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FRANKLIN CIRCUIT COURT
SALLY JUMP, CLERK

COMMONWEALTH OF KENTUCKY
FRANKLIN CIRCUIT COURT
DIVISION I
CIVIL ACTION NO. 12-CI-488

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APR 1 2 2012
FRANKLIN CIRCUIT COURT
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APPALACHIAN REGIONAL HEALTHCARE, INC. and ARH MARY BRECKENRIDGE HEALTH SERVICES, INC.

PLAINTIFFS

v.

KENTUCKY SPIRIT HEALTH PLAN, INC.

DEFENDANTS

Serve: Stites & Harbison, PLLC
250 West Main Street
Suite 2300
Lexington, KY 40507

COMMONWEALTH OF KENTUCKY, CABINET FOR HEALTH AND FAMILY SERVICES and ERIC FRIEDLANDER, Not Individually But In His Official Capacity As Interim Secretary, Cabinet For Health And Family Services

Serve: Eric Friedlander, Interim Secretary
Office of the Secretary
Cabinet for Health and Family Services
275 E. Main Street, 5W-A
Frankfort, Kentucky 40601

Serve: Jack Conway, Esq.
Office of Attorney General
Capitol Building, Suite 118
Frankfort, Kentucky 40601

Courtesy
Copy: Christina Heavrin, Esq. (Regular Mail)
Office of General Counsel
Cabinet for Health and Family Services
275 E. Main Street, 5W-A
Frankfort, Kentucky 40601

COMPLAINT

Plaintiffs, Appalachian Regional Healthcare, Inc. and ARH Mary Breckinridge Health Services, Inc., for their Complaint, state as follows:

This is an action to recover damages caused by Defendants' failure to pay for Medicaid services as required by law as well as for declaratory and injunctive relief to prevent further violations of the law.

THE PARTIES.

1. Plaintiffs, Appalachian Regional Healthcare, Inc. and ARH Mary Breckinridge Health Services, Inc. (collectively "**ARH**"), are not-for-profit, tax-exempt Kentucky corporations. ARH operates eight acute care hospitals in southeastern Kentucky, in addition to numerous physician practices, rural health clinics, diagnostic services, home health agencies and other services. Accordingly, it is the predominant provider of health care services to an economically challenged and medically needy region of the state.

2. Defendant Kentucky Spirit Health Plan, Inc. ("**Kentucky Spirit**") is a Kentucky for-profit insurance corporation.

3. The Defendant, Cabinet for Health and Family Services (the "**Cabinet**"), is the administrative agency of the Commonwealth of Kentucky assigned responsibility for administering the Kentucky Medical Assistance Program ("**KMAP**") pursuant to KRS 205.510 to 205.630. These statutes provide for the implementation of the federal Medicaid program in Kentucky in accordance with the provisions of Title XIX of the Social Security Act and applicable federal regulations. The Cabinet

administers KMAP through its Department for Medicaid Services as provided in KRS 194A.030(2).

4. Defendant, Eric Friedlander, is the Interim Secretary of the Cabinet for Health Services (the "**Secretary**") and is named in his official capacity. The Secretary has been joined specifically because injunctive relief is sought herein, among other forms of relief. Except when necessary, the Secretary will be referred to herein collectively with the Cabinet as (the "**Cabinet**").

JURISDICTION AND VENUE.

5. This action is brought pursuant to KRS 418.040 and KRS 446.070. The court has jurisdiction over this matter under KRS 23A.010, and venue is proper under KRS 452.405.

BACKGROUND AND FACTS.

a. The State Plan.

6. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396v ("**Medicaid Act**"), provides for the establishment of the Medicaid program. The Medicaid program is a cooperative federal-state program whereby the federal government provides financial assistance to the states so they may furnish medical care to low-income individuals and families in designated eligibility groups.

7. To qualify for federal financial participation, a state must submit a plan for medical assistance to the federal Centers for Medicare and Medicaid Services ("**CMS**") and secure its approval. *See* 42 U.S.C. § 1396a(a) and (b); 42 C.F.R. Pt. 430, sub pt. B. KMAP has been established according to such a plan that the Cabinet filed with CMS and that it updates or modifies periodically (the "**State Plan**").

