data will only increase this error percentage and findings. The **18%** error rate is of great concern as it only reflects errors that CI was able to capture based on access to key data points. As described throughout this report, missing data points, financials that do not add up, and claims that have been rolled up limit CI's ability to run all claims through the CI technology platform. These findings are only based on claims data that did not have limited data points or inaccurate allowed amounts (approved amounts).

CI observed that a significant portion of claims errors were the result of inadequate implementation of pre-payment review filters, edits, and safeguards ("filters") that would have captured and denied these charges. Failure to implement such reasonable fraud prevention filters and attempt to recover overpayment due to fraudulent coding has direct impact to both the plan and it's members.

ERROR TYPES

1. Unbundling

CI identified $2,581,570 in improper payments attributed to unbundling. Unbundling is when a healthcare service provider uses the billing codes for two or more separate procedures when the procedures were actually performed together and only one code should be paid.

Per the BCBS Michigan's Provider Manual[7], all procedures must be grouped, or bundled, under the most comprehensive procedure code. The excerpts shown below are from BCBS Michigan provider manual that replicates the methodology used by ClaimInformatics.

These are two types of unbundling and rebundling edits:

i. Two or more procedure codes are used to indicate parts of a service for which there is a single, more comprehensive code that accurately describes the entire service but was not included in the claim(s). (Codes A + B should be billed as Code C.)

ii. Two or more procedure codes are submitted for the same date of service, but one of the codes is a comprehensive code that more accurately represents the services performed and billed. (Codes A +B are billed, but Code A is included in Code B.) **(See example below)**

In addition, BCBS Michigan's Provider Manual describes in more detail the common types of unbundling scenarios as set forth below (this is important as it is the same logic used by ClaimInformatics) :

Mutually exclusive
Per BCBS Michigan's Provider Manual, mutually exclusive is described as "procedure codes for which the technique varies but the outcome is the same, such as a total abdominal hysterectomy or a vaginal hysterectomy. Additionally, procedures that represent overlapping services or report an initial and subsequent service are considered mutually exclusive. (Codes A and B are reported but the relationship is improper. Clinically, B opposes A.)"

Incidental procedures
Per BCBS Michigan's Provider Manual, a procedure is "incidental when it is performed at the same time as a more complex procedure and is an integral component of the primary procedure. (Codes A and B are billed but Code A is considered a component of the primary procedure, Code B.)"

[7] https://www.BCBS Michigan.com/content/dam/public/Providers/Documents/help/medicare-plus-blue-ppo-manual.pdf

CI incorporates standard unbundling methodology that is utilized throughout the industry and is referred to as "procedure-to-procedure" (PTP) edits. PTP edits are used within the industry to identify multiple types of unbundling. These edits work by defining pairs of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes that should not be reported and paid together on a claim for a variety of reasons, such as a provider performing several laboratory tests for a patient that are commonly grouped as a panel and fall under a single billing code. A provider may try to increase his or her reimbursement by submitting claim codes for each individual test in the panel

The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported. Each edit has a Column One and a Column Two HCPCS/CPT code. If a provider reports two codes of an edit pair for the same patient on the same date of service, the Column One code is eligible for payment but the Column Two code is denied, unless an appropriate modifier is used. Providers can append modifiers to HCPCS/CPT codes only if the clinical circumstances and documentation justify appending an modifier and the code pair combination has been assigned a Modifier Indicator of "1." Providers cannot append any modifier to just any HCPCS/CPT code solely to bypass a PTP code pair edit if clinical circumstances do not justify its use. As with all payors, BCBS Michigan has restrictions based on the modifier indicator column assigned to each HCPCS/CPT code.

Modifier Indicator	Definition
0 = Not Allowed	No modifiers associated with NCCI are allowed with this PTP code pair.
1=Allowed	The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.
9=Not Applicable	This indicator means an NCCI edit does not apply to this PTP code pair

Example of Unbundling Overcharge from Comau's Claims Data:

Claim Number	Line #	CPT (Service Code)	Modifier	PTP Modifier Indicator	Original Paid Amount	Comments
[redacted]	1	49650	50	"0"	$357.94	Laparoscopy, surgical; repair initial inguinal hernia
	2	44180	59	"0"	$1,179.45	Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure) This code is included within code 49650 and is considered overcharged
	3	S2900			$39.18	
				Total:	**$1,576.57**	

[8]Laparoscopic lysis of adhesions (CPT codes 44180 or 58660) is not separately reportable with other surgical laparoscopic procedures

The example above illustrates an improper payment due to unbundling that BCBS Michigan allowed and paid with Comau's plan assets. In this example, a combination of CPT service codes 49650 and 44180 was captured. Problematically, the service code 44180 is billed as a "separate procedure." According to CPT guidelines, service code 44180 is a procedure that is usually a routine part of completing a more comprehensive procedure. CPT states that you should not code a CPT with the

[8] See link to 2018 Manual, section 6,#5 https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive

terminology "separate procedure" in its code description when you are reporting a more extensive procedure that separate procedure is a part of. Thus, BCBS Michigan should have not reimbursed the 44180 service code, as the cost of this service is properly accounted for within the 49650 service code.

In response to this example, BCBS Michigan's Expert Rebuttal stated:

> ***"****ClaimInformatics reported a conflict with procedure codes 44180 and 49650 billed on the same claim. Yet because code 44180 was billed with modifier 59, the provider indicated that the service was distinct and separate from code 49650."*

> *"The allowance and payment of the charges under these circumstances cannot be described as a violation of BCBSM procedures or industry standards since the modifier codes exist for the purpose of allowing payment of both claims and BCBSM has historically paid claims where the modifier represents the service as a separate service.*

This response is flawed as it fails to account for the proper use of code modifiers. As described in the above and below charts, the PTP modifier is "0," meaning there is no modifier allowed in any circumstance that would allow for these two codes to be allowed and paid separately.

Thus, going back to the example claim above, there is no reasonable explanation as to why this code combination was allowed and paid by BCBS Michigan. Notably, the AMA/CMS PTP table does not allow the use of a modifier for this code pair, see snapshot of table below.

Column 1	Column 2	*=in existence prior to 1996	Effective Date	Modifier 0= not allowed 1=allowed 9=not applicable	PTP Edit Rationale
49650	44180	*	20060101	0	CPT "separate procedure" definition

It is important to note, this PTP edit became effective January 1, 2006. Coding decisions for edits are based on conventions defined in the AMA's CPT Manual, national and local policies and edits, coding guidelines developed by national health care organizations, analysis of standard medical and surgical practices, and a review of current coding practices. Prior to the implementation of proposed PTP code pair edits are released for review and comment to the AMA, national medical/surgical societies, and other national health care organizations, including nonphysician professional societies, hospital organizations, laboratory organizations, and DME organizations for review and comment prior to implementation.

2. MEDICALLY UNLIKELY EDITS (MUE)

CI identified $419,493 in aggregate paid claims of which a portion of this amount exceeded the maximum number of units allowed. In order to determine the actual overpayment, further processing would be required to determine the unit cost for each service line and then calculate the amount paid, that exceeded the maximum number of units. An MUE for a code is the maximum units of service that a provider would report under most circumstances for a single patient on a single date of service.

MUE's are designed to limit fraud and/or coding errors. They represent an upper limit that unquestionably requires further documentation to support. The ideal MUE is the maximum unit of service for a code on the majority of medical claims.

An MUE for a HCPCS/CPT code is the maximum Unit of Service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service. Not all HCPCS/CPT codes have an MUE. MUEs are developed based on HCPCS/CPT code descriptors, coding instructions, anatomic considerations, established AMA and CMS policies, nature of service/procedure, nature of analyte, nature of equipment, prescribing information, and clinical judgment. As with PTP edits, MUE coding rule sets are based on conventions defined in the AMA CPT manual, these are industry standard rule sets.

Example of MUE from Comau's Claims Data:

Claim Number	Line #	CPT (Service Code)	Units Billed	Maximum UOS Allowed (MUE)	Original Paid Amount	Comments
[redacted]	1	95004	96	**80**	$951.22	(*Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report. Maximum Units allowed 80*
	2	95024	47	**40**	$539.37	(*Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests*)
				Total:	**$1,490.59**	

The example above illustrates where the provider overcharged the number of units for each of the service codes listed. As illustrated, service code 95004 maximum units billable is 80, this provider billed 96 (an overcharge of 16 units) and for service code 95024, the maximum units billable is 40, this provider billed 47 (an overcharge of 7 units).

3. UPCODING

Per BCBS Michigan's Provider Manual, upcoding is described as "the billing of a higher-level service when a lower-level service is warranted or performed." Upcoding is a type of abuse where healthcare providers submit inaccurate billing codes to insurance companies in order to receive inflated reimbursements.

Example of Upcoding from Comau's Claims Data:

Claim Number	Claim Type	Date of Service	CPT/SERVICE CODE	Billed Amount
[redacted]	Emergency Room **Doctor**	[redacted]2019	99285 (Highest Level of Complexity)	$ 326.00
[redacted]	Emergency Room **Facility**	[redacted]2019	99281 (Lowest Level of Complexity)	$ 269.00

In this example, a patient was seen in the Emergency Room for "Laceration of lip and oral cavity without foreign body." Relatively, this a minor event. As one would expect, two claims are filed (1 represents ER Physician and 1 represents ER Facility.

In this case, the ER Physician (a BCBS Michigan network professional provider) billed the highest level of severity, billing a service code 99285 (life threatening event). Whereas, on a separate claim, the Hospital billed the lowest level of severity 99281 (minor event). There are only 5 service levels that can be billed for Emergency Room & Evaluation and Management services delivered within an emergency room setting. The lowest level of severity is defined under service code 99281 (minor procedure). The highest level of severity is defined under service code 99285 (life threatening event). It is obviously improper to reimburse a claim for a lip laceration which is billed as a life-threatening event by the Emergency Room Physician.

As defined by BCBS Michigan[9], professional and facility claims that meet defined requirements for claim submission (see section 13 of the Blue Cross Complete Provider Manual for detail), and that are appropriately coded based on all other applicable ICD-10, CPT, or CMS standards, will be reimbursed. After reimbursement, both professional and facility ED claims billing Level 4 or Level 5 services will be reviewed against the "NYU Emergency Room Algorithm" diagnosis list for severity of diagnosis. If diagnosis severity is not consistent with the level of service billed, Blue Cross will pursue recovery of the claim payment.

This upcoding of "Emergency Room" level of care is just one example. Another example of upcoding is an instance when you provide a follow-up office visit or follow-up inpatient consultation but bill using a higher level E&M code as if you had provided a comprehensive new patient office visit or an initial inpatient consultation. There are many scenarios where upcoding can occur, this is not an exhaustive list of examples.

4. NON-ADHERENCE TO PAYMENT GUIDELINES

Payment guidelines are established to determine the appropriate reimbursement amounts when processing a claim. In general, Payment Guidelines dictate the reimbursement methodology used to determine the maximum allowable for any given service and provider type. Whereas, billing and coding guidelines are specific to correct coding of a procedure, Payment Guidelines determine reimbursement of a procedure.

Below are examples of some industry payment guidelines that BCBS Michigan, as a third-party administrator and insurer, should adhere to. These standard payment guidelines utilized by ALL payors across ALL lines of business (Medicare, Medicaid, Commercial, Managed Care).

Multiple Surgery Payment Guideline: Multiple procedures (Modifier 51) and/or bilateral procedures (Modifier 50) performed during the same operative session by the same physician or associate are reimbursed:

- 100% allowable for highest paying surgical procedure
- 50% allowable for all additional surgical procedures

Bilateral surgery Payment Guidelines:When a surgical procedure code contains the terminology bilateral, or unilateral or bilateral, or the code is considered inherently bilateral, modifiers LT, RT, or 50. Reimbursement is as follows:

- Reimbursement is 150% of the fee schedule or contracted/negotiated rate of the procedure.

Assistant Surgery Payment Guideline: An assistant at surgery is defined as a physician, nurse practitioner, clinical nurse specialist, or physician assistant who is licensed and actively assists the physician in charge of a case in performing a surgical procedure. Doctors of medicine (MDs) and doctors of osteopathic medicine (DOs) must report physician modifier 80, 81, or 82, as applicable, on claims for assistant at surgery services. 80 -- Assistant surgeon 81 -- Minimum assistant surgeon 82 -- Assistant surgeon (when qualified resident surgeon not available).

- Specific codes are deemed not covered, as most surgical procedures do required an assistant surgeon
- When a service is covered, then the amount reimbursed typically is between 15-25% of Surgeon Maximum allowable

[9] https://www.mibluecrosscomplete.com/amslibs/content/dam/microsites/blue-cross-complete/bcc-emergency-services-level-of-care-review-policy.pdf

For example, an Assistant Surgeon is allowed to be reimbursed when the appropriateness of assistant surgeon services are met. Meaning, an assistant surgeon may be **allowed when medical necessity and appropriateness of assistant surgeon services are met**, and when the physician assistant/nurse practitioner/nurse midwife is under the direct supervision of a physician. The guidelines to determine efficacy of billing for an assistant surgeon is determined by the American College of Surgeons and other surgical specialty organizations. Each year, ALL procedures listed in the "surgery" section of the American Medical Association's Current Procedural Terminology (CPT book) an example of the table published can be found at https://www.facs.org/-/media/files/advocacy/pubs/2020-physicians-as-assistants-at-surgery-consensus.ashx.

Example of Non-Adherence to Payment Guidlines from Comau's Claims Data:

Claim Number	Claim Type	Date of Service	CPT/SERVICE CODE	Billed Amount
[redacted]	Assistant Surgeon	[redacted]2018	29806-AS-LT	$ 1,500

The claim reflects a procedure performed which does not warrant an assistant surgeon, and accordingly should not have been paid. BCBS Michigan should have clear payment guidelines specific to when an assistant surgeon is warranted, they simply do not just pay when a service for assistant surgery is billed.

PART 3: OTHER PROBLEMS WITH BCBSM'S DATA AND CLAIMS PROCESSING

DANIEL CROWELL REVIEW OF DECLARATION AND ANALYSIS

At the request of Varnum Law Firm, CI reviewed documents provided by Varnum Law Firm associated with the interview of BCBS Michigan representative Daniel Crowell; Mr. Crowell had performed a claims analysis specific to Urinalysis Drug Screening (UDS) analysis. The documents included a legal declaration accompanied by an excel data file of the analysis performed.

> **Excerpt from Declaration page:**
> "I analyzed Comau healthcare claims with urinalysis drug screening (UDS) procedure codes (80307, G4079, G4081, G4082, and G4083) for the dates of service January 1, 2017 through December 31, 2020 for the purpose of assessing whether any claim appears to have been paid at a grossly inflated rate, as alleged in the Amended Complaint."
>
> "To the best of my knowledge, the five UDS procedure codes listed above are all of the codes professional and facility providers use to bill urinalysis drug screening claims."
>
> "Based on this analysis, my conclusion is that there are no Comau healthcare claims with UDS codes that appear to have been paid at a grossly inflated amount, as alleged in the Amended Complaint."
>
> "The allowed amounts for UDS claims submitted by professional providers ranged from $4.50 to $172.84."
>
> "Similarly, the amounts Comau paid for UDS claims submitted by professional providers ranged from $4.50 to $172.84."
>
> "446 health care claims fell within the UDS codes analyzed during the 2017-2020 period (287 professional claims and 159 facility claims)."
>
> "Based on this analysis, my conclusion is that there are no Comau healthcare claims with UDS codes that appear to have been paid at a grossly inflated amount, as alleged in the Amended Complaint."

CI Observation(s):

1. Of the five (5) codes 80307, G4079, G4081, G4082, and G4083 listed in Mr. Crowell's declaration statement, four (4) codes appear to be incorrectly transposed, as these codes are non-existent service codes. Mr. Crowell's data file included his programming statement which included the correct codes '80307', 'G0479', 'G0481', 'G0482', 'G0483'

2. Mr. Crowell's analysis was incomplete as it did not include all UDS service codes. There are more than five (5) applicable Urinalysis Drug Screening (UDS) service codes. Mr. Crowell did not consider other UDS codes such as 80300 through 80306 or G0431,G0434,G0480 TO G0483,G0630 to G0657 & G0659.

3. The financial range reported by Daniel Crowell were inaccurate, see below differential:

Daniel Crowell Deposition Statement	**Daniel Crowell Data**
"The **allowed** amounts for UDS claims submitted by professional providers ranged from $4.50 to $172.84."	Range is $4.50 to $290.00

"Similarly, the amounts Comau **paid** for UDS claims submitted by professional providers ranged from $4.50 to $172.84." Range is $4.50 to $215.01

4. CI is unable to concur with Mr. Crowell's analysis as further findings correlate with our belief that the data provided is incomplete and contains significant gaps of missing information. In fact, the allowed amounts (AKA: Approved Amounts) have been deemed inaccurate by both ClaimInformatics and BCBS Michigan Expert (Crawford).

5. **Mr. Crowell's analysis demonstrates that BCBSM did not provide Comau with all existing claims data.**

CI mirrored this analysis and pulled data using the same data parameters described on the spreadsheet labeled "notes." CI was able to replicate Mr. Crowell's analysis using the flawed approach with limited services codes and missing data. However, enough evidence exists that the missing claims data would skew the data and that further exploration with complete data would most likely lead to a different outcome.

CI identified 14 claims with an aggregate billed amount of $19,364 and an aggregate paid amount of $1,157 that were not contained in the Comau data provided by BCBS Michigan.

