No. 26-11607

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

AETNA HEALTH INC., AETNA HEALTH INSURANCE COMPANY, AETNA LIFE INSURANCE COMPANY,

Plaintiffs-Appellants,

v.

RADIOLOGY PARTNERS, INC., MORI, BEAN AND BROOKS, INC.,

Defendants-Appellees.

On Appeal from the United States District Court
for the Middle District of Florida, No. 3:24-cv-01343-BJD-LLL
Hon. Brian J. Davis, U.S. District Judge

SUPPLEMENTAL APPENDIX FOR APPELLEES

Brian P. Miller
Samantha J. Kavanaugh
KING & SPALDING LLP
Southeast Financial Center
200 S Biscayne Boulevard
Suite 4700
Miami, FL 33131
(305) 462-6000

Paul Alessio Mezzina
Megan Michur
KING & SPALDING LLP
1700 Pennsylvania Avenue NW
Suite 900
Washington, DC 20006
(202) 737-0500
pmezzina@kslaw.com

Counsel for Defendants-Appellees

September 22, 2026

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

AETNA HEALTH INC., et al., *Plaintiffs*, v. RADIOLOGY PARTNERS, INC., et al., *Defendants*.	CASE NO.: 3:24-CV-01343-BJD-LLL

DEFENDANTS' REQUEST FOR JUDICIAL NOTICE FOR CONCURRENTLY FILED MOTION TO COMPEL ARBITRATION AND MOTION TO STAY, AND MOTION TO DISMISS

Pursuant to Fed. R. Evid. 201, Defendants Radiology Partners, Inc. ("RP") and Mori, Bean, and Brooks, Inc. ("MBB") (collectively "Defendants") respectfully request that the Court take judicial notice ("RJN") of the attached Exhibits, which include publicly-filed court records and arbitral filings related to those court records, in connection with Defendants' concurrently filed (1) Motion to Compel Arbitration and Motion to Stay ("MTC"); and (2) Motion to Dismiss ("MTD").

All documents for which judicial notice is sought are documents filed in a lawsuit or arbitration involving Aetna Life Insurance Company, one of the plaintiffs here (collectively with the other plaintiffs Aetna Health, Inc., a Florida corporation, and Aetna Health Insurance Company ("Aetna")).

Defendants are not requesting judicial notice of the Exhibits for the truth of the matters asserted therein. Rather, judicial notice is only sought for the respective relevance of each document to the issues raised in the concurrently filed motions, such as (a) Aetna's previous positions, for the portions of the motions based on estoppel for inconsistent positions, and (b) Aetna's knowledge of the content of each document as of the time of the document, for the portions of the motions based on Aetna's inability under the law to contend lack of knowledge or ability to know alleged facts for counts that require such lack of knowledge or ability to know. Accordingly, it would be inaccurate were Aetna to respond to the RJN by arguing that the RJN seeks judicial notice of the truth of the matters asserted. For example:

1. The MTC seeks to compel Aetna to arbitrate against not only MBB as a contracted party during the Contracted Period, but also RP as a non-signatory based on the doctrines of equitable estoppel and agency. The RJN includes a document showing Aetna previously used those same doctrines to successfully compel RP to arbitrate parallel theories Aetna brought in Texas. Therefore, those documents are relevant to the issue of judicial estoppel, regardless of the truth of the matter of the facts stated therein.
2. The MTD challenges all of Aetna's fraud-based counts, including those to vacate IDR arbitrations decisions rendered during the NSA

> Period after the Contract terminated in mid-2022, which require Aetna to allege facts sufficient to show that it: (1) did not know about the growth of MBB after it affiliated with RP; and (2) was not able to discover the alleged fraud with the exercise of due diligence prior to or during the NSA arbitrations. The RJN includes documents showing Aetna made the same allegations as here against RP and a RP affiliate in a prior arbitration in Texas late 2021-early 2022, well before the NSA Period. Therefore, those documents are relevant to rebut Aetna's purported inability to discover the alleged fraud, regardless of the truth of the matter of the facts stated therein.

The motions reference each of the specific documents for which judicial notice is sought.

ARGUMENT

"[I]n ruling on a motion to dismiss courts may supplement the allegations in a complaint with facts contained in judicially noticed materials." *K.T. v. Royal Caribbean Cruises, Ltd.*, 931 F.3d 1041, 1048 (11th Cir. 2019).

Fed. R. Evid. 201(b)(2) provides that the Court may judicially notice a fact that is not subject to reasonable dispute because it can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned. Fed. R.

Evid. 201(c)(2) states the Court must take judicial notice if a party requests it and the court is supplied with the necessary information.

I. The Court May Take Judicial Notice for Purpose of Showing that a Party Was on Notice of the Contents of Documents, Regardless of the Truth of the Facts Asserted in those Documents.

The Court may take judicial notice for the purpose of showing that a party was on notice of the contents of documents at the time those documents were filed or created. For example, and without limitation: "The court may take judicial notice of another court's docket entries and orders for the limited purpose of recognizing the filings and judicial acts they represent." *Geico Indem. Co. v. Vazquez*, No. 15-61442-CIV, 2016 WL 10587207, at *1 (S.D. Fla. Nov. 4, 2016). In reviewing the District Court's grant of a motion to dismiss a claim for negligence, the Eleventh Circuit in *Royal Caribbean* assessed whether the defendant there had "actual or constructive notice of the risk-creating condition." *Royal Caribbean*, 931 F.3d at 1044. Chief Judge Carnes, concurring specially with his own opinion, explained that the Court could take judicial notice of Cruise Line Incident Reports, for the purpose of showing that *Royal Caribbean* "knew or should have known that there was a serious problem...." *Id*. at 1050.

Similarly, the Eleventh Circuit has found it appropriate, for a court ruling on a motion to dismiss, to take judicial notice of a plaintiff's social media posts, "not for the truth of their contents but for what they reveal about Plaintiff's knowledge."

Trump v. Clinton, 626 F. Supp. 3d 1264, 1297 (S.D. Fla. 2022). The Court used the judicial notice of the plaintiff's tweets to show "that Plaintiff was aware of the basis of his claims since at least 2017" for purposes of assessing the defendant's statute of limitations defense. *Id*.

A. The Court May Take Judicial Notice of Court Records and Related Arbitral Records

Public records are among the permissible facts that a district court may consider when ruling on a motion to dismiss. *Univ. Express, Inc. v. U.S. S.E.C.*, 177 Fed. Appx. 52, 53 (11th Cir. 2006) (per curiam) (noting, in considering a motion to dismiss, public records are among the permissible facts a district court may consider).

Defendants seek judicial notice of publicly filed court records, including court records related to an arbitration between Aetna Life Insurance Company, a plaintiff here, and RP and an RP Texas affiliate (the "Arbitration"), for purpose of noticing that those filings were filed, and the averments therein were made by Aetna in them, showing Aetna's awareness at the time of those assertions that overlaps with Aetna's purported lack of knowledge here. *United States v. Jones*, 29 F.3d 1549, 1553 (11th Cir. 1994) (court could "take notice that the affidavits were filed **and the averments were made**." (citing *FDIC v. O'Flahaven*, 857 F. Supp. 154, 157-58 (D.N.H. 1994)) (emphasis added).

Defendants also seek judicial notice of related arbitral filings from the Arbitration for the purpose of showing Aetna's knowledge at the time of those filings that is reflected by those filings. Courts in the Eleventh Circuit, and elsewhere, have taken judicial notice of arbitration decisions, the claims brought therein, and even the underlying arbitration filings for purpose of noticing that those decisions have been rendered, claims asserted, and filings occurred. *See Taxinet Corp. v. Leon*, 114 F.4th 1212, 1227 (11th Cir. 2024) ("We can and do take judicial notice of the existence of this arbitral proceeding"); *see also Vital Pharms. v. PepsiCo, Inc.*, 528 F. Supp. 3d 1295, 1301-03 (S.D. Fla. 2021) (prior emergency arbitration order regarding the same dispute was appropriate for judicial notice to evaluate collateral estoppel defense and preclusive effect); *Glob. Indus. Inv. Ltd. v. Chung*, No. 19-CV-07670-LHK, 2020 WL 5355968, at *3 (N.D. Cal. Sept. 7, 2020) (court took judicial notice of publicly filed arbitration award, as well as filings from the underlying arbitration as relevant to claim preclusion analysis in ruling on motion to dismiss.); *Colonial Oaks Assisted Living Lafayette, L.L.C. v. Hannie Dev., Inc.*, 972 F.3d 684, 688 fn. 9 (5th Cir. 2020) (court took judicial notice of arbitration interim order filed in another court).

The arbitral filings that courts take judicial notice of include the arbitration pleadings when the scope of the claims asserted in the arbitration is relevant to defenses raised on a motion to dismiss, such as *res judicata*. *See, e.g.*, *Crawley v.*

Macy's Retail Holdings, Inc., No. 15 CIV. 2228 (KPF), 2018 WL 4954099 at *1, fn. 1 (S.D.N.Y. Oct. 11, 2018) (court took judicial notice of demand for arbitration and resulting arbitration award where defendant asserted *res judicata* and collateral estoppel defenses); *Champion Pro Consulting Group, Inc. v. Impact Sports Football, LLC*, 976 F. Supp. 2d 706, 714 (M.D.N.C. 2013) (court took judicial notice of prior arbitration in ruling on motion to dismiss based on collateral estoppel); *Stephens v. Trump Org. LLC*, 205 F. Supp. 3d 305, 309 n.5 (E.D.N.Y. 2016); *Purjes v. Plausteiner*, Case No. 15-cv-2515, 2016 WL 552959, at *4 (S.D.N.Y. Feb. 10, 2016) (court took judicial notice of arbitration filings to evaluate preclusive effect on claims asserted in complaint).

For the reasons set forth above, Defendants respectfully request that this Court take judicial notice of the following Exhibits attached hereto, including but not limited to the specific excerpts identified below:

Exhibit No.

Public Court Records

1. **Aetna Life Insurance Company's Application To Confirm Award And For Entry Of Final Judgment filed on August 5, 2024 [ECF No. 1]; *Aetna Life Insurance Co. v. Singleton Associates, P.A.*; United States District Court for the Southern District of Texas; Case No. 4:24-cv-02910.**

This document was filed by Aetna in Texas federal court relating to the Texas Arbitration. RJN can be taken of the entire document for what it shows about

Aetna's knowledge and assertions at the time of the document and referenced events.

Below are several relevant excerpts:

> Page 1: Applicant Aetna Life Insurance Company ("**Aetna**") is a Connecticut corporation with a principal place of business in Hartford, Connecticut.
>
> Page 4: As alleged in Aetna's counterclaim, many of the radiology services billed by SAPA were not payable under the Agreement because they were provided by physicians who were ***not*** covered under the Agreement—namely, physicians who were ***not*** part of SAPA… According to Aetna's pleadings, in late 2014, and unbeknownst to Aetna, a self-proclaimed "national radiology practice" called Radiology Partners acquired SAPA and began billing Aetna improperly under SAPA's name and federal Tax Identification Number (TIN) for radiology services provided by unauthorized physicians who were outside of Houston, were not employees of SAPA, and were not approved by Aetna. The unauthorized billings by SAPA and Radiology Partners caused Aetna to overpay millions of dollars in radiology services, which were not covered by the Agreement.
>
> Page 5: On January 27, 2022, Aetna timely filed a First Amended Counterclaim against SAPA and a Third-Party Complaint and Demand for Arbitration against Radiology Partners (together, "**Aetna's Amended Counterclaim**"). Aetna's Amended Counterclaim alleged the similar causes of action from its original counterclaim but included additional allegations and overpayments extending back to 2014. Aetna also alleged that Radiology Partners had acted as SAPA's alter ego by billing Aetna for unauthorized radiology services under SAPA's name and TIN and improperly receiving the benefits of Aetna's overpayments. Aetna's Third-Party Complaint against Radiology Partners was accompanied by a Motion for Leave, which was subsequently granted by the Arbitrator on February 18, 2022.

2. **Singleton Associates, P.A.'s Motion to Dismiss Aetna's Application to Confirm Award and for Entry of Final Judgment filed on September 12, 2024 [ECF No. 9]; *Aetna Life Insurance Co. v. Singleton Associates, P.A.*; United States District Court for the Southern District of Texas; Case No. 4:24-cv-02910.**

This is a document filed by the RP-affiliated medical group in the Texas court about the Texas Arbitration. RJN can be taken of the entire document, as well as the exhibits attached thereto, for what they collectively show about Aetna's knowledge and assertions at the time of the document and referenced events. Below are several relevant excerpts:

> Page 19: The Interim Order (Phase Two) does not resolve any separate and independent claim because significant, interrelated damages issues arising from Singleton's Core Claims and Aetna's Counterclaims are unresolved, precluding finality.
>
> Page 20-21: Second, Phase Four will also address dueling claims for attorneys' fees that may represent a significant swing in the net amount awarded to either side. Singleton will seek an attorney's fees award against Aetna in Phase Four for prevailing on its already adjudicated breach of contract claim for underpayments (including underpayments on medical claims regulated by Texas law) pursuant to Texas statutes, including Chapter 38 of the Texas Civil Practice and Remedies Code and the Texas Prompt Pay Act. Aetna, however, is precluded from recovering attorney's fees against Singleton for breach of contract under the version of Chapter 38 applicable to the parties' arbitration because Singleton is a Professional Association. *See* Ex. M, Singleton Mot. for Summ. Disposition on Aetna's Claim for Attorneys' Fees Under Tex. Civ. Prac. & Rem. Code § 38.001. Multiple courts have recognized that attorneys' fees must be determined before a claim can be final. *In re Chevron US.A., Inc.*, 419 S.W.3d 341, 350 (Tex. App.—El Paso 2010, no pet.); *Kerr-McGee*, 924 F.2d at 471. This is an additional reason why the Interim Order has not finally and separately disposed of Aetna's breach of contract claim.

3. Interim (Phase One) Order entered on May 24, 2023, redacted version filed on September 12, 2024 as Exhibit 6 to Defendant Singleton Associates, P.A.'s Motion To Dismiss Aetna's Application to Confirm Award and for Entry of Final Judgment [ECF No. 9-6]; *Aetna Life Insurance Co. v. Singleton Associates, P.A.*; United States District Court for the Southern District of Texas; Case No. 4:24-cv-02910.

This is an attachment to RJN Ex. 2. Judicial notice can be taken of the entire document for what it shows about Aetna's knowledge and assertions at the time of the document and referenced events. Below are several relevant excerpts:

> Page 29: SAPA sued Aetna for breach of the [redacted] alleging that, beginning in the summer or fall of 2020, Aetna changed its systems to begin paying less than the Agreement's [redacted] of billed charges rate for physicians located outside of Houston.
>
> Page 31: Aetna failed to prove by a preponderance of the evidence that SAPA/RP tried to hide the relationship between SAPA and RP, their growth, or the use of the Agreement.
>
> Page 33: When SAPA submitted electronic claims as required by Aetna, it disclosed the service facility location information. The claims data revealed that SAPA was providing services across Texas.
>
> Page 33: Aetna failed to prove by a preponderance of the evidence the elements of fraudulent nondisclosure with respect to the services of physicians including the relationship between SAPA and RP, their expansion, growth, or the use of the Agreement. Aetna failed to prove by a preponderance of the evidence that SAPA/RP deliberately failed to disclose material facts, that it had a duty to disclose those facts, that Aetna was ignorant of those facts, that SAPA/RP intended Aetna to act or refrain from acting based on the non-disclosure, and that Aetna relied on the nondisclosure...
>
> Page 34: With respect to the Subcontracted Provider issue, Aetna failed to prove by a preponderance of the evidence that SAPA/RP made any representations, much less misrepresentations, to Aetna about whether its physicians were employees, shareholders, partners, or Subcontracted Providers and could have asked for documentation. But it did not do so. SAPA made no representations about that issue on its claims or elsewhere. Aetna also failed to prove by a preponderance of the evidence that SAPA/RP "deliberately failed to disclose material facts" and that they "intended the plaintiff [Aetna] to act or refrain from acting based on nondisclosure."
>
> Page 34: [G]iven the widespread use of contracted physicians in the industry, the preponderance of the evidence does not support a finding that SAPA

deliberately or recklessly failed to disclose material facts on this issue or that it intended for Aetna to act or refrain from acting.

Page 34: Aetna also contends that SAPA/RP committed fraud by submitting claims under SAPA's TIN, rather than the TIN for other entities such as [redacted].

Page 35: SAPA made no representations in the claim form about whether the physicians were employees, shareholders, partners, or Subcontracted Providers. Nevertheless, Aetna contends that SAPA committed fraud by billing Subcontracted Providers under its TIN. SAPA submitted claims under its TIN when it had an exclusive agreement with a hospital. SAPA used the same methodology for all payors and all hospitals. This was SAPA's practice beginning at or near the time that [redacted] acquired SAPA and started adding practices and exclusive hospital agreements.

Page 35: Aetna failed to prove by a preponderance of the evidence that it was improper for SAPA to submit claims under its TIN for services that SAPA provided pursuant to its hospital agreements when it used Subcontracted Providers provided by other groups and the entities.

Page 36: Aetna failed to prove by a preponderance of the evidence that SAPA loaned its TIN [or provider number] to others for the purpose of collecting money.

Page 37: In these circumstances, from a preponderance of the evidence, SAPA did not loan its NPI or TIN to the other groups. Rather, it contracted with other groups or entities to provide radiologists to SAPA so that SAPA could fulfill its contractual obligations with the hospitals. SAPA then billed Aetna for these services of the individual radiologists (not the group) using SAPA's own TIN and NPI numbers. From a preponderance of the evidence, Aetna failed to prove by a preponderance of the evidence that SAPA loaned its TIN to other entities or improperly billed under its TIN. This conclusion is supported by the testimony of [redacted], Aetna's former employee/expert, whose testimony indicates that SAPA had the right to staff and bill for radiology services if it had the PSA with the hospital by contract or assignment and "that whoever had that staffing agreement previously no longer has the right to bill for radiology services at those hospitals"—"if they are no longer a party to the agreement."

Page 38: Aetna failed to prove justifiable reliance with respect to its fraud claims and negligent misrepresentation claims by a preponderance of the evidence because it failed to exercise due diligence in protecting its affairs. As previously discussed, Aetna had information from SAPA and others that demonstrated the relationship between SAPA and RP, their growth, and the use of the Agreement.

Page 39: Aetna also failed to prove justifiable reliance regarding the Subcontracted Provider issue. During the time relevant to this dispute, contractors were often used by hospital-based physician groups. As part of the enrollment process or thereafter, Aetna could have asked SAPA about SAPA's relationship with providers and requested or demanded copies of the contracts.

Page 39: Additionally, the physician's names and NPI numbers were on the claims, but Aetna did not consider, as part of its claims adjudication process, each physician's relationship with other providers to determine the appropriate reimbursement rate.

Page 39: Aetna, in the exercise of due diligence, could have determined from its databases that these providers were associated with other groups and might well be Subcontracted Providers…Aetna failed to prove by a preponderance of the evidence that it justifiably relied on SAPA's representations or that it was ignorant of the facts and did not have an equal opportunity to discovery them.

Page 39: Finally, Aetna did not show that it actually relied on representations, misrepresentations, or nondisclosures. It programmed its claims adjudication system to rely solely on the billing providers' TIN and billing address and thereby disregarded all other information provided by SAPA. Aetna failed to prove by a preponderance of the evidence that SAPA committed fraud by billing Subcontracted Providers under its TIN.

Page 44: Aetna breached the Agreement to the extent that it failed to pay the [redacted] of billed reimbursement rate for physicians who were employees, partners, or shareholders of SAPA (regardless of where the services were provided, the type of facility, or any preapproval requirement for the facility) and to the extent that it recouped any such payments.

> Page 44: SAPA breached the Agreement to the extent to the extent (sic) it added, used, and billed for Subcontracted Providers who were not pre-approved by Aetna, but any such claims that are governed by chapters 43 or 1301 of the Texas Insurance Code are barred to if (and to the extent that) Aetna failed to comply with the statutory and regulatory deadlines regarding overpayments.
>
> Page 44: Aetna failed to prove any other causes of action by a preponderance of the evidence.

4. **Interim (Phase Two) Order entered on July 3, 2024, redacted version filed on September 12, 2024 as Exhibit 9 to Defendant Singleton P.A.'s Motion To Dismiss Aetna's Application to Confirm Award and for Entry of Final Judgment [ECF No. 9-9]; *Aetna Life Insurance Co. v. Singleton Associates, P.A.*; United States District Court for the Southern District of Texas; Case No. 4:24-cv-02910.**

This is an attachment to RJN No. 2. RJN can be taken of the entire document for what it shows about Aetna's knowledge and assertions at the time of the document and referenced events. Below are several relevant excerpts:

> Page 2: After an Order is issued on Phase Three, the following issues shall be addressed: (1) entitlement to attorneys' fees and costs; (2) the amount of any attorneys' fees and costs to be awarded if any; (3) issues related to pre-judgment interest; (4) issues related to post-judgment interest, and (5) any remaining issues.
>
> Page 30: Aetna Health Inc. and Aetna Life Insurance Company (including on behalf of the plans that it administers) shall recover nothing from Radiology Partners, Inc., Radiology Partners Management LLC, and Radiology Partners Matrix, PLLC for the Core Claims… Radiology Partners Management LLC, Radiology Partners, Inc., and Radiology Partners Matrix, PLLC are not jointly and severally liable for the awards against Singleton Associates, PA.

5. **Excerpts from Singleton Associates, P.A.'s May 28, 2021 Arbitration Demand [ECF No. 9-1]; *Aetna Life Insurance Co. v. Singleton Associates,***

***P.A.*; United States District Court for the Southern District of Texas; Case No. 4:24-cv-02910.**

This document is an excerpt from Singleton's Arbitration Demand and contains an excerpt of the arbitration provision that is substantially identical to the arbitration provision in the contract between Aetna and MBB for the Contracted Period. As set forth in RJN Ex. 7, Aetna used this provision to support its motion for leave to add RP to the Texas arbitration, based on equitable estoppel and agency doctrines.

> Page 1: Section 10.2.2 of the Agreement specifies the basis for arbitration: Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole arbitrator in accordance with the AAA's commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different remit, and judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof…

Court-Related Arbitral Records

6. **Aetna's First Amended Counterclaim filed on January 27, 2022. (Excerpts filed on September 12, 2024 as Exhibit 4 to Defendant Singleton P.A.'s Motion To Dismiss Aetna's Application to Confirm Award and for Entry of Final Judgment [ECF No. 9-4]; *Aetna Life Insurance Co. v. Singleton Associates, P.A.*; United States District Court for the Southern District of Texas; Case No. 4:24-cv-02910).**

This is a document referenced in RJN No. 1 at p. 5, ¶ 12. Judicial notice can be taken of the entire document, filed by Aetna on January 27, 2022, for what it

shows about Aetna's knowledge and assertions at the time of the document and referenced events. Below are several relevant excerpts:

> Page 1: Respondents Aetna Health Inc. and Aetna Life Insurance Company ("Aetna") file this Amended Counterclaim against Claimant Singleton Associates, P.A. ("Singleton").
>
> Paragraph 3: As it turns out, Radiology Partners—a "national radiology practice" backed by billion dollar investment firms—acquired Singleton in 2014. Since then, Radiology Partners—who claims not to employ physicians—has controlled Singleton and, on information and belief, attempted to assume obligations under the Agreement (albeit invalidly), without telling Aetna. But worse, Radiology Partners engaged in a fraudulent scheme to obtain payments from Aetna (including from the employee-funded benefit plans it administers) that were not due to Radiology Partners under the Agreement, in order to maximize profits for its own corporate financial gain and those of its investors.
>
> Paragraph 4: First, Radiology Partners exploited the Agreement's percentage-of-billed-charges payment methodology by significantly raising billed charges on claims to obtain exceedingly high reimbursement rates. Furthermore, in order to obtain the Agreement's lucrative reimbursement for all of Radiology Partners' affiliated physicians interpreting images at Texas hospitals—including hospitals located far outside of the Houston area and radiologists practicing remotely in other states—Radiology Partners submitted the claims for those services under the Singleton TIN. These were not "Singleton" physicians, however, and most of them were part of physician groups under separate contracts with Aetna (i.e., under different TINs). Nevertheless, Radiology Partners knowingly submitted medical claims using the Singleton TIN for all of these physicians, causing claims to pay under the Agreement that were payable, if at all, under a different provider agreement and at a lower rate. Aetna did not know the truth regarding these claims at the time of payment. But despite Radiology Partners' continued efforts to hide the truth to this day, Aetna knows now, at least, that these claims should not have been paid to Radiology Partners as described herein.
>
> Paragraph 51: After the acquisition, RPI acquired other group radiology practices throughout the State of Texas, ranging from the Rio Grande Valley to the Dallas metropolitan area, for example, as well as all over the country.

> Based on information and belief, RPI's acquisition of these practices and assumption of control and management, including through RP Management, were structured in the same or in a similar manner as Singleton.
>
> Paragraph 56: At some point after acquiring Singleton, Radiology Partners started submitting claims for services for hundreds of radiologists who were neither employees of, nor shareholders nor partners in, Singleton. Rather, these physicians were affiliated with Radiology Partners through other group practices and/or other Radiology Partners affiliates. A significant number of these services (many thousands) were provided at facilities outside of the Houston market.
>
> Paragraph 58: Based on information and belief, Radiology Partners also billed for the remote services of physicians employed by RP Matrix—and not Singleton—under the Singleton TIN.

7. Aetna's Motion for Leave to File Third-Party Claims Against Radiology Partners Affiliates filed January 27, 2022 in the Arbitration, without the exhibits thereto.[1] (referenced in Ex. 1 to this RJN at p. 5, ¶ 12).