8. The Medicaid Act requires that beneficiaries be permitted to receive healthcare services from participating providers of their choice, 42 U.S.C. §1396a(a)(23) (the "**freedom of choice**" provision), and that the state pay those providers directly on a fee-for-service basis according to state-established fee schedules. 42 U.S.C. §1396a(a)(30)(A).

b. <u>The Waiver.</u>

9. States may seek waivers from the requirements of the traditional fee-for-service program and its freedom of choice provision, so that healthcare services may be provided through managed care systems. In such systems, managed care organizations ("**MCOs**") sign contracts with the state to provide healthcare services to Medicaid beneficiaries in return for capitated rates. The MCOs enroll Medicaid beneficiaries as "**Members**" in their respective health plans, contract with providers to provide care to their Members, and pay those providers for their services.

10. Both the waiver and the contracts between the MCOs and the state must be approved by CMS and must comply with certain statutory and regulatory requirements. 42 U.S.C. §1396b(m)(2)(A)(iii); 42 C.F.R. §§438.86(b) & 438.6.

11. On June 13, 2011, the Cabinet submitted a request to CMS for a waiver under Section 1915(b) of the Act that was approved by CMS and became effective November 1, 2011 (the "**Waiver**").

12. To gain CMS approval and to fulfill these statutory and regulatory requirements, the Cabinet entered contracts with three insurance companies, Kentucky Spirit, Coventry Health and Life Insurance Co., Inc. ("**Coventry**"), and WellCare Health Insurance of Illinois dba WellCare of Kentucky, Inc. ("**WellCare**"), to act as MCOs and

provide healthcare services to Kentucky Medicaid beneficiaries that enrolled in each of their health plans.

c. <u>The Prompt Pay Requirements.</u>

13. CMS will approve implementation of a managed care system and grant a waiver of the freedom-of-choice requirements only if the waiver request satisfies certain conditions, including provisions ensuring that providers of healthcare services will be paid on a timely basis. Section 1396n(b)(4) specifically states, as follows:

> The Secretary ... may waive such requirement of Section 1396a of this title ... as may be necessary for a State ... to restrict the provider from (or through) whom an individual ... can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept and comply with the reimbursement, quality, and utilization standards under the state plan ... if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services **and if providers under such restriction are paid on a timely basis in the same manner as health care practitioners must be paid under Section 1396a(a)(37)(A) of this title** (emphasis added).

14. Section 1396u-2(f) entitled "Timeliness of Payment" also provides that in contracting with its MCOs under a waiver, a state must ensure that payments to providers will be made on a timely basis. That section states:

> A contract ... with a Medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State Plan ... who are enrolled in the organization on a timely basis consistent with the claims payment procedures described in Section 1396a(a)(37)(A) of this title unless the health care provider and the organization agree to an alternate payment schedule....

15. Section 1396a(a)(37)(A) (the **"Prompt Pay Provision"**) referenced in the two aforesaid provisions requires, in turn, that a state Medicaid plan must provide for claims payment procedures that

> ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of such claims....

16. Kentucky also has its own Prompt Pay Statutes, KRS 304.17A-700 to 304.17A-730 and KRS 205.593, KRS 304.14-135 and KRS 304.99-123, which apply to Kentucky Spirit as a managed care organization under contract with the Cabinet to manage care, process health care claims and pay for services provided to Kentucky Medicaid recipients covered under the Waiver and enrolled in Kentucky Spirit's Medicaid managed care plan.

17. These state Prompt Pay Statutes are apply to Kentucky Spirit by virtue of the fact that it is an insurer authorized by the Kentucky Department of Insurance to do business in the Commonwealth of Kentucky. *See* KRS §§304.17A-005 & 304.17A-700.

18. Kentucky Spirit was well aware of its duty to comply with these Prompt Pay laws as the Cabinet also incorporated these prompt pay provisions into its contract with Kentucky Spirit. Thus, Section 29.1 of the Cabinet's contract with Kentucky Spirit provides, as follows:

> In accordance with the Balanced Budget Act (BBA) Section 4708, the Contractor shall implement Claims payment procedures that ensure 90% of all Provider Claims

for which no further written information or substantiation is required in order to make payment are paid or denied within thirty (30) days of the date of receipt of such Claims and that 99% of all Claims are processed within ninety (90) days of the date of receipt of such Claims. In addition, the Contractor shall comply with the Prompt-Pay statute, codified within KRS 304.17A-700-730, as may be amended, and KRS 265.593, and KRS 304.14-135 and 99-123, as may be amended.

The Contractor shall notify the requesting provider of any decision to deny a claim, or to authorize a service in an amount, direction, or scope that is less than requested. The notice to the provider need not be in writing.

Any conflict between the BBA and Commonwealth law will default to the BBA unless the Commonwealth requirements are stricter.