The below 14 claims were not provided in the raw claims file

Claim Number	Date of Service	CPT/SERVICE CODE	Billed Amount
[redacted]	[redacted]2017	G0483	$3,404.84
[redacted]	[redacted]2017	G0483	$3,404.84
[redacted]	[redacted]2017	G0483	$3,404.84
[redacted]	[redacted]2017	G0483	$3,404.84
[redacted]	[redacted]2018	G0483	$3,404.84
[redacted]	[redacted]2018	Y3000	$190.00
[redacted]	[redacted]2018	G0483	$987.68
[redacted]	[redacted]2018	Y3000	$90.00
[redacted]	[redacted]2018	G0481	$200.00
[redacted]	[redacted]2018	80307	$125.00
[redacted]	[redacted]2018	Y3010	$69.00
[redacted]	[redacted]/2018	Y3010	$212.00
[redacted]	[redacted]/2018	G0483	$377.00
[redacted]	[redacted]2019	Y3000	$90.00

Total Billed: $19,364.88

In addition, CI identified 8 claims with an aggregate billed amount of $3,936 and aggregate paid amount of $350.81 that were not contained in Mr. Crowell's analysis.

These 8 claims were missing from Mr. Crowell's analysis

Claim Number	Date of Service	CPT/Service Code	Billed Amount
[redacted]	[redacted]/2018	80307	$1,200.00
[redacted]	[redacted]/2017	80307	$61.00
[redacted]	[redacted]/2018	80307	$90.00
[redacted]	[redacted]/2018	80307	$165.00

[redacted]	[redacted]2018	G0483	$850.00
[redacted]	[redacted]/2018	G0483	$370.38
[redacted]	[redacted]/2019	G0483	$350.00
[redacted]	[redacted]/2018	G0483	$850.00

Total Billed: $ 3,936.38

Conclusion

CI's initial data concern regarding the potential of missing data appears to be validated as demonstrated in the aforementioned review of the BCBS Michigan external data source provided by Mr. Crowell.

OUT OF NETWORK - CLAIM PRICING DISPARITY

The below analysis was performed only on claims where network indicator is labeled with an "N" across all claims, including but not limited to claims incurred in and out of the State of Michigan. It does not include claims subjected to FLIP LOGIC.

CI performed additional analysis on all paid out of network professional claims. The original total record/line count was 22,284 before 7,786 records with no available national average data were removed & excluded from the analysis. CI deployed and matched the national average allowable [10] across the remaining 14,497[11] records. CI selected the 2019 CMS national average table for benchmarking purposes, allowing us to consider the highest level of reimbursement. Of the 14,497 out of network professional services with total payments of $528,707, approximately 77% ($409,383) of total paid exceeded the national average.

Below represents CI's benchmarking study for Out of Network- **Professional Claims**

National Average		
Range	**# Records**	**Plan Paid**
= or < 100%	5,974	$119,323.77
Between 101% and 200%	7,869	$314,997.32
Between 201% and 300%	367	$52,980.14
Between 301% and 500%	149	$15,194.35
Between 501 and 999%	109	$9,675.27
> 1,000 %	29	$16,536.37
	14,497	**$528,707.22**

$409K

Similarly, CI performed additional analysis on all paid out of network facility claims. The original total record/line count was 22,843 records before 2,043 records were removed and excluded from the analysis; the records were excluded as they were either inpatient and/or there was no national Ambulatory Payment Classifications (APC) rate (**APC** is CMS-Centers for Medicare's method of paying for facility outpatient services for the Medicare program). CI deployed and matched the national average allowable [12] across the remaining 2,800 records. CI selected the 2019 CMS APC national average table for benchmarking purposes, this allowed us to consider the highest level of reimbursement. Of the 2,800 of network professional services totaling $2,899,823.18 in paid claims, an estimated 50% ($1,432,564) exceeded the national average.

Below represents CI's benchmarking study for Out of Network -**Outpatient Facility claims**

National Facility Average		
Range	**# Records**	**Paid**
< 100%	2,282	$1,467,258.37
Between 101% and 200%	419	$903,281.95
Between 201% and 300%	56	$303,744.21
Between 301% and 500%	28	$101,030.33
Between 501 and 999%	12	$101,607.79

$1.433K

[10] https://data.cms.gov/Medicare-Physician-Supplier/Medicare-National-HCPCS-Aggregate-Summary-Table-CY/w9tx-4vq9/data and https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/**Part-B-National-Summary-Data-File**/Overview

[11] 66 records had -0- unit value out of 14,498 records. CI applied 1 unit to each of the 66 service lines.

[12] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2019-Annual-Policy-Files

> 1,000 %	3	$22,900.53
	2,800	**$2,899,823.18**

REVIEW OF TOP PAID CLAIMS

CI reviewed the electronic data containing "high expenditure claims" and discovered that a majority of them had:

a) no payee assignment
b) no line-item financial detail
c) no billed amount
d) incomplete patient history
e) large debit adjustments (12 months from initial processing of claim)
f) large credit adjustments (12 months from initial processing of claim)

In addition, lag time for adjustments may impact stop loss reimbursement[13]. While BCBS Michigan states payee information has been provided, no payee data was provided on $2.2 million of the $2.6 million in the claims listed below, nor were other critical data points required as minimal standards under ERISA. The numbers in the table below are embedded in the values for other categories in this review

Upon discovering missing payee information on the top paid claims, CI reviewed the entire dataset and discovered **30,091 claims,** representing an **aggregate paid of $25,456,645** had no payee information.

Claim Number	Provider Name	Sum Billed	Paid	CI Observation
[redacted]	UNIVERSITY OF MICHIGAN MEDICAL HEALTH SYSTEM.	$0.00	**$618,231.51**	**Patient admitted on [redacted]2010 through [redacted]2010 (50 Day stay)** No Payee in data No billed charge in data No Authorized Amount in data No line-item financial detail No patient history of other services (with exception of 1 claim for durable medical equip and 1 claim for radiology)
[redacted]	Hurley Medical Center	$507,541.45	*$256,911.89*	**Patient admitted on [redacted]/2012 through [redacted]/2012 (44 Day stay)** No Payee Data
			$165,565.67	No Line-Item financial detail 12 Months later released a majority of discount- could impact stop loss coverage
		Total Paid	**$422,477.56**	No patient history of other services (with exception of ambulance and ER claim)
[redacted]	Beaumont Hospital	$603,517.88	**$209,635.46**	**Patient admitted on [redacted]/2013 through**

[13] Companies providing health insurance for their employees through a self-insured plan often subscribe to stop loss policies in order to protect themselves against catastrophic claims. The organization which takes the insurance policy is called the insured and the employees and other people who are covered through the policy are called participants. Most of the time there is an annual limit for the stop loss amount for each participant and an aggregate amount for each policy year. The premium is calculated for each employee for each month. The premium is based on the number of participants, age of the participants and various other information. ***Most policies require claims to be filed timely, claims filed not within the policy timely filing limits maybe denied.***

				[redacted]/2014 (47 day stay) Normal patient history (all provider types present) Payee indicator shows paid to provider of service 12 Month lag in processing- this could impact stop loss coverage
[redacted]	UNIVERSITY OF MICHIGAN MEDICAL HEALTH SYSTEM	$363,328.27	**$205,342.53** ($205,342.53)	**Patient admitted on [redacted]/2006 through [redacted]/2007 (33 day stay)** 12 Month lag in re-adjudicating this claim that was backed out and credited on 01/08/2008. This may have impacted stop loss We do not have original processing record or history for these dates of service
[redacted]	UNIVERSITY OF MICHIGAN MEDICAL HEALTH SYSTEM	$0.00	**$196,312.00**	**Patient admitted on [redacted]/2010 through [redacted]/2010 (20 day stay)** No Payee Data No Billed Charge in data No Authorized Amount In data No Line-Item Financial detail
[redacted]	HENRY FORD HOSPITAL	$361,068.50	**$194,310.00**	**Patient admitted [redacted]2017 through [redacted]/2017 (39 day stay)** Payee indicator shows paid to provider of service All other service claims rejected (professional claims)
[redacted]	UNIVERSITY OF MICHIGAN MEDICAL HEALTH SYSTEM	$544,819.34	**$45,025.82**	First claim processed No Payee Data No Authorized Amount in data No line-item Financial detail
			($45,025.82)	11 Months from initial claim paid. The plan was credited original payment
[redacted]		$154,089.23	$154,089.23	Second Claim for same service processed No Payee Data No Authorized Amount in Data No line-item Financial Detail
			($154,089.23)	9 Months from initial claim paid. The plan was credited original payment
[redacted]		$149,053.29	$149,053.29	Final claim processed **No Payee Data** **No Authorized Amount in data** **No line-item Financial detail**

Monies paid	**$2,616,954.96**
Credits	**($404,457.58)**
Total Less Credit	**$2,212,497.38**

CI is presenting this data to demonstrate that even on high dollar claims where one could reasonably assume that extra scrutiny would be applied, several claims were re-processed indicating significant overpayments along with missing key data elements, such as billed charge.

About ClaimInformatics

ClaimInformatics™ is a payment integrity firm dedicated to identifying improperly paid health care claims. With our transparent, state-of the-art, highly secure, HIPAA-compliant system, our fully integrated, cloud-based platform provides granular forensic reviews of all health care claim transactions/data sets. Our proprietary system contains thousands of unparalleled algorithms that our team of industry experts developed over the past decade and that cover a broad range of error type categories including billing & coding, payment guideline, summary plan description, contracted rates, episode of care, and fraud, waste & abuse.

Contract Term(s):
CI was engaged by Varnum LLP to review paid claims data extract provided by BCBS Michigan for a fixed fee of $25,000. The scope of the engagement comprised of identifying potential overcharges and identify pricing disparity.

CI undertook this project on as independent consultant to perform an analysis in an objective manner. We were not asked to reach any particular conclusion and our fee was not contingent upon the final results of our work, nor the outcome of the litigation.

Attestation:

Statements made in this report are based on my personal knowledge and, to the best of my knowledge, are true. If called upon as a witness, I can testify competently as to the truth of the statements made in this declaration.

The statements made in this report are a complete statement of all opinions I will express if called upon as a witness, and a complete statement of the basis and reasons for my opinions.

The facts and data that were considered when forming my opinions are contained in this report.

Any exhibits that will be used to summarize or support my opinions if called upon as a witness are contained in this report.

I am an adult over the age of 18 years. I have not been called upon as an expert witness nor have I provided expert testimony in any legal matter in the previous four years.

I am a Co-founder of ClaimInformatics, a company that specializes in healthcare claim review and recovery services, including discovery and recovery of improper payments for healthcare services. I have over 30 years' experience in health care claim analytics, processing, pricing, auditing, recoupments and proper billing, coding and reimbursement of Medicare like rates.

I have not authored any publications in the previous 10 years.

A statement of the compensation I will be paid for the study and testimony related to this case is contained in this report.

Dawn Cornelis

Dawn Cornelis
Chief Transparency Officer
ClaimInformatics
January 20, 2022

DAWN CORNELIS

Riverside, CA - d.cornelis@claiminformatics.com

Nationally sought-after industry thought leader for healthcare payment integrity with decades of experience in building and leading teams to uncover fraud, waste and abuse and other payment errors.

Experience

ClaimInformatics – Bloomfield, CT
Co-Founder Chief Transparency Officer 2017 - Present
Provide strategic direction based on prior expertise to ensure best-in-class healthcare claim payment integrity solutions.

- Provide leadership and vision for state-of-the art, comprehensive payment integrity system
- Key architect of ClaimIntelligence™ payment integrity platform
- Supervise all analytical activities, maintaining high standards to ensure ultimate client satisfaction
- Lead team in identifying fraud, waste and abuse and other healthcare payment errors

ClaimReturn – Dallas, TX
Co-Founder Chief Operating Officer 2012 - 2015
Established leading team to recovery healthcare improper payments.

- Secured $4.2 million funding investment while managing team of 45 employees
- Identified and recovered hundreds of millions of dollars of improper payments through pre and post payment containment programs.
- Provided claim system administration for Provident Life and Transamerica Occidental.
- Built and motivated high performing team of data analysts and IT developers.
- Developed ClaimIQ for forensic review of healthcare claims data with client-facing web portal access

Claim Audit and Recovery Services (Formerly Claim Recovery Services) – Columbus, GA
Founder and Chief Operating Officer 1993 - 2012
Co-led efforts as the industry's first healthcare claim audit and recovery firm.

- Established strong national alliance partnerships with major insurance companies and health systems including AIG World, Global Options, Mutual of Omaha, Principal Financial Group, Deloitte, PHCS/Multiplan, Jefferson Health System and Seton Health System
- Developed Medstar 3.7 to auto adjudicate adjustments and negotiated settlement claims
- Identified and recovered hundreds of millions of dollars of improper payments through pre and post payment containment programs

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Additional

Invented Episode of Care logic to capture upcoding and additional improper payments.
Patent Inventor: #20150127370-Continuity of Care
Speaker at national forms including Institute for Healthcare Consumerism.
Participant in roundtable sessions on Federal and state regulations pertaining to healthcare claim payments.
Featured on Relentless Health value podcast in July 2020*: EP285: The Fascinating Story of Billions of Dollars Going Missing When the Back Office Pays Health Care Bills, With Dawn Cornelis, Cofounder and Director of Transparency at ClaimInformatics – Relentless Health Value*
Featured on Reconstructing Healthcare Podcast in September 2020: Reconstructing Healthcare: Innovative Solutions For Employers To Lower Their Healthcare Costs
SIIA (Self Insurance Institute of America- Transparency Legislation, workgroup participant, March 2021
IFEBP (International Foundation of Employee Benefit Plans), member - August 2019

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LINDA MYRICK

Overgaard, AZ - l.myrick@claiminformatics.com

Certified Professional Coder (CPC) and Instructor (CPC-I) through AAPC with
more than 20 years of experience in medical coding.

Experience

ClaimInformatics – Bloomfield, CT
Senior Data Analyst 2021 - Present
Analyze healthcare claims data to identify overpayments

- Review, identify and validate improper payment of medical claims.
- Ensure payments in compliance with billing and coding regulations for all provider types and plans following payor specific, CMS and Medicaid guidelines.
-

Valenz Health – Phoenix, AZ
Claim Administration Director, Claim Resolution Manager/Edit and Special Projects Manager 2014 - 2020
Payment integrity analysis

- Managed Medical Claim Appeals and Negotiations
- Validated Medical DRG codes and edits
- Ensured company remained compliance with HIPAA regulations in role as Compliance Officer
- Provided medical claims coding instruction to staff

TriWest Healthcare Alliance – Phoenix, AZ
Pricing and Coding Led/Supervisor of Claims Support 2004 - 2013
Lead for Claims Field Support and Recoupment

- Assign accurate codes to all patient records and prior authorization requests
- Analyze claims for accuracy

Professional Credentials

Certified Professional Coder (CPC) and Instructor (CPC-I) Number **01136537 through AAPC**
ICA- Medical and Dental: Completed Exam
HIAA Fundamentals of Insurance Part A & B: Completed Both Exams
AAPC Certification for Professional Coding

Additional

Medical Insurance and Billing

- CPT, ICD-10 & HCPCS Coding
- DRG, Revenue Codes, UB Coding
- Coding direct from Medical Records
- Revenue Cycle Pro /Encoder Pro/3M
- HCC Educated
- Developed CPT, ICD-10 HCPCS, DRG Coding, Training Guides and Manuals
- Authorizations and Referrals HMO, PPO, and Indemnity Plans.
- Processing Claim Forms –COB
- Project implementation

Bill Review, Claim Audits, Claim Negotiations and Provider Contracting
Medicare/Tricare /Data Analysis
Development of Coding Policies and Procedures
HIPAA Compliance Trainer
Computer Experience
Microsoft Word Advanced Excel PowerPoint

Appendix A

The following chart illustrates 3,626 claims processed by BCBS Michigan (home plan) on behalf of **"unknown healthcare providers"** (evidence countering BCBS Michigan's assertion that these claims were processed under blue card/Host plan):

Year/Payee	Claim Count	Comau Paid Amount
*NULL	212	$370,811.88
2008	62	$97,937.11
2009	37	$12,668.16
2010	60	$41,239.15
2011	30	$32,583.32
2012	23	$186,384.14
Provider	3,221	$305,787.87
2007	2	$151.34
2008	670	$53,216.47
2009	494	$36,736.87
2010	565	$39,559.37
2011	592	$41,591.40
2012	406	$50,950.90
2013	16	$8,239.65
2014	158	$31,012.40
2015	170	$17,622.32
2016	81	$12,412.84
2017	44	$12,846.20
2018	12	$794.33
2019	11	$653.78
Subscriber	193	$56,824.43
2007	1	$168.23
2008	13	$464.01
2009	11	$15,748.20
2010	11	$1,948.83
2011	56	$13,005.56
2012	44	$8,654.44
2013	16	$2,913.68
2014	25	$9,610.39
2015	8	$1,261.03
2016	5	$2,593.10
2017	2	$456.96
2018	1	$0.00
	3,626	$733,424.18

**Note: 211 claims totaling $370K plan assets paid with NO "provider information" or "PAYEE assignment"*

Appendix B

The following table illustrates a $3.3 Million Gap between what the client was charged and what the claims data supports

BCBS Michigan Client Quarterly Settlement Report
Settlement Report versus Claims Data
Possible Missing Data $3.3 Million (66 months/22 quarterly reports)