This is a document referenced in RJN No. 1 at p. 5, ¶ 12. Judicial notice can be taken of the entire document, filed by Aetna on January 27, 2022, for what it shows about Aetna's knowledge and assertions at the time of the document and referenced events. Below are relevant excerpts:

> Page 6: The Radiology Partners Affiliates are bound by the arbitration agreement under Texas law regardless of whether they signed the Agreement. "[C]ourts have held that so long as there is some written agreement to arbitrate, a third party may be bound to submit to arbitration." *Bridas S.A.P.I.C. v. Gov't of Turkmenistan ("Bridas I")*, 345 F.3d 347, 355 (5th Cir. 2003). "Ordinary principles of contract and agency law may be called upon to bind a nonsignatory to an agreement whose terms have not clearly done so." Id. at 356. In cases where, as here, the FAA applies, state law still governs

[1] If the Court wants the exhibits thereto Defendants will file them. But some may contain patient health information or other material warranting filing under seal, and the RJN does not seek judicial notice of them, so they were not included with this filing to conserve judicial resources.

who is "bound" by an arbitration agreement, and under Texas law, the Radiology Partners Affiliates are bound to the one here under direct-benefits estoppel and/or the alter ego doctrine. *See id*. at 355-56, 358-60; *Bridas S.A.P.I.C. v. Gov't of Turkmenistan ("Bridas II")*, 447 F.3d 411, 416-20 (5th Cir. 2006); *Wood v. PennTex Res., L.P.*, 458 F. Supp. 2d 355, 369-73 (S.D. Tex. 2006), aff'd sub nom. *Wood v. PennTex Res., L.P.*, 322 Fed. App'x 410 (5th Cir. 2009); *In re Weekley Homes*, 180 S.W.3d 127, 130-35 (Tex. 2005).

LOCAL RULE 3.01(g) CERTIFICATION

Pursuant to Local Rule 3.01(g), the undersigned certifies that counsel for Defendants conferred with counsel for Plaintiffs on February 24, 2025 by e-mail, and Plaintiffs oppose the relief sought herein.

Respectfully submitted this 25th day of February, 2025.

Glenn Solomon
Admitted Pro Hac Vice
Christopher Charles Jew
Admitted Pro Hac Vice
KING & SPALDING LLP
633 West Fifth Street, Suite 1600
Los Angeles, CA 90071
Telephone: 213-443-4355
Email: gsolomon@kslaw.com
cjew@kslaw.com

Sara Brinkmann
Admitted Pro Hac Vice
KING & SPALDING LLP
1100 Louisiana Street, Suite 4100
Houston, TX 77002-5213
Telephone: 713-751-3200
Email: sbrinkmann@kslaw.com

/s/Samantha J. Kavanaugh
Samantha J. Kavanaugh
Florida Bar No.: 0194662
Michael H. Thompson
Florida Bar No.: 1045189
KING & SPALDING LLP
Southeast Financial Center
200 S. Biscayne Blvd., Suite 4700
Miami, FL 33131
Telephone: 305-462-6000
Email: skavanaugh@kslaw.com
mhthompson@kslaw.com

Counsel for Defendants Radiology Partners, Inc. and Mori, Bean, and Brooks, Inc.

Dkt. 29-3

Exhibit 3

AMERICAN ARBITRATION ASSOCIATION

SINGLETON ASSOCIATES, PA	§	
	§	
VS	§	CASE NO. 01-21-0004-0763
	§	
AETNA US HEALTHCARE, INC *et al*	§	
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INTERIM (PHASE ONE) ORDER

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AMERICAN ARBITRATION ASSOCIATION

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	§	
VS	§	
	§	
RADIOLOGY PARTNERS, INC. *et al*	§	

INTERIM (PHASE ONE) ORDER

An in-person Phase One hearing commenced on January 9, 2023 and ended on January 28, 2023.[1] Thereafter, the parties filed post-hearing briefs on an agreed schedule.[2] Additional briefing was requested and received in April 2023. Having considered the prior orders entered in this matter, the testimony, the documents admitted in evidence,[3] the arguments of counsel, the elements of the causes of actions and defenses, and the briefing, this order is issued.

I. PARTIES

Radiology Partners, Inc. ("RPI") was founded in 2012 by several people, including [redacted]

Singleton Associates, P.A. ("SAPA") is a Texas entity that signed a Physician Group Agreement with Aetna U.S. Healthcare and its affiliates in 2002. [redacted], M.D. purchased SAPA in 2014.

Radiology Partners Management LLC ("RPM") is owned [redacted]

[1] Representatives of the parties and counsel for all parties appeared in person or remotely as reflected in the Hearing Transcript.
[2] The post-hearing briefs filed in February and March 2023 will be referred to as follows: Aetna's Initial Post-Hearing Brief (Aetna's Brief), SAPA's Initial Post-Hearing Brief (SAPA's Brief), Aetna's Response to SAPA's Brief (Aetna's Response), and SAPA's Reply to Aetna's Brief (SAPA's Reply).
[3] The documents admitted in evidence are reflected in the Hearing Transcript and the Order Relating to Exhibits and Evidence (2-3-23).
[4] "Radiology Partners Management" was frequently transcribed as "Radiology Partners management."
[5] [redacted]

[redacted]

Radiology Partners Matrix, PLLC ("Matrix"), an Oklahoma PLCC, is a professional medical practice that provides the professional component of remote teleradiology services through its licensed physician employees or independent contractors. Its sole member is [redacted], M.D. Matrix provided radiologists to staff some of the hospitals covered under SAPA contracts.[7]

In this order, Singleton will be referred to as "SAPA." RPI, RPM, and Matrix will be referred to as "RP." For convenience, SAPA and RP collectively will be called "SAPA/RP" or "RP/SAPA."

Aetna U.S. Healthcare, Inc. and its affiliates were the signatories to the SAPA Physician Group Agreement. The Respondents who answered and filed a counterclaim against SAPA were **Aetna Life Insurance Company** and **Aetna Health, Inc.** Those entities subsequently filed a First Amended Counterclaim and Third-Party Complaint and Demand in Arbitration against SAPA and the three RP entities. All Aetna entities will be called "Aetna."

II. OVERVIEW OF THE FACTS

SAPA and Aetna executed a Physician Group Agreement in 2002; this Agreement will be referred to as the Agreement or Stipulated Agreement ("SA"). The Agreement's initial term was three years; the Agreement automatically renewed for one-year unless written notice of non-renewal was given at least 180 days before the end of the then current term. (SA § 7.1). The Agreement was amended several times. The reimbursement rates changed over time from [redacted] of billed charges when the Agreement was signed to [redacted] of billed charges by 2019. Under the Agreement, SAPA was to provide Covered Services to Aetna's Members "through Participating Group Providers" and was to submit claims for Covered Services rendered to Members by "Participating Group Providers." (SA §§ 1.1, 3.4). Aetna was to process and pay claims submitted by SAPA for Covered Services provided by Participating Group Providers to Members of health plans that Aetna insured or administered. (SA § 3.1).

In 2002, SAPA radiologists provided radiology services to patients at two Houston hospitals: St. Luke's Episcopal Hospital, located on Bertner, and Texas Children's Hospital, located on Fannin. SAPA stopped providing services at Texas Children's at some point.

[redacted]

[6] [redacted]

[7] SAPA failed to prove by a preponderance of the evidence any cause of action against Matrix, which will likely be dismissed.

[redacted]

After [redacted] acquired SAPA, SAPA started obtaining exclusive Professional Services Agreements with many hospitals across Texas. It did so by contracting directly with the hospitals or by obtaining an assignment of the contracts from the radiology practices that held them. When SAPA obtained an assignment, it obtained an assignment of the entire agreement. [redacted]. After SAPA obtained an assignment of the agreement between a hospital and a group, it typically executed a new contract in its own name with the hospital shortly thereafter.

When SAPA had exclusive contracts with hospitals, SAPA staffed these hospitals in a variety of ways including by using (1) individual physician providers who were employees or independent contractors of SAPA, (2) radiologists provided pursuant to Professional Service Agreements (independent contractor arrangements) that SAPA had with radiology groups or other entities, and (3) locum tenens physicians, typically retained through a company.

SAPA submitted claims to Aetna for services provided at hospitals it staffed, using the electronic format that provided the HCFA 1500 information required by the Agreement. [redacted] The claims submission included the name, location, and NPI number of the hospital where the services were provided and the identity of the physician who provided the services and that physician's NPI number. When SAPA had a Professional Service Agreement with a hospital,[8] whether by direct contract or by assignment, and staffed the hospital as described in the preceding paragraph, the claims information named SAPA as the billing provider and provided SAPA's billing address, Taxpayer Identification Number, and NPI number. SAPA followed the same practice when billing all other Payors.

The claims information demonstrates that SAPA submitted claims to Aetna for services provided by radiologists at hospitals across Texas. SAPA billed Aetna for those services for many years, and Aetna paid those claims in the normal course of business until mid-2020.

Meanwhile, in late 2018 or 2019, [redacted] purchased the majority interest in [redacted] SAPA then obtained exclusive agreements to provide services to two hospital systems [redacted] previously held those agreements but assigned them to SAPA. The two hospital systems consented to the assignments effective September 2019. Later, SAPA and the hospital systems signed exclusive agreements, which became the governing documents. CX-819 and CX-820.

[8] The term "hospital" or "facility" may be used interchangeably.

Somewhat contemporaneously with [redacted] acquisition of [redacted], SAPA entered into a Professional Services Agreement with [redacted]. CX-968. Under the terms of this independent contractor agreement, effective September 1, 2019, SAPA engaged [redacted], and [redacted] agreed to be engaged, "to make available one or more Radiologists to provide Services as reasonably requested by SAPA for SAPA's customers." *Id.* at §1.1. The customers listed in the agreement included [redacted]

Beginning in May 2019, SAPA/[redacted] began adding or attempting to add [redacted] physicians to the Agreement. CX-8. Many of these physicians were [redacted] physicians with their "primary service street" and "primary service town" designated as [redacted].

By September 4, 2019, Aetna learned, through [redacted], that [redacted] would be billing under the SAPA TIN for services provided at [redacted]. Aetna Network Management for Houston and [redacted] discussed this matter internally. They decided that they would not add [redacted] physicians to the SAPA Agreement because they believed that the Agreement was limited to the Houston Market.[9] Aetna did not add the [redacted] physicians to the Agreement. From a preponderance of the evidence, Aetna did not tell SAPA, at that time, that Agreement was limited to the Houston Market, that SAPA/RP could not add [redacted] physicians to the Agreement, or that Aetna had not added the physicians to the Agreement. Based upon the preponderance of the evidence, SAPA was not told that the Agreement was limited to the Houston Market until sometime in 2020.[10]

As previously discussed, SAPA had contracts to provide radiology services at certain [redacted] hospitals pursuant to its exclusive agreements with their hospital systems (originally obtained by assignments from [redacted] that were approved by hospitals). SAPA fulfilled its obligations to provide radiologists to these hospitals primarily, if not exclusively, by using radiologists who were employed by or contracted with [redacted]. [redacted] provided these physicians to SAPA pursuant to [redacted] Professional Services Agreement with SAPA.

In 2019 and the first half of 2020, it was business as usual for the parties. SAPA did not know that Aetna had not added the [redacted] physicians to the Agreement. SAPA provided radiology services at the [redacted] facilities using Subcontracted Providers provided to SAPA by [redacted]. SAPA submitted claims for those radiology services under the SAPA TIN. The claims disclosed the names, addresses, and NPI numbers for the facilities where those services were being provided and the names of the physicians and NPI numbers for the physicians who were providing those services. Aetna paid those bills under the Agreement's [redacted] of billed charges reimbursement rate pursuant to its claims adjudication process, which

[9] At times, Aetna seemed to argue that the Agreement was limited to St. Luke's, Texas Children's, and Memorial Hermann facilities in Houston, but at other times, it used the term Houston Market. For convenience, the term Houston Market will be used.

[10] A June 10, 2020 email from Aetna to SAPA states that Aetna did not have a contract in the [redacted] Market. CX-85.

made payments based only on the Group's TIN.[11] SAPA took payment of claims by Aetna as confirmation that the physicians and service locations were acceptable to Aetna.

Things changed in 2020. Aetna employee [redacted] decided to review Physician Group Agreements for hospital-based radiologists in Houston. A number of those agreements (including SAPA's) were percentage of billed charges agreements, which were no longer acceptable to Aetna. By early 2020, Aetna had decided to renegotiate those agreements as it felt that the percentage of billed charges agreements placed Aetna at a competitive disadvantage with other payors.

In mid-2020, Aetna Network personnel learned that the amount it was spending for radiology services in [redacted] had increased substantially. Upon investigation, Aetna's network personnel learned that the explanation for the increase was that SAPA's claims for services provided at [redacted] were being paid at SAPA's [redacted] of billed charges reimbursement rate, rather than the lower rate in [redacted] agreement with Aetna. That occurred because Aetna's claims adjudication system paid based on the TIN provided on the claim. This was a surprise to Aetna personnel who apparently thought that, when Austin physicians were not added to the Agreement, the services they provided would not be reimbursed at the Agreement's reimbursement rate.

As a result of this discovery, Aetna intensified its efforts to renegotiate the SAPA-Aetna Agreement and began to seek information from SAPA/RP to use to recoup money previously paid to SAPA.

By letter dated August 14, 2020, Aetna sent notice, pursuant to Section 8.1 of the Agreement, that it was that it was changing the Agreement's reimbursement rate from [redacted] of billed charges to [redacted] of Then Current Houston, TX RBRVS Fee Based Schedule-Technical Rate" for certain CPT4 Codes and 100% of Aetna Market Fee Schedule for all other services, effective November 12, 2020. A-254. Later, the effective date of the change was moved to December 22, 2020. A-257.

Aetna was interested in negotiating a new contract. Beginning in September 2020, [redacted] and Aetna officials (including Aetna's [redacted]) exchanged emails and met remotely. These discussions were not productive. On October 13, 2020, [redacted]

[11] As stated in Aetna's discovery responses: "the claim system pays under the Tax Identification Number reported on a claim when the billing address, Pay To address, or the service address, which is distinct from the facility address, match, depending on the demographic information on the claim." Tr. 7: 2428. *See also* [redacted] Tr. 9: 3205-06 ("our systems were defaulting based on solely on the Tax ID number being in-network and the billing address being whatever, [redacted] For convenience, instead of saying that Aetna paid based on the Tax ID number and billing address, this order may say that Aetna paid based solely on the SAPA TIN with the understanding that includes the billing, "pay to," or service address.

notified Aetna that it was terminating the Aetna-SAPA Physician Group Agreement effective February 10, 2021. Meanwhile, the parties continued discuss a new contract without any success.

By the time the dust settled: (1) Aetna had exercised its right to unilaterally reduce the Agreement's reimbursement rate, effective December 22, 2020 as previously discussed;[12] (2) SAPA had terminated the Agreement effective February 10, 2021 as previously discussed, (3) Aetna decided to pay the Agreement's [redacted] of billed charges rate for between [redacted] physicians that it was willing to accept as being in the Houston Market through the termination date,[13] (4) Aetna changed its systems to begin paying a different reimbursement rate for physicians outside the Houston Market, and (5) Aetna began recoupments efforts and then paused them.

The parties were unsuccessful in resolving their billing dispute and did not negotiate a new agreement. Since the Agreement terminated in early 2021, SAPA has been out-of-network with Aetna but continues to provide services to Aetna insureds at out-of-network rates unless the parties negotiate a different rate on a case-by-case basis.

III. ARBITRATION DEMAND, COUNTERCLAIM, AND THIRD-PARTY CLAIM

Arbitration Demand

SAPA invoked the arbitration provision of the Agreement and filed an arbitration demand against Aetna, seeking, among other things, to recover damages for all the incorrect non-payments, underpayments, and recoupments that Aetna caused.[14] (Demand ¶16). SAPA alleged that Aetna breached the terms of the Agreement and violated the Texas Prompt Pay Act. The dollar amount of SAPA's claim was "in excess of ten million dollars."

Aetna's First Amended Counterclaim and Third-Party Complaint

Aetna answered the demand, brought a counterclaim against SAPA, and stated that the amount of Aetna's counterclaim was more than $20 million. Subsequently, Aetna brought an amended counterclaim against SAPA and a third-party demand against the RP entities on its own behalf as the provider of fully-insured health plans and as claims administrator for self-funded, employer-established health plans. Aetna alleged causes of action for breach of contract, tortious interference, fraud, fraudulent inducement, negligent misrepresentation, money had and received

[12] In December 2020, Aetna decided to cancel the rate reduction and allow SAPA to remain under the existing [redacted] billed charged reimbursement rate for services provided by physicians in the Houston Market. Tr. 8:3109.
[13] Two points of uncertainty may need to be addressed in Phase Two. First, the number of physicians that Aetna determined were in the Houston Market. At one point, the [redacted] number was discussed and, at another, a [redacted] number was discussed. Second, while Aetna intended use the [redacted] POC reimbursement rate for Houston Market physicians until the contract terminated, it is not clear whether that happened. A-108, pp. AO11429 and AO11431.
[14] SAPA alleged that Aetna identified more than $29 million in allegedly incorrect payments to SAPA and that SAPA had, at that time, identified close to $500,000 in improper recoupments. (Demand ¶¶ 5, 11).

(in the alternative), unjust enrichment (in the alternative), and alter ego.[15] Aetna later stated that the amount of its counterclaim/third party demands was eighty-three million dollars.[16]

IV. SIGNIFICANT PRE-HEARING RULINGS

Order on Jurisdictional Issues (4/4/22)

The parties' respective motions/objections on jurisdictional claims were denied. In its post-hearing briefs, Aetna reurged its motion/objection; the reurged motion/objection to jurisdiction is denied.

Order on Motion to Stay, Bifurcate, and Phase (4/5/22)

Certain issues were bifurcated. Bifurcated issues included the following: (1) SAPA's "other claims" as set forth in paragraphs 43 to 48 of its Demand, (2) damages claims, and (3) Aetna's Alter Ego claim.

SAPA's "other claims" were claims other than those related to the claim that the Agreement was limited to the Houston Market." (Demand, ¶ 43). As the case developed, the parties addressed the Subcontracted Provider issue in their motions for summary judgment, their evidence, and their post-hearing briefs. The Subcontracted Provider issue is addressed in this Phase One order.

Order on Selection of Sample Bills and Production of Documents Related to those Sample Bills (4-8-22)

In addition to the discovery permitted under the scheduling order, additional discovery was permitted pursuant to this order, which included discovery pertaining to certain Sample Bills.

Order on Singleton's Motion for Partial Summary Disposition on the Houston Argument and Aetna's Cross-Motion (9-13-22)

The summary judgment order stated that the Agreement does not contain a geographic restriction that limits the facilities where SAPA provides services to those located in Houston or the Houston Metro area.

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[15] In its post-hearing briefs, Aetna used the term "fraudulent nondisclosure" rather than "fraudulent inducement" and argued "Had and Received," but did not separately argue "Unjust Enrichment."

[16] Aetna states that the $83 million is based on the total amount paid by Aetna on the disputed claims. Aetna has acknowledged that it owes something on the claims but alleges that it is unable to calculate the correct amount without more information.

Order on Singleton's Motion for Summary Disposition on Subcontracted Provider Issue and Aetna's Cross-Motion (9-13-22)

The summary judgment order stated that the Agreement does not authorize the use of subcontractors except as provided in Section 2.2 of the Agreement and Section F (more precisely Section I(F)) of the Specialist Physician Participation Criteria Schedule ("SPPCS"). (SA, p. 24).

Order on Issues to be Tried in Phase One (12/21/22)

Since damages, certain "Other Claims," and "Alter Ego" will be addressed in Phase Two, the causes of action to be tried in Phase One are:

a. The causes of actions raised in SAPA's Demand other than SAPA's Other Claims and Aetna's defenses to those causes of action. However, as noted previously, the Subcontracted Provider issue was tried by the parties and will be addressed in this order.

b. The causes of action raised in Aetna's First Amended Counterclaim and Third-Party Complaint and Demand in Arbitration, except for Aetna's Alter Ego Claims, and any defenses thereto.

V. AETNA'S BREACH OF CONTRACT CLAIM

SAPA and Aetna sued each other for breach of the 2002 Physician Group Agreement. SAPA's Phase One breach of contract claims relate to Aetna changing its systems in the summer or fall of 2020 to begin paying less than the Agreement's [redacted] of billed charges reimbursement rate for physicians located outside of Houston and for related recoupments that Aetna made.[17] Aetna alleges that SAPA breached the Agreement by billing under SAPA's TIN for services provided outside the Houston Market, by its use of Subcontracted Providers, and in various other respects. SAPA contends that the Agreement covered all SAPA physicians (employed and contracted) and all locations (statewide) and that Aetna breached the Agreement to the extent it did not pay the Agreement's reimbursement rates for all physicians and locations and to the extent that it recouped any payments previously made.

[17] SAPA argues it was Aetna who chose to apply the Agreement to all locations and physicians, noting that SAPA's bills did not state whether the bills were in or out of network and did not identify a specific Aetna agreement applicable to the bills. (SAPA's Reply, pp. 3-6). [redacted]

All SAPA's breach of contract allegations against Aetna overlap with some of Aetna's breach of contract allegations. Accordingly, SAPA's breach of contract claims will be addressed as part of or following the discussion of Aetna's breach of contract claims and SAPA's defenses.

A. Breaches Alleged by Aetna

Aetna alleges that SAPA breached the Agreement in the following respects: (1) by billing for physicians who were not Group Providers; (2) by billing for physicians and locations not approved by Aetna; (3) by failing to provide the notice required under Section 1.4; (4) by failing to provide the notice required under Section 1.5; and (5) by refusing to return overpayments as required by Section 3.1.

1. Billing for Services of Physicians who were not Group Providers

The parties contracted for "Participating Group Providers" to provide Covered Services to Aetna's Members. (SA § 1.1). SAPA agreed to "submit claims to [Aetna] for Covered Services rendered to Members by Participating Group Providers." (SA § 3.4). Aetna agreed to pay, or when it was not the applicable Payor to notify each Payor to pay, Group for Covered Services rendered to Members by Participating Group Providers. (SA § 3.1).

[redacted]

SAPA submitted claims for SAPA employees and Subcontracted Providers.[18] SAPA's employees were Participating Group Providers ("PGPs"). (SA §§ 12.8, 12.10). A key issue is whether Subcontracted Providers were PGPs.

a. Definition of PGP

The Agreement was [redacted]

[redacted]

[18] In this Interim Order, the term "Subcontracted Providers" includes Subcontracted Providers and subcontractors.

licensed physicians in your Group ("Participating Group Providers") will furnish Covered Services to Members . . ."

SAPA argues that Subcontracted Providers are PGPs.[19] SAPA essentially argues that there are two definitions of Participating Group Providers (one in the letter on page 2 of the Agreement and one in the Definitions section of the Agreement) and that the first definition governs.[20] (SAPA's Brief, pp. 9-13).

While the letter is part of the Agreement, there are not two definitions of Participating Group Provider; the term is defined once and that is in the Definitions section of the Agreement. (SA §12.10). The Agreement unambiguously provides that Group Providers and Participating Group Providers must be employees, shareholders, and partners of the Group. (SA §§ 12.8, 12.10). The parenthetical ("Participating Group Provider") on page two does not define the term "Participating Group Provider" as "all licensed physicians in your Group," although that phrase is consistent with the definition of PGP. Rather, the parenthetical, "Participating Group Provider," on page 2 emphasizes the requirement that the licensed physicians in the group be Participating Group Providers as defined in the Section 12.10 of Agreement. That conclusion is supported by the other provisions of the Agreement, which require preapproval of Subcontracted Providers and require that the language in Exhibit A be included in any agreements that SAPA has with Subcontracted Providers. *Evanston Ins. Co. v. Atofina Petrochemicals, Inc.* 256 S.W.3d 660 (Tex. 2008), cited by SAPA, is distinguishable as that case involves the construction of exceptions and limitations on an insurance policy and, in those cases, special construction principles require such provisions to be strictly construed against the insurer and in favor of the insured. *Id.* at 668. *Gonzalez v. Mission American Ins. Co.*, 795 S.W.2d 734, 737 (Tex. 1990) is inapplicable as this Agreement is unambiguous.

Additionally, even if the definition of PGP was the "licensed physicians in your Group," SAPA's Subcontracted Providers would not be PGPs as they are not physicians in SAPA's Group. Rather, they are SAPA's independent contractors, who received 1099s from SAPA, or were employees or contractors of other Groups or entities, who paid them and issued W-2s or 1099s to them.[21] Subcontracted Providers were not in SAPA's Group, regardless of whether the "definition" on page 2 or the definition in Section 12 is used.

Subcontracted Providers were not PGPs.

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[20] SAPA does not appear to have made this claim in the summary judgment filings on the Subcontracted Provider issue.

[21] Sometimes a physician might be an employee, and, at other times, the same physician might be a Subcontracted Provider.

b. Subcontracted Providers

The summary judgment order provided that the Agreement does not authorize the use of Subcontracted Providers except as provided in Section 2.2 of the Physician Group Agreement and Section F of the Specialist Physician Participation Criteria Schedule ("SPPCS"). SAPA contends that Section F (more specifically Section I(F)) is inapplicable because this case does not involve the use of specialists retained by individual physicians; rather it involves the use of specialists retained by a Group. Additionally, SAPA challenges the summary judgment order with respect to the finding that Section 2.2 requires preapproval, citing the testimony of [redacted] While the parties have different interpretations of that testimony, [redacted] clearly testified that "subcontractors had to be approved." Tr. 12:4270. Further, [redacted] testimony does not change the meaning of the unambiguous language of the Agreement: "Regarding the use of subcontractors, other than locum tenens, Group must obtain the approval of the Company prior to utilizing any subcontractors to provide Covered Services to Members." (SA, § 2.2). *See also* Summary Judgment Order on the subcontracted provider issue.

Pre-approval of Subcontracted Providers by Section 2.2 and by Section I(F) (when applicable) was required. SAPA's participation in the enrollment process by adding physicians did not satisfy the pre-approval requirement of the Agreement because SAPA did not inform Aetna that any of its providers were Subcontracted Providers or obtained pre-approval to use them. SAPA argues that "the industry standard process for communicating acceptance or approval in the managed care industry is for a health plan to pay or deny a physician's initial bills involving that Physician." (SAPA's Brief, pp. 44-45). Even if it is, after-the-fact approval of a physician by payment of a claim is not the pre-approval required by the Agreement, which is approval "prior to utilizing any subcontractor to provide Services to Members."

The preponderance of the evidence establishes that SAPA did not notify Aetna that it was using Subcontracted Providers or request pre-approval, and Aetna did not pre-approve the use of SAPA Subcontracted Providers.

SAPA contends that it substantially performed "its most material obligation under the Agreement of providing quality professional radiology services to Aetna's Members." (SAPA's Brief, p. 35). "The doctrine of substantial compliance excuses contractual deviations or deficiencies which do not severely impair the purpose underlying the purposes of the contractual provision." *Burtch v. Burtch,* 972 S.W.2d 882, 889 (Tex.App.—Austin 1998, no pet.).

While the provision of quality radiology services is no doubt important, other

considerations were equally, if not more, important to Aetna. These considerations included Network Management and reimbursement rates. Aetna wanted to know who was in its network, including whether Subcontracted Providers were rendering services to Members, so that it could manage its network and reimbursement rates and thereby be competitive in the marketplace. The CFOs and HR personnel who negotiated with Aetna did not have "quality" on their contract negotiation spreadsheets; their decisions "economically-driven" based on rates and network match. Tr. 12:4109.

SAPA also contends substantial performance is "substantiated by Aetna's behavior during the Agreement, including that Aetna did not treat any deficiency in Singleton's performance as material." (SAPA's Brief, p. 35). But the preponderance of the evidence established that Aetna did not know that SAPA was using Subcontracted Providers. Thus, Aetna's behavior does not establish that the breach was immaterial.

SAPA also argues that any breach of the requirement to obtain preapproval was immaterial because Aetna did not care whether care was provided by Subcontracted Providers or employees.[22] "In determining the materiality of a breach, courts will consider, among other things, the extent to which the nonbreaching party will be deprived of the benefit that it could have reasonably anticipated from full performance." *Hernandez v. Gulf Group Lloyds,* 875 S.W. 2d 691, 693 (Tex. 1994). "The less the non-breaching party is deprived of the expected benefit, the less material the breach." *Id.*

In support of its position that Aetna did not care whether Subcontracted Providers were used, SAPA points out that Aetna never asked whether its providers were employees, shareholders, partners, or Subcontracted Providers. Nevertheless, the preponderance of the evidence established that the breach of the provision requiring SAPA to obtain preapproval for the use of Subcontracted Providers was material. It was part of Aetna's network management, including its efforts to have reimbursement rates that allowed it to be competitive in the marketplace. If SAPA had requested preapproval of Subcontracted Providers, many of whom were providing services outside the Houston Market, Aetna Network would have learned that (1) SAPA was using the services of Subcontracted Providers, who were current or former members of groups that had lower reimbursement rates, but was billing those radiologists at Agreement's higher reimbursement rate, and (2) SAPA was billing under its TIN for services provided outside of the Houston Market, which Aetna believed was prohibited under the Agreement, and was being paid at rates above the market rate in those markets. Based upon the preponderance of the evidence, upon learning this information, Aetna would have attempted to renegotiate its Agreement with SAPA to have separate Agreements for each market at

[22] Many of the provisions were put in place as a result of an Agreement between Aetna and the Texas Attorney General. (SA p.1). In bold italicized print, the Agreement required that any Group or Participating Providers who contract with any Subcontracted Provider must agree to comply and ensure that all Subcontracted Providers comply with Exhibit A. (SA § 1.3). Exhibit A (also in italics and bold print) provides the language that SAPA was required to use in its Subcontracted Provider Agreements. (SA, pp. 20-21).

competitive rates in each market and, if negotiations were unsuccessful, Aetna would have terminated the Agreement.

Based upon the contract and the preponderance of the evidence, SAPA breached the Agreement with respect to its use of Subcontracted Providers without preapproval from Aetna.

c. Section 11.7

Aetna contends that SAPA violated Section 11.7 of the Agreement, which provides that the Agreement shall not be assigned, subcontracted, delegated, or transferred by Group. (Aetna's Brief, p. 10). SAPA observes that the focus of the provision was "entity-level transactions, not subcontracting for doctors," citing the testimony of [redacted] who testified that Section 11.7 refers to "major events such as assignment, delegation, or transfer of the Agreement in toto to another entity." Tr. 12:4288-4289. Based upon the language of the Agreement and a preponderance of the evidence, SAPA did not assign, delegate, or transfer this Agreement in toto (or otherwise) to another entity in violation of Section 11.7.

d. Section 2.1

Aetna alleges that SAPA used other provider groups to perform its services in violation of section 301.006(a) of the Texas Business Organizations Code and thereby violated Section 2.1 of the Agreement. (Aetna's Brief, pp. 12-13). Section 2.1 states: "Group represents and warrants that . . . it and Participating Group Providers shall comply with all applicable laws and regulations related to this Agreement, including, but not limited to, laws related to fraud, abuse, discrimination, disabilities, confidentiality, self-referral, false claims and prohibitions of kickbacks . . ."

Section 301.006 provides that "[a] professional association . . . may provide a professional service in this state only through owners, managerial officials, employees, or agents, each of whom (1) is a professional individual; and (2) is licensed in this state to provide the same professional service provided by the entity." TEX. BUS. ORGS. CODE § 301.006(a)(1). Aetna's contention is that "in most instances where SAPA alleged the use of 'Subcontracted Providers' it contracted with another provider group and not a 'professional individual.'" (Aetna's Brief, p. 12). The parties engage in a lot of back and forth about whether or not the physicians are agents of the group or independent contractors. Based on the parties' briefing, there is no case law that addresses this issue.

Aetna's complaint is a highly technical complaint. From a preponderance of the evidence, the services were provided by appropriately licensed and credentialed personnel; Aetna's [redacted]/expert stated that quality of care was not an issue.

In this case, SAPA negotiated contracts with groups and entities that provided radiologists to SAPA for its use in staffing hospitals that SAPA had under contract. For example, SAPA engaged [redacted] and [redacted] agreed to be engaged by SAPA, "to make available one or more

Radiologists to provide services as reasonably requested by SAPA for SAPA's customers." CX-968. [redacted] was not performing the services; rather [redacted] was providing radiologists to SAPA to perform services.

Even if SAPA violated section 301.006 when it contracted with a physician group to provide radiologists, which is far from certain, the cases cited by Aetna to show that it has an actionable cause of action for the alleged statutory violation are not on point. In both of those cases, the plaintiffs suffered actual damage from the violations. *See Bernard v. L.S.S. Corp,* 532 S.W.3d 409 (Tex. Civ. App.—Austin 1976, writ ref'd n.r.e.) (damages to personal guarantors caused by a violation of the law leading to foreclosure of the landlord's property); *Thornton v. Arlington Indep. School Dist.*, 332 S.W.2d 395 (Tex. Civ. App.—Fort Worth 1960, writ ref'd n.r.e.) (affirming award of delay damages caused by failure to obtain necessary permits which, in turn, was caused by failure to comply with City requirements for licensing electricians). Unlike *Bernard* and *Thornton*, Aetna sustained no damage caused by any failure to comply with section 301.006 of the Texas Business Organizations Code. There was no breach or actionable breach of Section 2.1.

To summarize, Subcontracted Providers were not PGPs under the Agreement. SAPA was required to obtain pre-approval for the use of Subcontracted Providers. Aetna proved by a preponderance of the evidence that SAPA breached the Agreement to the extent that it added and used Subcontracted Providers without obtaining pre-approval from Aetna. Aetna failed to prove by a preponderance of the evidence that SAPA violated Sections 11.7 or 2.1 of the Agreement.

2. Billing for Physicians and Facilities that were not "approved"

Aetna alleges that SAPA "billed for the services of hundreds of physicians that were not 'approved' by Aetna at hundreds of facilities that were not 'approved' by Aetna." (Aetna's Brief, p. 14). The terms "approve," "approved," and "approval" are used several times in the Agreement. Relevant to this issue is the use of the term "approval" in Sections 1.7 and 2.2. The phrase "accepted" is used in the definition of Participating Group Provider, but the term "approved" is not used. (SA § 12.10). Aetna sometimes uses the phrase "approved and accepted" or similar language; that phrase is not used as such in the Agreement.

a. Approved Facilities

Aetna originally contended that services were improperly provided at locations outside of the Houston Market, but the summary judgment order establishes that there was no geographic restriction.

Aetna contends that SAPA breached the Agreement by submitting claims for services provided at facilities that were not approved by Aetna. The Summary Judgment order stated that "Singleton may provide services at facilities approved in advance by Aetna, which include

Participating Hospitals. . ."[23] Participating Hospitals include any hospital which has a current valid contract to provide Covered Services to Members. [redacted] Aetna's contention that SAPA breached the Agreement by providing services at Participating Hospitals is without merit.

Aetna also contends that SAPA breached the Agreement by submitting claims, under this hospital-based physician agreement, for services provided at facilities that were not hospitals. It is not necessary to decide that issue. If Aetna is correct, any such claims (as well as any claims that services were provided at hospitals that were not Participating Providers or were not provided at approved facilities) are barred by SAPA's ratification, waiver, and quasi estoppel defenses as discussed in greater detail later in this Interim Order.

b. Approved Physicians

Despite the summary judgment order that there was no geographic restriction in the Agreement and the definitions in Sections 12.10 and 12.11, Aetna argues that physicians must be accepted and approved by Aetna to be added to the Houston Market. Aetna cites [redacted] testimony. After [redacted] discussed Sections 12.8 and 12.10, she was asked why Aetna would have included those definitions in its SAPA contract and she replied: "It's important for us to know who is covered under a contract. It's important for us to also accept and approve who is added to the contract." Tr. 7:2504.

Section 12.10 of the Agreement provides that Participating Group Provider is a "Group Provider who has been *accepted as a Participating Provider* by the Company." (emphasis added). A "Participating Provider is "[a]ny physician . . . or other individual or entity involved in the delivery of health care or ancillary services who or which has *a current valid contract* to provide Covered Services to Members." (SA §12.11) (emphasis added).

The Agreement states that a Participating Group Provider is a Group Provider who has been "accepted" as a Participating Provider, which means that the physician must have a current valid contract to provide Covered Services to Members. This provision does not require that a physician be "accepted" and/or "approved" for a specific contract such as the Aetna-SAPA contract or a specific market to be accepted as a Participating Provider. Thus, under the Agreement, a PGP is an employee, shareholder, or partner who has been accepted as a Participating Provider by virtue of having a current valid contract with Aetna.

Aetna had an enrollment process for providers to use to enroll or add physicians or make changes as required by Section 1.5 of the Agreement and Section I(B)(1) of the SPPCS. SAPA used this process to add physicians to its Group. Aetna used it internally to approve adding a physician to a particular contract in a specific market. For example, a Network Manager would

[23] The summary judgment order referenced Participating Hospitals, rather than other Participating Provider entities, because, at the time, there appeared to be no contention that SAPA billed for services provided at entities other than hospitals.

notify PDS, another Aetna department, that it approved adding a SAPA physician to the SAPA contract in the Houston Market.

To Aetna, the enrollment process focused on what was variously described as enrolling, linking, or adding providers to a particular contract and market. But to SAPA, the information was submitted to add a physician to the Group—not to a market.

Regardless of what Aetna or SAPA thought about the enrollment process, the Agreement governs. The Agreement states that a physician must be "accepted" as a Participating Provider, which means that the physician must have a current valid contract to provide Covered Services to Members. It does not require physicians to be "approved" by Aetna to be added to a specific market and contract.

Being "accepted by Aetna as a Participating Provider by the Company" by virtue of having "a current valid contract to provide Covered Services to Members" is not the same thing as being added to a specific contract or market with the approval of a network manager. (SA §§ 12.10, 12.11). That conclusion finds support in the testimony of [redacted]. When answering a question about why Section I(F) of the SPPCS required subcontractors to be Participating Providers, he replied: "Well, if they are going to subcontract for the short-term coverage of Aetna patients, it's helpful to Aetna to have doctors that are already under contract that have passed credentialing when that applies, and that are loaded into our systems, and understand Aetna's policies and procedures." Tr. 12:4135.

SAPA did not breach the Agreement by billing under its TIN for facilities or physicians who were not "approved by Aetna."[24]

3. Failing to provide Section 1.4 Notice

Aetna contends that SAPA breached Section 1.4 by failing to notify Aetna of significant changes in the Group's capacity, including mergers and acquisitions. Section 1.4 provides:

[redacted]

[24] This "approval" is different than the "pre-approval" required for Subcontracted Providers." (SA § 2.2).

(SA § 1.4) (emphasis added).

This provision does not require SAPA to notify Aetna of mergers or acquisitions. Nor does it require SAPA to notify Aetna of "any significant changes in the capacity of the Group." Rather, the requirement is for SAPA to notify Aetna "if there are any significant changes in the capacity of the Group to provide or arrange for the provision of Covered Services for Members."

Based on the language of the provision and the preponderance of the evidence, SAPA did not breach Section 1.4 by failing to notify Aetna of the Group's increased capacity or its mergers and acquisitions.[25]

4. Failing to comply with Section 1.5

Section 1.5 provides in pertinent part:

[redacted]

Applying principles of contract construction, this provision does not require SAPA to give formal written notice to the notice address when providing the list of the physicians or additions of physicians. Further, the preponderance of the evidence establishes that SAPA gave Aetna its list in 2002 as required by the Agreement and subsequently provided physician additions as required by the Agreement via Aetna's enrollment process as requested by Aetna.

a. Enrollment Process

Aetna's discovery responses stated that "Aetna has no policies and procedures relating to the enrolling, re-enrolling, or changing the enrollment of a radiologist who is a member of a group and is a hospital-based physician."[26] CX-53 (Aetna's Amended Response to SAPA's First RFP 12).

The ways that Aetna's Network Managers accepted physician additions changed over time. Initially, it was by letters, faxes, and emails. Later, it included demographic spreadsheets,

[25] If that were required, SAPA provided Aetna information from which Aetna could have determined that SAPA had an increase in capacity including the February 2018 presentation to at least one Network Management Executive (Samantha Townsend) and others. Also, the increased capacity would have been evident from the claims data and the TDI report, which revealed that SAPA was providing state-wide services.

[26] The parties used the terms "enrolled," "added," and "linked" in describing this process.

portals, and rosters.[27] In 2016, Aetna's [redacted] asked SAPA to use a spreadsheet ("Demographic Spreadsheet" or "spreadsheet"). A-275. The spreadsheet was subsequently revised from time to time. Then, the requirement to add physicians was eliminated altogether for a time: "The providers listed below came from the Aetna onboarding tool ad an indicator that they are joining the group—at this time, we don't have to load them to the agreement." CX-4.

Aetna alleges that the proper way to notify Aetna was to submit a roster by email to Network Management: "Importantly, Aetna's 2020 manual requires the use of rosters." (Aetna's Response, p. 13 fn 19). That manual was dated November 2020, only a couple of months before the Agreement terminated. The evidence indicated that a new government mandate, effective January 1, 2021, required Aetna to print all hospital-based physicians in their directory. That likely heightened the interest in rosters for hospital-based physicians in 2020.

Aetna's reliance on rosters to add physicians during the relevant time period is contrary to Aetna's discovery responses which state "additions, terminations, and updates to the demographics of hospital-physician groups were made through the submission of a completed Demographic Add/Change/Term Excel spreadsheet" and "[a]dditions were approved or denied, as applicable, based on the information provided in the spreadsheet, and physicians were loaded, termed or modified in the provider record, as applicable, through systems maintained by Aetna's Provider Data Services (PDS)." CX-49 (Aetna's Answers to Interrogatory 2).

b. Enrollment of Physicians

Aetna argues that SAPA failed to prove by a preponderance of the evidence that its physicians were approved, but as previously discussed, there was no contractual requirement that physicians be approved other than the preapproval requirement for Subcontracted Providers. The issue here is whether SAPA complied with the requirement to add physicians as required by Section 1.5 and the SPPCS.

Aetna had the burden of proof on its claim that SAPA failed to comply with Section 1.5. Thus, Aetna had to prove by a preponderance of the evidence that SAPA failed to provide the initial list and failed to notify Aetna of additions, although SAPA had this burden on its affirmative claims. Regardless of whose burden it was, the preponderance of the evidence shows that SAPA complied or substantially complied with the Section 1.5 requirements by providing its initial list to Aetna and by notifying Aetna of its additions.[28]

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[27] Aetna addresses SAPA's apparent confusion with the process. [redacted]

[28] The doctrine of substantial compliance excuses exactitude in the performance of contractual duties where any deviations or deficiencies do not seriously impair the purpose of the underlying contractual provision. *James Const. Group, LLC v. Westlake Chem. Corp.*, 650 S.W. 3d 392, 405 (Tex. 2022).

[redacted], testified that SAPA utilized its [redacted] system to integrate its practices and facilities. Tr. 3:983. As part of that process, SAPA/RP personnel enrolled physicians in Medicare and Commercial Plans, including Aetna's. [redacted] testified to her belief that most of the [redacted] providers on the list of providers that SAPA provided Aetna in [redacted] were enrolled. Tr. 3:1015. Her testimony that SAPA diligently enrolled physicians with health plans. including Aetna's, was consistent with considerable evidence that showed that SAPA was very attentive to making sure that it performed all steps necessary to onboard physicians.

[redacted] testimony was also supported by the evidence that Aetna identified between [redacted] SAPA physicians in the Houston Market. Additionally, one of Aetna's spreadsheets (CX-8) contains the names of more than [redacted] physicians that SAPA attempted to enroll. This alone accounts for over [redacted] physicians and does not include any of the other documented requests or take into account that, for a time, Aetna told SAPA it was not necessary to load physicians at all.

It is not surprising that very few enrollment documents were produced. Neither party retained or expected each other to retain documentation of the specific requests, and it appears that they did not do so. SAPA relied, in part, on payment of claims as evidence that physicians were enrolled. Aetna's [redacted] testified that one of ways that a provider could confirm enrollment was Aetna's payment of claims.

The preponderance of the evidence establishes that SAPA complied with Section 1.5 by providing its initial list of physicians and then complied or substantially complied with the requirement that SAPA provide Aetna with physician additions.[29]

5. Violating Section 3.1

Between November 2020 and May 2021, [redacted] on behalf of Aetna, sent letters to SAPA demanding that SAPA return alleged overpayments, [redacted]. The stated overpayment reason was "Claims were incorrectly submitted under the Singleton Associates, P.A. Tax Identification Number."

SAPA did not return the alleged overpayments. Thus, Aetna contends that SAPA violated Section 3.1 of the Agreement, which states: [redacted]

[29] Aetna argues that "[e]vidence of the parties' course of performance in this case further supports the reasonable interpretation that Aetna had to approve new physicians at new locations." (Aetna's Brief, p. 17). That is not a reasonable interpretation of the parties' course of conduct. SAPA was adding physicians—it was not seeking to have physicians approved to be added to a particular market or location. The Agreement did not contain any geographic restrictions and, when SAPA added physicians, it listed their hospital affiliations, which was strong evidence that they were practicing in locations outside of Houston.

[redacted]

This provision is inapplicable. This part of Section 3.1 speaks to a situation where the Group identifies an error, such as when "Aetna mistakenly pays more than the necessary amount on a claim or erroneously makes a payment it was not required to make." *Itani v. Viant, Inc.*, No. 4:10-CV-852-Y, 2012 WL 13019683, *4 (N.D. Tex. Sept. 4, 2012). This provision does not require SAPA to notify Aetna when Aetna, rather than SAPA, has identified alleged overpayments or payments made in error, particularly when SAPA does not believe there were any overpayments or payments made in error. Furthermore, this provision does not require SAPA to return overpayments within ten days. SAPA did not breach Section 3.1.

6. Summary pertaining to SAPA's alleged breaches

Aetna proved by a preponderance of the evidence that SAPA breached the Agreement with respect to the requirement that Group obtain the approval of Aetna before utilizing Subcontracted Providers to provide Covered Services to Members. Aetna failed to prove any other breaches by a preponderance of the evidence.

B. SAPA's Defenses to Aetna's Breach of Contract Claims

SAPA argues that Aetna's breach of contract claims are barred by ratification, waiver, and quasi-estoppel, Section 3.1, and state and federal regulations. SAPA had the burden of proof on its affirmative defenses. *White v. Harrison,* 390 S.W. 3d 666, 672 (Tex. App.—Dallas 2012, no pet.).

1. SAPA's Ratification Defense

SAPA contends that Aetna ratified the Agreement as to all physicians (including Subcontracted Providers) and all locations by paying Aetna's claims for all locations and all physicians. "The elements of ratification are: (1) approval by act, word, or conduct; (2) with full knowledge of the facts of the earlier act; and (3) with the intention of giving validity to the earlier act." *Motel Enterprises, Inc. v. Nobani*, 784 S.W.2d 545, 547 (Tex. App.--Houston [1st Dist.] 1990, no writ); "A party ratifies an agreement when—after learning all of the material facts—he confirms or adopts an earlier act that did not then legally bind him and that he could have repudiated." *White,* 390 S.W. 3d at 672. Under Texas law, once a party ratifies a contract, it may not later withdraw the ratification and seek to avoid the contract. *Missouri Pac. R.R. Co. v. Lely Dev. Corp.*, 86 S.W.3d 787, 792 (Tex.App.--Austin 2002, pet. dism'd).

a. All Locations

For reasons previously discussed, it is not necessary to address the ratification issue with respect to geographic restrictions or preapproval of Participating Providers.

But, even if or when the Agreement had contained a geographic restriction, a restriction on the type of facility, or an approval requirement for facilities,[30] Aetna ratified the Agreement with respect to "all locations," meaning that Aetna ratified as to all geographic locations and all facility types, regardless of whether they were "approved" by Aetna.

SAPA's enrollment information disclosed that its physicians practiced at hospitals throughout the state. Further, SAPA submitted many claims (SAPA says hundreds of thousands) each of which disclosed the name, address, and NPI for the facility where the services were provided. Based on this information and its own databases, Aetna would have known the location of the facility, the type of facility, and whether the facility was a Participating Provider or otherwise approved. Aetna paid SAPA's claims even when the claims disclosed, for example, that the services were being provided outside of the Houston Market. Aetna Network Managers submitted at least one report to the Texas Department of Insurance that showed that SAPA provided services at facilities throughout Texas at in network rates.

Aetna disregarded its enrollment information. More importantly, Aetna made a conscious decision to set up its claims adjudication system to disregard service facility location information that was provided in the claims and pay based solely on the billing provider's TIN and billing address.

SAPA proved by a preponderance of the evidence that Aetna ratified the Agreement as to all locations, all types of facilities, and any approval requirement for facilities. Having ratified the Agreement in this regard for many years, Aetna could not withdraw the ratification.

b. Subcontracted Providers

SAPA contends that Aetna ratified the Agreement's application to all SAPA physicians (including Subcontracted Providers) by paying SAPA's bills under the Agreement's rates. (SAPA's Brief, p. 31). SAPA failed to prove by a preponderance of the evidence that Aetna knew that it was using Subcontracted Providers. SAPA did not disclose to Aetna that it was using Subcontracted Providers and did not obtain the necessary pre-approval. Aetna did not ratify the Agreement as to Subcontracted Providers with full knowledge of the facts. SAPA failed to prove by a preponderance of the evidence the elements of a ratification defense as to Subcontracted Providers but did prove it as to "all locations."

2. SAPA's Waiver Defense

SAPA contends that Aetna waived any arguments about limiting the Agreement to a subset of SAPA's locations and physicians. (SAPA's Brief, p. 33). "Waiver occurs when a party intentionally relinquishes a known right or engages in conduct inconsistent with claiming that right." *Eagle Oil & Gas Co. v. Tro-X, L.P.*, 619 S.W.3d 699, 709 (Tex. 2021). While the

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[30] From a preponderance of the evidence, Aetna had no policy for adding a hospital to an agreement.

waiver does not need to be explicit, it may be implied by conduct only if, in light of the surrounding facts and circumstances, it is unequivocally inconsistent with claiming that right. *Id.* Intent to waive must be "clear, decisive, and unequivocal." *Id.* Waiver is generally a question of fact. *Id.*

a. All Locations

As previously discussed, Aetna ratified the Agreement as to "all locations." For the reasons discussed under "Ratification," Aetna also waived any objection to billing for services provided at "all locations" unless waiver is prohibited by the non-waiver clause in Section 11.1 of the Agreement as alleged by Aetna.

"[A] party's rights under a nonwaiver provision may indeed be waived expressly or impliedly." *Shield Limited Partnership v. Bradberry,* 526 S.W. 3d 471, 482-83 (Tex. 2017). "[A] nonwaiver provision absolutely barring waiver in the most general terms might be wholly ineffective." *Id.* at 484. The validity and applicability of a nonwaiver provision must be determined on a case-by-case basis. The Court analyzed the nonwaiver provision in *Bradley* and said: "we can say with certainty that accepting late rental payments could not waive the parties' agreement that contractual rights, remedies, and obligations will not be waived on that basis, especially when the lease provides a specific method for obtaining a waiver." *Id.* The Court upheld that nonwaiver provision because it provided both (1) that waivers must be in writing and (2) that the landlord's "acceptance of late installments shall not be a waiver and shall not estop Landlord from enforcing that provision . . ." *Id.* Unlike *Bradberry*, this Agreement only had a very general nonwaiver provision.

This Agreement's very general nonwaiver provision does not preclude waiver with respect to "all locations." SAPA proved by a preponderance of the evidence that Aetna waived the Agreement's requirements as to "all locations," including all geographic locations, all types of facilities, and any approval requirement for facilities.

b. Subcontracted Providers

While SAPA disagrees that there was a pre-approval requirement for Subcontracted Providers, it argues, in the alternative, that Aetna waived any such requirement "by accepting them without ever asking, tracking, or providing a method of considering their contract status or method with Singleton." (SAPA's Brief, p. 33). [redacted] (SA § 2.2). SAPA's argument improperly shifts the responsibility for compliance with this provision from SAPA to Aetna. SAPA failed to prove by a preponderance of the evidence that Aetna knew that SAPA was using Subcontracted Providers and was using them without preapproval. SAPA failed to prove by a preponderance of the evidence that Aetna waived the preapproval requirement for Subcontracted Providers, but SAPA proved waiver

with respect to "all locations."

3. SAPA's Quasi-Estoppel Defense

SAPA contends that Aetna is precluded from "rescinding its approvals under the Agreement for the facilities where Singleton provided services, or from rescinding its acceptance of all of Singleton's providers as PGPs under the Section 12.10." (SAPA's Brief, p. 32).