Quarterly Report Time Period	Blue Cross (Hospital)	Blue Shield (Professional)	Total Settlement Report	BCBSM RAW Medical Only Data
01/01/2008 through 03/31/2008	$ 1,324,116.00	$ 1,028,462.00	**$ 2,352,578.00**	**$2,319,066.64**
10/01/2008 through 12/31/2008	$ 1,314,845.00	$ 1,094,516.00	**$ 2,409,361.00**	**$2,422,288.17**
04/01/2009 through 06/30/2009	$ 979,919.00	$ 868,535.00	**$ 1,848,454.00**	**$1,842,269.47**
07/01/2009 through 09/30/2009	$ 1,117,160.00	$ 1,021,976.00	**$ 2,139,136.00**	**$2,103,701.44**
10/01/2009 through 12/31/2009	$ 1,233,398.00	$ 917,930.00	**$ 2,151,328.00**	**$1,810,033.52**
01/01/2010 through 03/31/2010	$ 1,042,755.00	$ 1,029,812.00	**$ 2,072,567.00**	**$1,985,827.81**
04/01/2010 through 06/30/2010	$ 1,544,649.00	$ 1,047,644.00	**$ 2,592,293.00**	**$2,528,578.22**
10/01/2010 through 12/31/2010	$ 1,317,595.00	$ 1,057,681.00	**$ 2,375,276.00**	**$2,331,570.06**
01/01/2011 through 03/31/2011	$ 1,284,816.00	$ 1,058,180.00	**$ 2,342,996.00**	**$2,290,255.07**
04/01/2011 through 06/30/2011	$ 1,379,670.00	$ 1,076,653.00	**$ 2,456,323.00**	**$2,292,434.15**
07/01/2011 through 09/30/2011	$ 1,384,913.00	$ 954,661.00	**$ 2,339,574.00**	**$2,203,237.65**
10/01/2011 through 12/31/2011	$ 1,567,046.00	$ 1,134,985.00	**$ 2,702,031.00**	**$2,525,710.21**
01/01/2012 through 03/31/2012	$ 1,589,128.00	$ 990,796.00	**$ 2,579,924.00**	**$2,520,523.66**
04/01/2012 through 06/30/2012	$ 1,427,051.00	$ 1,141,333.00	**$ 2,568,384.00**	**$2,408,960.87**
07/01/2012 through 09/30/2012	$ 1,504,020.00	$ 1,172,552.00	**$ 2,676,572.00**	**$2,488,678.47**
10/01/2012 through 12/31/2012	$ 1,838,083.00	$ 1,312,674.00	**$ 3,150,757.00**	**$2,868,633.14**

01/01/2013 through 03/31/2013	$ 1,512,682.00	$ 1,136,420.00	**$ 2,649,102.00**	**$2,323,536.91**
04/01/2013 through 06/30/2013	$ 1,657,796.00	$ 1,125,345.00	**$ 2,783,141.00**	**$2,456,540.73**
07/01/2013 through 09/30/2013	$ 1,654,573.00	$ 1,043,781.00	**$ 2,698,354.00**	**$2,639,374.98**
10/01/2013 through 12/31/2013	$ 1,337,719.00	$ 1,191,103.00	**$ 2,528,822.00**	**$2,236,222.52**
01/01/2014 through 03/31/2014	$ 1,642,467.00	$ 1,115,244.00	**$ 2,757,711.00**	**$2,280,380.99**
04/01/2014 through 06/30/2014	$ 1,546,772.00	$ 1,178,109.00	**$ 2,724,881.00**	**$2,691,057.61**
		Total (s)	**$ 54,899,565.00**	**$51,568,882.29**

$3,330,682 Missing

Appendix C

BCBS Michigan Email (BCBSM-Comau 00029305)

The below represents excerpts (highlighted in blue font) from internal email communications from within BCBS Michigan. These emails disclose the background of the FLIP LOGIC referenced in this report. This information was derived from discovery document bates stamped **BCBSM-Comau 00029305**.

In 1997 processing logic was implemented for non-par claims that would ***FLIP*** **the par status on the claim and process at charge when referring provider information is submitted on the claim.** It was assumed that the referring provider is most likely par and thus will be referring the member within the network. This is done without checking whether providers are participating, as we do not currently have the capability of providers outside of Michigan.

1. Recent Review of benefit design documents confirmed that the majority of non-Auto groups on NASCO classic (201 in total) have elected to pay at the Host-allowed rate for non-par claims, with the exception of "no-choice" situation (services performed by hospital-based providers where the member has no ability to select a provider**). "Flipping" logic** is in direct contradiction with the group-elected benefit.

2. In the past few years, the dynamic shifted and BCBSM is observing abusive provider billing practices. In the absence of controls in the system logic that would flag suspicious claim activity, claims continue to be processed as "pay sub at charge", often many times over and above the customary amount for such services. The [redacted] account is the latest group to raise a concern on lab fees (urinalysis) in excess of $300K for one of their members in one year.

In 2016, BCBSM processed 30,000 non-par claims at charge when Host pricing was available. The sum of those charges was $30.5M and resulted in a payment amount of $26.7M. With the application of the Host Plan Pricing, the total allowed amount for these claims would have been $7.1M; a potential savings of $23.M in benefit costs.

Who is impacted?

- BlueCard transactions initiated by non-par providers for 201 customer groups on NASCO classic with exception of Auto.
- MOS processing is not impacted at large, unless a group made a request for exception processing by means of MOS mod/rider. MOS default logic is to pay "Host allowed".

By allowing reimbursement "at charges," providers bill and get fully reimbursed for highly inflated costs of services. In most scenarios, the member is not aware or consented to referral being made out of network (for example labs). It has been suggested that group customers may not be fully aware of the implications of the "flipping" system logic. As the reimbursement "at charges" in most case by far exceeds the Host plan allowed amount, it became lucrative for providers to de-par to circumvent host plan cost controls.

BCBS Michigan Email (BCBSM-Comau 2000027428)

The below represents excerpts (highlighted in blue font) from email, specific to report compiled that outlines out of network participating providers that were processed at participating in network providers. This information was derived from discovery documents bates stamped BCBSM-Comau 000027428 and BCBS Comau 000027429.

Please see the attached OOS Professional Non Par Data for Comau Group from 2016-2018. All 3 years are in the one tab

Attachment to BCBSM Email (BCBSM-Comau 000027429)

The below represents data contained in a report labeled "bcbs comau 2000027429" and is referred to in the aforementioned email document bates stamped BCBSM-Comau 200007428, some fields were removed or relabeled so that information could fit.

Claims highlighted in red as mentioned on page 9 of this report.

Please see the attached OOS Professional Non Par Data for Comau Group from 2016-2018

ICN_ NUM	CLAIM TYPE	PYMT DATE	Charge	Allowed	Paid	COST_SHARE	PAT_LIABILITY	CUST_GRP_NUM	GROUP NAME	FUNDING TYPE
[redacted]	82 - PPO Professional	2016-01-08	$2,638.00	$2,638.00	$2,638.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-03-25	$1,313.73	$373.90	$0.00	$373.90	$1,313.73	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-08-19	$375.00	$375.00	$375.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-08-19	$7,200.00	$7,200.00	$7,200.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-08-31	$375.00	$375.00	$375.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-08-31	$7,200.00	$7,200.00	$7,200.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-09-30	$170.00	$170.00	$170.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-02-19	$1,404.00	$119.50	$119.50	$0.00	$1,284.50	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-05-27	$1,590.00	$106.74	$106.74	$0.00	$1,483.26	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-07-22	$1,590.00	$1,590.00	$1,564.91	$25.09	$25.09	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-07-22	$375.00	$375.00	$375.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-08-19	$1,590.00	$1,590.00	$1,590.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-08-19	$375.00	$375.00	$375.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-09-16	$144.41	$144.41	$144.41	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-09-30	$5,450.00	$731.32	$731.32	$0.00	$4,718.68	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2016-11-18	$4,950.00	$118.81	$118.81	$0.00	$4,831.19	71587	COMAU INC.	ASC

[redacted]	82 - PPO Professional	2016-12-23	$110.00	$50.89	$0.00	$50.89	$110.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-07-21	$64.73	$64.73	$64.73	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-07-21	$159.30	$159.30	$159.30	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-07-21	$8.27	$8.27	$8.27	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-07-21	$80.48	$80.48	$80.48	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-03-10	$1,358.00	$946.00	$756.80	$189.20	$601.20	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-04-21	$2,007.00	$242.36	$0.00	$242.36	$2,007.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-06-30	$3,850.00	$1,877.00	$0.00	$1,877.00	$3,850.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-09-22	$2,970.00	$2,970.00	$2,970.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-10-31	$671.00	$671.00	$663.19	$7.81	$7.81	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-06-09	$1,522.50	$1,522.50	$1,434.55	$87.95	$87.95	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-06-23	$192.40	$49.96	$39.96	$10.00	$152.44	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-06-23	$242.86	$62.58	$50.06	$12.52	$192.80	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-10-06	$96.40	$25.88	$20.70	$5.18	$75.70	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-11-10	$838.00	$838.00	$344.38	$493.62	$493.62	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-05-05	$151.28	$151.28	$151.28	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-03-17	$245.00	$245.00	$220.00	$25.00	$25.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-04-14	$70.00	$70.00	$0.00	$70.00	$70.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-04-21	$394.00	$284.00	$0.00	$284.00	$394.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-04-28	$3,345.70	$547.76	$547.76	$0.00	$2,797.94	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2017-04-28	$160.48	$160.48	$0.00	$160.48	$160.48	71587	COMAU INC.	ASC

[redacted]	82 - PPO Professional	2018-01-26	$7,500.00	$7,500.00	$7,261.67	$238.33	$238.33	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-01-26	$12.42	$12.42	$12.42	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-01-26	$750.00	$750.00	$750.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-01-12	$16,500.00	$16,500.00	$16,500.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-01-19	$93.20	$20.98	$0.00	$20.98	$93.20	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-01-19	$165.74	$41.54	$0.00	$41.54	$165.74	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-02-16	$120.38	$120.38	$108.34	$12.04	$12.04	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-04-20	$1,500.00	$1,500.00	$1,500.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-04-20	$216.20	$216.20	$194.58	$21.62	$21.62	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-04-20	$476.43	$476.43	$428.79	$47.64	$47.64	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-04-27	$755.00	$236.14	$175.09	$61.05	$579.91	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-11-30	$160.00	$78.59	$78.59	$0.00	$81.41	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-11-23	$4,950.00	$122.79	$122.79	$0.00	$4,827.21	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-11-23	$75.00	$6.55	$6.55	$0.00	$68.45	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-11-30	$1,314.00	$224.00	$224.00	$0.00	$1,090.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-12-07	$200.00	$113.49	$90.79	$22.70	$109.21	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-01-12	$4,950.00	$119.50	$119.50	$0.00	$4,830.50	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-03-16	$146.86	$37.24	$0.00	$37.24	$146.86	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-03-16	$970.00	$970.00	$776.00	$194.00	$194.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-03-16	$6,400.00	$6,400.00	$5,672.40	$727.60	$727.60	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-08-10	$216.00	$119.06	$94.06	$25.00	$121.94	71587	COMAU INC.	ASC

[redacted]	82 - PPO Professional	2018-08-24	$216.00	$119.06	$94.06	$25.00	$121.94	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-12-21	$330.00	$160.64	$160.64	$0.00	$169.36	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-03-16	$160.00	$78.09	$78.09	$0.00	$81.91	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-09-21	$216.00	$119.06	$94.06	$25.00	$121.94	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-09-21	$3,715.00	$3,715.00	$3,715.00	$0.00	$0.00	71587	COMAU INC.	ASC
[redacted]	82 - PPO Professional	2018-12-14	$2,850.00	$228.74	$228.74	$0.00	$2,621.26	71587	COMAU INC.	ASC

Appendix D

Declaration of data and source documents used in this review

This document outlines information that I and other ClaimInformatics professionals reviewed during the course of performing the COMAU analysis.

Data Files

March 29th, Initial BCBSM Data files (Medical & RX claims)

42 Files

BCBSM- Comau 00000287	BCBSM- Comau 00000308 RX
BCBSM- Comau 00000288	BCBSM- Comau 00000309 RX
BCBSM- Comau 00000289	BCBSM- Comau 00000310 RX
BCBSM- Comau 00000290	BCBSM- Comau 00000311 RX
BCBSM- Comau 00000291	BCBSM- Comau 00000312 RX
BCBSM- Comau 00000292	BCBSM- Comau 00000313 RX
BCBSM- Comau 00000293	BCBSM- Comau 00000314 RX
BCBSM- Comau 00000294	BCBSM- Comau 00000315
BCBSM- Comau 00000295	BCBSM- Comau 00000316
BCBSM- Comau 00000296	BCBSM- Comau 00000317
BCBSM- Comau 00000297	BCBSM- Comau 00000318
BCBSM- Comau 00000298	BCBSM- Comau 00000319
BCBSM- Comau 00000299	BCBSM- Comau 00000320
BCBSM- Comau 00000300	BCBSM- Comau 00000321
BCBSM- Comau 00000301 RX	BCBSM- Comau 00000322
BCBSM- Comau 00000302 RX	BCBSM- Comau 00000323
BCBSM- Comau 00000303 RX	BCBSM- Comau 00000324
BCBSM- Comau 00000304 RX	BCBSM- Comau 00000325
BCBSM- Comau 00000305 RX	BCBSM- Comau 00000326
BCBSM- Comau 00000306 RX	BCBSM- Comau 00000327
BCBSM- Comau 00000307 RX	BCBSM- Comau 00000328

April 28th, 2021 Final BCBSM Data files (Medical Only)

28 Files

BCBSM- Comau 00001519	BCBSM- Comau 00001540
BCBSM- Comau 00001520	BCBSM- Comau 00001541

BCBSM- Comau 00001521
BCBSM- Comau 00001522
BCBSM- Comau 00001523
BCBSM- Comau 00001524
BCBSM- Comau 00001525
BCBSM- Comau 00001526
BCBSM- Comau 00001527
BCBSM- Comau 00001528
BCBSM- Comau 00001529
BCBSM- Comau 00001530
BCBSM- Comau 00001531
BCBSM- Comau 00001532
BCBSM- Comau 00001533
BCBSM- Comau 00001534
BCBSM- Comau 00001535
BCBSM- Comau 00001536
BCBSM- Comau 00001537
BCBSM- Comau 00001538
BCBSM- Comau 00001539
BCBSM- Comau 00001542
BCBSM- Comau 00001543
BCBSM- Comau 00001544
BCBSM- Comau 00001545
BCBSM- Comau 00001546
BCBSM Data Dictionary
BCBSM Not Covered Code Descriptions

QUARTERLY SETTLEMENT REPORTS (pdf files received prior to December 2021)

BCBSM Quarterly Settlement Documents

01_1994.03-1994.05QuarterlySettlement.pdf.pdf	2010.01-2010.03 QS.pdf
02_1995.06-1995.08QuarterlySettlement.pdf.pdf	2010.04-2010.06 QS Revised.pdf
03_1998.09-1998.11QuarterlySettlement.pdf.pdf	2010.04-2010.06 QS.pdf
04_1998.12-1999.02QuarterlySettlement.pdf.pdf	2010.10-2010.12 QS.pdf
05_1999.03-1999.05QuarterlySettlement.pdf.pdf	2010.10-2010.12.pdf
06_1999.06-1999.08QuarterlySettlement.pdf.pdf	2011.01-2011.03.pdf
07_1999.09-1999.11QuarterlySettlement.pdf.pdf	2011.04-2011.06.pdf
08_1999.12-2000.02QuarterlySettlement.pdf.pdf	2011.07-2011.09.pdf
09_2000.03-2000.05QuarterlySettlement.pdf.pdf	2011.10-2011.12.pdf
10_2000.09-2000.11QuarterlySettlement.pdf.pdf	2012.01-2012.03.pdf
11_2000.12-2001.02QuarterlySettlement.pdf.pdf	2012.04-2012.06.pdf
12_2001.03-2001.05QuarterlySettlement.pdf.pdf	2012.07-2012.09.pdf
13_2001.06-2001.08QuarterlySettlement.pdf.pdf	2012.10-2012.12 QS.pdf
14_2001.09-2001.11QuarterlySettlement.pdf.pdf	2013.01-2013.03 QS.pdf
15_2001.12-2002.02QuarterlySettlement.pdf.pdf	2013.04-2013.06 QS (2).pdf

16_2002.06-2002.08QuarterlySettlement.pdf.pdf
17_2002.09-2002.11QuarterlySettlement.pdf.pdf
18_2002.12-2003.02QuarterlySettlement.pdf.pdf
19_2003.03-2003.05QuarterlySettlement.pdf.pdf
20_2003.06-2003.08QuarterlySettlement.pdf.pdf
2008.01-2008.03 QS.pdf
2008.10-2008.12 QS.pdf
2009.01-2009.3 QS.pdf
2009.04-2009.06 QS.pdf
2009.07-2009.09 QS.pdf
2009.10-2009.12 QS.pdf
2013.04-2013.06 QS.pdf
2013.07-2013.09 QS.pdf
2013.10-2013.12 QS.pdf
2014.01-2014.03 QS Revised.pdf
2014.01-2014.03 QS.pdf
2014.04-2014.06 QS.pdf
2014.07-2014.09 QS.pdf
21_2003.09QuarterlySettlement.pdf.pdf
22_2003.10-2003.12QuarterlySettlement.pdf.pdf
23_2004.01-2004.03QuarterlySettlement.pdf.pdf
24_2004.07-2004.09QuarterlySettlement.pdf.pdf

Annual Settlement Reports

BCBSM Annual Settlement Documents

2007 Annual Settlement.pdf
2009 Annual Settlement1.pdf
2010 Annual Settlement1.pdf
2011 Annual Settlement1.pdf
2012 Annual Settlement.pdf
2013 Annual Settlement.pdf
2014 Annual Settlement.pdf
2016 Annual Settlement.pdf
2017 Annual Settlement.pdf
2018 Annual Settlement.pdf

Other Documents (received prior to December 2022)

Other Documents

9 Distinct Documents- BCBSM Comau Benefit Guides (BAGGS)

3 -Summary Plan Documents (Labeled 2008,2012 & 2015)

Initial Complaint & First Amended Complaint filed 12/13/19

Varnum letter dated 06/25/2021 to Bodman regarding missing data elements
BCBSM attorney letter dated 7/29/2021 providing code descriptions for Claim Disposition and Place of Service codes

Daniel Crowe Deposition

Data file provided by Daniel Crowe

Varnum letter dated 10/08/2021 to Bodman regarding Data Deficiency
Bodman letter dated 10/20/2021 to Varnum Responding to Varnum letter
BCBSM Data Dictionary
BCBSM Not Covered Code Descriptions

BCBSM Internal Communications (produced by BCBSM on November 24, 2021)

BCBSM-Comau 00025595
BCBSM-Comau 00029228
BCBSM-Comau 00029233
BCBSM-Comau 00029290
BCBSM-Comau 00029292
BCBSM-Comau 00029296
BCBSM-Comau 00029305
BCBSM-Comau 00029310
BCBSM-Comau 00029315
BCBSM-Comau 00029066
BCBSM-Comau 00027406
BCBSM-Comau 00025588
BCBSM-Comau 00026239
BCBSM-Comau 00026255
BCBSM-Comau 00026891
BCBSM-Comau 00027150
BCBSM-Comau 00026898
BCBSM-Comau 00027428
BCBSM-Comau 00027429
BCBSM-Comau 00029418
BCBSM-Comau 00029439
BCBSM-Comau 00027430

List of URL's

URL'S

https://www.BCBS Michigan.com/content/dam/public/Providers/Documents/help/medicare-plus-blue-ppo-manual.pdf
https://www.mibluecrosscomplete.com/amslibs/content/dam/microsites/blue-cross-complete/bcc-emergency-services-level-of-carereview-policy.pdf

https://data.cms.gov/Medicare-Physician-Supplier/Medicare-National-HCPCS-Aggregate-Summary-Table-CY/w9tx-4vq9/data and https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-DataFile/Overview
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files-Items/2019- Annual-Policy-Files
https://www.BCBS Michigan.com/providers/help/faqs/national-provider-identifier-faq/what-is-npi.htm

This document was prepared by Dawn Cornelis, Chief Transparency

EXHIBIT F

ASC Shared Savings | Internal Sales FAQs

SHARED SAVINGS OVERVIEW

What is shared savings?
Blue Cross is launching a package of Payment Integrity services using a shared savings arrangement. Shared savings enables Blue Cross to introduce various programs to avoid cost or recover savings for its customers, while retaining or "sharing" in a portion of the savings. On behalf of our customers, we've strategically partnered with several vendors that will enable us to capture additional savings on claims. With their technology, we can reduce re-work, maximize cost-cutting measures, and make sure our customers are getting the best value from doing business. This program does not affect administration fees.