"Quasi-estoppel (estoppel by contract) is a term applied to certain legal bars, such as ratification, election, acquiescence, or acceptance of benefits." *Fortney 921 Lot Development Partners, I, L.P., v. Paul Taylor Homes, LTD,* 349 S.W. 3d 258, 268 (Tex.—Dallas 2011, pet. denied). "It is a long-standing doctrine applied to preclude contradictory positions: it precludes a person from asserting, to another's disadvantage, a right inconsistent with a position previously taken." *Id.* "[T]here can be no ratification or estoppel from acceptance of benefits by a person who did not have knowledge of all the relevant facts." *Frazier v. Wynn,* 472 S.W.2d 750, 753 (Tex. 1971).

a. All Locations

SAPA contends that Aetna's claims regarding "all locations" are barred by quasi-estoppel. Aetna disagrees, citing *Quality Infusion* in support of its position. *Quality Infusion Care, Inc. v. Health Care Serv. Corp.,* 224 S.W.3d 369, 381 (Tex. App.—Houston [1st Dist.] 2006, no pet.) *Quality Infusion* involved a situation in which "appellees paid *some* of the claims QIC submitted for subscribers who do not have out-of-network benefits" but "appellees did not consistently do so." 224 S.W.3d at 381 (emphasis added). The court held: "We likewise conclude that appellees' occasional payment of claims for subscribers with no out-of-network benefits does not entitle QUI to assert a right under the contract to be paid as an in-network provider." *Id.* Unlike *Quality Infusion,* this matter does not involve an occasional payment of claims for other locations; it involves a situation where the preponderance of the evidence establishes that Aetna consistently paid claims for all locations and types of locations and regardless of any preapproval requirement for locations.

For the reasons discussed in the "all locations" section under SAPA's ratification and waiver defenses, the quasi-estoppel doctrine bars Aetna's "all locations" breach of contract claims. Having paid claims for many years that provided information concerning the locations of the facilities (which were in Aetna's databases and which Aetna could have used to determine the types of facilities, whether they were participating providers, and whether they were otherwise approved), Aetna cannot now take a position that is contradictory to that position to SAPA's detriment.

SAPA proved the elements of quasi-estoppel with to "all locations" by a preponderance of the evidence. The quasi-estoppel doctrine bars Aetna's breach of contract claims as all

locations including all geographic locations, all types of facilities, and any approval requirement for facilities.

b. Subcontracted Providers

SAPA argues that the doctrine of quasi-estoppel applies with respect to Subcontracted Providers, stating that the doctrine precludes Aetna "from rescinding its acceptance of all Singleton's Providers as PGPs under Section 12.10." (SAPA's Brief, pp. 32-33). To begin, Aetna did not accept SAPA's Subcontracted Providers as PGPs. SAPA's Subcontracted Providers were not PGPs. While SAPA enrolled Subcontracted Providers, the preponderance of the evidence established that Aetna did not know they were Subcontracted Providers and SAPA did not tell Aetna that they were Subcontracted Providers or obtain preapproval to use them.

The doctrine of quasi-estoppel applies "where a person has, with knowledge of the facts, acted or conducted himself in a particular manner, or asserted a particular claim, title, or right, he cannot afterwards assume a position inconsistent with such an act claim or conduct to the prejudice of another." *Fortney,* 349 S.W. 3d at 268. "The doctrine applies when it would be unconscionable to allow a person to maintain a position inconsistent with one in which he acquiesced." 349 S.W.3d at 268. SAPA failed to prove by a preponderance of the evidence that Aetna knew SAPA was using Subcontracted Providers. Accordingly, SAPA failed to prove quasi-estoppel with respect to the use of Subcontracted Providers.

To summarize, SAPA proved by a preponderance of the evidence its defenses of ratification, waiver, and quasi-estoppel as to "all locations." SAPA failed to prove its defenses of ratification, waiver, and quasi-estoppel as to Subcontracted Providers.

4. SAPA's 3.1 Defense

SAPA contends that Aetna communicated approval of the claims by payment and Aetna's overpayment claims are barred as a matter of law by [redacted]

[redacted]

[redacted] Based upon a preponderance of the evidence, Aetna did not communicate approval before paying the claims, particularly the Sample Claims. Thus, SAPA contends Aetna communicated approval by paying SAPA's claims and that, as a result, Aetna cannot reverse payment decisions absent one of the exceptions, such as fraud.[31] (SAPA's Brief, p. 59).

The main issue is whether, in context of this provision, Aetna's claims are barred because [redacted]

The *Itani* opinion, cited by SAPA in support of its argument, says "that *once* Aetna has communicated approval of a claim for a covered service, *then* it must pay that claim, absent fraud or some other narrow exception." 2012 WL 13019683 at *5 (emphasis added). The court held, "Given that the TIOPA Agreement obligates Aetna to pay for claims *for which it has previously communicated approval,* and *considering Aetna communicated its approval of the claims* at issue, *Aetna must pay* those claims and is not entitled to reimbursement." *Id.* * 5 (emphasis added). It is not clear from the opinion that Itani claimed that Aetna communicated approval by payment as alleged by SAPA in this proceeding. Regardless, [redacted] SAPA failed to provide its Section 3.1 defense by a preponderance of the evidence.

5. SAPA's Regulatory Bar Defenses

State and federal laws or regulations have deadlines for payors or administrators to request material information, make a benefits determination, communicate determinations, and pay claims. SAPA contends that federal requirements or similar state law requirements bar Aetna's claims.

a. Federal Law

Federal law provides strict timeframes for health plans to investigate and pay bills. *See* SAPA's Brief, pp. 28-29 (citing various Code of Federal Regulations provisions) and SAPA's

[redacted]

Response to Arbitrator's Questions, p. 4 (citing products covered by the Affordable Care Act, 42 U.S.C. § 300gg and 29 C.F.R. § 2560.503-1).

SAPA argues that Aetna's overpayment arguments could have been raised before making payments and that allowing Aetna's "new arguments" would render the guidelines a nullity. (SAPA's Brief, p. 62). While federal statutes and regulations supply a framework with various deadlines, SAPA has not cited a specific federal law or Code of Federal Regulation provision that prohibits lawsuits or arbitration proceedings against providers for breach of contract or tort causes of action. The regulations appear to be designed to protect against unfair denials and delayed payment of claims rather than to provide defensive immunity against a plan or payor's affirmative claims against a provider.

SAPA cites *Harlick v. Blue Shield of California,* 686 F.3d 699, 719-20 (9th Cir. 2012) and *Collier v. Lincoln Life Assurance Co.,* 53 F. 4th 1180 (9th Cir. 2022), but those cases are not on point as they pertain to judicial review of administrative proceedings involving plan participants who were denied benefits and not claims brought by a payor or administrator against a provider for breach of contract or torts.[32]

SAPA does not contend that Aetna's state law breach of contract and tort law claims are barred by ERISA, but it bears noting that they are not. Federal cases establish that an insurer or administrator may pursue state law causes of action against a healthcare provider for breach of contract and torts which are independent of ERISA and, hence, not preempted by ERISA. *See, e.g., Blue Cross & Blue Shield of Mississippi v. Sharkey-Issaquena Community Hosp,* No. 3:17-CV-338-DPJ-FKB, 2017 WL 6375954, at *4 (S.D. Miss. December 13, 2017) ("the state-law claims for breach of contract, fraud, civil conspiracy, negligent misrepresentation and unjust enrichment do not address areas of exclusive federal concern;" rather they are based on the contract and state law); *Conn. Gen. Life Ins. Co. v. True View Surgery Center One, LP,* 128 F. Supp. 3d 501, (D. Conn. 2015) (holding that Cigna's state law claim of fraud was not preempted by ERISA because the crux of the state law fraud claim was the surgical centers' alleged misconduct—the fraudulent billing practices—and not the terms of the ERISA-governed plans").

By their terms, federal law does not impose a legal bar to prevent a party from seeking recoupment for overpayments or damages for breach of contract, fraud, or other torts.

[32] *Harlick* is also distinguishable because it involved a situation where the Payor had sufficient information to withhold benefits but held that "basis in reserve rather than communicate it to the beneficiary." 686 F.3d at 720-21. Here, Aetna did not know of SAPA's use of Subcontracted Providers and was not holding those grounds "in reserve."

b. Texas Law[33]

The Agreement was governed by Texas law. (SA § 11.2). SAPA argues that, where applicable, Texas prompt pay laws and regulations bar Aetna's claims. Aetna serves in two different roles: (1) as the administrator for self-funded and governmental plans and (2) as an insurer for fully insured (non-governmental) plans. The applicable laws vary based upon Aetna's role.

1. Self-funded and government plans

Texas prompt pay laws are inapplicable when a claims administrator administers self-funded and state government plans. *Health Care Service Corp. v. Methodist Hospitals of Dallas,* 814 F.3d 242, 253 (5th Cir. 2016) (holding that prompt pay laws are inapplicable when a claims administrator administers self-funded and state government plans); *Stanissis v. Dyncorp Int'l LLC,* No. 3:14-CV-2736-D, 2015 WL 1931417, at *8 (N.D. Tex. April 29, 2015) ("The Texas Supreme Court has held that, although private self-funded employee benefits plans operate like insurers, they are not regulated like insurance companies and are not engaged in the business of insurance for purposes of the Texas Insurance Code"). *See also FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) ("an employee benefit plan governed by ERISA shall not be 'deemed' an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts").

Aetna's breach of contract claims against SAPA pertaining to self-funded plans and government plans are not barred by Texas prompt pay laws.[34]

2. Fully Insured Plans

Aetna contends that the prompt pay laws only apply in the routine payment situations and that nothing in the statutes deprives an insurer of its independent causes of action under Texas law for the providers' own wrongdoing, as opposed to the return of routine overpayments under a plan. (Aetna's Brief, pp. 51-52). SAPA responds that Aetna's approach is wrong and would effectively eviscerate the laws governing claims processing and prompt pay.

The Texas prompt pay laws have provisions addressing overpayments: TEX. INS. CODE §§ 843.350 (HMOs), 1301.132 (Preferred Provider Plans). Other than these overpayment statutes and regulations, SAPA cites no provision that would bar Aetna's overpayment claims. State law

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[33] In its Post-Hearing Briefs, SAPA [redacted] The cases cited by SAPA are distinguishable, and its contention is without merit.

[34] In addition to self-funded and state government plans, prompt payment laws may not be applicable to other plans. *S. Tex. Health Sys. v. Care Improvement Plus of Tex. Ins. Co.,* No 7:14-CV-912, 2015 WL 9257021, at * n. 12 (S.D. Tex. September 28, 2015). In connection with Phase Two, it may be necessary to determine whether specific plans are exempt from Texas prompt pay laws.

does not bar Aetna's overpayment claims unless they are barred by the overpayment provisions of the Texas Prompt Pay Laws.

Section 1301.132 provides that an "insurer may recover an overpayment to a physician or health care provider if (1) not later than the 180th day after the date the physician or provider receives the payment, the insurer provides written notice of the overpayment to the physician or provider that includes the basis and specific reasons for the request for recovery of funds . . ." TEX. INS. CODE § 1301.132(a)(1). Section 843.350 provides the same requirement for HMOs.

Section 21.2818 of chapter 28 of the Texas Administrative Code addresses overpayment of clean claims[35] under chapters 843 and 1301 of the Texas Insurance Code. 28 Tex. Admin. Code §§ 21.2801, 2818. Under the relevant provisions, a managed care carrier (MCC) such as Aetna, "may recover a refund due to overpayment or completion of an audit if: (1) the MCC notifies the physician or the provider of the overpayment not later than the 180th day after the date of receipt of the overpayment; or (2) the MCC notifies the physician or the provider of the completion of an audit under § 21.2809 of this title (relating to Audit Procedures)." 28 Tex. Admin. Code § 2818.

Importantly, Texas Administrative Code provision relating to overpayments states: "Subsections (a) – (e) of this section do not affect an MCC's ability to recover an overpayment in the case of fraud or material misrepresentation." 28 Tex. Admin. Code § 21.2818(f). Thus, Sections 843.350 and 1301.132 and the Texas Administrative Code provisions bar Aetna's breach of contract claims, but not its fraud or material misrepresentation claims. As addressed later in this Interim Order, Aetna failed to prove fraud and tort causes of action by a preponderance of the evidence. Accordingly, the Texas statutes and regulations bar Aetna's overpayment claims based on breach of contract with respect to claims under sections 843.350 and 1302.132 of the Texas Insurance Code unless Aetna took the steps required by the statutory and regulatory deadlines.[36]

3. Summary Re SAPA's Regulatory Bar Defense

To summarize: (1) Aetna's fraud, misrepresentation, and breach of contract claims are not barred hy federal statutes and regulations, (2) Chapters 843 and 1301 of the Texas Insurance Code, where applicable, bar Aetna's overpayment claims based on breach of contract, but do not bar fraud and misrepresentation claims, and (3) claims that do not come under Chapters 843 or 1301 of the Texas Insurance Code are not harred by Texas law.

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[35] The elements of a clean claim are set forth in 28 Tex. Admin. Codc § 21.2803.

[36] Whether claims come under the overpayment provisions and whether Actna took required actions in a timely manner are Phase Two issues.

C. Summary of Aetna's Breach of Contract Claims and SAPA's Defenses

Aetna proved by a preponderance of the evidence that SAPA breached the Agreement by not obtaining pre-approval for the use of Subcontracted Providers. Aetna failed to prove any other breach of contract by SAPA.

With respect to SAPA's defenses, SAPA proved by a preponderance of the evidence that, even if Aetna proved a breach of contract with respect to "all locations" (including all geographic locations, all types of facilities, and any approval requirement for facilities) any such breach is barred by ratification, waiver, and quasi-estoppel. With respect to the Subcontracted Provider issue, SAPA failed to prove its ratification, waiver, and quasi-estoppel defenses by a preponderance of the evidence.

SAPA failed to prove its Section 3.1 defense. SAPA failed to prove its defenses under federal and state prompt pay statutes except with respect to overpayments that come under chapters 843 and 1301 of the Texas Insurance Code and the corresponding regulations.

VI. SAPA'S CLAIMS

SAPA sued Aetna for breach of the [redacted] alleging that, beginning in the summer or fall of 2020, Aetna changed its systems to begin paying less than the Agreement's [redacted] of billed charges rate for physicians located outside of Houston. Aetna also began a recoupment process to recover monies that it claimed constituted overpayments, which SAPA alleges thereby converted previously paid bills into unpaid or underpaid bills.

A. SAPA's Breach of Contract Claim

SAPA filed its Arbitration Demand against Aetna for breach of contract seeking to recover damages for "incorrect non-payments, underpayments, and recoupments that Aetna caused."[37] SAPA must plead and prove the elements of its breach of contract claim. *Pathfinder Oil & Gas, Inc. v. Great W. Drilling, Ltd.*, 574 SW.3d 882, 890 (Tex. 2019). The issue is whether Aetna breached the Agreement by paying less than the Agreement's reimbursement rate of [redacted] of billed charges beginning in the summer or fall of 2020 and by its recoupment efforts.

1. Employees, Partners, and Shareholders

Based upon the analysis of both Aetna and SAPA's breach of contract claims, SAPA proved by a preponderance that Aetna breached the Agreement to the extent that it failed to pay the [redacted] reimbursement rate for physicians who were employees, shareholders, or partners of SAPA (as opposed to being Subcontracted Providers) regardless of any issues regarding the

[37] As previously discussed, SAPA also sued for "other claims," that is for claims other than the Houston argument. Aetna's "other claims" are to be addressed in Phase Two except to the extent that "other claims" (such as the Subcontracted Provider issue) were tried by the parties in Phase One.

facility including the location of the facility, the type of facility, or "approval" of the facility.[38] Aetna also breached the Agreement to the extent that it recouped any such payments.

2. Subcontracted Providers

As previously discussed, the Agreement required pre-approval of Subcontracted Providers. SAPA failed to prove by a preponderance of the evidence that it obtained preapproval to use Subcontracted Providers. Accordingly, SAPA failed to prove by a preponderance of the evidence that Aetna breached the Agreement with respect to Subcontracted Providers.

B. SAPA's Statutory Claims

In paragraphs 67 to 69 of its Demand, SAPA sought full payment, statutory penalties, attorneys' fees, and costs from Aetna for violations of the Texas Prompt Pay Act (TPPA) by failing to reimburse Singleton at the contracted rate within thirty days of submission of bills. TEX. INS. CODE §§ 843.342, 843.343, 1301.137, 1301.108. In general, these provisions apply to insured, non-governmental plans that are issued in Texas. With respect to plans governed by these provisions, an HMO or insurer is required to comply with the TPPA's claims-processing requirements, which include payment of the contracted rate within the statutory deadlines. A HMO or insurer who fails to comply with those requirements is subject to payment of the amount due, penalties, attorneys' fees, and costs. *Id.*

Aetna contends that it is not liable for penalties because the claims were not "payable" and were not clean claims. (Aetna's Brief, pp. 56-57 citing TEX. INS. CODE §§ 843.342(a) and 1301.137(a)).

Based upon other findings in this interim order, any chapter 843 and 1301 claims that SAPA submitted for SAPA's employees, partners, and shareholders (regardless of where the services were provided, the type of facility, or whether the facility was "approved") were claims that were payable and were clean claims. To the extent that Aetna did not pay those claims within the statutory deadlines or underpaid those claims by paying less than the Agreement's reimbursement rate, Aetna violated the TPPA.

The claims that SAPA submitted for Subcontracted Providers were not payable based on the Agreement's requirement that Subcontracted Providers be pre-approved and the preponderance of the evidence establishing that they were not preapproved. Accordingly, SAPA failed to prove by a preponderance of the evidence that Aetna violated the TPPA with respect to the Subcontracted Provider claims.

Any issues relating to whether a plan comes within chapters 843 and 1301 of the Texas

[38] SAPA's employees were those physicians who received W-2s from SAPA. SAPA had no partners or shareholders.

Insurance Code, whether particular claims were timely paid, the amount due at the contracted rate, penalties, costs, and attorneys' fees will be determined in Phase Two.

VII. AETNA'S FRAUD CLAIMS

Aetna contends that Respondents "defrauded Aetna into paying claims." "To establish fraud, a plaintiff must show that (1) the defendant made a false, material misrepresentation; (2) the defendant knew the misrepresentation was false or made it recklessly as a positive assertion without any knowledge of its truth; (3) the defendant intended to induce the plaintiff to act upon the representation; and (4) the plaintiff justifiably relied on the representation, which caused the plaintiff injury." *Barrow-Shaver Resources Co. v. Carrizo Oil & Gas, Inc.*, 590 S.W. 3d 471, 496 (Tex. 2019). In footnote 69, Aetna also claims that SAPA committed fraud by non-disclosure. In footnote 115, Aetna alleges SAPA committed negligent misrepresentation.[39]

A. Misrepresenting Facts Surrounding the Services of Physicians

Aetna contends that SAPA misrepresented the facts surrounding the services of physicians by concealing certain information and by making false, material statements. (Aetna's Brief, pp. 27-28).

1. Concealment

"Fraud by nondisclosure, a subcategory of fraud, occurs when a party has a duty to disclose certain information but fails to disclose it." *Bombardier Aerospace Corp. v. SPEP Aircraft Holdings, LLC,* 572 S.W. 3d 213, 219 (Tex. 2019). "To establish fraud by non-disclosure, the plaintiff must show: (1) the defendant deliberately failed to disclose material facts; (2) the defendant had a duty to disclose such facts to plaintiff; (3) the plaintiff was ignorant of the facts and did not have an equal opportunity to discover them; (4) the defendant intended plaintiff to act or refrain from acting based on the nondisclosure; and (5) the plaintiff relied on the non-disclosure which resulted in injury." *Id.* at 219-220 (internal quotation marks omitted).

Aetna contends that SAPA misrepresented the facts surrounding the services of physicians so that "Aetna would not catch on to its scheme to boundlessly expand the agreement to cover its ever-growing corporate affiliations." (Aetna's Brief, pp. 27-28). Aetna provided a timeline to support its position. *Id.* at pp. 28-35. Based on a review of all the evidence (including the evidence cited in Aetna's timeline), Aetna failed to prove by a preponderance of the evidence that SAPA/RP tried to hide the relationship between SAPA and RP, their growth, or the use of the Agreement.

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[39] The elements of negligent misrepresentation are: "(1) the representation is made by a defendant in the course of his business, or in a transaction in which he has a pecuniary interest; (2) the defendant supplies false information for the guidance of others in their business; (3) the defendant did not exercise reasonable care or competence in obtaining or communicating the information; and (4) the plaintiff suffers pecuniary loss by justifiably relying on the representation." *Henry Schein, Inc. v. Stromboe,* 102 S.W. 3d 675, 686 n.24 (Tex. 2002) (internal quotations marks omitted).

As early as February 2014, an RP consultant contacted Aetna to discuss renegotiating contracts for two entities that were associated with Radiology Partners. The consultant offered to have a phone call involving key Aetna personnel (including [redacted]) and the [redacted] although it does not appear that call took place.

SAPA was acquired by [redacted] effective November 2014. By no later than March 2016, [redacted], an Aetna Network Manager, demonstrated that he was aware of the relationship between RP and SAPA by asking SAPA/RP's [redacted]: "Also, did your TIN owner name change to Radiology Partners or is it still Singleton & Associates?" A-261. [redacted] responded that "[t]here has been no change to our name or tax ID number." *Id.*

In 2018, at SAPA/RP's request, RP/SAPA and Aetna met in Aetna's offices in Sugarland. The participants included top RP/SAPA officials, including [redacted] and [redacted], and key Aetna officials including [redacted], Executive Director, Network. Aetna presented a PowerPoint presentation, which was also emailed to Aetna. As reflected in the slides, RP/SAPA's stated objectives for the meeting included presenting the concept of "value-based care" and "familiarizing Aetna with SAPA." CX-1. RP/SAPA's goal was to negotiate a new contract that included compensation for value-based care. The slides contained numerous references to Radiology Partners and Singleton. The slides contained no misrepresentations about SAPA, stating that they had "more than [redacted] Hospitals and Care Sites" and "more than [redacted] radiologists." The credible evidence indicates that, during that meeting, SAPA/RP mentioned that it was providing services outside of Houston—in Dallas and West Texas as an example. Far from minimizing its size, RP and SAPA were touting it. The fact that this meeting was held establishes that, far from hiding RP's existence and its relationship with SAPA, RP and SAPA were marketing it and hoping to negotiate a new contract that contained value-based compensation.

In May 2018, [redacted] and [redacted] communicated regarding and signed a Medicare Amendment to the Agreement. (SA, pp. 30-31). In December 2019, [redacted], Credentialing Manager for [redacted] (a group that was not affiliated with RP), responded to an email from an Aetna Network employee, stating that she ([redacted]) was no longer the point of contact for West Houston Radiology Associates as [redacted]. [redacted] referred Aetna to [redacted], providing her name, title, and contact information including her office and fax numbers and her email address at radpartners.com. A-338.

In addition, when SAPA enrolled physicians, it provided the information requested on the Demographic Spreadsheet, including hospital affiliations and hospital locations, when requested. This information indicated that, in many instances, services were being provided outside of the Houston Market. In the case of the [redacted] Subcontracted Providers, the information provided to Aetna showed an [redacted] service location.

When SAPA submitted electronic claims as required by Aetna, it disclosed the service facility location information. The claims data revealed that SAPA was providing services across Texas. Network Management sent a report to TDI showing that Aetna was paying SAPA in network for claims arising out of services provided across Texas.

Aetna failed to prove by a preponderance of the evidence the elements of fraudulent nondisclosure with respect to the services of physicians including the relationship between SAPA and RP, their expansion, growth, or the use of the Agreement. Aetna failed to prove by a preponderance of the evidence that SAPA/RP deliberately failed to disclose material facts, that it had a duty to disclose those facts, that Aetna was ignorant of those facts, that SAPA/RP intended Aetna to act or refrain from acting based on the non-disclosure, and that Aetna relied on the nondisclosure, which will be discussed in a later section.[40]

2. Misrepresentations

Aetna uses its timeline to argue that SAPA made false, material misrepresentations. Two specific issues, service address and Subcontracted Providers, will be addressed here.

As to the service address issue, Aetna contends that SAPA committed fraud by using [redacted] as the Service Address for most of the physicians that SAPA added. SAPA was a hospital-based provider that had always provided services at more than one hospital and consistently used the Bertner Avenue address as the service location for its providers.

In March 2016, when Aetna's [redacted] sent SAPA what appears to be the first spreadsheet, "service address" was one of the fields on the spreadsheet that Singleton asked [redacted] (SAPA) to use. In April 2016, [redacted] provided [redacted] (Aetna) a roster that listed over 100 radiologists, all with [redacted] service addresses. A-273. This was at a time when the preponderance of the evidence established that Aetna's Singleton knew that RP/SAPA was providing services to at least two hospital systems at multiple locations in the "Houston area" and that [redacted] (SAPA) knew he knew. Yet, Aetna raised no objection to the use of the same service location address for all of SAPA's hospital-based physicians at that time. A-268.

Thereafter, the spreadsheet was revised, and Aetna requested the service location as well as hospital affiliations and hospital locations for hospital-based physicians. A-267.When SAPA added providers by filling out the spreadsheet, SAPA provided, among other things, the physician's name (columns A & B), the service location (columns J & K—usually [redacted], the physician's hospital affiliations (column AB), and the hospital locations for hospital-based physicians (column AC). *See* A-0267. Aetna could readily determine from the spreadsheets that SAPA was using the same service location for all physicians and that the

[40] Aetna also failed to prove by a preponderance of the evidence the elements of fraud or negligent misrepresentation.

physicians who were being added provided services at many different hospitals, including hospitals outside of Houston. For example, on the spreadsheet at A-267, [redacted] physicians were listed. They all had the same Bertner Avenue service location, but most had hospital affiliations and hospital locations outside of Houston. *See also* A-316 listing [redacted] physicians with service locations [redacted] but many had hospital affiliations and locations outside of Houston. Aetna failed to prove all the elements of fraud, fraudulent nondisclosure, and negligent misrepresentation cause of action with respect to the service location issue.

With respect to the Subcontracted Provider issue, Aetna failed to prove by a preponderance of the evidence that SAPA/RP made any representations, much less misrepresentations, to Aetna about whether its physicians were employees, shareholders, partners, or Subcontracted Providers. Aetna could have asked SAPA to state whether the physicians were employees, shareholders, partners, or Subcontracted Providers and could have asked for documentation. But it did not do so. SAPA made no representations about that issue on its claims or elsewhere. Aetna also failed to prove by a preponderance of the evidence that SAPA/RP "deliberately failed to disclose material facts" and that they "intended the plaintiff [Aetna] to act or refrain from acting based on nondisclosure." To this day, based on a preponderance of the evidence, SAPA does not believe that the Agreement prohibited the use of Subcontracted Providers or required their preapproval. Given that conclusion and given the widespread use of contracted physicians in the industry,[41] the preponderance of the evidence does not support a finding that SAPA deliberately or recklessly failed to disclose material facts on this issue or that it intended for Aetna to act or refrain from acting.

Having considered the evidence on the service location issue, the Subcontracted Provider issue, and all other alleged misrepresentations and concealments outlined in Aetna's timeline and brief, Aetna failed to prove the elements of fraud, fraudulent nondisclosure, or negligent misrepresentation by a preponderance of the evidence regarding the services of physicians' issues.

B. Submitting Claims under SAPA's TIN

Aetna also contends that SAPA/RP committed fraud by submitting claims under SAPA's TIN, rather than the TIN for other entities such as [redacted]

1. Billing under SAPA's TIN for Subcontracted Providers

Under the Agreement, SAPA was required to submit its bills electronically, providing the information required by HCFA 1500 forms or subsequent forms adopted for that purpose. (SA §3.4). SAPA provided the information required by HCFA 1500 and followed the guidance provided in the NUCC Instruction Manual. Among other things, SAPA's claim submissions

[redacted]

provided Aetna the name of the patient, the service facility location information (the name, address, and NPI number for the facility where the imaging was performed), and the name and NPI number of the physician who read the images.[42]

SAPA made no representations in the claim form about whether the physicians were employees, shareholders, partners, or Subcontracted Providers.[43] Nevertheless, Aetna contends that SAPA committed fraud by billing Subcontracted Providers under its TIN.[44] SAPA submitted claims under its TIN when it had an exclusive agreement with a hospital. SAPA used the same methodology for all payors and all hospitals. This was SAPA's practice beginning at or near the time that [redacted] acquired SAPA and started adding practices and exclusive hospital agreements.[45]

Aetna failed to prove by a preponderance of the evidence that it was improper for SAPA to submit claims under its TIN for services that SAPA provided pursuant to its hospital agreements when it used Subcontracted Providers provided by other groups and the entities.

The Agreement contemplates that there will be circumstances in which a specialist physician might use a subcontractor and, in those circumstances, [redacted] and [redacted] (SA, p. 25, § I(F)). This language indicates that the billing entity would be SAPA and that SAPA would compensate the subcontractor. The Agreement does not provide that, in such circumstances, SAPA would submit claims under the Subcontracted Provider's TIN.

Aetna has a [redacted]

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[42] Because of Medicare's reimbursement guidelines, the service facility location for Medicare claims is not where the images were performed but, rather, where they were read. The preponderance of the evidence shows that those guidelines were not applicable to commercial products.

[43] During the hearing, [redacted]r presented a new theory that a certain modifier should have been used on the bills for locum tenens. That evidence was excluded but, even it had been admitted, the evidence would not have changed the outcome because Aetna admitted that its claims adjudication process paid based on the billing provider's TIN and its address. It would not have considered any modifier in adjudicating and paying claims. Thus, there was no actual or justifiable reliance.

[44] To the extent that Aetna contends SAPA/RP committed fraud by submitting claims for "all locations," that argument is without merit for reasons previously discussed including, but not limited to the following: (1) there was no geographic restriction, (2) SAPA's spreadsheets demonstrated that physicians were practicing across Texas, (3) SAPA's claim information disclosed the locations where services were provided, and (4) Aetna Network sent a report to TDI disclosing that SAPA provided services across Texas. Aetna failed to prove any of the elements of fraud, fraud by nondisclosure, and negligent misrepresentation on this issue.

[45] The purpose of the taxpayer ID is to report income to the IRS for tax purposes; Aetna's use of the TIN to adjudicate claims is incidental to that purpose.

[redacted] Indeed, the new contract template that Aetna provided SAPA provides that SAPA (the Provider) may use Group Providers (employees, contractors, or others), that SAPA will accept the rates in the applicable Service and Rate Schedule, regardless of where the services were performed, that SAPA would promptly pay all Group Providers and require all Group Providers to look to SAPA for payment. CX-79a § 1.4(a) & (b). A reasonable interpretation of this template is that SAPA would bill under its TIN for its Subcontracted Providers and would be responsible for paying the Subcontracted Providers.

Even though there is nothing inherently improper about SAPA billing Subcontracted Providers under its TIN, Aetna contends that SAPA improperly loaned its TIN to other entities. Aetna's billing expert, [redacted], testified that [redacted].

Aetna failed to prove by a preponderance of the evidence that SAPA loaned its TIN [or provider number] to others for the purpose of collecting money.

First, SAPA did not loan its TIN or provider number to another group for purposes of "collecting money." SAPA's agreements with the hospitals were not simply contracts to bill. When SAPA had a direct contract with a hospital, it had all the obligations under the contract including, among other obligations, the staffing responsibilities. In cases where SAPA was assigned the contract, it likewise had all the obligations and responsibilities attendant to the contract. For example, when [redacted] consent to assign its exclusive provider agreement to SAPA. [redacted] agreed to the assignment [redacted]. The contracts and assignments were not simply contracts to bill; these contracts placed all the responsibilities and obligations on SAPA.

Second, when SAPA had the exclusive hospital agreement, SAPA was the entity that had the obligation to provide radiologists to the bospital's radiology department. SAPA could fulfill this obligation by using its own employees or contractors or by using radiologists provided by staffing companies such as locum tenens companies or [redacted], or by using radiologists provided by other groups or entities. When SAPA used radiologists provided by other groups or entities, SAPA was providing the services, but it was fulfilling its obligation using radiologists provided by another group or entity. In the case of [redacted], for example, [redacted] did not provide the radiology services at the hospitals where SAPA had the exclusive

agreements. Rather, SAPA provided the radiologists to staff the department using radiologists obtained from [redacted], pursuant to its independent contractor agreement between SAPA and [redacted].

In these circumstances, from a preponderance of the evidence, SAPA did not loan its NPI or TIN to the other groups. Rather, it contracted with other groups or entities to provide radiologists to SAPA so that SAPA could fulfill its contractual obligations with the hospitals. SAPA then billed Aetna for the services of the individual radiologists (not the group) using SAPA's own TIN and NPI numbers. From a preponderance of the evidence, Aetna failed to prove by a preponderance of the evidence that SAPA loaned its TIN to other entities or improperly billed under its TIN. This conclusion is supported by the testimony of [redacted], Aetna's former employee/expert, whose testimony indicates that SAPA had the right to staff and bill for radiology services if it had the PSA with the hospital by contract or assignment and "that whoever had that staffing agreement previously no longer has the right to bill for radiology services at those hospitals"—"if they are no longer a party to the agreement."[46] Tr. 12: 4246-47.

2. Fraud by billing under SAPA's TIN

Even if SAPA acted improperly in billing under its own TIN, Aetna failed to meet its burden to show that SAPA committed fraud in any respect, including by submitting claims to Aetna for Subcontracted Providers under SAPA's TIN. Aetna failed to prove by a preponderance of the evidence that SAPA knew that it was making a false representation or made a false representation recklessly. SAPA thought it was proper to bill Subcontracted Providers under its TIN for several reasons. First, as previously discussed, SAPA had all the responsibilities under the hospital agreements, including the duty to staff, and determined that it was appropriate to submit claims under its TIN for that reason. Second, based on a preponderance of the evidence, SAPA believed, albeit incorrectly, that the use of Subcontracted Providers without preapproval under the Agreement was proper. SAPA's belief that it was proper to bill under SAPA's TIN was not fraudulent or reckless,[47] given SAPA's belief that preapproval was not required for Subcontracted Providers and given that the use of Subcontracted Providers without preapproval is commonplace in the industry and accepted by payors.

Further, Aetna failed to prove by a preponderance of the evidence that SAPA intended Aetna to act based solely on its TIN. SAPA provided more information to Aetna than just its TIN. It provided the service facility location information and the name and NPI number for the

[redacted]

[47] SAPA also used and consulted with Imagine, the top leading healthcare billing system vendor for many radiology and ancillary providers across the United States and XIFIN, an independent billing vendor who provides billing management services to RP and other radiology practices.

rendering physician, all of which is information Aetna could have used to determine whether services were being provided at appropriate facilities by providers who were associated with other groups. Additionally, Aetna did not prove by a preponderance of the evidence that SAPA knew Aetna only relied on the TIN in its claims adjudication process. Indeed, the testimony of Aetna network personnel established that (1) the claims adjudication process was not posted on Aetna's website or provided to groups or providers and (2) they (Aetna Network personnel) did not know (and were very surprised to learn) that Aetna relied solely on the TIN in processing claims. From a preponderance of the evidence, it seems unlikely that SAPA knew that Aetna relied solely on the TIN in adjudicating claims when Aetna's own network personnel did not know that.[48] Aetna failed to prove, by a preponderance of the evidence, the elements of fraud, fraud by nondisclosure, or negligent misrepresentation regarding the SAPA's use of the TIN.

C. Reliance/Justifiable Reliance

To establish the fourth elements of its fraud and negligent misrepresentation claims, RP was required to show that it justifiably relied on the defendant's representations. *Barrow-Shaver Res. Co.* 590 S.W. 3d at 496; *Henry Schein, Inc.,* 102 S.W. 3d at 686 n.24. Similarly, with respect to fraud by nondisclosure, a plaintiff must show that "the plaintiff was ignorant of the facts and did not have an equal opportunity to discover them" and the plaintiff relied on the non-disclosure. *Bombardier,* 572 S.W. 3d at 219-220.

A "party claiming fraud has a duty to use reasonable diligence in protecting his own affairs." *Barrow-Shaver Res. Co.* 590 S.W. 3d at 497. In an arms-length transaction, "the defrauded party must exercise ordinary care for the protection of his own interests and is charged with knowledge of all of the facts which would have been discovered by a reasonably prudent person similarly situated." *Id.* "[A] plaintiff may not 'blindly rely on a representation by a defendant' when the plaintiff's knowledge, experience, and background alert it to investigate the defendant's representations before acting in reliance on those representations." *Id. citing J.PMorgan Chase Bank, N.A. v. Orca Assets G.P., L.L.C.,* 546 S.W.3d 648, 654 (Tex. 2018). A person may not justifiably rely on a misrepresentation if there are "red flags." *Id.* at 655.

Aetna failed to prove justifiable reliance with respect to its fraud claims and negligent misrepresentation claims by a preponderanee of the evidence because it failed to exercise due diligence in protecting its affairs. As previously discussed, Aetna had information from SAPA and others that demonstrated the relationship between SAPA and RP, their growth, and the use of the Agreement. Aetna had enrollment information that alerted Aetna that SAPA was enrolling and using physicians whose hospital affiliations outside of Houston Market and were likely providing services at hospitals outside the Houston Market. When attempts were made to enroll

[redacted]

[redacted]. Additionally, Aetna sent TDI information that demonstrated that SAPA was providing services state-wide. Aetna had "red flags" to indicate that SAPA was providing services outside the Houston Market at locations that were not approved by Aetna.

Aetna also failed to prove justifiable reliance regarding the Subcontracted Provider issue. During the time relevant to this dispute, contractors were often used by hospital-based physician groups. As part of the enrollment process or thereafter, Aetna could have asked SAPA about SAPA's relationship with the providers and requested or demanded copies of the contracts. Aetna could have used the provider names provided in both the enrollment process and in its claims to search its databases to determine each provider's relationship with other entities. Additionally, the physician's names and NPI numbers were on the claims, but Aetna did not consider, as part of its claims adjudication process, each physician's relationship with other providers to determine the appropriate reimbursement rate. Aetna, in the exercise of due diligence, could have determined from its databases that these providers were associated with other groups and might well be Subcontracted Providers. This same information would have revealed whether SAPA was the appropriate billing provider as opposed to some other billing provider. Importantly, by September 2019, Aetna network personnel knew that SAPA [redacted] had tried to add [redacted] physicians to the Agreement and knew that something was going on with SAPA's TIN [redacted]. This was "red flag" that something was going on with SAPA [redacted]. Aetna failed to prove by a preponderance of evidence that it justifiably relied on SAPA's representations or that it was ignorant of the facts and did not have an equal opportunity to discover them.

Finally, Aetna did not show that it actually relied on representations, misrepresentations, or nondisclosures. It programmed its claims adjudication system to rely solely on the billing providers' TIN and billing address and thereby disregarded all other information provided by the SAPA. Aetna failed to prove by a preponderance of the evidence that SAPA committed fraud by billing Subcontracted Providers under its TIN.[49]

Aetna failed to prove by a preponderance of the evidence the elements of fraud, fraud by nondisclosure, or negligent misrepresentation in any respect. Aetna's fraud, fraud by non-disclosure, and misrepresentation causes of action fail.

VIII. AETNA'S TORTIOUS INTERFERENCE CLAIMS

Aetna alleges that SAPA tortiously interfered with Aetna's contracts with various provider groups [redacted]. "To establish a claim for

[49] While SAPA did not commit fraud by billing for Subcontracted Providers, SAPA did breach the Agreement by enrolling or adding physicians when the physicians were Subcontracted Providers without obtaining the pre-approval for their use as required by the Agreement.

tortious interference with an existing contract, a plaintiff must establish: (1) the existence of a valid contract subject to interference; (2) that the defendant willfully and intentionally interfered with the contract; (3) that the interference proximately caused the plaintiff's injury; and (4) that the plaintiff incurred actual damage or loss." *Baylor Scott & White v. Project Rose MSO, LLC,* No. 12-20-00246-CV, 2021 WL 3871957 at *18 (Tex.App.—Tyler August 30, 2021, pet. denied).

Aetna had existing agreements with certain radiology groups. The agreements authorized [redacted]

Aetna contends that SAPA/RP interfered with its contracts with the Groups by [redacted]

Aetna's description of what happened, [redacted] is not factually correct. First, in some instances, the SAPA directly contracted with a hospital. But even when an assignment occurred, the facilities did not transfer or assign the agreements. Rather, the group assigned its contract with the facility to SAPA; the facility simply approved the transfer. Second, the groups did not transfer "contracts to bill" to SAPA. In the case of the assignment of a group's hospital agreement to SAPA, SAPA was assigned a group's entire agreement with the hospital and assumed all the obligations and responsibilities of the prior group, not just the billing functions. In other instances, SAPA directly contracted with a facility and obtained an exclusive contract with the hospital. In those cases, SAPA had all the rights and responsibilities, and the prior group had none. Third, Aetna's argument that everything remained the same after the transfer except for the billing responsibilities is not correct; after the transfer SAPA was responsible for all the obligations under the agreements between the hospital and SAPA (whether as an assignee or a direct contractor with the facility). Fourth, while Aetna contends that the only entity that benefited was RP, the preponderance of the evidence establishes that, from the perspective of the physicians and groups, they were happy to receive the benefits of affiliating with SAPA/RP including its management, clinical expertise and improvements, and technical expertise. And, from a preponderance of the evidence, it appears that some of these benefits flowed to Aetna's members as well.

[50] As previously discussed, SAPA did not breach the Agreement's notice requirements. Aetna has cited no provisions that required SAPA or the groups to terminate the agreements with Aetna when a group no longer had the contract with the hospital although it appears that Aetna had the option to terminate in those circumstances. *See e.g.* A-3 § 6.2.

The factual underpinning of Aetna's tortious interference claim is incorrect; the tortious interference claims fail for that reason alone.

Baylor Scott & White v. Project Rose MSO, LLC, No. 12-20-00246-CV 2021 WL 3871957 at *18 (Tex. App.—Tyler Aug. 30, 2021, pet. denied) establishes the elements of a tortious interference claim, but the facts of that case are far different from the facts in this case and do not constitute legal authority to support the proposition that tortious interference with Aetna's agreement with a group occurred when: (1) SAPA properly obtained exclusive provider agreements (by direct contract or assignment) with hospitals; (2) SAPA negotiated professional services agreements with groups or entities to provide radiologists to SAPA in these circumstances in which the group and entity contracts with Aetna do not require them to maintain a provider agreement with the hospital; (3) SAPA, the entity that provided to the services to the hospital, billed for those services under its TIN (rather than improperly billing under the TIN of another entity that no longer had the contract with the hospital); and (4) Aetna decided to set up its claims adjudication system to pay claims based solely on the billing provider's TIN and address and disregarding all the information that SAPA provided in the enrollment and claims process. Aetna failed to prove by a preponderance of the evidence a willful and intentional act of interference with Aetna's Agreement with the providers by SAPA.

Given the finding that Aetna failed to prove tortious interference by a preponderance of the evidence, it is not necessary to address the justification defense. Nevertheless, the issue will be addressed. "The justification defense is based on the exercise of either (1) one's own legal rights or (2) a good-faith claim to a colorable legal right, even though that claim ultimately provides to be mistaken." *Overnite Transp. Co. v. Int'l Bhd. of Teamsters,* No. 03-00-00390-CV, 20101, WL 300247, at *1 (Tex.App.—Austin March 29, 2001, pet. denied.)

SAPA/RP asserts the justification defense, arguing that SAPA, as a hospital-based physician group, was justified in taking action to gain the exclusive right to staff and provide services at the facilities and, when it has that exclusive contract, it is "legally justified in interfering with another party's alternative relationship with the hospital." SAPA's Brief p. 66, citing *Calvillo v. Gonzalez,* 922 S.W.2d 928, 929 (Tex. 1996). In *Calvillo,* the Court said: "under these facts Calvillo's exclusive contract with the hospital justifies, as a matter of law, his interference with another party's prospective business relations," and "[g]ood faith is not a relevant factor in determining justification if the defendant acts to assert a legal right."[51]

Aetna responds by citing *Overnite Transp. Co. v. Int'l Bhd. of Teamsters,* No. 03-00-00390-CV, WL 300247, at *1 (Tex.App.—Austin March 29, 2001, pet. denied) for the proposition that a defendant cannot assert the defense of justification if [redacted] Aetna

[51] The court also held that its construction of the justification defense also applies to claims of tortious interference with existing contracts. *Id.* at 929.

claims that RP [redacted] While Aetna does not believe that this arrangement benefited anyone other than RP, the preponderance of the evidence established that the physicians who provided services to Aetna Members believed that it did.

Aetna failed to prove tortious interference by a preponderance of the evidence, and SAPA/RP proved its justification defense by a preponderance of the evidence.

IX. AETNA'S HAD AND RECEIVED CLAIMS

Aetna alleges that it is entitled to "money had and received," which is equitable in nature. "A cause of action for money had and received is not premised on wrongdoing, but 'looks only to the justice of the case and inquires whether the defendant has money which rightfully belongs to another." *Plains Exploration & Production Co. v. Torch Energy Advisors, Inc.*, 473 S.W. 3d 296, 302 n.4 (Tex. 2015) (internal quotations omitted). It is a doctrine to prevent unjust enrichment. *Id.*

"Generally speaking, when a valid, express contract covers the subject matter of the parties' dispute, there can be no recovery under a quasi-contract theory . . .". *Fortune Production Co. v. Conoco, Inc.* 52 S.W.3d 671, 684 (Tex. 2000). The Agreement covers the subject matter of the parties' dispute. Accordingly, Aetna's unjust enrichment and money had and received claims are without merit and denied.

X. SAPA'S STATUTE OF LIMITATIONS DEFENSES

Aetna's claim for breach of contract seeks damages for claims arising as early as 2014, even though it did not file its breach of contract claim until July 2021. Aetna argues that its claims are not barred by the statute of limitations based on (1) estoppel in avoidance of limitations and (2) the discovery rule. (Aetna's Brief, p. 45).

A. Avoidance by Estoppel

"Estoppel in avoidance of limitations may be invoked in one of two ways: either a potential defendant conceals facts that are necessary for the plaintiff to know he has a cause of action or the defendant engages in conduct that induces the plaintiff to forego a timely suit regarding a cause of action that plaintiff knew existed."[52] *Dean v. Frank W. Neal & Assoc., Inc.*, 166 S.W.3d 352, 358 (Tex.App.—Fort Worth 2005, no pet.). Aetna alleges that equitable estoppel in avoidance of limitations because [redacted] The issues here have been previously addressed. Through

[52] Aetna does not appear to contend that SAPA engaged in conduct induced it to forgo a timely suit regarding a cause of action that plaintiff knew existed. The preponderance of the evidence does not support such a contention.

its enrollment process and its claims, SAPA disclosed the physicians that it was adding, their hospital affiliations, the identity of the physicians who provided services, and the service facility location for the facilities where the services were provided. SAPA did not conceal these facts or misstate these facts, and Aetna had the right to investigate these facts had it chosen to do so.

Aetna failed to prove the elements of estoppel by avoidance by a preponderance of the evidence; limitations is not tolled by estoppel.

B. Discovery Rule

Alternatively, Aetna argues that the discovery rule tolls the statute of limitations on all of Aetna's claims as far back as the earliest claim improperly submitted under SAPA's TIN number. (Aetna's Brief, p. 47).

"Normally a cause of action accrues when a wrongful act causes some legal injury." *Via Net v. TIG Ins. Co.,* 211 S.W.3d 310, 313 (Tex. 2006). A breach of contract claim accrues when the contract is breached. *Id.* at 314. Under the discovery rule, accrual of a cause of action may be deferred, but the Texas Supreme Court has "restricted the discovery rule to exceptional cases to avoid defeating the purpose behind the limitation's statutes." *Id.* at 313.

The discovery rule applies if the nature of the injury is inherently undiscoverable and evidence of the injury is objectively verifiable. *Id.* The alleged injuries, including the submission of claims under SAPA's TIN for the services of Subcontracted Providers who were not preapproved and at locations that were not approved, were objectively verifiable. The issue here is whether the injury was inherently undiscoverable.

"An injury is inherently undiscoverable if it is, by its nature, unlikely to be discovered within the prescribed limitations period despite the exercise of due diligence." *Id.* quoting *Wagner & Brown, Ltd. v. Harwood,* 58 S.W. 3d 732, 734-35 (Tex. 2001). "This legal question is decided on a categorical rather than a case-specific basis; the focus is on whether the *type* of injury rather than a *particular* injury was discoverable." *Id.*

The Texas Supreme Court has been reluctant to apply the discovery rule in breach of contract cases. In *Via Net*, the court stated that it had "twice refused to apply the discovery rule to defer accrual until a breach of contract is discovered." *Via Net,* 211 S.W.3d at 314. *Via Net* was a third time. Since contracting parties are generally not fiduciaries, "due diligence requires that each protect its own interests." *Id.* "Due diligence may include asking a contract partner for information needed to verify contractual performance." *Id.* Based on the information previously discussed, Aetna failed to prove by a preponderance of the evidence that it exercised due diligence with respect to relevant issues in this case.

Aetna failed to prove the applicability of the discovery rule by a preponderance of the evidence. Limitations is not tolled by the discovery rule.

XI. FINDINGS AND CONCLUSIONS

Accordingly, the following findings and conclusions are issued in Phase One:

SAPA's Claims

1. Aetna breached the Agreement to the extent that it failed to pay the [redacted] of billed reimbursement rate for physicians who were employees, partners, or shareholders of SAPA (regardless of where the services were provided, the type of facility, or any preapproval requirement for the facility) and to the extent that it recouped any such payments.[53]

2. Aetna did not breach the Agreement to the extent that it failed to pay for services of Subcontracted Providers.

3. With respect to claims that come under chapters 843 and 1301 of the Texas Insurance Code, Aetna violated chapters 843 and 1301 if (and to the extent that) it failed to pay the claims of SAPA employees, shareholders, and partners (regardless of where the services were provided, the type of facility, or any preapproval requirement for the facility) within the time periods set forth in the statutes and regulations and is subject to the requirement that it pay those claims at the contracted rate and be subject to statutory penalties, costs, and attorney's fees.

Aetna's Claims

4. SAPA did not breach the Agreement by submitting claims under its TIN for services provided by SAPA's employees, partners, and shareholders[54] (regardless of where the services were provided, the type of facility, or any preapproval requirement for the facility).

5. SAPA breached the Agreement to the extent to the extent it added, used, and billed for Subcontracted Providers who were not pre-approved by Aetna, but any such claims that are governed by chapters 843 or 1301 of the Texas Insurance Code are barred to if (and to the extent that) Aetna failed to comply with the statutory and regulatory deadlines regarding overpayments.

6. Aetna failed to prove any other causes of action by a preponderance of the evidence.

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[53] SAPA employees were those physicians who received W-2s issued by SAPA.

[54] See footnote 50.

7. The applicable statute of limitations for breach of contract is four years from the claim date; equitable tolling and the discovery rule do not toll the statute of limitations.

Other Orders

8. The parties are ordered to begin conferring on the next steps no later than June 15, 2023 and to attempt to reach an agreement on the next steps.

9. The parties are ordered to report their agreements or, failing that, their respective positions on matters on which there is no agreement on or before June 29, 2023.

Signed this 24 day of May, 2023.

Patricia Chamblin, Arbitrator

Dkt. 29-6

Exhibit 6

AMERICAN ARBITRATION ASSOCIATION

SINGLETON ASSOCIATES, P.A.,	§	
	§	
Claimant,	§	
	§	
v.	§	**Case No. 01-21-0004-0763**
	§	
AETNA HEALTH INC. AND AETNA LIFE INSURANCE COMPANY,	§	
	§	
	§	
Respondents.	§	

AETNA'S FIRST AMENDED COUNTERCLAIM

Respondents Aetna Health Inc. and Aetna Life Insurance Company ("Aetna") file this Amended Counterclaim against Claimant Singleton Associates, P.A. ("Singleton").[1]

I. INTRODUCTORY STATEMENT

1. When Aetna contracted with Singleton in 2002, Singleton was a Houston-based radiology group staffing two hospitals in Houston. Consistent with the parties' intent, Singleton, for years, submitted healthcare claims under its physician group agreement with Aetna ("Houston Group Agreement" or "Agreement") for services of physicians located in Houston and who were employees or owners of the group, as required under the Agreement. At some point after 2014—but unbeknownst to Aetna at the time—Singleton began improperly submitting claims for services of unauthorized physicians from outside of Houston and even Texas, using Singleton's Federal Tax Identification Number ("TIN"). In 2020, Aetna uncovered this misconduct and tried to further investigate Singleton's relationships with the unauthorized physicians, as well as its relationship with one or more entities known collectively as "Radiology Partners," who had some sort of

[1] Aetna's Answer and Affirmative Defenses are not withdrawn but are not amended at this time.

elusive affiliation with Singleton at that point.

2. When Aetna could not get the requested information—or straight answers—from Singleton about these relationships, Aetna stopped paying the unauthorized physicians under the Agreement. Aetna also demanded the return of overpayments made prior to this discovery. By this time, persons acting on behalf of both "Singleton" and "Radiology Partners" terminated the Agreement and then filed this arbitration in the name of "Singleton" in an effort to stop the overpayments. They did so with shameless allegations of Aetna's efforts to take advantage of physicians during a pandemic, when, as it turns out, Radiology Partners has been gouging Aetna and its members for years based on the submission of false medical claims under the Agreement.