What is happening and why is Blue Cross moving in this direction?
To better address cost management needs, Blue Cross is offering new services to generate incremental value for our customers. The initial set of services included within this shared savings approach will focus on avoiding or recovering overpayments due to a variety of provider billing errors. This `shared savings' model will better align incentives to encourage more innovation in cost saving programs we design on behalf of our customers. The recoveries that Blue Cross retains helps to make investment in technologies to further advance our capabilities for customers. This move aligns Blue Cross to what is already happening in the market with other national carriers as well as other Blue Cross plans, but does so with a very thoughtful approach — choosing only those services that make most sense for both the customer and Blue Cross. By establishing certain services in a shared savings model (mainly focused on programs with high value propositions). We're able to invest in new ways to increase the value of our customers' health care dollar.

How is the approach Blue Cross is taking compared to what is happening in the market?
Strategically, Blue Cross has chosen very specific services in which to apply the shared savings model. This is focused on five principles: 1) Incremental margin. The need for Blue Cross to drive sustainable margin improvements. 2) Aligning incentives. The enhanced savings model enables Blue Cross to align financial incentives with ASC groups.

3) Incremental and transparent. The program offers opportunities for our groups to capture additional savings over what they currently receive from our programs. With enhanced reporting, they will see these dollars laid out in their savings invoice. (provided by the technology of new vendor- CDR Associates). 4) Competitive pricing. Pricing is structured and priced to align with our competitors and the industry at large. 5) Scalable. This is an outward focused approach.

The vendors chosen to aid Blue Cross in executing the additional programs are experts in the field and help us lay the groundwork for future enhancements. If decided, more programs can easily be appended to the enhanced offerings. Other carriers, including United Health Care, Aetna and Cigna have launched a variety of shared savings initiatives for their ASC customers, which add up to significant fees. But our approach has been to ensure services are chosen carefully, and incentives are aligned to deliver value and positive ROI to our customers.

Why is Blue Cross doing this now?
Blue Cross has historically performed several cost management services within the base administrative fee our customers pay. Our ASC customers have told us they're looking for new ideas to help curb claim cost. In order to bring incremental value to our customers without the need to raise fixed administrative fees, Blue Cross has decided to align to what is already occurring out in the market. This enables the investment in further advancing these efforts to create a win-win for our customers.

Who does this impact?
All ASC customers will be included in these new programs (both PPO and HMO). In the unlikely event that a group customer does not want to participate, there will be a robust opt out process that will need to be followed with the appropriate VP/executive approvals. This process will be followed to ensure the customer understands the incremental value they are declining.

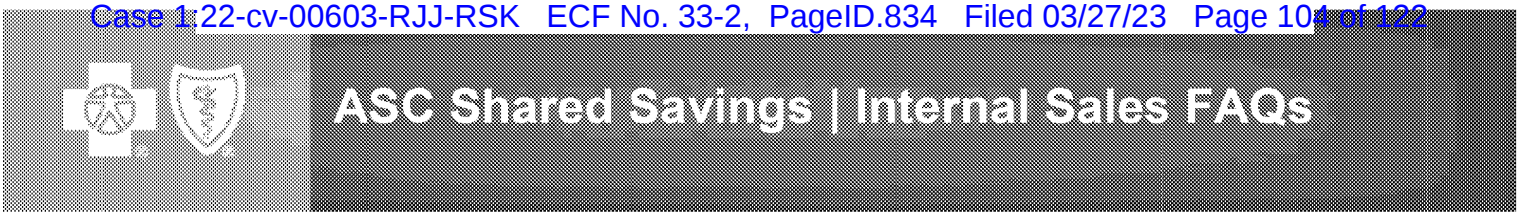
When will this start for ASC customers?
This new model will start upon renewal with January 1, 2018 effective dates and upon renewal thereafter.

PAYMENT INTEGRITY PACKAGE

What programs is Blue Cross including in the shared savings model?
Initially, Blue Cross is offering a **Payment Integrity** package within the shared savings pricing model.

The Payment Integrity package includes Pre-pay Forensic Bill Review, Advanced Payment Analytics, Subrogation and Credit Balance Recovery services. Other programs are currently being evaluated, including things like pharmacy rebates and out-of-network discounts.

1. Pre-pay Forensic Bill Review. What does it entail?
Pre-pay Forensic Bill Review provides a review of high cost inpatient claims to detect and resolve billing errors *after* adjudication, but prior to payment. These services will be performed by a 3rd party vendor called **Equian.**



What is different about Pre-pay Forensic Bill Review vs. what is already being offered to ASC customers today?
Today, Blue Cross reviews claims prior to payment as part of the base administration fee for self-funded groups, but not itemized provider bills. The high dollar edit reviews we currently perform post payment focus on pricing accuracy rather than billing accuracy.

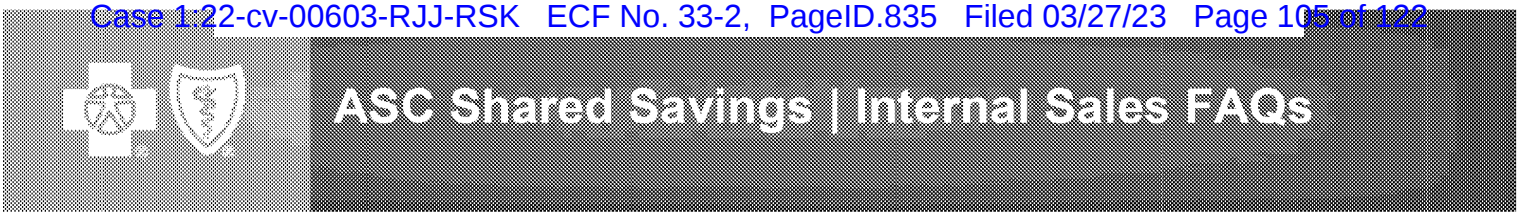
In addition, our current post-pay audits primarily focus on clinical appropriateness and they exclude out-of-state facilities and some in-state facilities. Moving forward with *Pre-pay Forensic Bill Review,* a thorough and comprehensive review of the hospital's itemized bill is done by a 3rd party vendor, Equian. Sophisticated technology and data analytics in addition to expert clinical review by nurses, physicians, accountants and certified coders to identify errors and compliance issues *before the claim is paid.* This program will review all claims meeting the $25,000 threshold that are inpatient and are paid as outliers to current diagnostic edit process, **OR** are paid under a percent charge reimbursement methodology. This includes both in and out-of-state claims, and Par and Non-par providers.

Does Pre-pay Forensic Bill Review include behavioral health?
Yes, for inpatient facilities only.

Since Pre-pay Forensic Bill Review is all about avoidance vs. recovery, how does my customer get the procedure detail?
We are currently working on an inquiry process to handle these requests from your customers.

2. Advanced Payment Analytics. What does it entail?
Advanced Payment Analytics offers advanced data mining capabilities to identify claim overpayments not previously detected and recover the overpayment from providers after payment is rendered. These services will be performed by a 3rd party vendor called Cotiviti.

What is different about Advanced Payment Analytics vs. what is already being offered to ASC customers today?
Today, Blue Cross performs several post-pay claim review services under the base ASC admin fee. This includes data mining for provider billing errors, COB, and overpayment identification. It also includes provider audits for catastrophic outliers, facility outpatient issues, readmission, etc. Fraud, waste and abuse is also part of our base fee, including investigations, detection and recovery. Cotiviti is currently engaged in Blue Cross's fully insured book of business, delivering millions worth of incremental savings. We will now engage Cotiviti as a 2nd pass or "safety net" for our ASC customers who participate in the Payment Integrity package. With Cotiviti, we enhance our post-pay efforts with a robust library of proprietary data mining algorithms and analytics to detect overpayment on paid claims.



In addition, we will leverage dedicated doctors, nurses, claims coders, auditors and other experts at Cotiviti to validate potential overpayments for customers and continuously monitor hundreds of medical and payment policy content resources to develop new algorithms to help recover more.

Blue Cross will continue to make every attempt to recover savings using our internal base services, but Cotiviti will lag our internal operations by 90 — 120 days to ensure Blue Cross still has time to run its robust processes prior to initiating its 2nd pass run.

What is the dollar threshold for Advanced Payment Analytics?
There is no dollar threshold. Cotiviti will review all charges, regardless of dollar amount.

If a customer stays opted in, effective 1/1/18, will Cotiviti review claims prior to this date?
Yes. Reviews will go back 18 — 24 months, retroactive to 1/1/18.

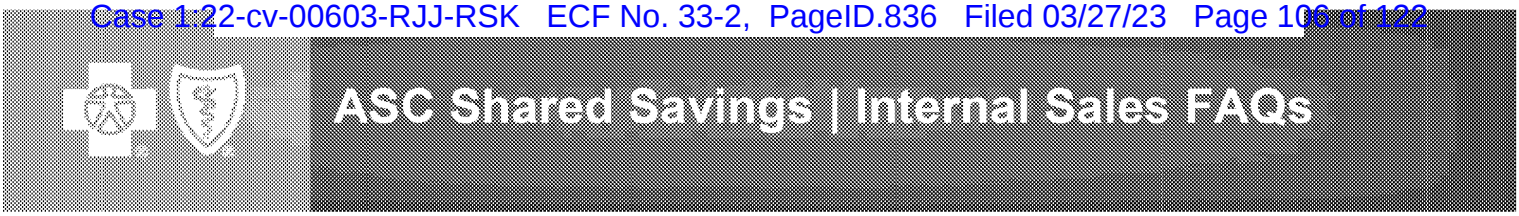
Are pharmacy claims included in Advanced Payment Analytics?
Not now, but this feature is under future consideration.

3. **Subrogation. What does it entail?**
Subrogation involves the detection and recovery of 3rd-party liability claims where a 3rd party is accountable for the expense. Blue Cross currently performs these services in-house today, but is making investments to enhance the program moving forward.

What is different about Subrogation vs. what is already being offered to ASC customers today?
Blue Cross will continue to manage its high-performance Subrogation process internally without the use of a vendor. We are continuously enhancing our processes to deliver maximum savings to our customers. Shifting toward a shared savings approach with this service will ensure Blue Cross is able to invest to further advance its capability on behalf of our customers.

4. **Credit Balance Recovery. What does it entail?**
Credit Balance Recovery is the detection and recovery of credit balances on hospital patient accounting systems due to Blue Cross (i.e. ASC customers). These services will be performed by a 3rd party vendor called CDR. Today, approximately $8 million per year is recovered for both fully insured business and ASC.

What is different about Provider Credit Balance Recovery vs. what is already being offered to ASC customers today?
Blue Cross currently performs several post-pay claims review services for ASC customers in Michigan.



Moving forward, we are expanding our partnership with **CDR Associates** to get them into more facilities, to detect, analyze and resolve credit balances on hospital patient accounting systems. Proprietary analytic software will identify credit balances currently hidden within hospital systems. A dedicated team will work with hospital management to facilitate approval and resolution of credit balances.

What's in it for ASC customers with the Payment Integrity package? What's the value?
In total, Blue Cross estimates that the services delivered under the Payment Integrity package drive incremental savings of $3.50 per contract per month. The Prepay and Advanced Payment Analytics services are net-new and incremental to what ASC customers experience from Blue Cross today. The other services within the Payment Integrity package are enhanced offerings. This presents a significant opportunity for our customers to receive additional value through the implementation of these programs. Under the shared savings arrangement, our customers only incur costs to operate the programs when savings are realized. Therefore, they are risk free, incremental and deliver a guaranteed ROI for our customers.

Will Blue Cross be using outside vendors to perform these additional services?
Yes. Blue Cross will be employing the services of outside vendors to deliver incremental value to customers.

We will be bringing these vendors into our current operating model. These vendors include, but are not limited to Equian, Cotiviti, and CDR Associates.

These vendors are leaders in their respective areas of specialty. By employing 3rd party vendors to deliver on the bulk of these value-added programs, we help ensure that the latest technologies, processes and techniques are regularly introduced on behalf of our customers.

If this is so good, will Blue Cross be implementing these programs for its own fully insured book of business?
Yes. Blue Cross believes strongly in the value of these programs and is contracting with these same vendors to realize savings through recoveries in its own fully insured population. For example, Blue Cross engages with Equian today for Pre-pay Forensic Bill Review (effective 1/1/17) and is projected to realize $15 — 20 million in savings.

Blue Cross also contracts with Cotiviti today for Advanced Payment Analytics on its fully insured population and realizes savings of $12 — 15 million per year.

Will there be a fixed administrative fee to operate any of these programs?
No. Rather than charging our customers a fixed administration fee for these programs, Blue Cross will wait until the customers realize savings and then retain a portion of savings to help cover our costs for the programs.

Will this change result in a reduction of administrative fees for ASC customers?
No. The Payment Integrity package represents incremental value to ASC customers for the services offered. There will be no adjustments to the administration fee as a direct result of a group moving to the package.

From a member perspective, what happens if a member has already paid a provider (e.g. member with a high-deductible plan with HSA), and it is determined through these additional reviews that the provider made an error?
Similar to any situation where a provider has overbilled and so forth, the provider would then be responsible for crediting the patient's account or issue a refund check to the member.

ADMINISTRATION

Under normal business process, if an account manager has an at jeopardy group that requires review of admin fees, this would follow the normal review process, but not because of this program.

Since some of the services offered within the Payment Integrity package are already included in the base admin fee today (e.g. Subrogation), but wouldn't there be an adjustment to the admin fee?
Blue Cross is making these changes to align with what is already happening in the self-funded market. Even considering the changes being made, Blue Cross remains very competitive from a total cost standpoint with our customers. By shifting very focused services to a different pricing model, this helps to ensure Blue Cross can innovate and amplify the savings we deliver to our customers.

Why isn't Blue Cross reducing our admin expense since subrogation will no longer be covered under the ASC agreement?
Blue Cross is focused on introducing new and enhanced programs that will directly bring quantifiable cost savings to our ASC customers.

Significant (multi million) capital investment is required for Blue Cross to launch and operate these cost-saving programs and fully integrate them into our business model. As a result, we will not be reducing admin expense.

ASC Shared Savings | Internal Sales FAQs

What happens if a customer chooses not to participate in the Payment Integrity package?
If a customer chooses to `opt out' of the Payment Integrity package, they will not realize the incremental savings of the services provided. Blue Cross will offer Subrogation exclusively within the Payment Integrity package and no longer part of base admin services.

Are customers required to participate in all 4 of the services that are part of the Payment Integrity package?
Yes. The Payment Integrity package is offered as a `package,' meaning that it is an all-in deal. The underlying services included in the package cannot be offered in a piecemealed fashion.

My customer currently carves out Subrogation to a 3rd party vendor. How will this be handled?
Customers who currently carve out Subrogation services to a 3rd party vendor will have an opportunity to participate in the Payment Integrity package. As a matter of fact, this represents an opportunity to bring Subrogation business back to Blue Cross. The customer will be permitted to opt into the package and given a one year grace period to bring their Subrogation business to Blue Cross. If this does not occur within a year, the group will be removed from the package.

Is it mandatory for customers to participate?
Yes. To ensure our group customers don't miss out on the value, Blue Cross will automatically opt ASC group customers into the Payment Integrity package.

In the unlikely event that a customer does not want to obtain this additional value and wishes to `opt out' of the program, a robust exception process will need to be followed, including approvals by appropriate segment VPs. This process is in place to ensure customers fully understand the decision they're making by declining these value-added services.

What kind of documentation is needed in terms of contracts, etc.?
The new Payment Integrity shared savings programs will be disclosed on a new version of the Schedule A that customers will need to sign prior to their renewal date. A new contract outlines that Blue Cross will no longer be performing Subrogation, for instance, under the base administration services. A signed amended contract and new schedule A will be required for these new programs to operate for the customer. This contract language will be the same for both PPO and HMO business.

How are customers with multi-year contracts to be handled?
ASC customers will have the option of joining the Payment Integrity package now or at the specified contract renewal time.