3. As it turns out, Radiology Partners—a "national radiology practice" backed by billion dollar investment firms—acquired Singleton in 2014. Since then, Radiology Partners—who claims not to employ physicians—has controlled Singleton and, on information and belief, attempted to assume obligations under the Agreement (albeit invalidly), without telling Aetna. But worse, Radiology Partners engaged in a fraudulent scheme to obtain payments from Aetna (including from the employee-funded benefit plans it administers) that were not due to Radiology Partners under the Agreement, in order to maximize profits for its own corporate financial gain and those of its investors.

4. First, Radiology Partners exploited the Agreement's percentage-of-billed-charges payment methodology by significantly raising billed charges on claims to obtain exceedingly high reimbursement rates. Furthermore, in order to obtain the Agreement's lucrative reimbursement for ***all*** of Radiology Partners' affiliated physicians interpreting images at Texas hospitals—including hospitals located far outside of the Houston area and radiologists practicing remotely in other states—Radiology Partners submitted the claims for those services under the Singleton TIN. These

were not "Singleton" physicians, however, and most of them were part of physician groups under separate contracts with Aetna (i.e., under different TINs). Nevertheless, Radiology Partners knowingly submitted medical claims using the Singleton TIN for all of these physicians, causing claims to pay under the Agreement that were payable, if at all, under a different provider agreement and at a lower rate. Aetna did not know the truth regarding these claims at the time of payment. But despite Radiology Partners' continued efforts to hide the truth to this day, Aetna knows now, at least, that these claims should not have been paid to Radiology Partners as described herein.

5. Aetna seeks to recover the payments it made as a result of the wrongful conduct of not only Singleton, but also Radiology Partners, based on their breaches of the Agreement and fraudulent billing scheme. Further, Aetna seeks the return of these payments on behalf of the employee benefit plans it administers and that Singleton and Radiology Partners defrauded. Aetna is entitled to recovery of these damages.

II. PARTIES

6. Counterclaimant Aetna Health Inc. is a Texas corporation with a principal place of business in Texas.[2]

7. Counterclaimant Aetna Life Insurance Company, Inc. is a Connecticut corporation with a principal place of business in Hartford, Connecticut.

8. Claimant/Counterclaim-Respondent Singleton Associates, P.A., is a Texas professional association, formerly with a principal place of business in Houston, Texas, until it was acquired by Radiology Partners. It now lists its principal place of business in El Segundo, California.

[2] Aetna and its affiliates, including Aetna Life Insurance Company, offer access to health plans to more than 1.8 million people in Texas. Aetna Health Inc. contracted on "behalf of itself and its Affiliates," including Aetna Life Insurance Company, and, further, under Section 11.7 of the Houston Group Agreement, Aetna is entitled to assign, delegate or transfer the Agreement to any affiliate. (*See* Agreement § 11.7.).

9. For identification of Radiology Partners, the entities affiliated with Singleton include Radiology Partners, Inc. ("RPI"), Radiology Partners Management, LLC ("RP Management"), and Radiology Partners Matrix, PLLC ("RP Matrix"). All of these entities collectively, including Singleton, are referred to herein as "**Radiology Partners**."

III. JURISDICTION AND VENUE

10. Pursuant to Section 10.2.2 of the Houston Group Agreement, "[a]ny controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof" shall be settled by arbitration administered by the American Arbitration Association.[3] (Agreement § 10.2.2.) All claims asserted herein arise out of and are related to the Agreement.

11. Singleton is a signatory to the Houston Group Agreement.

12. Venue is proper in Houston because a substantial part of the events or omissions giving rise to the claims alleged herein occurred in Houston. When the contract was negotiated, Singleton's principal office was located at 6720 Bertner, MC 2-270, Houston, Texas, in St. Luke's Episcopal Hospital; the Agreement was negotiated, at least in part, in Houston; the service locations listed in the Agreement are St. Luke's Episcopal Hospital and Texas Children's Hospital, both in Houston; Singleton represented to Aetna that physicians were being added to the Agreement to provide services at 6720 Bertner, in Houston; representations were made to Aetna about physicians being added to the Agreement by persons working and/or residing in Houston; Aetna witnesses are located in Houston; and some services at issue were provided in Houston.

[3] Any controversy or claim seeking injunctive or any other form of equitable relief is expressly not to be settled by the arbitration. (*Id.*)

IV. FACTUAL STATEMENTS

A. The Impacted Health Plans

13. Aetna is authorized to bring this action to recover overpayments caused by Radiology Partners' illegal and tortious conduct on behalf of Aetna's fully insured and self-funded health plans.

14. Aetna brings these counterclaims on its own behalf as the provider of fully-insured health plans through which individuals, employees and employers pay Aetna premiums in exchange for Aetna agreeing to pay their healthcare claims using Aetna's money. A small portion of the claims at issue in this case are fully insured claims. Thus, Aetna was induced to pay its own funds to Radiology Partners using Singleton's TIN as part of the improper billing scheme.

15. Significantly, Aetna also brings these counterclaims as claims administrator for self-funded, employer-established health plans that retain Aetna as a third-party administrator to process employees' and their families' healthcare claims and to pay those claims out of funds contributed by employers and their employees. For these self-funded plans, Aetna does not underwrite or insure the benefits being paid. Rather, claims covered under self-funded health plans are paid directly by employers and employees using their own money. Accordingly, Radiology Partners profited as part of the improper billing scheme at the expense of the employers and employees, who fund these self-funded health plans.

16. Any monies recovered by Aetna in this action will be distributed, after costs, to the impacted fully insured and self-funded health plans.

B. Aetna's Managed Care System Is Designed To Contain Health Care Costs

17. Aetna is a managed care company that offers a broad range of integrated healthcare and related plans and services to its plan sponsors and member employees.

18. Aetna's network of contracted medical providers is a key component of Aetna's efforts to ensure that healthcare benefits are affordable to its plan sponsors and member employees.

19. Through contracts with physicians and medical facilities, Aetna can establish predictable rates of payment for medical care that are less costly.

20. Health benefit plans encourage members to use in-network providers, an arrangement beneficial to both the provider, who enjoys increased member volume, and the member, who receives appropriate healthcare services, at a discounted cost.

21. When an Aetna member receives in-network healthcare, the Aetna member is responsible for the payment of a co-pay, deductible and/or co-insurance. Whether a member must pay more out of pocket can be impacted by the amounts allowed for a claim by Aetna if the co-pay, deductible or co-insurance amounts have not been previously met.

22. To encourage Aetna members to seek care at in-network providers, healthplans often require a member to pay significantly higher co-pays, deductibles or co-insurance when they see an out-of-network provider.

23. This participating provider network structure provides predictable costs to Aetna, its plan sponsors and their member employees and helps keep their healthcare affordable.

C. The Houston Group Agreement

24. Singleton and Aetna entered into the Houston Group Agreement effective September 15, 2002.

25. At the time, Singleton was a radiology group made up of individual radiologists or "Group Providers" that provided services in Houston at two facilities: St. Luke's Episcopal Hospital and Texas Children's Hospital.

26. Under the limited scope of the Houston Group Agreement, Aetna agreed to

reimburse Singleton at a high rate of reimbursement using a percentage of billed charges.

27. To ensure that the Agreement protected Aetna and its plan sponsors from inappropriate billing, the Houston Group Agreement included various provisions.

28. One of those provisions is the Service and Billing Location form, which specified the service location and billing addresses for Singleton as St. Luke's Episcopal Hospital and Texas Children's Hospital while using the Singleton TIN.

29. Under Section 4.1, Singleton also agreed to comply with Aetna's Participation Criteria and Policies regarding, among other things, measures designed to control healthcare costs and ensure member safety, such as quality improvement/management/assessment, and utilization management, including precertification of elective admissions and procedures, and credentialing. (*See* Agreement § 4.1.)

30. Importantly, the Houston Group Agreement did not provide unlimited access for any radiologist in the United States to bill under the Agreement.

31. Under Section 1.3, Singleton agreed that each Participating Group Provider shall execute an individual participation agreement with Aetna.

32. Under Section 1.4, Singleton agreed to provide notice, at the earliest possible time, of any significant changes in Singleton's capacity to provide services to Aetna members, including, "but not limited to," any significant reduction in the number of participating Group Providers. (Agreement § 1.4.)

33. Likewise, under Section 1.5, Singleton agreed to provide Aetna with a complete list of Singleton's Group Providers, including, but not limited to, names and office addresses. (*See* Agreement § 1.5.) Singleton was required to notify Aetna of "any change in this information" within ten (10) days of acquiring such knowledge. (*Id.*)

34. Under Section 2.2, if Singleton chose to use subcontractors to provide any services to Aetna members, where appropriate under the Agreement, Singleton further agreed to provide notice to Aetna and obtain its approval. (*See* Agreement § 2.2.) Section 12.19 defined a "Subcontracted Provider" as "[a]ny provider contracted with Group or a Participating Group Provider to provide services to [Aetna] Members." (Agreement § 12.19.)

35. Pursuant to Section 2.8, a Group Provider was a "duly licensed and qualified health care provider who is employed by, or who is a partner or shareholder of Group." (Agreement § 2.8.)

36. Section 12.10, in turn, provided that a "Participating Group Provider" was a Group Provider who has been accepted as a Participating Provider by Aetna. (Agreement § 12.10.)

37. Singleton also could not share confidential information with third party providers or other entities, without Aetna's permission. Under Section 4.6, Singleton agreed to keep any Proprietary Information "strictly confidential," except for governmental authorities having jurisdiction. (Agreement § 4.6.) Section 12.15 specifically defined Proprietary Information as including, but not limited to, Aetna's "payment rates." (Agreement § 12.15.)

38. Under Section 11.7, Singleton further agreed not to assign, subcontract, delegate or transfer the Agreement in any manner to third party providers or other entities. (*See* Agreement § 11.7.)

39. To provide Aetna with additional protection from inappropriate billing, Singleton agreed to return or arrange the return of any overpayments after becoming aware of them pursuant to Section 3.1. (*See* Agreement § 3.1)

D. The Rise of Private Investment-Backed Entities Like Radiology Partners In Hospital-Based Physician Groups

40. Based on its website, "Radiology Partners (RadPartners) is a national radiology practice consisting of a group of radiology practices across the U.S. that are licensed to practice medicine and provide patient care. RadPartners refers to all practices owned and/or managed by subsidiaries of Radiology Partners, Inc. . . ." Radiology Partners is backed by billion dollar private investment firms and grown rapidly to relationships with more than 1,000 radiologists today (from only 180 radiologists reportedly in 2014).

41. Hospital-based physicians, like radiologists, emergency room doctors or anesthesiologists, are typically not chosen by a patient.

42. Recognizing the opportunity to exploit the healthcare system, large private investment firms have invested heavily to acquire or invest in hospital-based physician practice groups, while attempting to skirt the edges of the illegal practice of medicine and, at the same time, causing hospital-based physician costs to skyrocket out of control.[4]

43. Radiology Partners is no stranger to this world. In addition to the sizeable investments in Radiology Partners by massive private investment firms, Radiology Partners is run by former DaVita executives, who have touted Radiology Partners' use of an organizational

[4] This phenomenon has led to state and federal legislation to combat the problem. *See* Surprise Medical Bills Cost Americans Millions. Congress Finally Banned Most of Them., The New York Times, December 22, 2020 (https://www.nytimes.com/2020/12/20/upshot/surprise-medical-bills-congress-ban.html); Surprise Billing Protections: Help Finally Arrives For Millions Of Americans, The Commonwealth Fund, December 17, 2020, https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law; Private Equity Is The Driving Force Behind Surprise Medical Billing, Americans for Financial Reform, March 30, 2020, https://ourfinancialsecurity.org/2020/03/fact-sheet-private-equity- driving-force-behind-surprise-medical-billing/; Investors' Deep-Pocket Push To Defend Surprise MedicalBills, Kaiser Health News, https://khn.org/news/investors-deep-pocket-push-to-defend-surprise- medical-bills/. This legislation has been opposed by the private investment firms using sham lobbying entities to hide their identities. *See* Mystery Solved: Private-Equity Backed Firms Are Behind Ad Blitz On 'Surprise Billing', The New York Times, September 16, 2019, https://www.nytimes.com/2019/09/13/upshot/surprise-billing-laws-ad-spending-doctor-patient- unity.html.

structure used in "other areas of healthcare." DaVita is, of course, a notorious dialysis provider blamed for exponentially increasing the costs of dialysis in the United States.

E. Radiology Partners' Misconduct And Violations Of The Houston Group Agreement

44. In 2014, RPI acquired Singleton from its physician owners in Houston. Based on public reports, RPI acquired a "majority interest" in Singleton.

45. Based on information and belief, at that time, Anthony Gabriel, M.D., a California resident and RPI's Co-Founder and Chief Operating Officer, became the sole physician owner and manager of Singleton. As Aetna knows now, through "management contracts," RPI assumed control and management of all operations of Singleton, including, but not limited to, functions such as medical billing and administration of Singleton's contracts with third-party payers, including Aetna.

46. Based on information and belief, through Dr. Gabriel's ownership of Singleton, the P.A. became what is known as a "captive" professional association. Through this common ownership, the P.A. is and was controlled by RPI, with the P.A.'s profits effectively running through RPI's management companies and back to the equity investors.

47. Through various contracts, RPI and RP Management share in the revenue generated under the Singleton TIN, including payments made by Aetna under the Houston Group Agreement.

48. Singleton did not notify Aetna of this change in ownership.[5]

49. Having taken control of Singleton, Radiology Partners willfully and intentionally obscured the true nature of its acquisition from Aetna.

[5] Although Radiology Partners has alleged that Aetna "knew" that RPI and its subsidiaries were managing and controlling Singleton, Radiology Partners did not give Aetna notice of this acquisition or the facts regarding its alleged "management" of Singleton. Although "radpartners" email addresses and "Radiology Partners" branding appeared on occasional correspondence over time, it is not uncommon for consultants to act on behalf of providers. As it turns out, however, Radiology Partners was much more than that. Moreover, as explained below, Radiology Partners intentionally obscured the true nature of its relationship with Singleton for years—and still tries to in this arbitration.

50. Prior to the acquisition, Aetna previously had refused to provide the same lucrative rates under the Agreement to other physician groups that had recently been acquired by Radiology Partners. Radiology Partners, therefore, acquired Singleton, hid the true nature of the acquisition from Aetna—which was a complete change in ownership—and then started billing those other physicians under the Agreement. Based on information and belief, Singleton disclosed Aetna's confidential proprietary information to Radiology Partners and its affiliates prior to the acquisition. What Radiology Partners did next, however, was even more egregious.

51. After the acquisition, RPI acquired other group radiology practices throughout the State of Texas, ranging from the Rio Grande Valley to the Dallas metropolitan area, for example, as well as all over the country. Based on information and belief, RPI's acquisition of these practices and assumption of control and management, including through RP Management, were structured in the same or in a similar manner as Singleton.

52. Importantly, Aetna had separate provider agreements with most, if not all, of these acquired provider groups. Aetna negotiated these separate agreements based on the local market and competitive data in that market, as well as that group's historical service and billing profile, e.g., most frequent types of services and billed charge amounts.

53. Furthermore, RPI recruited physicians and staffed the administrative support for the Singleton P.A. and all of RPI's other subsidiaries across the country, including those persons who performed the billing and credentialing under the various payer agreements. RPI and/or RP Management set the billing rates for Singleton, and, based on information and belief, as well as RPI's other subsidiaries, including RP Matrix.

54. In most if not all instances, the Houston Group Agreement provided a higher rate of payment for the same services as Aetna's other group agreements. This is particularly true

because Radiology Partners charged exceedingly high billed charges after the acquisition, thereby exploiting the percentage-of-billed charge methodology in the Agreement.

55. Furthermore, RP Matrix was established by Radiology Partners to employ and provide teleradiology through remote, offsite radiologists.

56. At some point after acquiring Singleton, Radiology Partners started submitting claims for services for hundreds of radiologists who were neither employees of, nor shareholders nor partners in, Singleton. Rather, these physicians were affiliated with Radiology Partners through other group practices and/or other Radiology Partners affiliates. A significant number of these services (many thousands) were provided at facilities outside of the Houston market.

57. Most, if not all, of these radiologists were part of separate and existing in-network contracts with Aetna that paid substantially less, and often negotiated in other non-Houston markets.

58. Based on information and belief, Radiology Partners also billed for the remote services of physicians employed by RP Matrix—and not Singleton—under the Singleton TIN.

59. To get past Aetna's claims processing system, the claims from these other radiologists were submitted to Aetna using the Singleton TIN. Radiology Partners submitted these claims, knowing that Aetna's claims processing system would automatically adjudicate and pay those claims relying on the use of the Singleton TIN in the claim form. Radiology Partners submitted these false claims in which they posed as Singleton to obtain the higher reimbursement rates under the Agreement.

60. Aetna had not approved most of these physicians to be added to the Agreement. And for the relatively few that it did, Aetna relied on representations made by Radiology Partners, including employees of RPI and RP Management, that these physicians were Group Providers who

would be providing services in Houston, particularly at the 6720 Bertner address. For several physicians, this was not true; in fact, these physicians were not providing services anywhere near Houston.

61. After the merger, Aetna was contacted from time to time by various persons purported acting on behalf of Singleton about adding physicians to the Agreement, making the misrepresentations described above. At least one of these representatives used a "radpartners" email address, but during the same 2016-2017 timeframe, also wrote letters on "Singleton Associates, P.A." letterhead. When Aetna asked if Radiology Partners had acquired Singleton, however, the representative dodged the question.

62. Network managers at Aetna handle the day-to-day administration of the Agreement. On several occasions, Aetna network managers told Singleton's representatives to notify Aetna of changes to the practice group through them, the network managers. Even after being told, however, these representatives would attempt an end-run around network managers and try to add the physicians through other operations at Aetna.

63. On several occasions over time, Aetna also asked various representatives of Singleton for a complete or current roster of Singleton physicians. Nevertheless, they uniformly failed to provide one, indicating a deliberate decision to withhold this information from Aetna.[6]

64. Regardless of whether Aetna had added the physician to the Agreement, the claim system paid claims under the Singleton contractual rate based on the TIN reported on the claim until Aetna discovered (in part) Radiology Partners' wrongdoing. Additionally, Aetna relies on information received in its claim system, including information from billing providers, for

[6] Based on information and belief, these representatives were employees of RPI or its subsidiaries. Some worked out of Radiology Partners' California operations. Furthermore, RP Management provided "credentialing" services for Radiology Partners subsidiaries, such as Singleton.

reporting and other operations.

65. Aetna relies on its providers—particularly its contracted providers, who are, typically, trusted partners—to bill honestly and accurately represent their practice group. As it turns out, once acquired and controlled by RPI and its subsidiaries, Aetna could no longer trust this provider.

66. In the summer of 2020, Aetna detected aberrational claims activity from providers billing with the Singleton TIN but seemingly located outside of Houston. Aetna began investigating the matter to better understand this suspicious claim activity, which Aetna later learned were false claim submissions.

67. Even before that, however, Aetna identified that the claims spend for the Houston-based Singleton had grown in size significantly. Due to the unexpectedly high spend, Aetna attempted to engage Singleton over a new contract rate in early 2020 in an effort to reset the Agreement to a market competitive and sustainable rate. Singleton largely ignored those attempts.

68. To reduce the exposure to Singleton's contract rate, on September 23, 2020, Aetna formally proposed a new contract rate pursuant to Section 8.1 of the Houston Group Agreement. (*See* Agreement § 8.1.) This rate sought to align the 18-year old Agreement with the current market rate for radiology providers in the Houston market.

69. In October 2020, Aetna responded to a purported Singleton representative named Fredricka Richards, who, because of her email address, Radiology Partners seemingly employed. When asked by Aetna to identify her employer, Ms. Richards stated that both Singleton and Radiology Partners separately employed her.

70. When Aetna raised the issue of its rate proposal with Ms. Richards, she claimed that the Singleton high percentage of billed charge contract rate was, in her view, market

competitive across Texas. Aetna reminded her that the Agreement was Houston-based, a position with which she disagreed, notwithstanding the fact that neither she nor Radiology Partners had negotiated the Agreement. Aetna also disagreed that the Singleton rate was market competitive, another fact only highlighted by Singleton's efforts to run claims from all over Texas and elsewhere through the Agreement. The parties left off with Aetna requesting a physician roster for Singleton, a non-disclosure agreement with Radiology Partners, and a counter-proposal.

71. In response to Aetna's September rate proposal, on October 13, 2020, Radiology Partners provided notice of its intention to terminate the Houston Group Agreement effective February 2021, while, at the same time, continuing discussions with Aetna in an effort to reach agreement. The termination letter was on "Singleton Associates, P.A." letterhead and signed by Fredricka Richards as "Vice President, Payor Strategy and Contracting, and Corporate Counsel."

72. On October 23, 2020, Ms. Richards promised that Radiology Partners would provide the requested physician roster within a short period of time.

73. Meanwhile, Aetna began paying claims for the claims for the unauthorized physicians (based on what Aetna could discern at the time) at a reduced rate in an effort to mitigate the damages to Aetna, its plan sponsors and members, pending resolution of the parties' discussions. Aetna also retained a third party vendor, Equian, to start providing formal notice of past overpayments and to start the process of recouping the overpayments.

74. On November 5, 2020, Ms. Richards provided Radiology Partners' comments to a draft non-disclosure agreement from Aetna but did not provide the promised physician roster. This refusal to provide a roster was consistent with Radiology Partners' past practices of refusing to do so when Aetna had requested that information.

75. Thereafter, Aetna provided Ms. Richards with courtesy copies of letters regarding

the false billings under the Agreement, including claims lists.

76. On December 8, 2020, rather than provide the promised physician roster, Singleton disclosed to Aetna the Texas hospital locations purportedly staffed by Singleton, including those located outside of Houston. In an attempt to gain leverage, Ms. Richards made clear that terminating the Agreement would cause significant disruption to Aetna and its members, given Singleton's extensive footprint. When questioned about the fact that one of the identified practices, Austin Radiology Associates ("ARA"), had a separate in-network agreement with Aetna but had billed using the Singleton TIN, Ms. Richards responded that ARA continued as a separate entity. At that time, she disclosed that Singleton (apparently many months before) had acquired ARA's hospital-based radiology business, thereby implying that ARA physicians were billing for services under multiple Aetna contracts, using different TINs, including the Singleton TIN. Rather than negotiate over a market competitive rate, Ms. Richards refused to accept anything other than the inordinately high rate under the Houston Group Agreement.

77. On December 17, 2021, Aetna sent a formal letter to Singleton accepting its termination of the Agreement.

78. Thereafter, the parties had discussions about Aetna's efforts to collect the overpayments resulting from the falsely submitted claims.

79. Those discussions culminated on January 22, 2021, when Radiology Partners sent a letter to Aetna, objecting to any attempt by Aetna to recoup the overpayments resulting from the false claims. Notably, among other things, Radiology Partners claimed that the Texas Prompt Pay Act ("TPPA") barred the collection of most of the overpayments as untimely even though the TPPA does not apply to self-funded claims (the majority of the overpayments), that Aetna had "ratified" the false claims, and that Singleton had provided notice to Aetna of the unauthorized

providers billing to the Houston Group Agreement in any event. None of this is true.

80. Contrary to Radiology Partners' argument, the TPPA does not apply to self-funded claims as a matter of law. The Texas Legislature passed the TPPA in 1997, and subsequently charged the Texas Department of Insurance with the TPPA's enforcement. *See* Tex. Ins. Code Ann. §§ 36.001, 1301.007. According to the Department of Insurance, the TPPA is not applicable to "[s]elf-funded ERISA plans."[7] Likewise, the website's "Prompt Pay FAQs" section instructs that "[t]he prompt pay laws . . . are not applicable to self-funded ERISA plans."[8]

81. In addition to the Texas Insurance Department's view, the Fifth Circuit Court of Appeals has squarely held that the "[the TPPA] does not apply to a third-party administrator of self-funded employer plans." *Aetna Life Ins. Co. v. Methodist Hosps. of Dallas*, 640 Fed Appx. 314, 318 (5th Cir. 2016) (citing *Health Care Serv. Corp. v. Methodist Hosps. of Dallas*, 814 F.3d 242 (5th Cir. 2016).

82. Finally, the TPAA does not bar attempts, like those of Aetna, to recover overpayments induced through fraud, even with regard to fully-insured plans.

83. Worse yet for Singleton, the Houston Group Agreement itself made clear that the TPAA did not apply to self-funded claims. Under Section 3.1 of the Agreement, if Aetna paid a Clean Claim later than forty-five (45) days of submission, upon appropriate written notice to Aetna, Aetna agreed to pay a contracted penalty of 1.5 percent per month simple interest on the eligible, unpaid portion of that Clean Claim. (*See* Agreement § 3.1.) But in the event of a late payment by Aetna of a Clean Claim *for a self-funded plan*, Singleton agreed that Aetna did not

[7] Tex. Dep't of Ins., *Finding Your Way to Prompt Pay*, https://www.tdi.texas.gov/hprovider/documents/pp_fywtpp.pdf (last visited Apr. 5, 2021).

[8] Tex. Dep't of Ins., *Prompt Pay FAQs*, Other Questions, https://www.tdi.texas.gov/hprovider/ppsb418faq.html (last visited Apr. 5, 2021).

need to pay either Singleton's billed charges *or* the contracted penalty.

84. Radiology Partners' argument that Aetna had "ratified" its false claims fared no better. Ratification is "the adoption or confirmation by a person, *with knowledge of all material facts*, of a prior act that did not then legally bind that person and which that person had the right to repudiate." *Lesikar v. Rappeport*, 33 S.W.3d 282, 300 (Tex. App. - Texarkana 2000, no pet.) (emphasis added). Here, Aetna did not knowingly approve Radiology Partners billing multiple hundreds of physicians, regardless of the location of the physicians or whether they were Group Providers, through the Agreement using Singleton's TIN. Nor was there any request for Aetna to approve any Subcontractors under the Agreement, and, in any event, it did not approve of any such Subcontractors or Subcontractor contracts. Moreover, it would be impossible for Aetna to approve something it was not made aware of.

85. Additionally, any purported waiver by Aetna of a breach of the Agreement (even if Aetna had known the facts, which it did not) did not operate as a waiver of any subsequent breach thereof under the plain terms of the Agreement. (*See* Agreement § 11.1.)

86. Similarly, under Section 8.1, no amendment of the Agreement is effective unless signed and agreed by authorized representatives of both parties. Radiology Partners has produced no such amendment. (*See* Agreement § 8.1.)

87. Indeed, Radiology Partners failed to provide Aetna with the requested proof that it sent appropriate notice to Aetna of the intent to add the unauthorized physicians, or that Aetna knowingly agreed to add those physicians. Section 11.10 of the Agreement required Singleton to send any notice required under the Agreement in writing by overnight delivery service with proof of receipt, or by certified mail return receipt requested. (*See* Agreement § 11.10.) Only upon mutual agreement of the parties, could notices be given by email or by other electronic means. The

parties had to send notices to the addresses designated in Section 11.10.

88. Upset that Aetna had stopped its scheme, in February 2021 Radiology Partners attempted to frighten Aetna's members by mailing letters to them, claiming that Aetna had tried to force Singleton out-of-network unless it accepted an unacceptable contract rate. Radiology Partners urged those members to call and pressure Aetna, complain to the Texas Department of Insurance, or change their health coverage altogether, thus interfering with Aetna's relationships with those members and plan sponsors in violation of the Houston Group Agreement. Under Section 9.3 of the Agreement, Singleton had expressly agreed not to interfere with Aetna's contractual relations with plan sponsors. (*See* Agreement § 9.3.)

89. Equally inappropriate and misleading was Radiology Partners' failure to inform the members that it had been billing their claims under the Houston Group Agreement in an effort to take advantage of the inordinately high reimbursement rate, a portion of which would be borne by these members. Singleton also neglected to inform the members that Aetna, in fact, had proposed a market-level rate to Singleton under the terms of the Agreement to control the members' healthcare costs.

90. While on March 3, 2021, Singleton finally provided Aetna with a physician roster of approximately 500 physicians billing under the Houston Group Agreement (with many outside of Houston and even Texas) for the last twelve (12) months after multiple requests by Aetna, Radiology Partners maintained its refusal to produce copies of the notices that Radiology Partners claimed to have sent to Aetna to add providers. Nor did Radiology Partners provide an explanation of the relationship between Singleton (or, as Aetna now understands) Radiology Partners and the physicians whose services were billed under the Houston Group Agreement, including examples of the agreements, if any, with those physicians. Similarly, Radiology Partners provided only the

previously described vague and evasive description of its relationship with Singleton: it is a "management services relationship, through which Radiology Partners provides support to Singleton to help Singleton achieve its clinical goals." Since then, however, Aetna has discovered that Radiology Partners provides much more than support; rather, Radiology Partners, Inc., itself or directly through its affiliates, exercises complete control.

91. In short, Radiology Partners' billing scheme has victimized Aetna, its plan sponsors and their member employees, causing them to pay millions of dollars to which it was not entitled. Accordingly, it is particularly galling that instead of returning Aetna the overpayments, Radiology Partners, in the name of Singleton, initiated this arbitration against Aetna, using the false narrative that Aetna manufactured this dispute in the middle of a pandemic in an effort to force Singleton into an unreasonably low contract rate.

92. Singleton, working under the control of, at the direction of, and/or in concert with, Radiology Partners, has engaged in wrongful conduct intended to maximize its profits, including, but not limited to: (a) breaching the Houston Group Agreement; (b) causing other Aetna in-network providers to breach their contracts with Aetna; and (c) fraudulently billing for services under the Houston Group Agreement by unauthorized providers, including physicians who are not part of Singleton altogether.

93. Because of this conduct, Aetna has been damaged in an amount to be determined at trial.

V. CONDITIONS PRECEDENT

94. Aetna has met all conditions precedent to recover in this case, or alternatively, those conditions have been waived by Claimant.

VI. COUNTERCLAIM ONE (BREACH OF CONTRACT)

95. Aetna realleges and incorporates by reference the foregoing paragraphs.

96. Pursuant to Section 1.4 of the Houston Group Agreement, Singleton agreed to provide notice, at the earliest possible time, of any significant changes in Singleton's capacity to provide services to Aetna members. (*See* Agreement § 1.4.)

97. Under Section 1.5, Singleton agreed to provide Aetna with a complete list of Singleton's Group Providers, including, but not limited to, names and office addresses. Singleton agreed to notify Aetna of "any change in this information" within ten (10) days of acquiring such knowledge. (Agreement § 1.5.)

98. Under the Agreement, Singleton also agreed to provide and bill for services at St. Luke's Episcopal Hospital and Texas Children's Hospital, using the Singleton TIN.

99. Under Section 2.2, if Singleton chose to use subcontractors to provide Covered Services to Aetna members, where appropriate, Singleton agreed to provide notice to Aetna and obtain its approval. (*See* Agreement § 2.2.) The Agreement further carried specific subcontracting responsibilities for the use of subcontractors, as well as Aetna's approval.

100. Pursuant to Section 2.8, a Group Provider may only be a "duly licensed and qualified health care provider who is employed by, or who is a partner or shareholder of Group." (Agreement § 2.8.)

101. Section 12.10, in turn, provided that a "Participating Group Provider" is a Group Provider who has been accepted as a Participating Provider by Aetna. (*See* Agreement § 12.10.)

102. Under Section 4.6, Singleton also agreed to keep any Proprietary Information "strictly confidential," except for governmental authorities having jurisdiction. Section 12.15 specifically defined Proprietary Information as including, but not limited to, Aetna's "payment

rates." (Agreement § 4.6.)

103. Under Section 11.7, Singleton further agreed not to assign, subcontract, delegate or transfer the Agreement in any manner to third party providers or other entities. (*See* Agreement § 11.7.)

104. Under Section 2.1, Singleton agreed to comply with all applicable laws and regulations related to the Agreement, including, but not limited to, laws related to fraud, confidentiality, false claims and prohibition on kickbacks.[9] (*See* Agreement § 2.1.)

105. In violation of its duties and obligations under the Agreement, Radiology Partners[10] billed for services performed by unauthorized physicians using the Singleton TIN without providing appropriate notice and obtaining the prior approval of Aetna, and by improperly assigning, subcontracting and/or delegating the Agreement to third party providers.

106. The submission of a claim to Aetna constitutes a certification and representation that the information shown on the claim is true, accurate and complete.

107. By submitting claims for the services of unauthorized providers, as well as physicians who were not actually Singleton radiologists, Radiology Partners represented that the physicians were employees and owners of Singleton and were entitled to bill under the Agreement.

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[9] For example, Texas law mandates that health care providers only charge proper and reasonable fees, as follows:

> (a) A hospital, treatment facility, mental health facility, or health care professional may not submit to a patient or a third party payor a bill for a treatment that the hospital, facility, or professional knows was not provided or knows was improper, unreasonable, or medically or clinically unnecessary.

Tex. Health & Safety Code § 311. 0025(a). Texas law also prohibits health care providers from engaging in unprofessional conduct. Tex. Occ. Code § 105.002. The law prohibits a health care provider, in connection with the provider's professional activities, from knowingly presenting (or causing to be presented) a false or fraudulent claim for the payment of a loss under an insurance policy. It further prohibits a health care provider, in connection with its professional services, from knowingly preparing, making, or subscribing to any writing, with the intent to present or use the writing, or allow it to be presented or used, in support of a false or fraudulent claim under an insurance policy.

[10] Again, "Radiology Partners" is defined herein collectively to include Singleton.

They also falsely represented the correct TIN of the provider, resulting in breaches of the Agreement and payments under the Agreement to which they were not entitled.

108. Singleton has also violated its duties and obligations under the Agreement by disclosing Proprietary Information to third parties, including, but not limited to, RPI, RP Management and RP Matrix, and third party providers.

109. In further violation of its duties and obligations under the Agreement, Singleton failed to provide Aetna with access to information relating to its compliance with the Agreement under Section 6.2, including, but not limited to, information relating to Singleton's relationship with the third party providers billing under the Agreement as well as Radiology Partners. (*See* Agreement § 6.2.)

110. Singleton, acting under the control of Radiology Partners, including RPI and RP Management, breached the Agreement, including the Specialist Physician Participation Criteria Schedule and other Forms and Schedules, and including but not limited to, breach of each of the contractual provisions listed herein.

111. Furthermore, RPI, RP Management and Singleton designed this scheme to exploit the Agreement for higher-rate payments to which they were not entitled.

112. As a direct and proximate result of Singleton's breaches of the Agreement, Aetna has been damaged in an amount to be determined at trial.

113. Singleton, RPI, and RP Management are jointly and severally liable for each of the respective breaches.

VII. COUNTERCLAIM TWO (TORTIOUS INTERFERENCE)

114. Aetna realleges and incorporates by reference the foregoing paragraphs.

115. During the relevant time period, Aetna had valid in-network contracts with

providers whose services were submitted improperly under the Houston Group Agreement.

116. These contracts contained provisions that required the in-network providers to bill for all services provided by those providers to Aetna members pursuant to the terms of the contracts.

117. Radiology Partners (each of them) knew of the existence of these in-network contracts.

118. Despite this knowledge, Radiology Partners intentionally interfered with, attempted to defeat, and procured the breach of Aetna's network contracts by causing the non-Singleton providers to bill for services under the Houston Group Agreement using the Singleton TIN.

119. Radiology Partners' conduct constitute wrongful interference with Aetna's contractual relationships with its in-network providers.

120. There was no proper justification for the interference and procurement ofthese breaches by Radiology Partners.

121. Because of the breach of the in-network contracts caused by Radiology Partners, Aetna has been damaged in the form of improper payments to Radiology Partners. The amount of Aetna's damages will be determined at trial.

122. Singleton, RPI and RP Management are jointly and severally liable for the tortious conduct.

VIII. COUNTERCLAIM THREE (FRAUD)

123. Aetna realleges and incorporates by reference the foregoing paragraphs.

124. Radiology Partners engaged in a fraudulent billing scheme that included intentionally submitting false medical claims to Aetna under Singleton's TIN for the purpose of obtaining lucrative payments for services under the Agreement that they were not entitled to

receive. The medical claim submissions contained material misrepresentations about the servicing physician, and Aetna relied upon those misrepresentations in paying the claims at the rate in the Agreement.

125. Radiology Partners knowingly made material misrepresentations and omissions to Aetna on claims that they submitted, or caused to be submitted, with the intent to induce Aetna to rely on those misrepresentations and omissions and to pay the claims.

126. The submission of a claim to Aetna constitutes a certification and representation that the information shown on the claim is true, accurate and complete, and the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts.

127. Based on information and belief, Singleton, RPI, RP Management and RP Matrix conspired to design this scheme, and the billing and coding on the claims was performed by RPI and/or RP Management.

128. Each time Radiology Partners submitted, or caused to be submitted, a claim, it represented that the provider was entitled to bill under the Agreement for the services.

129. Each time Radiology Partners submitted, or caused to be submitted, a claim, it represented that the physician was a Group Provider.

130. As discussed above, the Agreement imposed certain conditions before Singleton could bill for physicians under the Agreement.

131. In submitting claims to Aetna, Radiology Partners, among other things, represented that the servicing/billing location of the servicing provider was Houston, Texas, which is data used to process and pay the claim.

132. That the physicians whose services that Radiology Partners was billing under the Agreement were not authorized to bill under the Agreement, and/or that the physicians were not

employees of, or partners or shareholders in, the Singleton P.A., was information material to Aetna's determination of whether claims submitted by Radiology Partners were payable.

133. Radiology Partners made the aforementioned misrepresentations and omissions with the intent to induce Aetna to make payment on the claims under the Agreement that were not payable as billed.

134. RP Matrix, also controlled by RPI, employed physicians who provided remote services, including for example, interpreting images for services provided at Texas hospitals by physicians living and working in other states. These physicians were not employees or owners of Singleton but were billed by Radiology Partners as though they were.

135. Aetna reasonably relied on the aforementioned misrepresentations and omissions and paid the submitted claims.

136. Because Aetna processes over one million claims per workday, the vast majority are auto-adjudicated by Aetna's claims systems. Due to the volume of claims that Aetna processes, Aetna does not investigate every medical record for accuracy before payment – doing so would grind the healthcare system to a halt. Instead, Aetna reasonably relied on Radiology Partners' representations that the information submitted in the claims was true, accurate and complete, and did not know that Radiology Partners was misrepresenting or concealing material facts.

137. In furtherance of the fraudulent scheme, Singleton, RPI and RP Management each made continuing false or misleading statements to Aetna regarding the service locations of the physicians, the ownership of Singleton and the physicians' affiliation with Singleton when attempting to add certain physicians to the Agreement and/or in Aetna's investigation of the facts. Additionally, or alternatively, Radiology Partners intentionally omitted material information leaving a false impression of the truth.

138. Radiology Partners knowingly submitted false medical claims to Aetna. Radiology Partners knew that Aetna did not intend to pay for non-Singleton physicians or non-Houston services under the Agreement. Accordingly, Radiology Partners submitted false claims such that Aetna would pay those non-Singleton and non-Houston services under the Agreement.

139. Additionally, or alternatively, Radiology Partners was deliberately silent when it had a duty to speak and intended for Aetna to rely upon its omissions or concealment in processing, paying and/or investigating the medical claims, and well as when Aetna was trying to investigate Singleton's relationship with physicians and/or Radiology Partners.

140. As a direct and proximate result of Singleton and Radiology Partners' misrepresentations and omissions, Aetna has been damaged in an amount to be determined at trial.

141. Aetna pleads common-law fraud, and, alternatively, pleads fraud by nondisclosure based on the foregoing.

142. Singleton, RPI, RP Management, and RP Matrix are jointly and severally liable for the tortious conduct.

IX. COUNTERCLAIM FOUR (FRAUDULENT INDUCEMENT)

143. Aetna realleges and incorporates by reference the foregoing paragraphs.

144. Radiology Partners knowingly made the aforementioned misrepresentations and omissions to Aetna on claims that they submitted, or caused to be submitted, with the intent to induce Aetna to rely on those misrepresentations and omissions, to pay the claims, and to continue the parties' contractual relationship, which Aetna would not have otherwise done without Radiology Partners' misrepresentations.

145. Aetna was injured by the payments that it made to Singleton because Aetna paid for the claims based on Radiology Partners' material misrepresentations.

146. Aetna was also injured by continuing a contractual relationship with Singleton based on Radiology Partners' misrepresentations.

147. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, Aetna has been damaged in an amount to be determined at trial.

148. Singleton, RPI, RP Management, and RP Matrix are jointly and severally liable for the tortious conduct.

X. COUNTERCLAIM FIVE (NEGLIGENT MISREPRESENTATION)

149. Aetna realleges and incorporates by reference the foregoing paragraphs.

150. Radiology Partners knowingly made the aforementioned material misrepresentations and omissions to Aetna on claims that they submitted, made them without regard to their truth or falsity, made them under circumstances in which Radiology Partners ought to have known of their falsity, or made them negligently and without the exercise of reasonable care or competence.

151. Radiology Partners intended and expected that Aetna would rely on its misrepresentations and omissions.

152. Aetna justifiably relied on the aforementioned misrepresentations and omissions and paid the submitted claims.

153. Radiology Partners had superior and special knowledge of its practice of submitting claims from unauthorized providers without proper notice to and approval by Aetna.

154. Radiology Partners had a duty to disclose to Aetna information material to the claims that it submitted for reimbursement.

155. Radiology Partners understood that it had a special relationship of trust and confidence toward Aetna that gave rise to a duty to speak and disclose material information

regarding the claims being submitted.

156. As a direct and proximate result of Radiology Partners' misrepresentations and omissions, Aetna has been damaged in an amount to be determined at trial.

157. Singleton, RPI, RP Management and RP Matrix are jointly and severally liable for the tortious conduct.

XI. COUNTERCLAIM SIX (MONEY HAD AND RECEIVED – in the alternative)

158. Aetna realleges and incorporates by reference the foregoing paragraphs.

159. In addition, or in the alternative, Radiology Partners are all liable under money had and received. Aetna paid claims to Singleton that it would not have paid but for the wrongful conduct of Radiology Partners as described herein. Based on information and belief, those monies were further distributed to RPI, RP Management and/or RP Matrix, who each received profits from their fraudulent scheme, including the monies paid by Aetna on behalf of the plans and Aetna's own policies.

160. Radiology Partners—each of them—entered into a conspiracy to bill unauthorized providers under the Houston Group Agreement.

161. Without revealing to Aetna the truth, Radiology Partners gouged Aetna, its plan sponsors and their member employees.

162. The excessive amounts paid by Aetna should be returned to Aetna in good conscience. Accordingly, Aetna seeks the return of money had and received to compensate Aetna, its plan sponsors and their member employees.

XII. COUNTERCLAIM SEVEN (UNJUST ENRICHMENT – in the alternative)

163. Aetna realleges and incorporates by reference the foregoing paragraphs.

164. In addition, or in the alternative, Radiology Partners is liable under the principle of

unjust enrichment. Aetna may recover based on unjust enrichment because Radiology Partners used fraud and undue advantage to obtain a benefit to which it was not entitled.

165. Radiology Partners submitted claims to Aetna that Aetna would not have paid but for the wrongful conduct of Radiology Partners as described herein.

166. When Aetna paid Singleton for services it was not obligated to pay, Singleton received a benefit from Aetna through its fraudulent billing practices. Based on information and belief, those monies were further distributed RPI, RP Management and/or RP Matrix, who each received profits from their fraudulent scheme, including the monies paid by Aetna on behalf of the plans and Aetna's own policies. As a result, Radiology Partners have been unjustly enriched and Aetna, its plan sponsors and their member employees have been injured.

167. It would be inequitable for Radiology Partners to retain amounts Aetna paid as a result of their wrongful conduct alleged herein.

168. Accordingly, Aetna seeks the return of that money to compensate Aetna, its plan sponsors and their member employees.

XIII. ALTER EGO

169. Aetna realleges and incorporates by reference the foregoing paragraphs.

170. RPI assumed ownership and control of Singleton to use it as a sham business for the purpose of perpetuating a fraud on Aetna by submitting false and misleading healthcare claims that induced Aetna to pay millions of dollars in higher in-network rates for radiology services for RPI's affiliated physicians than would otherwise be due. RPI, directly and through its subsidiary, RP Management, used Singleton to engage in this scheme to defraud Aetna and avoided or delayed Aetna's discovery of the fraud by submitting medical claims under Singleton's TIN when, in fact, the radiology services were provided by physicians who were

employed by other Radiology Partners subsidiaries operating under different TINs and in different markets outside of Houston.

171. In addition, or in the alternative, RPI acquired and operated Singleton as a mere tool or business conduit through which it perpetuated a fraud on Aetna for its own profits. RPI, directly and through its subsidiary, RP Management, controlled Singleton by carrying out various executive and operational responsibilities. RPI, RPI Management, RP Matrix and Singleton operate as a single unit. There is no separate website and Singleton has no separate identity from Radiology Partners. Upon information and belief, Radiology Partners finances Singleton, pays the salaries of personnel acting on behalf of Singleton, as well as other expenses of Singleton, and uses Singleton's property (if any) as its own. But RPI, directly and through its subsidiaries, used Singleton's TIN to defraud Aetna, as described herein.

172. As a result of the fraudulent scheme and improper claims submissions, RPI, RP Management, and RP Matrix were paid tens of millions of dollars for services under the plans to which they were not entitled.

173. In addition, or in the alternative, RPI acquired Singleton to hide and/or prevent Aetna or its affiliates from discovering that Radiology Partners was wrongfully and fraudulently submitting medical claims. By doing so, RPI, RP Management and RP Matrix used Singleton to justify the wrongful and improper billing practices.

174. Accordingly, no legally valid corporate shield exists between RPI and Singleton, and Singleton's existence and activities in Texas, including its tortious conduct, are properly imputed to RPI.

XIV. JOINT AND SEVERAL LIABILITY

175. Alternatively, each Singleton, RPI, RP Management and RP Matrix, aided, abetted, assisted, encouraged and/or conspired with one another to commit the fraudulent and/or negligent conduct described herein. As a consequence, their wrongful conduct was a substantial factor in causing harm to Aetna.

176. They conspired to take over separate provider groups, significantly raised billed charges, then cherry-picked the most lucrative contract(s) under which to bill their new provider groups, while consistently evading Aetna's questions about the true nature of their operations.

177. Aetna seeks to recover its actual damages incurred from Radiology Partners' wrongful actions, and Singleton, RPI, RP Management, and RP Matrix are each liable for its own torts and for the acts of the other. Thus, Aetna is entitled to an award of damages from Radiology Partners, jointly and severally.

XV. DISCOVERY RULE

178. To the extent necessary, Aetna affirmatively pleads the discovery rule applies to applicable claims.

XVI. ATTORNEYS' FEES

179. Aetna is entitled to an award of its attorneys' fees and costs under the Agreement and pursuant to Section 38.001 of the Texas Civil Practice and Remedies Code.

XVII. RESERVATION OF RIGHT TO AMEND

180. Aetna reserves the right to amend and supplement its claims as appropriate.

XVIII. PRAYER

WHEREFORE, Aetna respectfully requests an award in its favor and granting the following relief:

a. That all relief requested by way of the Claimant's Demand be denied with prejudice;

b. That Singleton take nothing in this action;

c. That judgment be entered in Aetna's favor and awarding it compensatorydamages as requested herein, and any and all other damages to which it is entitled;

d. That Aetna be awarded its attorneys' fees and costs; and

e. Any other relief the Arbitrator deems appropriate under the law.

Respectfully submitted,

By: */s/ John B. Shely*

JOHN B. SHELY
Texas State Bar No.18215300
jshely@HuntonAK.com
M. KATHERINE STRAHAN
Texas State Bar No. 24013584
kstrahan@HuntonAK.com
HUNTON ANDREWS KURTH LLP
600 Travis, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200

ATTORNEYS FOR COUNTERCLAIMANTS

CERTIFICATE OF SERVICE

I hereby certify that on January 27, 2022, a true and correct copy of the foregoing was served by email on all counsel of record.

/s/ M. Katherine Strahan
M. Katherine Strahan

Dkt. 29-7

Exhibit 7

AMERICAN ARBITRATION ASSOCIATION

SINGLETON ASSOCIATES, P.A.,	§	
	§	
Claimant,	§	
	§	
v.	§	**Case No. 01-21-0004-0763**
	§	
AETNA HEALTH INC. AND AETNA LIFE INSURANCE COMPANY,	§	
	§	
	§	
Respondents.	§	

AETNA'S MOTION FOR LEAVE TO FILE THIRD-PARTY CLAIMS AGAINST RADIOLOGY PARTNERS AFFILIATES

Respondents Aetna Health Inc. and Aetna Life Insurance Company ("Aetna") move for leave to file third-party claims against Radiology Partners, Inc., Radiology Partners Management, LLC, and Radiology Partners Matrix, PLLC (collectively, "Radiology Partners" or "Radiology Partners Affiliates").

I. BACKGROUND

Since Singleton filed this arbitration, Aetna has uncovered a fraudulent pattern of conduct that Radiology Partners has tried to hide from Aetna since 2014. Before that time, Singleton was a Houston-based radiology group staffing two hospitals in Houston. Consistent with the parties' 2002 Physician Group Agreement ("Agreement"), Singleton, for years, submitted healthcare claims for services of authorized physicians who were located in Houston and were employees or owners of the group, to be paid under the Agreement. Aetna ***later*** learned that, after some sort of elusive affiliation with Radiology Partners, Singleton began improperly submitting claims for services of unauthorized physicians from outside of Houston, and even outside of Texas, using Singleton's Federal Tax Identification Number ("TIN"). In 2020, Aetna uncovered this misconduct

and tried to investigate Singleton's relationships with the physicians and Radiology Partners.

When Aetna could not get the requested information—or straight answers—about these relationships from Singleton, Aetna stopped paying the unauthorized physicians under the Agreement. Aetna also demanded the return of overpayments made prior to this discovery. By this time, persons acting on behalf of both "Singleton" and "Radiology Partners" terminated the Agreement. Then, still without providing requested information or exhausting Aetna's dispute-resolution process, Radiology Partners filed this arbitration in the name of "Singleton" in an effort to stop the recovery of overpayments. During the arbitration, however, Radiology Partners has insisted that it controls Singleton and must be part of the arbitration process. Yes, it should.

What Aetna has since been able to uncover is that Radiology Partners acquired control of Singleton in 2014, and then, in breach of the Agreement, wrongfully used the Agreement to benefit its equity-backed "national radiology practice." Among other things, Radiology Partners exploited the Agreement's reimbursement methodology by raising billed charges to obtain exceedingly high reimbursement rates. Then, in order to secure those rates for ***all*** of Radiology Partners' affiliated physicians who interpret images at Texas hospitals—including hospitals located far outside of the Houston area and radiologists practicing remotely in other states—Radiology Partners billed all of those services under the Singleton TIN. These were ***not*** "Singleton" physicians, however, and most of them were part of physician groups under separate contracts with Aetna (i.e., under different TINs). Radiology Partners knowingly submitted medical claims using the Singleton TIN for non-Singleton physicians, causing Aetna to pay claims under the Agreement that were payable, if at all, under different provider agreements and at lower rates.

These fraudulent claims have resulted in excessive payments to "Singleton" that were not due. Aetna asserted counterclaims in this arbitration to recover these payments on behalf of the

health benefit plans it administers, including employee-funded health plans. Aetna now seeks to join the real party in interest to its claims, Radiology Partners, Inc., who, through its ownership and control of Singleton, including through its other subsidiaries—Radiology Partners Management, LLC, and Radiology Partners Matrix—perpetrated fraud on Aetna to wrongfully obtain benefits under the Agreement. Additionally, based on information and belief, Radiology Partners purported to assume Singleton's contractual obligations under the Agreement in connection with their acquisition of Singleton (though prohibited by the Agreement), and received the monies paid by Aetna.

Aetna's specific allegations against each of the Radiology Partners Affiliates are set forth in Aetna's First Amended Counterclaim and Third-Party Complaint and Demand in Arbitration ("Third-Party Complaint").[1] Each of the Radiology Partners Affiliates is subject to the Agreement's arbitration provision, and Aetna intends to pursue these claims against each of them. Therefore, in the interest of avoiding duplicative legal proceedings and ensuring a fair and equitable final arbitration hearing, this tribunal should respectfully grant this Motion and permit Aetna to join the Radiology Partners Affiliates to this arbitration, as opposed to separate actions.[2]

II. ARGUMENT AND AUTHORITIES

A. The law favors resolution of Aetna's third-party claims in these proceedings.

The most efficient way to resolve Aetna's claims against Radiology Partners is by including them in this arbitration. Texas law favors joinder of related claims in arbitration proceedings to prevent multiple determinations of the same matter. *Jack B. Anglin, Inc. v. Tipps*,

[1] *See* Exhibit 1, Third-Party Complaint.