ASC Shared Savings | Internal Sales FAQs

INVOICING AND REPORTING

How will ASC customers be charged for the new Payment Integrity services being offered by Blue Cross?
It is important to note; Blue Cross will only retain its portion of the savings once the customer has realized the incremental benefit expense savings.
A fee of 30% of each recovery will be retained for self-funded customers. This fee supports vendor costs and internal administrative costs associated with these services.

What's in the fee that Blue Cross is collecting?
The 30% Blue Cross retains from these recoveries supports all vendor costs and internal administrative costs associated with these services. Our customers do NOT pay a fee on top of this. Blue Cross contracts with and pays vendors directly for their services for these programs as part of the savings it retains.

How will customers see these charges?
Blue Cross will include line items on the monthly customer invoice. In addition, detailed reporting will be accessible via e-bookshelf to provide claim level detail to support the charges each month.

How will my customers know they're getting value out of this program?
Each month, Blue Cross will generate detailed reporting to outline costs that were avoided or recovered through the services offered within the Payment Integrity package.

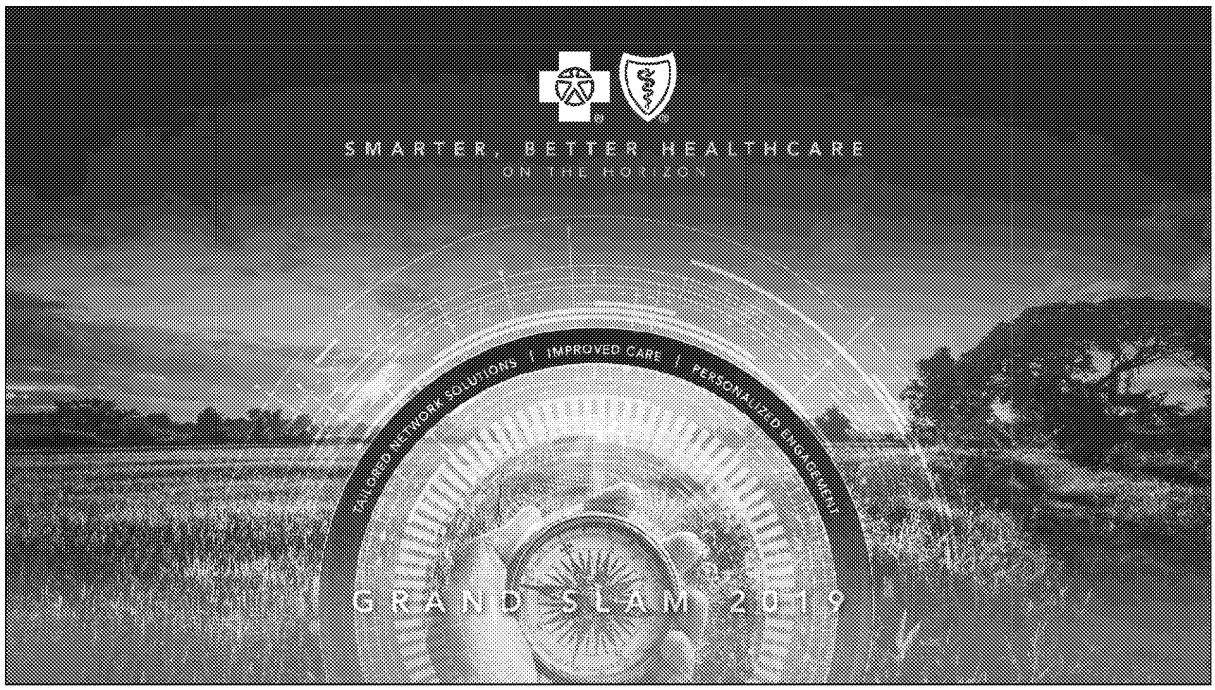
COMMUNICATING THIS TO CUSTOMERS

How will this be communicated to customers?
We're counting on the sales team to have one-on-one conversations as needed with group customers. Impacted sales team members will be asked to attend training beginning in April and offered through June.

Following the preparation of our internal salesforce, Blue Cross will issue a Field Alert and Agent Alert to notify external agents.

Agents will have an opportunity to participate in training. This will also be a discussion point at Agent Grand Slam in June. Beginning in May, the Marketing team will have communications tools available for one-on-one discussions with your group customers, including a customer presentation, customer FAQs and overview flier(s).

EXHIBIT G


SMARTER, BETTER HEALTHCARE
ON THE HORIZON
TAILORED NETWORK SOLUTIONS | IMPROVED CARE | PERSONALIZED ENGAGEMENT
GRAND SLAM 2019

Payment Integrity: Ensuring the Accuracy of Claims

Marcia Varner
Director, Payment integfity Operations

Paul Ozdarski
Manager, Payment In€egrity Unit

Jennifer Kuhar
Finess Systems Analyst, Payment it tegrii Operations

Payment integrity program overview

Blue Cross' claims processing practices consistently deliver industry-leading outcomes with respect to claim payments, and average above 99% accuracy *(as measured by the Blue Cross Blue Shield Association's Independent measurement methodology).*

Payment Integrity, an enterprise capability stream, takes actions to ensure health claims are submitted, and paid accurately, proactively and correctly, by the responsible party, for eligible members, according to medical, benefit and reimbursement policies and contractual term. Not in error or duplicate and free of wasteful or abusive practices.

We currently deliver a broad range of services (base savings programs) within the current administrative fee that are designed to help manage claim costs. Blue Cross is working toward the ability to further define and report the value delivered under these services.

Base savings programs included in administrative *fee:*

- Overpayment data mining
- Provider audits
- Fraud, waste and abuse
- Coordination of benefits
- Voluntary credit balance
- Primary claims editor (value not included)

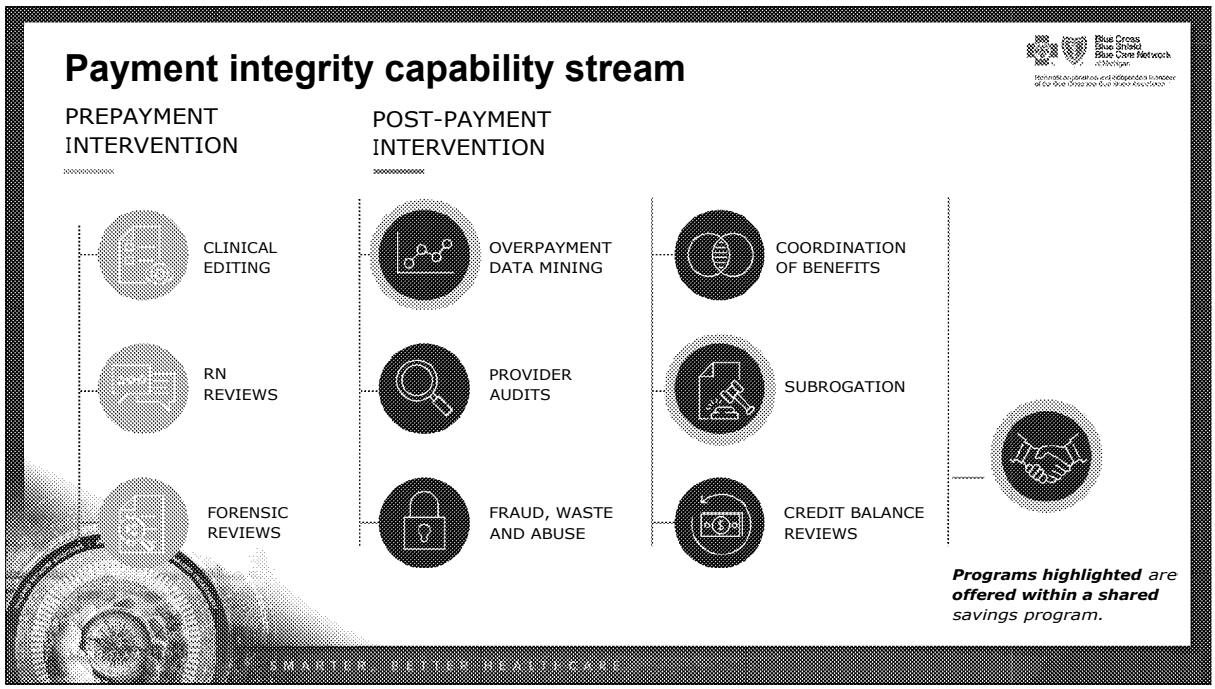
Payment integrity program overview

In addition to base recovery programs, Blue Cross is focused on deploying services with rongvalue prepositons that can be demonstrated in a transparent manner. These incremental programs, delivered under a shared savings model, will provide an enhanced level of review.

This is a risk-free value proposition as customers will not be charged unless savings are delivered under these programs.

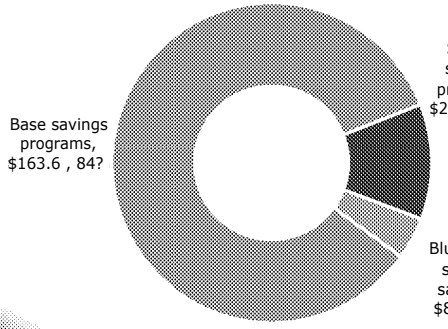
Slimed savings programs include:

- Prepay forensic review
- Advanced payment a na lytics
- Involuntary credit balance
- Subrogation

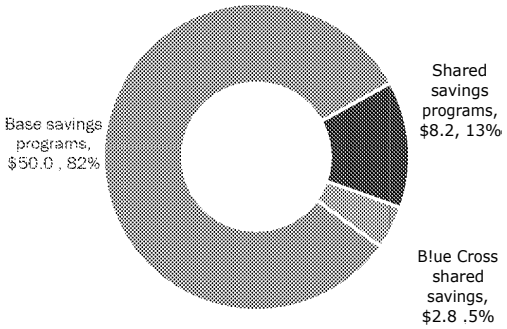

Payment integrity capability stream
PREPAYMENT INTERVENTION
POST-PAYMENT INTERVENTION
CLINICAL EDITING
RN REVIEWS
FORENSIC REVIEWS
OVERPAYMENT DATA MINING
PROVIDER AUDITS
FRAUD, WASTE AND ABUSE
COORDINATION OF BENEFITS
SUBROGATION
CREDIT BALANCE REVIEWS
Programs highlighted are offered within a shared savings program.

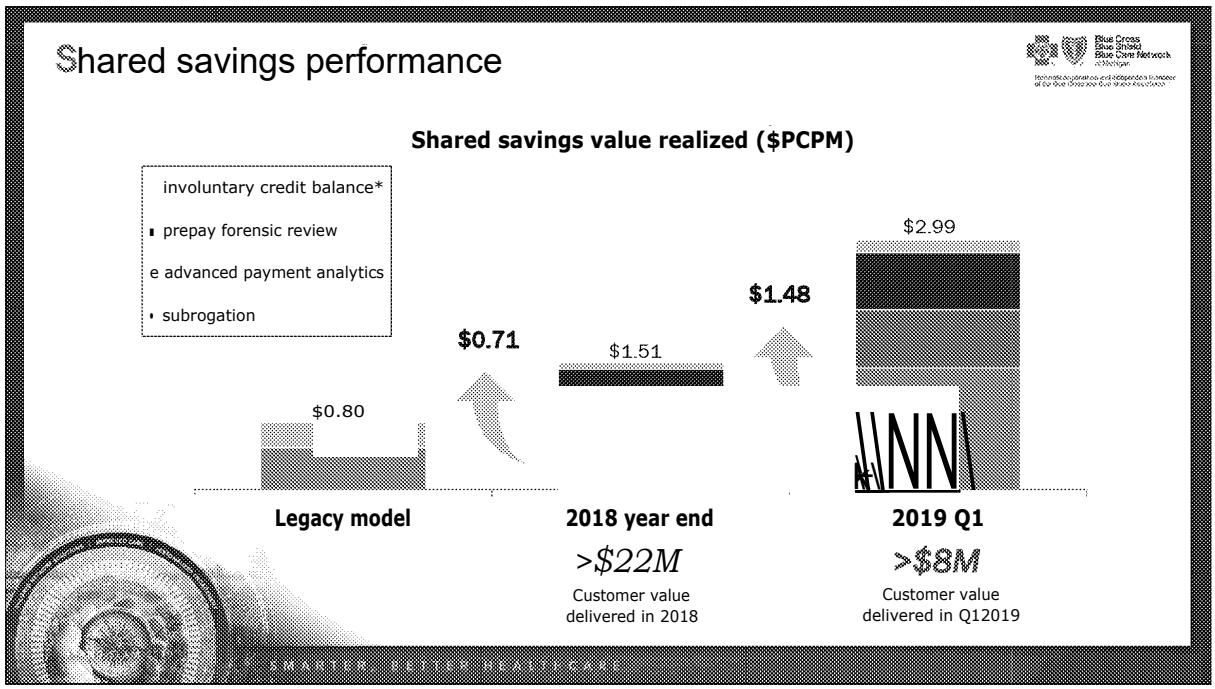
Payment Integrity highlights

2018 Payment Integrity value



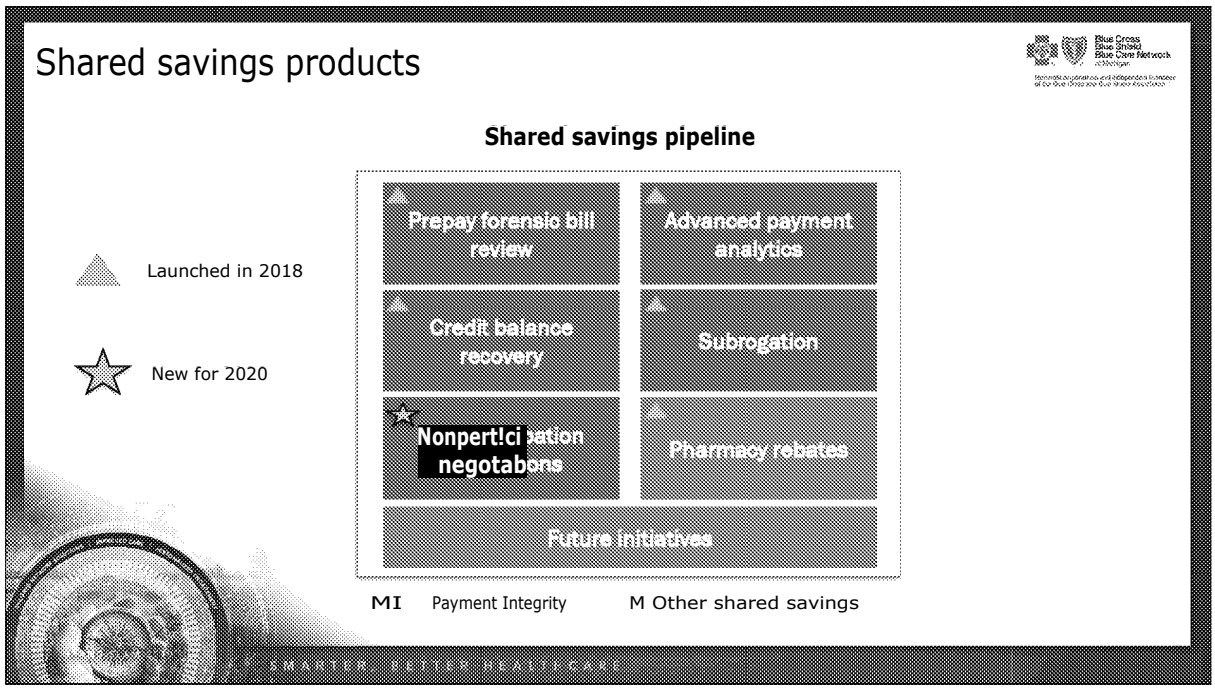
2019 Q1 Payment Integrity value

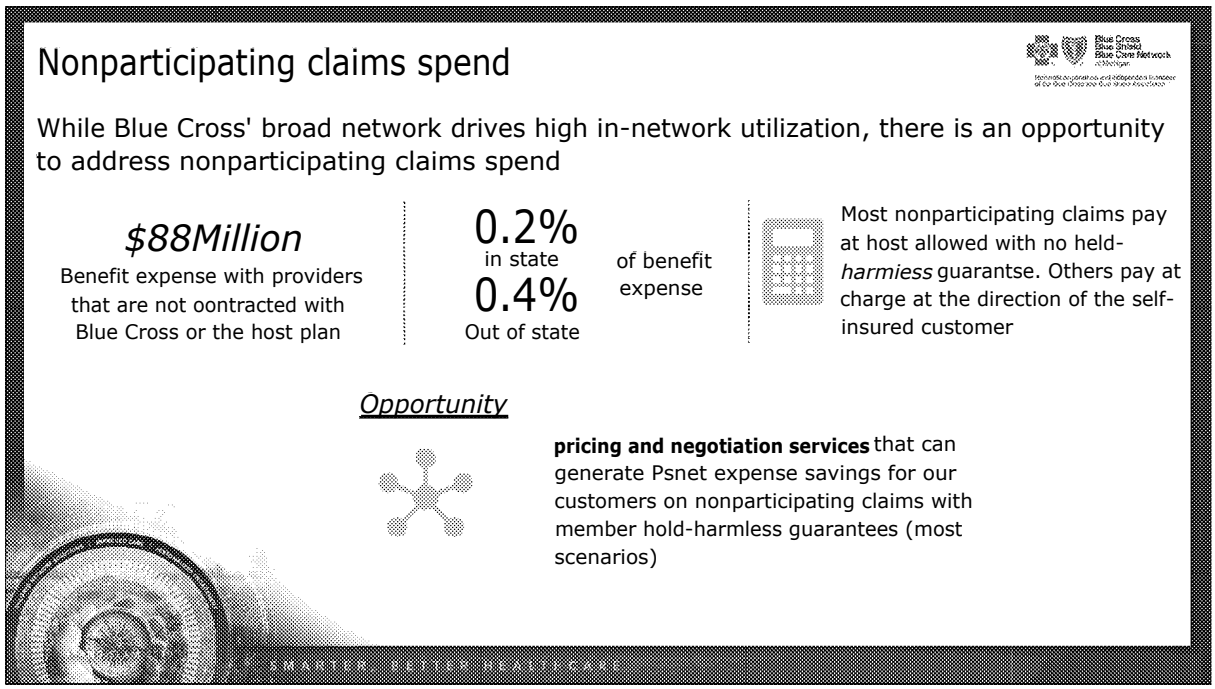




2018 number is all credit balance - voluntary credit balance is still coming through under base and is not reflected in shared savings.