[2] Aetna files its Amended Counterclaim as a matter of right prior to the deadline in Preliminary Order No. 4, and seeks leave only to file the Third-Party Complaint against the Third-Party Respondents, upon which they can be served and properly joined.

842 S.W.2d 266, 271 (Tex. 1992); *Branch Law Firm L.L.P. v. Osborn*, 532 S.W.3d 1, 21 (Tex. App.—Houston [14th Dist.] 2016, pet. denied). Generally, courts will compel arbitration of claims that are "factually intertwined" with claims subject to an arbitration agreement. *See Tipps*, 842 S.W.2d at 271 (compelling arbitration of non-contract claims that were factually intertwined with breach of contract claim); *Osborn*, 532 S.W.3d at 18-21 (allowing joinder of nonsignatory's claims to prevent multiple proceedings).

As set forth in the Third-Party Complaint, Aetna's claims against Radiology Partners arise out of the same transactions and occurrences as its counterclaims against Singleton. Indeed, since Aetna's claims against Radiology Partners are, at least, factually intertwined with its claims against Singleton (and Singleton's claims against Aetna), joining Radiology Partners to this arbitration serves the interest of judicial efficiency and avoids duplicative proceedings over the same matter. *See id.*

Moreover, as explained in more detail herein, Radiology Partners has made representations in these proceedings that it "manages" and "controls" Singleton as a basis to inject itself into this arbitration, and has effectively participated all along. It, therefore, should be joined in the interest of fairness to avoid any attempt to play a shell game in discovery and the final hearing—i.e., later claiming that the party performing the relevant conduct is not present.[3] *See* AAA Commercial Rule 23 (authorizing arbitrator "to issue any orders necessary to . . . achieve a fair, efficient and economical resolution of the case"). Tribunal, therefore, should allow the joinder of Aetna's claims against Radiology Partners in this arbitration.

[3] As such, Radiology Partners should be estopped from arguing otherwise.

B. Radiology Partners is the real party in interest in this arbitration.

Although it brought this arbitration only in Singleton's name, based on representations made in advancing its positions on disputed issues before this tribunal, Radiology Partners has been claiming control of Singleton since the outset of this proceeding. For instance, Singleton's counsel has repeatedly emphasized the need for Radiology Partners to access documents under the Agreed Protective Order (notably, over Aetna's objections) and to attend the IDR meeting because of its management and control over Singleton. Examples of such representations from Singleton's counsel include:

- arguing that Radiology Partners is an "affiliate" under Texas law because it has "managerial control" of Singleton;[4]
- stating that "the manager Singleton has contracted with for many years to manage Singleton's business, Radiology Partners, must be at the IDR";[5]
- stating that "it would be counterproductive to exclude the management company individuals who have been interfacing with Aetna, handling the contracting, and managing [Singleton's] business affairs";[6]
- stating that "[e]mployees of Radiology Partners are the ones analyzing claims data and legal positions for the medical group they manage, Singleton," and "Singleton's manager [i.e., Radiology Partners] has always handled these issues for many years";[7]
- stating that "there can be no meaningful IDR without Singleton's manager [Radiology Partners] seeing the documents and attending."[8]

Tellingly, *no one* from Singleton attended the IDR meeting—only representatives of

[4] Exhibit 2, Email from Vinay Kohli to Arbitrator Chamblin, Nov. 23, 2021.

[5] Exhibit 3, Email from Vinay Kohli to Arbitrator Chamblin, Nov. 19, 2021.

[6] Ex. 2.

[7] *Id*.

[8] *Id*.

Radiology Partners. Therefore, since Radiology Partners has acted as the real party in interest in this arbitration, they cannot credibly claim any prejudice or that Aetna's claims against them should be litigated separately.

C. Radiology Partners is bound by the arbitration agreement even as a nonsignatory.

The Radiology Partners Affiliates are bound by the arbitration agreement under Texas law regardless of whether they signed the Agreement. "[C]ourts have held that so long as there is *some* written agreement to arbitrate, a third party may be bound to submit to arbitration." *Bridas S.A.P.I.C. v. Gov't of Turkmenistan ("Bridas I")*, 345 F.3d 347, 355 (5th Cir. 2003). "Ordinary principles of contract and agency law may be called upon to bind a nonsignatory to an agreement whose terms have not clearly done so." *Id*. at 356. In cases where, as here, the FAA applies, state law still governs who is "bound" by an arbitration agreement, and under Texas law, the Radiology Partners Affiliates are bound to the one here under direct-benefits estoppel and/or the alter ego doctrine. *See id.* at 355-56, 358-60; *Bridas S.A.P.I.C. v. Gov't of Turkmenistan ("Bridas II")*, 447 F.3d 411, 416-20 (5th Cir. 2006); *Wood v. PennTex Res., L.P.*, 458 F. Supp. 2d 355, 369-73 (S.D. Tex. 2006), *aff'd sub nom. Wood v. PennTex Res., L.P.*, 322 Fed. Appx. 410 (5th Cir. 2009); *In re Weekley Homes,* 180 S.W.3d 127, 130-35 (Tex. 2005).

a. Direct-benefits estoppel.

Under direct-benefits estoppel, even if a nonsignatory to an arbitration agreement has "not asserted a claim under the contract containing the arbitration clause, arbitration could be compelled if that nonparty 'deliberately seeks and obtains substantial benefits from the contract itself' in other ways." *Wood*, 458 F. Supp. 2d at 366 (quoting *Weekley Homes,* 180 S.W.3d at 132). The Texas Supreme Court "agree[s] with the federal courts that when a nonparty consistently and knowingly insists that others treat it as a party, it cannot later turn its back on the portions of the

contract, such as an arbitration clause, that it finds distasteful." *Weekley Homes*, 180 S.W.3d at 135 (internal quotations and citations omitted). "A nonparty cannot both have his contract and defeat it too." *Id.* "The keys are whether the nonsignatory demanded and received substantial and direct benefits under the contract containing the arbitration clause, by suing the signatory under that contract or otherwise; the relationship between the claims to be arbitrated and the contract; and whether equity prevents the nonsignatory from avoiding the arbitration clause that was part of that contract." *Wood*, 458 F. Supp. 2d at 371.

Here, direct-benefits estoppel prevents Radiology Partners from avoiding the arbitration provision in the Agreement. *See id.* at 369-73; *Weekley Homes*, 180 S.W.3d at 131-35. As more fully set forth in the Third-Party Complaint, Radiology Partners, through the control of Singleton, knowingly demanded and obtained direct and substantial benefits under the Agreement by billing Aetna for services provided by unauthorized physicians using Singleton's TIN. By intentionally submitting these false medical claims to Aetna, Radiology Partners sought and obtained over $83 million in payments from Aetna at the lucrative rates authorized only for Group Physicians as defined in the Agreement.[9] Finally, as further explained in the Third-Party Complaint, the claims that Aetna seeks to arbitrate against Radiology Partners are directly related to the Agreement, as they include breach of the Agreement, the fraudulent submission of claims under the Agreement, and joint and several liability for other wrongful actions taken with respect to the Agreement.

Radiology Partners breached the Agreement, or caused Singleton to breach the Agreement,

[9] Singleton has not produced its operative agreements with Radiology Partners, but presumably, it attempted to assume Singleton's obligations under the Agreement. Though no actual assumption/assignment could have occurred since section 11.7 of the Agreement prohibits such assumptions/assignments, Radiology Partners should be estopped from avoiding the arbitration agreement to the extent it attempted to assume Singleton's obligations under the Agreement. Indeed, such a purported assignment would be additional proof that Radiology Partners "deliberately [sought] . . . substantial benefits from the contract itself. . . ." *See Wood*, 458 F. Supp. 2d at 366 (citing *Weekley Homes*, 180 S.W.3d at 132).

and obtained benefits from that breach which they would not have obtained but for their use of the Agreement. Therefore, even as a nonsignatory, Radiology Partners is bound by the arbitration provision in the Agreement under direct-benefits estoppel. *See Wood*, 458 F. Supp. 2d at 369-73; *Weekley Homes*, 180 S.W.3d at 131-35.

b. Alter ego.

Likewise, Radiology Partners is bound by the arbitration agreement as the alter ego of Singleton. *See Bridas I*, 345 F.3d at 358-60. "Under the alter ego doctrine, a corporation may be bound by an agreement entered into by its subsidiary regardless of the agreement's structure or the subsidiary's attempts to bind itself alone to its terms, when their conduct demonstrates a virtual abandonment of separateness." *Id*. at 358-59 (internal quotation marks omitted). The alter ego doctrine is distinct from agency law because the laws of agency "are not equitable in nature, but contractual, and do not necessarily bend in favor of justice." *Id*. at 359. "Courts are thus comparatively free from the moorings of the parties' agreements when considering whether an alter ego finding is warranted." *Id*. "The corporate veil may be pierced to hold an alter ego liable for the commitments of its instrumentality only if (1) the owner exercised complete control over the corporation with respect to the transaction at issue and (2) such control was used to commit a fraud or wrong that injured the party seeking to pierce the veil." *Id*.

Here, and as further described in the Third-Party Complaint, the "control" prong is satisfied because Radiology Partners' and Singleton's conduct demonstrated a virtual abandonment of separateness. *See Bridas II*, 447 F.3d at 417-20; *Bridas I*, 345 F.3d at 358-59. By their own admissions, Radiology Partners, Inc. is an affiliate that—either itself or directly through its subsidiaries—"manages" and "controls" all operations of Singleton under circumstances indicating that Radiology Partners is the real party in interest as to the claims asserted by and

against Singleton. Indeed, Singleton and Radiology Partners have common ownership, officers, and directors, as shown on the Texas Secretary of State website.[10]

Although Radiology Partners hid and refused to provide Aetna with relevant information regarding its relationship with Singleton, upon information and belief, Radiology Partners finances Singleton, pays the salaries of personnel acting on behalf of Singleton and other expenses of Singleton, and uses Singleton's property (if any) as its own. Likewise, the business departments and daily operations of Singleton and Radiology Partners operate as a single unit, as evidenced by, *inter alia*, the same person—Fredricka Richards—negotiating with Aetna as an "employee" of ***both*** Radiology Partners and Singleton. And, upon information and belief, Radiology Partners receives the profits generated by Aetna's payments under the Agreement.

The "fraud or injustice" prong is likewise satisfied. *See Bridas II*, 447 F.3d at 416-17. Radiology Partners exercised complete control over Singleton with respect to the transactions under the Agreement, and such control was used to perpetuate a fraud against Aetna by billing it for services provided by unauthorized physicians using Singleton's TIN. Radiology Partners' conduct caused substantial injury to Aetna—specifically, over $83 million in payments. Considering all aspects of the relationship between Radiology Partners and Singleton, Radiology Partners is bound by the arbitration provision in the Agreement because it is an alter ego of Singleton. *See id.* at 416-20; *Bridas I*, 345 F.3d at 358-60.

III. CONCLUSION

Aetna respectfully requests that the Arbitrator grant Aetna written consent to add Radiology Partners, Inc., Radiology Partners Management, LLC, and Radiology Partners Matrix,

[10] *See* Exhibit 4, Management Pages from Texas SOS Website for Singleton and Radiology Partners, Inc., showing that Dr. Anthony Gabriel is an officer and/or director of both entities.

PLLC, to this arbitration with the filing of the Third-Party Complaint. Aetna further requests all other relief to which it is entitled.

Respectfully submitted,

By: */s/ John B. Shely*

JOHN B. SHELY
Texas State Bar No. 18215300
jshely@HuntonAK.com
M. KATHERINE STRAHAN
Texas State Bar No. 24013584
kstrahan@HuntonAK.com
HUNTON ANDREWS KURTH LLP
600 Travis, Suite 4200
Houston, Texas 77002
Telephone: (713) 220-4200

ATTORNEYS FOR RESPONDENTS/COUNTERCLAIMANTS

CERTIFICATE OF SERVICE

I hereby certify that on January 27, 2022, a true and correct copy of this document was served by email on all counsel of record.

/s/ M. Katherine Strahan
M. Katherine Strahan

Dkt. 49

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

AETNA HEALTH INC., AETNA LIFE INSURANCE COMPANY, and AETNA HEALTH INSURANCE COMPANY, *Plaintiffs*, vs. RADIOLOGY PARTNERS, INC. and MORI, BEAN AND BROOKS, INC., *Defendants*.	Case No. 3:24-cv-01343-BJD-LLL

PLAINTIFFS' RESPONSE IN OPPOSITION TO DEFENDANTS' REQUEST FOR JUDICIAL NOTICE

Defendant Radiology Partners, Inc. ("Radiology Partners") and Mori, Bean and Brooks, Inc. ("MBB") (collectively "Defendants") filed what they call a Request for Judicial Notice. *See* D.E. 29. In truth, it is a request for judicial resolution of disputed facts. Specifically, Defendants want this Court to judicially notice 200 pages selected by Defendants from a Texas arbitration between Aetna, Radiology Partners, and a Texas-based Radiology Partners affiliate, Singleton Associates (the "Texas Arbitration"). *See* D.E. 29 at 7–17. But the Texas Arbitration—which arose from a contract and conduct governed by Texas law—has no bearing here or on the pending motions. Because Defendants' request for judicial notice is improper under Federal Rule of Evidence 201(b) and Eleventh Circuit precedent, Aetna respectfully requests that the Court deny Defendants' request for judicial notice.

In support of their motion to dismiss, Defendants ask the Court to dismiss "all of Aetna's fraud-based counts" because they say the Texas Arbitration documents prove "Aetna's inability . . . to contend lack of knowledge" or reasonable reliance on Defendants' misrepresentations.[1] D.E. 29 at 2. This is simply an effort to dispute well-pleaded factual allegations in Aetna's Complaint that must be accepted as true for Defendants' motion to dismiss. The Court "may only take judicial notice of court records for the limited purpose of establishing the fact of such litigation, the record's existence, and the record's content." *Sprengle v. Smith Maritime, Inc.*, 660 F. Supp. 3d 1337, 1352-53 (M.D. Fla. 2023) (citations omitted). Defendants ask the Court to go much farther, including drawing inferences (*e.g.*, that Aetna *must have known* that Radiology Partners and MBB were engaged in fraud in Florida because it knew Radiology Partners and Singleton were engaged in fraud in Texas). This is inappropriate on a motion to dismiss.

Defendants ask the Court to take judicial notice of the same documents in support of their motion to compel arbitration. Frankly, Aetna is unclear why Defendants need the Court to take judicial notice, and Defendants do not explain. Unlike with a motion to dismiss, Defendants are free to present evidence outside the four corners of the Complaint in support of their motion to compel arbitration. Therefore, the request for judicial notice in this context appears to be unnecessary.

[1] Defendants apparently contend that, because Aetna discovered Radiology Partners' fraudulent conspiracy with Singleton in Texas, Aetna must have known about Radiology Partners' fraudulent conspiracy with MBB in Florida. The argument is illogical.

For these reasons, Aetna respectfully requests that the Court deny Defendants' request for judicial notice.

LEGAL STANDARDS

Under Federal Rule of Evidence 201(b), "a court may judicially notice a fact that is not subject to reasonable dispute because it: (1) is generally known within the trial court's territorial jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." *Id.* "[T]he taking of judicial notice of facts is, as a matter of evidence law, a highly limited process. The reason for this caution is that the taking of judicial notice bypasses the safeguards which are involved with the usual process of proving facts by competent evidence in district court." *Shahar v. Bowers*, 120 F.3d 211, 214 (11th Cir. 1997).

A court may judicially notice documents filed in a prior suit if the filings "are public records whose existence is not subject to reasonable dispute." *Sprengle*, 660 F. Supp. 3d at 1351. But "courts may not take judicial notice of court records for the truth of the matters asserted in those records." *Id.* (emphasis in original) (collecting cases). "Instead, courts may only take judicial notice of court records for the limited purpose of establishing the fact of such litigation, the record's existence, and the record's content." *Id.* (collecting cases); *see also United States v. Jones*, 20 F.3d 1549, 1553 (11th Cir. 1994) ("Accordingly, a court may take notice of another court's order only for the limited purpose of recognizing the 'judicial act' that the order represents or the subject matter of the litigation.").

ARGUMENT

I. Defendants cannot use judicial notice to dispute the well-pleaded allegations in the Complaint on a motion to dismiss.

With respect to their motion to dismiss, Defendants hope to use their exhibits to dispute Aetna's well-pleaded factual allegations in the Complaint. *See*, *e.g.*, D.E. 29 at 2–3 (asking the Court to dismiss Aetna's "fraud-based counts" because the documents prove knowledge and lack of reasonable reliance by Aetna). This is an impermissible attempt to bypass the requirement that, on a motion to dismiss, "allegations in the complaint are taken as true and construed in the light most favorable to the plaintiffs." *Rivell v. Priv. Health Care Sys., Inc.*, 520 F.3d 1308, 1309 (11th Cir. 2008). This is the primary reason that Defendants' request for judicial notice should be denied, but not the only reason.

To start, the Court should not take judicial notice of non-public portions of Defendants' exhibits in ruling on their motion to dismiss. "A court may take judicial notice of the *public* record, without converting the motion to dismiss to a motion for summary judgment, because such documents are capable of accurate and ready determination." *Moore v. Potter*, No. 3:04-cv-1057-J-32HTS, 2006 WL 2092277, at *5 (M.D. Fla. July 26, 2006) (emphasis added) (citations omitted). But significant portions of Defendants' exhibits do not appear in the public record; for example, Defendants quote from portions of Aetna's First Amended Counterclaim in the Texas Arbitration that do not appear on a public docket. *See, e.g.*, D.E. 27 at 27 (attributing quotes to "Texas FAC, 51, ¶ 3-4"); Ex. 4 to Deft. Singleton P.A.'s

Mot. to Dismiss, *Aetna Life Insurance Co. v. Singleton Associates, P.A.*, No. 4:24-cv-02910 (N.D. Tex.), ECF No. 9-4 (four-page excerpt of Aetna's First Amended Counterclaim containing only second half of paragraph 4). That Defendants needed to file a declaration authenticating these non-public exhibits, *see* D.E. 31 at ¶¶ 14–15, underscores the extent to which those documents are not "capable of accurate and ready determination" as required for a proper exercise of judicial notice. *Moore*, 2006 WL 2092277, at *5.

The Court should also decline Defendants' invitation to use the proposed exhibits for anything more than "establishing the fact of such litigation, the record's existence, and the record's content." *Sprengle*, 660 F.Supp.3d at 1351. For example, Defendants ask the Court to extrapolate from an order in the Texas Arbitration that the fraudulent billing practices at issue in this case were somehow standard in the industry, *see* D.E. 27 at 11–12; the cited portions of the order say nothing of the kind, but even if they did, there would be no way to establish a fact like industry billing standards from an arbitral filing without improperly accepting the truth of *something* stated in that record. *See Bayport Fin. Serv. (USA) Inc. v. BayBoston Managers, LLC*, Case No. 1:22-cv-21306-JEM/Becerra, 2023 WL 2633298, at *8 (S.D. Fla. Mar. 3, 2023), *report and recommendation adopted* 2023 WL 2631502 (S.D. Fla. Mar. 24, 2023) (rejecting request to take judicial notice of the facts gleaned from bankruptcy transcripts as "squarely prohibited in the Eleventh Circuit").

Similarly, Defendants' attempt to prove Aetna's knowledge of their fraud by reference to arbitral filings involving a different medical group in Texas—on a motion to dismiss—is flatly inconsistent with how judicial notice is intended to operate. *See* D.E. 27 at 27. A party's knowledge of fraud (or lack thereof) constitutes "a fact-intensive inquiry, as evidenced by Defendants' request for judicial notice in their Motion to Dismiss . . . and should not be decided without a more complete evidentiary record." *Whertec, Inc. v. Salmon*, No. 3:20-cv-1254-BJD-PDB, 2021 WL 3555676, at *4 (M.D. Fla. Apr. 28, 2021). The existence and contents of the publicly filed Texas Arbitration materials could be appropriate for judicial notice in certain contexts, but Defendants' request that the Court read those filings about a separate scheme perpetrated by Radiology Partners and Singleton in Texas as definitive proof that Aetna had actual knowledge of Radiology Partners' and MBB's scheme in Florida is inconsistent with the requirement that, on a motion to dismiss, all facts be construed "in the light most favorable to the plaintiff." *Hill v. White*, 321 F.3d 1334, 1335 (11th Cir. 2003).

Aetna alleged that it was unaware of Defendants' scheme. *See e.g.*, Compl. ¶¶ 188–201, 332. Defendants will have their opportunity to contest that allegation and develop facts they consider to be in their favor. Indeed, they may develop those facts now if they elected to proceed in discovery. Instead, they are fighting to avoid *any* discovery into their actions. *See* D.E. 36.

II. There is no reason for the Court to take judicial notice of Defendants' exhibits in connection with their motion to compel arbitration.

"[I]n ruling on a motion to compel arbitration, the Court may consider matters outside the four corners of the complaint." *Lowe v. Charter Commc'n Holdings LLC*, No: 6:19-cv-1621-Orl-40EJK, 2019 WL 13248799, at *1 (M.D. Fla. Nov. 5, 2019) (citation omitted). Given this fact, it is unclear why Defendants did not simply file their exhibits in support of their motion to compel. Defendants do not explain why they need the Court to take judicial notice, but if they did so expecting that it would grant the materials anything more than their ordinary evidentiary value, they are incorrect; judicially noticed documents, just like evidence viewed under a "summary judgment-like standard" on a motion to compel, *Bazemore v. Jefferson Cap. Sys., LLC*, 827 F.3d 1325, 1333 (11th Cir. 2016), remain subject to the restrictions of the Federal Rules of Evidence. *Cf. Jones*, 29 F.3d at 1553 (explaining that court may not take judicial notice of a document filed in another court for the truth of the matter asserted therein). Aetna respectfully submits that there is no reason to take judicial notice of the proposed exhibits in connection with Defendants' motion to compel arbitration. At most, they should be considered exhibits offered in support of that motion.

CONCLUSION

Defendants' request for judicial notice is improper on a motion to dismiss because Defendants ask the Court to accept statements contained in their proposed exhibits for the truth of the matters asserted *and draw inferences* therefrom.

Defendants' request for judicial notice in connection with their motion to compel arbitration is completely unnecessary. Thus, Aetna respectfully requests that the Court deny the request for judicial notice in its entirety.

Dated: April 18, 2025

ROBINS KAPLAN LLP

/s/ Jared J. Burns
Jared J. Burns
Fla. Bar #1003415
JBurns@robinskaplan.com
10151 Deerwood Park Blvd.,
Building 200, Suite 250
Jacksonville, FL 32256
P: (612) 349-8500

Nathaniel J. Moore*
NMoore@robinskaplan.com
Marcus A Guith*
MGuith@robinskaplan.com
Kyle D. Nelson*
KNelson@robinskaplan.com
800 LaSalle Avenue, Suite 2800
Minneapolis, MN 55402
P: 612.349.8500

Paul D. Weller*
PWeller@robinskaplan.com
1325 Avenue of the Americas, Suite 2601
New York, New York 10019
P: 212.980.7400

Attorneys for Plaintiffs Aetna Health Inc., Aetna Life Insurance Company, and Aetna Health Insurance Company

*Admitted *pro hac vice*

Dkt. 79

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

AETNA HEALTH INC., et al.,

Plaintiffs,

Case No. 3:24-cv-1343-BJD-LLL

v.

RADIOLOGY PARTNERS, INC., et al.,

Defendants.
_____/

ORDER

THIS CAUSE is before the Court on the Report and Recommendation (Doc. 74; Report), entered by the Honorable Laura L. Lambert, United States Magistrate Judge. In the Report, the Magistrate Judge recommends that the Court strike the Complaint (Doc. 1) and that Plaintiffs be directed to file an amended complaint that complies with the mandates detailed in the Report. Report at 15. No objections were filed, and the matter is ripe for review.

The Court "may accept, reject, or modify, in whole or in part, the findings or recommendations made by the magistrate judge." 28 U.S.C. § 636(b). If no specific objections to findings of fact are filed, the district judge is not required to conduct a *de novo* review of those findings. See Garvey v. Vaughn, 993 F.2d 776, 779 n.9 (11th Cir. 1993); see also 28 U.S.C. § 636(b)(1). Further, if no objections to a magistrate judge's report and recommendation

are filed, the district court reviews legal conclusions only for plain error and only if necessary in the interests of justice. Shepherd v. Wilson, 663 F. App'x 813, 816 (11th Cir. 2016); see also Mitchell v. United States, 612 F. App'x 542, 545 (11th Cir. 2015) (noting that under 11th Circuit Rule 3-1, the appellant would have waived his ability to object to the district court's final order on a report and recommendation where appellant failed to object to that report and recommendation). "Under plain error review, we can correct an error only when (1) an error has occurred, (2) the error was plain, (3) the error affected substantial rights, and (4) the error seriously affects the fairness, integrity or public reputation of judicial proceedings." Symonette v. V.A. Leasing Corp., 648 F. App'x 787, 790 (11th Cir. 2016) (citing Farley v. Nationwide Mut. Ins. Co., 197 F.3d 1322, 1329 (11th Cir. 1999)).

Upon independent review of the entire record, the undersigned finds no plain error in the Report's recommendations.

Accordingly, after due consideration, it is

ORDERED:

1. The Court **ADOPTS** the Magistrate Judge's Report and Recommendation (Doc. 74) as the opinion of the Court.

2. The Complaint (Doc. 1) is **STRICKEN**.[1]

[1] The Clerk of the Court shall leave the original Complaint (Doc. 1) on the docket.

3. **On or before October 3, 2025**, Plaintiffs shall file an amended complaint that complies with the Report. **On or before October 24, 2025**, Defendants shall respond to the amended complaint.

4. Defendants' Motions to Dismiss and to Compel Arbitration (Docs. 27 and 28) are **DENIED as moot**.

DONE and **ORDERED** in Jacksonville, Florida this ***12th*** day of September, 2025.

BRIAN J. DAVIS
United States District Judge

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Copies furnished to:

Counsel of Record
Unrepresented Parties

CERTIFICATE OF SERVICE

I hereby certify that on September 22, 2026, the foregoing was filed with the Clerk of the United States Court of Appeals for the Eleventh Circuit using the CM/ECF system, which will cause a notice of electronic filing to be served on all registered counsel of record.

/s/Paul Alessio Mezzina
Paul Alessio Mezzina

Counsel for Defendants-Appellees