Note that the PCPM is related only to groups that have opted into the bundle (SavingsPackageOptn = Y). Large groups have been removed) and 2018 only factors the last 8 months of year to account for ramp up in Q1 2018.


Shared savings products
Launched in 2018
New for 2020
Shared savings pipeline
Prepay forensic bill review
Advanced payment analytics
Credit balance recovery
Subrogation
Nonpert!ci ation negotabons
Pharmacy rebates
Future initiatives
MI Payment Integrity
M Other shared savings



BCBSM's customers incur approximately $88M annually in benefit expense with providers that are not contracted with BCBSM or the Host plan.
This represents 0.2% of total benefit expense for customers in-state and 0.4% out-of-state.
Most non-par claims pay at host allowed with no hold harmless guarantee while some pay at charge at the direction of the self-insured customer.
MultiPlan delivers pricing and negotiation services that can generate benefit expense savings, via cost avoidance, for our customers on non-par claims with member hold harmless guarantees (most scenarios).
MultiPlan is the dominant market leader; clients include 9 of the top 10 U.S. health insurers and 9+ BCBS Plans.
Starting in 2020, self-insured customers will have the option to activate MultiPlan's services in a shared savings arrangement to further minimize non-par benefit expense.

itipian services: Augmenting our industry ending ciaims proving practices

.I Multi an.

Market-leading vendor

Clients include nine of the top 10 U.S. health insurers and more than nine Blue plans

* Incremental service not included in the PCPM admin" fee

Nonparticipation pricing and negotiation

- Comprehensive solution to price nonparticipating claims through Milt€plan's negotaUon seMoes using clinimi and benchmerWng tools.
- Applies to commercial claims, in state and out of state (BlueCard®) and all claim types: facility and professional.

MultiPlan services available in 2020

Market positioning

- Enhanced service that provides additional controls on claims spend
- Delivered by MultiPlan, the industry leader in nonparticipating pricing and negotiations
- Offered as optional stand-alone program (not integrated into 2018 Payment Integrity bundle)
- Available to ASC customers on renewal starting in **2020**

Value (estimated) summary

- Program is estimated to generate up to $0.53 PCPM in savings (book of business) with ASC customers retaining 70% of the value created
- Value calculated as total reduction in original claim allowed amount (inclusive of member cost-sharing)
- Value will depend on nonparticipating pricing approach and utilization, host decisions and MultiPlan success rate

Program scope

- Using MdUp€an's negotiation services as well as their clinical and benchmarking tools.
- Applies to commerc€al claims; in state and out of state (BlueCard)
- All claim types are in scope, both facility and professional
- Claims from network PPO and Traditional network providers excluded

Terms and conditions

- Program terms will be disclosed in Schedule A
- Renewals will assume customers will opt in, while providing an Opt out process
- ASC customers will retain 70% of value and Blue Cross will retain 30%
- Transparent monthly value reporting is provided, consistent with the Payment Integrity bundle

Key takeaways

Blue Cross is committed **to helping customers effectively manage health care costs**

We continue to focus on adding **gen/Ices with strong value propositions** that can be **demonstrated to our customers In a transparent manner**

Customers are **realizing savings** generated by the **Payment integrity bundle introduced** in 2018

The **nonparticipating** negotiation **service,** delivered by MultiPlan, that will be launched in 2020, will generate incremental **benefit-expanse savings** for customers

customers **will not be charged** if **we do not deliver savings**

EXHIBIT 2

2013 WL 12181764
Only the Westlaw citation is currently available.
United States District Court, E.D.
Michigan, Southern Division.

Joyce FOREBACK, Plaintiff,
v.
J.C. EXPEDITING, et al., Defendants.

Case No. 13-10185
|
Signed 10/15/2013

Attorneys and Law Firms

Joseph F. Lucas, Skupin & Lucas, Detroit, MI, for Plaintiff.

Justin Evans, Michael J. Hutchinson, Hutchinson Cannatella, P.C., Detroit, MI, for Defendants.

ORDER

JULIAN ABELE COOK, JR., U.S. District Judge

***1** On January 16, 2013, the Plaintiff, Joyce Foreback, filed this lawsuit, complaining that the Defendants, J.C. Expediting and Spirit Automotive, an Ohio corporation, are legally responsible for the severe injuries that she sustained on November 2, 2011.

Currently before the Court is an unopposed motion by Foreback who seeks to obtain authority to file an amended complaint that would add an additional defendant (namely, Prestige Delivery Systems, Inc.) to this litigation. It is Foreback's belief that Prestige Delivery is a necessary party to this controversy because of its connection with her accident in November of 2011.

I.

During all of the times that are relevant to this lawsuit, Foreback was employed as a delivery driver by J.C. Expediting. Foreback asserts that on November 2, 2011, while acting with the permission of (1) her employer, and (2) the owner of the motor van that was being driven by her, found herself in an extremely life-threatening situation which caused her to strike a stationary post, and sustain serious injuries. Following the impact, the damaged vehicle caught fire and was burned.

II.

The Federal Rules of Civil Procedure provide that, unless an amendment is filed under circumstances that are not applicable here, a party may amend its pleading only with the consent of the opposing party or the specific authority of the court. Fed. R. Civ. P. 15(a). This Rule is to be construed liberally, and the court "should freely give leave when justice so requires." Fed. R. Civ. P. 15(a)(2). The Supreme Court, speaking of the Federal Rules generally as well as of Rule 15 in particular, has stated that it is "entirely contrary to the spirit of the Federal Rules of Civil Procedure for decisions on the merits to be avoided on the basis of [ ] mere technicalities." *Foman v. Davis*, 371 U.S. 178, 181 (1962); *see also Jet, Inc. v. Sewage Aeration Sys.*, 165 F.3d 419, 425 (6th Cir. 1999) (citation omitted) ("[T]he thrust of Rule 15 is ... that cases should be tried on their merits rather than the technicalities of pleadings."). The underlying purpose of allowing parties to amend their pleadings is to permit the issues to be tried on the merits. *Foman*, 371 U.S. at 182 ("If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits.").

The Supreme Court has articulated several factors that are relevant to the propriety of granting leave to amend. "In the absence of any apparent or declared reason—such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.–the leave sought should, as the rules require, be 'freely given.' " *Foman*, 371 U.S. at 182; *see also Commercial Money Ctr., Inc. v. Ill. Union Ins. Co.*, 508 F.3d 327, 346 (6th Cir. 2007) ("Factors that may affect that determination include undue delay in filing, lack of notice to the opposing party, bad faith by the moving party, repeated failure to cure deficiencies by previous amendment, undue prejudice to the opposing party, and futility of the amendment.").

III.

***2** Here, there is no implication within the record that Foreback's request is the result of bad faith or a dilatory

motive. *See* *Troxel Mfg. Co. v. Schwinn Bicycle Co.*, 489 F.2d 968 (6th Cir. 1973) (affirming denial of motion to amend where plaintiff had already lost on summary judgment and appeal, and then sought to present alternative theory of recovery that had been previously available to it). Moreover, because this is her first such request, there has been no failure to cure deficiencies by amendments previously allowed. While such a course will by necessity delay resolution of these issues and cause the Defendants to incur additional expense, this prejudice does not constitute "undue prejudice" because Prestige Delivery's participation is necessary for this Court to fairly and fully adjudicate the matter. Finally, Foreback's request comes before any depositions or significant discovery has been taken, thus allowing all parties ample time to reconsider their litigation strategy moving forward.

In light of these factors and the liberal policy expressed under Fed. R. Civ. P. 15(a)(2), the Court will grant Foreback's request to amend the complaint with respect to adding Prestige Delivery as a Defendant to the lawsuit.

IV.

For the reasons that have been set forth above, the Court (1) grants Foreback's motion to amend (ECF No. 21); and (2) amends the caption in this case to add "Prestige Delivery Systems, Inc." as a Defendant. Foreback is directed to file her amended complaint (attached as Exhibit 2 to Plaintiff's motion to amend) within a period of ten (10) days from the date of this order.

IT IS SO ORDERED.

All Citations

Not Reported in Fed. Supp., 2013 WL 12181764

End of Document

2022 WL 17828960
Only the Westlaw citation is currently available.
United States District Court, W.D. Michigan, Southern Division.

HERITAGE GUITAR, INC., Plaintiff,
v.
GIBSON BRANDS, INC., Defendant.

Case No. 1:20-cv-229
|
Signed December 21, 2022

Attorneys and Law Firms

Allyson T. Slater, Mark A. Ford, Vinita Ferrera, Wilmer Cutler Pickering Hale & Dorr LLP, Boston, MA, Gary J. Mouw, Varnum Riddering Schmidt & Howlett LLP, Grand Rapids, MI, Holly A. Ovington, Wilmer Cutler Pickering Hale and Dorr LLP, London, United King, Jared D. Hoffman, Mark Matuschak, Wilmer Cutler Pickering Hale & Dorr LLP, New York, NY, for Plaintiff.

Andrea Bates, Elizabeth Jane Poland Andujar, Kurt Schuettinger, Bates & Bates LLC, Atlanta, GA, John A. Conway, John D. LaDue, SouthBank Legal, South Bend, IN, Steve Howen, Waco, TX, Steven Susser, Carlson, Gaskey & Olds, P.C., Birmingham, MI, for Defendant.

OPINION

HALA Y. JARBOU, CHIEF UNITED STATES DISTRICT JUDGE

***1** This case began as a trademark infringement and breach of contract case between Plaintiff Heritage Guitar, Inc. and Defendant Gibson Brands, Inc. Heritage then sought and was granted leave to file a second amended complaint asserting federal and state antitrust claims. Gibson's answer to Heritage's second amended complaint included additional counterclaims. Before the Court is Heritage's motion to strike the counterclaims filed with Gibson's answer to Heritage's second amended complaint. (ECF No. 167.)

I. BACKGROUND

Heritage initially brought suit seeking declaratory relief holding that it has neither infringed on Gibson's intellectual property nor breached the 1991 Settlement Agreement between the two parties. (*See* 1st Am. Compl., ECF No 15.) Gibson's answer to Heritage's amended complaint included six counterclaims: (1) breach of contract; (2) trademark infringement in violation of 15 U.S.C. § 1114(1); (3) trademark counterfeiting in violation of 15 U.S.C. § 1114(1); (4) false designation of origin, passing off, and unfair competition in violation of 15 U.S.C. § 1125(a); (5) trademark infringement in violation of Michigan common law; and (6) false designation of origin, passing off, and unfair competition in violation of Michigan common law. (*See* Answer to Am. Compl., ECF No. 62.)

The Court entered a Case Management Order setting a deadline of September 15, 2021, to amend the pleadings. (4/16/2021 Case Mgmt. Order, ECF No. 74.) On July 21, 2021, Heritage sought leave of the Court to file a second amended complaint (Mot. for Leave to File Second Am. Compl., ECF No. 84), which the Court granted. (12/13/2021 Op., ECF No. 101; 12/13/21 Order, ECF No. 102.) Heritage's second amended complaint included four additional causes of action under federal and state antitrust laws: (1) monopolization in violation of 15 U.S.C. § 2; (2) attempted monopolization in violation of 15 U.S.C. § 2; (3) monopolization in violation of Mich. Comp. Laws § 455.773; and (4) attempted monopolization in violation of Mich. Comp. Laws § 445.773. (*See* 2d Am. Compl., ECF No. 104.)

Gibson filed a partial motion to dismiss the antitrust claims pled in the second amended complaint (Mot. to Dismiss Second Am. Compl., ECF No. 105), which the Court denied. (6/6/2022 Op., ECF No. 135; 6/6/2022 Order, ECF No. 136.) Gibson then filed its answer to Heritage's second amended complaint on June 21, 2022. (Answer to 2d Am. Compl., ECF No. 147.) In its answer, Gibson reasserted its previous counterclaims with new theories and factual allegations. Gibson also added new counterclaims for violating federal and state trade secret acts. (*See id.*)

II. STANDARD

Rule 12(f) of the Federal Rules of Civil Procedure provides that upon motion of a party, "the Court may strike from a pleading an insufficient defense or any redundant, immaterial, impertinent, or scandalous matter." Fed. R. Civ. P. 12(f).

" 'Motions to strike are viewed with disfavor and are not frequently granted.' " *ACT, Inc. v. Worldwide Interactive Network, Inc.*, 46 F.4th 489, 499 (6th Cir. 2022) (quoting *Operating Eng'rs Loc. 324 Health Care Plan v. G & W Cosntr. Co.*, 783 F.3d 1045, 1050 (6th Cir. 2015)). "Indeed, 'federal courts are very reluctant to determine disputed or substantial issues of law on a motion to strike; these questions quite properly are viewed as best determined only after further development by way of discovery and a hearing on the merits.' " *Id.* (quoting 5C Charles Alan Wright & Arthur R. Miller, *Federal Practice and Procedure* § 1381 (3d ed. Apr. 2022 update)).

III. ANALYSIS

***2** Heritage argues that the counterclaims alleged in Gibson's answer to Heritage's second amended complaint must be stricken for failure to seek leave of the Court in accordance with Rule 15 of the Federal Rules of Civil Procedure. Once stricken, Heritage argues that Gibson's initial counterclaims filed in response to Heritage's first amended complaint would remain the operative counterclaims. Gibson responds that the counterclaims filed in response to Heritage's second amended complaint are not amended pleadings that require leave from the court; rather, they may be asserted as of right in response to an amended pleading.

At issue is whether a party may assert new or different counterclaims as of right when answering an amended complaint. The Sixth Circuit has not ruled on this question. Recognizing this, both parties cite varying approaches taken by district courts when faced with the same question.[1] Heritage relies on the approach taken in *Bern Unlimited, Inc. v. Burton Corp.*, 25 F. Supp. 3d 170 (D. Mass. 2014). In *Bern*, the District of Massachusetts held that a party must seek leave from the court before filing an amended answer with new or different counterclaims. The District of Massachusetts reasoned that this

> approach appears to require the least contortion of the language of Rule 15(a), and is the most consistent with its purpose. A new or different counterclaim asserted after an amendment of the complaint is a "pleading" governed by Rule 15(a), but does not fall into either category of 15(a)(1). It therefore must fall under Rule 15(a)(2), which states that "the court's leave" (or the opponent's consent) is required "[i]n all other cases" before amending a pleading. Fed. R. Civ. P. 15(a)(2). Using this approach also has practical benefits. It would prevent a party from asserting new counterclaims that are made in bad faith, cause undue delay or prejudice, are futile, or abuse the legal process in some other way, and also has the virtues of simplicity and ease of application.

***3** *Id.* at 179. Because Gibson did not seek leave of the Court, Heritage argues its counterclaims were improperly asserted and must be stricken.

1 Federal courts have adopted at least six different approaches when answering this question:

> One approach is to always allow a party to file counterclaims without seeking leave of court in response to an amended complaint. *Walgreen Co. v. Hummer*, No. 1:10-CV-2902, 2012 WL 13033091, at *2 (N.D. Ohio May 3, 2012). A second approach is to never allow a party to file counterclaims without seeking leave of court in response to an amended complaint. *Bern Unlimited, Inc. v. Burton Corp.*, 25 F. Supp. 3d 170, 180 (D. Mass. 2014). A third approach is that "a party is only entitled to respond as of right to an amended complaint if its answer is strictly confined to the new issues raised by the amended complaint." *S. New England Tel. Co. v. Glob. NAPS, Inc.*, No. CIVA 3:04-CV-2075 JC, 2007 WL 521162, at *2 (D. Conn. Feb. 14, 2007). A fourth approach is that a party may assert new counterclaims without seeking leave of court if the amended complaint changed the theory or scope of the case, regardless of whether the counterclaim relates to the changes made to the amended complaint. *Tralon Corp. v. Cedarapids, Inc.*, 966 F. Supp. 812, 832 (N.D. Iowa 1997), *aff'd on other grounds*, 205 F.3d 1347 (8th Cir. 2000); *Krinsk v. SunTrust Banks, Inc.*, 654 F.3d 1194, 1202 (11th Cir. 2011). A fifth approach is that a party may

> assert new counterclaims without seeking leave of court if the amended complaint changed the theory or scope of the case so long as the new counterclaims "reflect the breadth of changes in the amended complaint." *Elite Entm't, Inc. v. Khela Bros. Entm't*, 227 F.R.D. 444, 446 (E.D. Va. 2005). The sixth approach, created just last year by the Second Circuit, calls for a sliding-scale rule depending on how far along the litigation has progressed. *GEOMC Co. v. Calmare Therapeutics, Inc.*, 918 F.3d 92, 100 (2d Cir. 2019).
>
> *Raymond James & Assocs., Inc. v. 50 North Front St. TN, LLC*, No. 18-CV-02104-JTF-TMP, 2020 WL 7332846, at *3 (W.D. Tenn. June 23, 2020), *report and recommendation adopted*, No. 218-CV-02104-JTF-TMP, 2020 WL 6694299 (W.D. Tenn. Nov. 13, 2020).

On the other hand, Gibson relies on the approach taken in *Tralon Corp. v. Cedarapids, Inc.*, 966 F. Supp. 812 (N.D. Iowa 1997). In *Tralon*, the Northern District of Iowa held that when a plaintiff files an amended complaint which changes the theory or scope of the case, the defendant may assert new counterclaims as of right. *Id.* at 832 (citing *Brown v. E.F. Hutton & Co., Inc.*, 610 F. Supp. 76, 78 (S.D. Fla. 1985)). "[T]he *Tralon* approach maximizes fairness and minimizes the risk of dismissal based on purely procedural grounds, which is consistent with Federal Rule 15's preference to resolve disputes on their merits." *Raymond James & Assocs., Inc. v. 50 North Front St. TN, LLC*, No. 218-cv-02104-JTF-TMP, 2020 WL 6694299, at *3 (W.D. Tenn. Nov. 13, 2020) (citing *Krupski v. Costa Crociere S. p. A.*, 560 U.S. 538, 550 (2010)).

Other district courts within the Sixth Circuit have adopted the *Tralon* approach. *See e.g.*, *Barry Fiala, Inc. v. Stored Value Sys., Inc.*, No. 02-2248 MAA, 2006 WL 2578893, at *2 (W.D. Tenn. Sept. 1, 2006) ("Because [the plaintiff's] Third Amended Complaint altered the scope of the case, SVS did not need leave of court to include new counterclaims and defenses in its answer."); *Medpace, Inc. v. Biothera, Inc.*, No. 1:12-cv-179, 2013 WL 5937040, at *1 (S.D. Ohio Nov. 4, 2013) ("[W]here a plaintiff files an amended complaint which changes the theory or scope of the case, the defendant is allowed to plead anew as though it were the original complaint.... Pleading anew includes pleading new counterclaims...." (internal citations and quotations omitted)). And this Court has also recognized a defendant's right to assert new counterclaims in response to an amended complaint. In *Moellers North America, Inc. v. MSK Covertech, Inc.*, 912 F. Supp. 269 (W.D. Mich. 1995), Judge Quist noted that:

> Rule 15(a) of the Federal Rules of Civil Procedure allows a party to plead in response to an amended complaint in accordance with the deadlines imposed by the Court and Rule 13 refers to both compulsory and permissive counterclaims as pleadings. *See e.g.*, *Salomon S.A. v. Alpina Sports Corp.*, 737 F. Supp. 720, 722 (D.N.H. 1990) (allowed revised counterclaims after an amended complaint was filed); *Joseph Bancroft & Sons Co. v. M. Lowenstein & Sons, Inc.*, 50 F.R.D. 415, 419 (D. Del. 1970) (same). Thus, the defendants' counterclaims were authorized by the Federal Rules of Civil Procedure.

Id. at 272.

Applying the *Tralon* approach to the facts of this case, the Court finds that Gibson's counterclaims were properly raised. Heritage's second amended complaint changed the scope of the case by adding federal and state antitrust claims of monopolization and attempted monopolization. This broadened the scope of the litigation beyond the relationship between the two parties to include Gibson's effect on the competitiveness of the relevant marketplace in general. Accordingly, Gibson was not required to seek leave of the Court prior to asserting new or different counterclaims when answering Heritage's second amended complaint.

***4** The rationale behind the *Tralon* approach also supports its application in this case. Heritage itself chose to expand the scope of this litigation. Gibson should not be denied that same opportunity in response. Moreover, the Court finds Rule 15's preference for adjudicating claims on their merits persuasive. The Court declines to foreclose Gibson's substantive counterclaims on a purely procedural basis.

Heritage argues that the Court should apply the *Bern* approach to avoid unfair prejudice. Gibson filed its new counterclaims

on June 21, 2022, after the Court's June 6, 2022, Opinion on its motion to dismiss. The fact discovery period closed on June 29, 2022, except for the sole purpose of taking a limited number of depositions. (4/20/2022 Order Extending Fact Disc., ECF No. 131; 6/21/2022 2d Am. Case Mgmt. Order, ECF No. 145.) Accordingly, Heritage had little to no time to conduct discovery on the new counterclaims. However, the answer to such prejudice is extending the discovery period to allow both parties to challenge the counterclaims on their merits, rather than foreclosing them on procedural grounds.

IV. CONCLUSION

For the reasons stated above, the Court will deny Heritage's motion to strike the counterclaims filed with Gibson's answer to the second amended complaint. (ECF No. 167.) Subsequent to a status conference, the Court will extend the discovery period to give the parties adequate time to conduct discovery on these counterclaims.

All Citations

Slip Copy, 2022 WL 17828960

End of Document

2015 WL 13173470
Only the Westlaw citation is currently available.
United States District Court, W.D. Michigan, Southern Division.

Jeff COURTRIGHT, Plaintiff,
v.
CITY OF BATTLE CREEK, et al., Defendants.

CASE NO. 1:14-CV-1297
|
Signed 08/20/2015

Attorneys and Law Firms

Amy J. Derouin, Bradley R. Johnson, Shawn Christopher Cabot, Christopher Trainor & Associates, White Lake, MI, for Plaintiff.

Saura James Sahu, C. Marcel Stoetzel, III, Jill H. Steele, Battle Creek, City of, Battle Creek, MI, for Defendants.

ORDER

ROBERT J. JONKER, UNITED STATES CHIEF DISTRICT JUDGE

***1** This is a fairly routine Section 1983 case alleging an unconstitutional arrest without probable cause, and excessive force in the course of effecting the arrest. Plaintiff alleges that defendants arrested him based only on a bogus tip that had no basis in fact; and that officers disregarded the information he gave them about a rotator cuff injury when they needlessly handcuffed him behind his back, aggravating the injury, rather than in front of him, which would have satisfied any security concerns without injuring him. In the Court's view, the law on both issues is well-established, and the only thing that needs to be done is development of a factual record, and then application of the well-established law to that factual record on summary judgment.

I. BACKGROUND

In this case, however, defendants moved to dismiss on the theory that plaintiff failed to plead a plausible constitutional violation of any kind (docket no. 11). The Court denied that motion after argument at the initial Rule 16 conference (docket no. 19). Because the defense motion arguably invoked qualified immunity, among other things, the defendants filed a notice of interlocutory appeal (docket no. 20).[1] Individual Defendants Wolf and Rathjen undoubtedly have the privilege of seeking interlocutory appeal from a denial of a motion invoking qualified immunity, assuming for purposes of argument that it was invoked here. This is part and parcel of the what qualified immunity means: namely, an immunity from not only judgment, but also the need to submit to the normal litigation process when—even accepting plaintiff's view of the facts—there is no way a rational fact finder could conclude that the individual defendants violated a clearly established right of the plaintiff. *See, e.g.*, *Pearson v. Callahan*, 555 U.S. 223, 231, 129 S. Ct. 808, 815, 172 L.Ed. 2d 565 (2009).

[1] In fact, Defendants' written papers rely fundamentally on a *Twombly* and *Iqbal* theory, not qualified immunity. *See Ashcroft v. Iqbal*, 556 U.S. 662, 129 S. Ct. 1937, 173 L.Ed. 2d 868 (2009); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 127 S. Ct. 1955, 167 L.Ed. 2d 929 (2007). The motion and principal brief of the Defendants does not even mention qualified immunity. The reply brief mentions the term only in passing in a single footnote. It was not until oral argument that Defendants began to focus more on qualified immunity in light of a recent Sixth Circuit case not addressed in briefing. This Court found the case distinguishable.

The individual defendants may well have the right to take their interlocutory appeal from a denial of a Rule 12 motion that invokes qualified immunity, among other things. But choosing to exercise that right so early in the case presents practical problems for the parties and the Court. In the first place, not all parties have a right to qualified immunity; only the individual defendants do. *See Pollard v. City of Columbus, Ohio*, 780 F.3d 395, 401 (6th Cir. 2015) (noting that municipalities are not entitled to qualified immunity). In this case, there is also an entity defendant—the employer of the police officers—sued on a policy and practice theory.

***2** The Court of Appeals may choose, in its discretion, to exercise pendent appellate jurisdiction over any claims against the municipality, but it is under no obligation to do so. *See Pollard v. City of Columbus, Ohio*, 780 F.3d 395, 401 (6th Cir. 2015) ("Nevertheless, to the extent the issues raised in the City of Columbus's appeal are 'inextricably

intertwined' with the officers' claims of qualified immunity, we may exercise pendent jurisdiction over the appeal."); *Marmelshtein v. City of Southfield*, 421 Fed.Appx. 596, 604 (6th Cir. 2011) ("Here, we are not faced with a situation in which the constitutional claims have failed as a matter of law. We therefore do not exercise pendent appellate jurisdiction ... and dismiss Southfield's appeal."). And merely because the individual officers exercise a right of interlocutory appeal does not automatically divest this court of jurisdiction over more of the case than the right of interlocutory appeal encompasses: namely, the right of the individual officers to have the denial of qualified immunity reviewed. That right does not automatically encompass claims against the entity employer. *See Crockett v. Cumberland Coll.*, 316 F.3d 571, 578–79 (6th Cir. 2003) (dismissing municipality's appeal for lack of jurisdiction); *Yates v. City of Cleveland*, 941 F.2d 444, 448 (6th Cir. 1991) (describing circumstances where an appeal would not divest a district court of jurisdiction).

Accepting the Defendants' argument—that the notice of interlocutory appeal divested this Court of jurisdiction of all the remaining claims of the lawsuit—cannot be squared with Sixth Circuit precedent. First, in *Crockett*, the Sixth Circuit expressly determined that neither the collateral order doctrine nor the concept of pendent appellate jurisdiction supported jurisdiction over a municipality's appeal, even though the Court simultaneously found that the individual officers were entitled to qualified immunity. *See Crockett*, 316 F.3d at 579. Second, even individual officers who would normally have a right of interlocutory appeal on a denial of qualified immunity cannot automatically assume their notice of appeal divests the trial court of power to proceed with the case. In *Yates*, the Sixth Circuit dedicates an entire section of a published opinion explaining why the right to take an interlocutory appeal of a denial of qualified immunity is "subject to waiver," and favorably endorsed two Seventh Circuit opinions indicating that where defendants file a dilatory appeal, one option is to "allow the district court to certify an appeal as frivolous and begin the trial." *Id.* at 448. Defendants do not address *Crockett* or *Yates* in either their motion for reconsideration or their notice of interlocutory appeal, nor do they address that district courts in this circuit cite *Yates* for this very proposition. *See, e.g.*, *Englar v. Davis*, No. 04-CV-73957, 2011 WL 2784801, at *5 (E.D. Mich. July 15, 2011) ("The Sixth Circuit 'determine[s] its own jurisdiction and is bound to do so in every instance.' However, in the case of interlocutory appeals based on a denial of qualified immunity, the Sixth Circuit has recognized the district courts' authority 'to certify an appeal as frivolous and begin the trial.' "). [2]

2 In *Dickerson v. McClellan*, 37 F.3d 251, 252 (6th Cir. 1994), the Sixth Circuit stated that there was "no authority that would permit a district court to dismiss a notice of appeal from such an order." But that is not the issue here. In *Dickerson*, a municipality's interlocutory appeal was not at issue. Moreover, even on the question limited to the individual officers' appeal, the Court did not purport to overrule *Yates*. Rather, it distinguished *Yates* and found simply that a district court cannot unilaterally dismiss a proper notice of appeal. Here, the municipality has no proper basis for an interlocutory appeal. Moreover, the individual defendants in this case did not even attempt to invoke qualified immunity until oral argument. If the defendants here have the right to freeze the trial court process with an interlocutory appeal, then the court of appeals will effectively be inviting interlocutory appeal in any § 1983 case in which the trial court denies a *Twombly* and *Iqbal* Rule 12(b)(6) motion. *See Iqbal*, 556 U.S. at 662; *Twombly*, 550 U.S. at 544. In this Court's view, this would be a misuse of the *Mitchell v. Forsyth* privilege of interlocutory appeal. *See Mitchell v. Forsyth*, 472 U.S. 511, 530, 105 S. Ct. 2806, 2817–18, 86 L.Ed.2d 411 (1985).

***3** Another practical problem for all involved—even the individual officers—is that the Rule 12 record is necessarily sparse. The only facts available to anyone at this point are those pleaded by the plaintiff. They don't provide a lot of detail, but in the Court's view, they do provide enough to demonstrate a plausible claim of constitutional violation if those facts and reasonable inferences from them are ultimately established. If it is true, that the officers had nothing but an obviously bogus tip on which to base their warrantless arrest, and that the prosecutor reached this same conclusion the morning after the arrest in deciding not to charge plaintiff, then the defendants' conduct would certainly violate clearly established constitutional law prohibiting arrest without probable cause. *United States v. Cooper*, 1 Fed.Appx. 399, 403–04 (6th Cir. 2001) (noting the reliability of an informant's tip is determined by the totality of the circumstances). And similarly, if it is true that officers knew of a particular vulnerability plaintiff had in his rotator cuff that would make traditional behind-the-back handcuffing

unnecessarily painful and damaging, and if the officers had no unusual security concerns, then disregarding that information and causing injury to plaintiff in the process could certainly lead to the conclusion that unconstitutionally excessive force was used. *See Crooks v. Hamilton Cnty., Ohio*, 458 Fed.Appx. 548, 549 (6th Cir. 2012) (finding allegation of tight handcuffing could amount to excessive force where plaintiff alleged "persistent claims of pain"); *see also Lyons v. City of Xenia*, 417 F.3d 565, 575 (6th Cir. 2005) (finding allegation of tight handcuffing could not amount to excessive force partly because "plaintiff did not allege that her physical complaints to the officers went unheeded").

Of course, the complete factual record may tell a much different story at summary judgment, but those facts are not available to anyone right now. Suppose, for example, that what plaintiff calls a bogus tip turns out to have included more detailed information either naming the plaintiff, or at least describing plaintiff in a way that a reasonable officer would easily identify him on sight. Or suppose the officers can demonstrate that plaintiff was heavily intoxicated at the time of arrest such that communication was impaired, or taking plaintiff into custody was unusually difficult. These are dozens of other possible factual permutations—some of which may well be beyond genuine dispute by the time of summary judgment—could paint a much different picture on a qualified immunity motion. So even if the defendant officers have the right to interlocutory appeal from a Rule 12 motion, it may not always be in even their interest to take the appeal before discovery, especially in a simple case like this with only a few witnesses to develop the main storyline.

II. ISSUES AND DISCUSSION

It was a combination of practical considerations like this that led the Court to make it clear to the parties that even though the officers themselves may choose to take an interlocutory appeal, the Court was going to hold to the parties who did not have that right—namely, the plaintiff and the municipality—to a normal case management schedule. Of course, the Court of Appeals may choose to intervene at any time, assert its pendent appellate jurisdiction over the claims against the municipal defendant, and direct this Court to stay all proceedings in the meantime. But unless and until that happens, this Court remains convinced that it retains jurisdiction to proceed with the claims against the municipality, which has no right to interlocutory appeal.

This has led to a series of motions. First, the defendant municipality has moved for reconsideration of this Court's decision to continue moving forward in the trial court with the claim against the municipality (docket no. 22). Second, Plaintiff moves to compel the defendants to respond to interrogatories and document requests (docket no. 28). And third, the plaintiff has moved for an order to show cause directed to a third party witness (the hotel where plaintiff was staying at the time of his arrest) for failure to honor a Rule 45 subpoena for documents (docket no. 29). For the reasons that follow, the Court **DENIES** the motion for reconsideration (docket no. 22); **GRANTS** the Motion to Compel to the extent it is directed to the municipal defendant only, and **DENIES** the Motion to Compel to the extent is seeks to compel party discovery from the individual defendants (docket no. 28); and **GRANTS** the request for a show cause to the third party witness (docket no. 29).

A. Reconsideration

***4** The Court remains convinced that an interlocutory appeal by the individual defendants does not automatically divest this Court of jurisdiction to proceed with the claims against the municipal defendant, which does not have a right to interlocutory appeal. *See Crockett*, 316 F.3d at 579. The Court of Appeals may choose to exercise pendent appellate jurisdiction, but it has no obligation to do so. And in the Court's view, a party without a right to interlocutory appeal does not have the power to freeze trial court proceedings merely by trying to assert a right to appeal that it does not have. The Court also remains convinced that practical case management augers in favor of allowing discovery to proceed on the claims against the municipality without waiting for the Court of Appeals to act on the interlocutory appeal of the individual defendants.

First, for reasons already noted, the factual record is at this point extremely limited, leaving only the plaintiff's allegations to test against clearly established law on arrest and use of force. It is always possible the Court of Appeals will find the complaint so poorly pleaded that it not only fails to state a claim, but also fails even to permit the plaintiff an opportunity to amend. But this seems unlikely. At worst, it would seem the Court of Appeals would return the case with instructions that the plaintiff be permitted an opportunity to amend to meet any deficiencies identified. *See generally Brown v. Matauszak*, 415 Fed.Appx. 608, 615 (6th Cir. 2011) (observing that "at least three circuits have held that if a complaint is vulnerable to a motion to dismiss, a district court must first permit the plaintiff to file a curative amendment,

even if the plaintiff does *not* seek leave to amend"). So the most likely result on appeal is a return to the trial court for at least some further proceedings, even if only an opportunity for plaintiff to file an amended complaint.

Second, the policy and practice claim against the municipality certainly overlaps in some ways with the individual claims against the officers, but the claims are still distinct. *Crockett* makes this clear by finding individual officers entitled to qualified immunity on interlocutory appeal, but by still dismissing the municipality appeal for lack of jurisdiction. *See* 316 F.3d at 579. It is easily possible to imagine a case in which the officers ultimately lose based on their personal conduct, but the municipality still wins because there is no evidence to support a policy or practice claim. Why not start developing the facts germane to this eventuality right now? It is also possible to imagine a case in which an unconstitutional arrest or use of force actually occurred, but in which the officers themselves are able to establish qualified immunity because the particulars of the constitutional right were not clearly established at the time they acted. Suppose, for example, that the municipality has a policy that turns out to be unconstitutional, but that the officers believed in good faith they were following in effecting a warrantless arrest on a tip, or applying behind-the-back handcuffing. Perhaps such a policy does expose the municipality to liability, even if the officers themselves are able to establish qualified immunity. Again, since the claims are distinct, why not begin developing the factual record now?

Third, at this stage of the case, the burdens of proceeding in the trial court are minimal, and the risks of delay are real and substantial. All this Court is expecting the parties to work on is the ordinary process of pretrial disclosures and discovery. In this particular case, that process is not likely to be especially onerous. There are only a handful of potential witnesses. There is not likely much documentary evidence. Why not get this information gathered now, before memories fade, and documents are misplaced or otherwise become unavailable? It may even be that some early discovery—which would no doubt include the deposition of the plaintiff—would expose previously unknown strengths or weaknesses in the case that could lead to early settlement. And even if that does not happen, at least the information can be gathered and marshaled now so that the delay that inevitably arises from interlocutory appeals is as limited as it can possibly be, in the event the case returns to the trial court for further proceedings.

***5** For these reasons, the Court **DENIES** the defense motion for reconsideration (docket no. 22).

B. Party Discovery

The Federal Rules of Civil Procedure subject all persons—parties or otherwise—to the possibility of being subpoenaed to provide testimony or other information germane to pending litigation. Fed. R. Civ. P. 45. Of course, there are limits on this to ensure that non-parties are not subject to unreasonable inconvenience or expense. Fed. R. Civ. P. 45(d). But it is ordinarily up to the party subpoenaed to seek relief. Fed. R. Civ. P. 45(d)-(e). The party serving the subpoena may seek judicial enforcement. Fed. R. Civ. P. 45(d)(2)(B)(i). Ultimately, a non-party witness that fails to comply with a subpoena without adequate excuse may be subject to contempt sanctions. Fed. R. Civ. P. 45(g). This regimen applies to all persons, including non-parties to litigation. And nothing in the law of qualified immunity protects an individual officer from being subject to subpoena under Rule 45 in an appropriate case.

Parties to litigation are, of course, subject to additional discovery obligations. In the first place, parties must submit to a deposition simply upon service of proper notice under Rule 30; no Rule 45 subpoena is required. Parties must also provide sworn responses to interrogatories under Rule 33, and respond to document requests under Rule 34, again without the need for a Rule 45 subpoena. The discovery obligations of parties are enforceable on motion under Rule 37. In the Court's view, when individual officers are parties to active litigation of claims against them in the trial court, they have party obligations like anyone else under Rules 30, 33, 34 and 37. However, when these officers have a pending interlocutory appeal, in the Court's view, they are *not* ordinarily obligated to submit to party discovery under these Rules because one of the points of the interlocutory appeal is to shield the officers from party discovery in an appropriate case. These officers—just like any other person—remain subject only to the Rule 45 subpoena power of the Court, though a trial court may decide that the pendency of an interlocutory appeal should shield the officers from the obligation to comply. This would be an individual, case-by-case application of Rule 45, not a categorical privilege.

Applying these principles to the pending discovery motions, the results are straightforward.

1. Motion to Compel (docket no. 28): Because the individual officers have a pending interlocutory appeal, they are not

obligated to comply with party discovery under Rule 33 and 34, and the plaintiff's Motion to Compel is **DENIED** to the extent it seeks interrogatory responses and Rule 34 document request responses from the individual defendants. But the municipality does remain subject to party discovery because it has no right of interlocutory appeal. Accordingly, the plaintiff's Motion to Compel is **GRANTED** to the extent it seeks interrogatory responses and document request responses from the municipal defendant. Those responses shall be served by the municipal defendant not later than September 3, 2015.

***6** *2. Motion for Show Cause* (docket no. 29): Non-Party witness Rodeway Inn/Travelers Inn has been served with a Rule 45 subpoena for records, and has not complied, objected or otherwise responded. On the present record, Plaintiff is entitled to enforcement of the subpoena, and non-party witness Rodeway Inn/Travelers Inn is **ORDERED** to comply with the subpoena not later than September 3, 2015, or show cause not later than August 28, 2015, why the subpoena should not be enforced.

III. CONCLUSION

If Defendants are correct that their interlocutory appeal can freeze the trial court process for all parties—even those who have no right to interlocutory appeal—the practical results are potentially far-reaching. In this case, the Defendants filed a routine *Twombly* and *Iqbal* Rule 12(b) motion that did not even raise qualified immunity explicitly. Qualified immunity came up only during oral argument at the initial Rule 16 conference. When the Court denied the Rule 12(b)(6) motion, all Defendants filed interlocutory appeals. The individual defendants at least arguably have a basis for qualified immunity since the issue came up at least tangentially. But the municipality certainly has no right to interlocutory appeal, but is nevertheless refusing to participate in the trial court process without even seeking or obtaining a stay. If Defendants prevail on this strategy, a proper and useful basis for interlocutory appeal on qualified immunity issues that genuinely raise a controlling issue of law will be stretched into a tool for bringing up virtually every denial of a *Twombly* and *Iqbal* Rule 12(b)(6) motion in a § 1983 case on interlocutory appeal. That will inevitably build needless delay into the litigation process and, in the Court's view, abuse the purpose of the limited right of interlocutory appeal in qualified immunity cases.

IT IS SO ORDERED.

All Citations

Not Reported in Fed. Supp., 2015 WL 13173470

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2020 WL 5793101
Only the Westlaw citation is currently available.
United States Court of Appeals, Sixth Circuit.

Damien SUBLETT, Plaintiff-Appellant,
v.
Jason S. HOWARD, et al., Defendants-Appellees.

No. 19-6094
|
FILED June 25, 2020

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF KENTUCKY

Attorneys and Law Firms

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Angela T. Dunham, Commonwealth of Kentucky, Frankfort, KY, for Defendants-Appellees.

Before: CLAY, ROGERS, and MURPHY, Circuit Judges.

ORDER

***1** Damien Sublett, a Kentucky prisoner proceeding pro se, appeals a district court judgment dismissing his civil rights complaints filed pursuant to 42 U.S.C. § 1983. This case has been referred to a panel of the court that, upon examination, unanimously agrees that oral argument is not needed. *See* Fed. R. App. P. 34(a).

Sublett filed a complaint against Jason S. Howard, a correctional officer employed at the Little Sandy Correctional Complex (LSCC), Sublett's former place of confinement. Sublett alleged that, on July 3, 2018, he entered the Institutional Religious Center (IRC), where both Muslim and Christian religious services were being held, and Howard asked him which religious service he was attending. When Sublett told Howard that he was attending the Muslim service, Howard searched him as well as several inmates behind him who were also attending the Muslim service. Sublett noticed that Howard was not searching the inmates who were attending the Christian service, so he "accosted" Howard, asked why Howard was only searching the inmates who were attending the Muslim service, and told Howard that his conduct was discriminatory toward the Muslim inmates. In "a loud voice," Howard told Sublett "to shut up" and leave the IRC and refused Sublett's request to speak to a supervisor.

On July 4, 2018, Howard "issued Sublett a disciplinary report for a possible disruption." Sublett was found guilty of the disciplinary report, which actually charged him with a "Nonviolent demonstration that could lead to disruption," and received fifteen days in segregation. The warden denied Sublett's appeal. Sublett alleged that Howard violated his First Amendment free speech rights because Howard searched him based on his Muslim religious beliefs and that Howard retaliated against him by issuing him a disciplinary report because he asserted an oral grievance regarding Howard's discriminatory treatment of Muslim inmates. He sought injunctive and monetary relief.

With leave of court, Sublett filed a supplemental complaint against Audria Lewis, also a correctional officer at LSCC. Sublett alleged that, on September 9, 2018, he was discussing his lawsuit against Howard with a legal aid "directly in front of the officer station" where Lewis was standing. When Sublett went to his room to retrieve the legal documents related to his lawsuit, Lewis "deactivated [his] room door," which prevented him from exiting. Sublett pressed the intercom button to ask for assistance with his door and Lewis responded, telling him that "if he keeps talking about the lawsuit against Howard, (she) Lewis would have [him] placed in segregation." The door to Sublett's room opened and he exited. Lewis told Sublett "to stand by the officer cab and don't say anything." Sublett asked Lewis "what he had done" and Lewis accused him of arguing with her. Lewis refused Sublett's request to speak to a supervisor, and he was placed in segregation.

Lewis issued Sublett a disciplinary report, stating that Sublett "was being argumentative, disrespectful." Sublett was found guilty of the disciplinary report and received fifteen days in segregation. The warden denied Sublett's appeal. Sublett alleged that Lewis made false allegations in the disciplinary report because he was never argumentative or disrespectful. He alleged that Lewis issued the disciplinary report in retaliation for the lawsuit that he had filed against Howard.

***2** The defendants filed motions for summary judgment under Federal Rule of Civil Procedure 56, claiming that Sublett's complaints were subject to dismissal for failure to exhaust administrative remedies. The district court granted the defendants' motions and dismissed Sublett's complaints. Sublett filed a motion for reconsideration. The district court

construed Sublett's motion to reconsider as a Federal Rule of Civil Procedure 59(e) motion to alter or amend the judgment, which the district court denied.

Sublett filed a timely appeal. He argues that the district court erroneously granted summary judgment in favor of the defendants because his retaliation claims are not grievable under Kentucky Department of Corrections policies and are not barred by *Heck v. Humphrey*, 512 U.S. 477 (1994).

We review de novo the "district court's grant of summary judgment." *Watson v. Cartee*, 817 F.3d 299, 302 (6th Cir. 2016). Summary judgment is proper when the evidence presented shows "that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "A fact is material if it 'might affect the outcome of the suit under the governing law[,]' and a dispute about a material fact is genuine 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.' " *McKay v. Federspiel*, 823 F.3d 862, 866 (6th Cir. 2016) (alteration in original) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)).

Inmates are required to exhaust all available administrative remedies prior to filing civil rights suits in federal court. 42 U.S.C. § 1997e(a). The "exhaustion requirement applies to all inmate suits about prison life, whether they involve general circumstances or particular episodes, and whether they allege excessive force or some other wrong." *Porter v. Nussle*, 534 U.S. 516, 532 (2002).

In order to properly exhaust administrative remedies, an inmate must comply with the grievance procedures established by the particular prison in which he is incarcerated. *Jones v. Bock*, 549 U.S. 199, 218 (2007). "The level of detail necessary in a grievance to comply with the grievance procedures will vary from system to system and claim to claim, but it is the prison's requirements, and not the [Prison Litigation Reform Act (PLRA)], that define the boundaries of proper exhaustion." *Id.* "Proper exhaustion demands compliance with an agency's deadlines and other critical procedural rules because no adjudicative system can function effectively without imposing some orderly structure on the course of its proceedings." *Woodford v. Ngo*, 548 U.S. 81, 90–91 (2006). "Non-exhaustion is an affirmative defense under the PLRA, with the burden of proof falling on" the defendants. *Risher v. Lappin*, 639 F.3d 236, 240 (6th Cir. 2011).

Kentucky has a four-step process for administratively exhausting inmate grievances, which is set forth in the Kentucky Corrections Policies and Procedures (CPP). First, an inmate must submit a written grievance within five days of the complained-of incident, prison officials will make an attempt to resolve the grievance informally, and the inmate will be notified of the informal resolution results. CPP 14.6 §§ II(J)(1)(a)(1), (b)(1), (b)(7). Second, if the inmate is dissatisfied with the results of the informal resolution, he may request a hearing before the grievance committee, and the committee will recommend a resolution. CPP 14.6 §§ II(J)(1)(b)(8), (2)(a). Third, if the inmate is not satisfied with the grievance committee's recommended resolution, he may appeal to the warden, who will "examine the grievance and make a decision." CPP 14.6 §§ II(J)(2)(j), (3)(a). Fourth, if the inmate is dissatisfied with the warden's decision, he may file an appeal to the commissioner, who will "review the grievance appeal and make a decision." CPP §§ II(J)(3)(c), (4)(b).

***3** In his motion for summary judgment, Howard argued that Sublett initiated a grievance against Howard related to the July 3, 2018, incident but did not complete the grievance process. Sublett's grievance was rejected as an improper attempt to grieve a disciplinary decision and he did not correct it to clarify that he was not grieving a disciplinary decision and resubmit it, despite the opportunity to do so. In her motion for summary judgment, Lewis argued that Sublett did not file any grievances against her related to the September 9, 2018, incident.

In response to the defendants' motions, Sublett argued that the grievance process was not available because the July 3 and September 9, 2018, incidents were non-grievable under CPP 14.6 § II(C)(4), which states that an "incident where the grievant received a disciplinary report and [the] report has been dismissed" is a non-grievable issue. Sublett argued that he received disciplinary reports related to both incidents so they are not grievable issues. Sublett also argued that he corrected and resubmitted his grievance against Howard but it was rejected a second time.

The district court concluded that Sublett failed to exhaust administrative remedies as to his discrimination and retaliation claims against Howard and his retaliation claim against Lewis. As for Sublett's contention that his claims against Howard and Lewis were non-grievable, the district court concluded that "an issue raised in a grievance related to the prison disciplinary process is non-grievable" and non-

cognizable "in a § 1983 action." The district court found that Sublett's claims that the disciplinary reports issued by Howard and Lewis were retaliatory for his protected conduct essentially challenged those disciplinary reports and were not cognizable in a § 1983 action under the reasoning of *Edwards v. Balisok*, 520 U.S. 641 (1997), and *Heck*. The district court rejected Sublett's contention that he corrected his rejected grievance against Howard, resubmitted it, and received another rejection. The district court determined that the documents that Sublett submitted in support of his argument were neither authenticated nor verified, contained "significant irregularities," and contradicted grievance records maintained by the LSCC grievance coordinator.

On appeal, Sublett argues that the district court erroneously granted summary judgment in favor of the defendants because his retaliation claims against them are non-grievable. Sublett argues that the grievance process was not available to him because he received disciplinary reports based on the incidents involving Howard and Lewis. Sublett relies on CPP 14.6 § II(C)(4) for the contention that all matters related to disciplinary reports and proceedings are not grievable.

Contrary to Sublett's argument, his retaliation claims against the defendants are grievable issues under CPP 14.6. Under CPP 14.6, an inmate may grieve "any aspect of [their] life in prison that is not specifically identified as a non-grievable issue." CPP 14.6 § II(B). Generally, the list of non-grievable issues consists of final decisions and dispute resolution procedures. *see* CPP 14.6 § II(C). Sublett argues that his claims are not grievable because they relate to incidents for which he received disciplinary reports. However, such incidents are only non-grievable if "the grievant received a disciplinary report and [the] report has been dismissed." CPP 14.6 § II(C)(4). Sublett received disciplinary reports after the July 3 and September 9, 2018, incidents, but those reports were not dismissed. *See id.* Sublett's retaliation claims against Howard and Lewis concerned prison life and conflicts with those correctional officers. Specifically, Sublett claimed that Howard and Lewis retaliated against him by issuing disciplinary reports because he engaged in the protected conduct of grieving Howard's alleged discriminatory treatment of Muslim inmates and filing a lawsuit against Howard. Although Sublett's retaliation claims are related to the disciplinary reports, they do not challenge the substance of the disciplinary reports or the outcomes of the disciplinary proceedings. Instead, the challenged conduct is the issuance of allegedly retaliatory disciplinary reports, a grievable matter. *Cf. Reynolds-Bey v. Harris*, 428 F. App'x 493, 501 (6th Cir. 2011) ("As distinct from the outcomes of misconduct hearings, the filing of retaliatory misconduct reports is grievable ...." (emphasis omitted)).

***4** In fact, the grievance that Sublett filed against Howard indicated a staff conflict as the subject matter and asserted that Sublett "received a disciplinary report in retaliation of [his] speech as to discrimination." This grievance against Howard was rejected as non-grievable with the notation that it could be corrected and returned. Yet, Sublett submitted no evidence to refute Howard's evidence that the grievance was never corrected and returned to either "the grievance coordinator or the grievance aide." Furthermore, Sublett offered no evidence to overcome Lewis's assertion that he did not file a grievance concerning his retaliation claim against her. "[A]n inmate cannot simply fail to file a grievance or abandon the process before completion and claim that he has exhausted his remedies ...." *Hartsfield v. Vidor*, 199 F.3d 305, 309 (6th Cir. 1999). Consequently, Sublett failed to exhaust his administrative remedies because his retaliation claims presented grievable issues and he neither completed the process as to Howard nor began the process as to Lewis.

The district court properly granted summary judgment in favor of Howard and Lewis based on Sublett's failure to exhaust administrative remedies. Because dismissal was appropriate on exhaustion grounds, we need not consider the district court's alternative basis under *Edwards* and *Heck* for dismissing Sublett's complaints.

Although dismissal was appropriate, we clarify that the dismissal of Sublett's complaints is without prejudice. A judgment of dismissal is presumed to be with prejudice if it is silent as to its prejudicial effect. *See* Fed. R. Civ. P. 41(b); *Nafziger v. McDermott Int'l, Inc.*, 467 F.3d 514, 518 (6th Cir. 2006). Here, because the district court's judgment is silent as to its prejudicial effect, it is presumed to be with prejudice. *See Nafziger*, 467 F.3d at 518. But the dismissal of a complaint on exhaustion grounds should be without prejudice. *See Hartsfield*, 199 F.3d at 309–10 (remanding for dismissal without prejudice of unexhausted claims).

Sublett does not challenge the district court's dismissal of his discrimination claim against Howard. Nor does he challenge the district court's rejection of his contention that he corrected and resubmitted his rejected grievance and received another rejection as to his retaliation claim against Howard. "Issues which were raised in the district court, yet not raised on appeal, are considered abandoned and not reviewable on

appeal." *Robinson v. Jones*, 142 F.3d 905, 906 (6th Cir. 1998). In other words, the "failure to raise an argument in [an] appellate brief ... [forfeits] the argument on appeal." *Radvansky v. City of Olmsted Falls*, 395 F.3d 291, 311 (6th Cir. 2005); *see also Geboy v. Brigano*, 489 F.3d 752, 767 (6th Cir. 2007). Thus, Sublett has abandoned any remaining claims raised in the district court and not addressed in his appellate brief.

Accordingly, we **AFFIRM** the district court's judgment and clarify that the dismissal is without prejudice.

All Citations

Not Reported in Fed. Rptr., 2020 WL 5793101

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