19. These same Prompt Pay requirements were also included in the Cabinet's emergency regulation, 907 KAR 17:005E, Section 56[1], promulgated to implement the Waiver.

20. The Commonwealth's Prompt Pay requirements are stricter than the BBA requirements. KRS 304.17A-702 requires that Kentucky Spirit reimburse its providers for a "clean claim" or send written or electronic notice denying or contesting the claim within thirty calendar days from the date the claim is received by Kentucky Spirit or any entity that administers or processes claims on Kentucky Spirit's behalf. The statute further provides that within these thirty calendar days, Kentucky Spirit shall (a) pay the total contracted reimbursement for the claim, (b) pay the portion of any claim that

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[1] On February 15, 2012, the Cabinet filed with the State Legislative Research Commission a new version of ordinary regulation 907 KAR 17:005, which deleted subsection (1)(a) from Section 56, while still requiring compliance with 42 U.S.C. §1396a(a)(37), 42 C.F.R. 447.45, KRS 205.593, KRS 304.14-135 and KRS 304.17A-700-730.

is not in dispute and notify its providers, in writing or electronically, of the reasons the remaining portion of the claim will not be paid or (c) notify its providers in writing or electronically, of the reasons no part of the claim will be paid.

21. Kentucky Spirit is further required to acknowledge receipt of original or corrected claims within forty-eight hours, if submitted electronically, or within twenty calendar days, for mail or non-electronic submissions. *See* KRS 304.17A-704(1). At the time Kentucky Spirit makes this required acknowledgement, it is also required to notify its providers if there is any information missing from the billing instrument, any errors in the billing instrument, or of any other circumstances which preclude it from being a clean claim. *Id.*

22. Thus, Prompt Pay policies and their importance to the public welfare and, in particular, to providers of health care services such as ARH have been stressed to Kentucky Spirit by their inclusion many times in both federal and state statutes and regulations as well as the MCO contract.

d. Out-of-Network Provider.

23. ARH and Kentucky Spirit originally entered into a Letter of Intent signifying their intentions to attempt to negotiate an agreement for ARH to be included as a provider in Kentucky Spirit's Kentucky Medicaid provider network. They never agreed on terms for a managed care provider agreement, however, and so as far as Kentucky Spirit is concerned, ARH is an out-of-network ("**OON**") provider.

e. Kentucky Spirit's Inadequate Network.

24. Without a contract with ARH, Kentucky Spirit does not have a provider network in Eastern Kentucky that satisfies the requirements of 42 U.S.C. §1396u-2(b)(5) and 42 C.F.R. §438.207(a) & (b).

25. Kentucky Spirit does not have sufficient providers in Region 8 to meet the requirements of Section 28 and in particular subsection 28.7 of its MCO contract with the Cabinet.

f. ARH Treats Kentucky Spirit's Members.

26. Even though ARH has not entered into a managed care provider agreement with Kentucky Spirit, it is still required by the Emergency Medical Treatment Act ("**EMTALA**") 42 U.S.C. §1395dd, to provide emergency services to Kentucky Spirit Members who present themselves to ARH emergency rooms needing emergency services.

27. In addition, since Kentucky Spirit does not have a network of providers in Eastern Kentucky that is adequate to provide access to health care services for many of its Members, it has given pre-authorizations to ARH to treat many of its Members needing services other than emergency services. Otherwise these Kentucky Spirit Members would have to go without needed health care or could obtain health care services only with great difficulty.

28. Thus, in keeping with EMTALA or in reliance on pre-authorizations by Kentucky Spirit, ARH has provided health care services to Kentucky Spirit Members as an OON provider. Since November 1, 2011, ARH has submitted thousands of clean claims for emergency or pre-authorized services on properly

completed billing instruments to Kentucky Spirit for payment for medical services provided to Kentucky Spirit's Members.

g. <u>Kentucky Spirit Does Not Promptly Pay.</u>

29. Kentucky Spirit has consistently and in the vast majority of the cases failed, however, to process and pay clean claims submitted by ARH within the time frames or according to any applicable Prompt Pay laws or provisions.

30. As of March 19, 2012, ARH had 1,609 clean claims with charges totaling $5,871,813 under submission and awaiting for payment by Kentucky Spirit. Eighty-three percent of those claims have been submitted to Kentucky Spirit for payment for more than thirty days. Forty-eight percent of those claims have been submitted for payment for more than ninety days.

h. <u>Kentucky Spirit Underpays.</u>

31. The Cabinet is required to pay Kentucky Spirit capitated rates that are certified to be actuarially sound and appropriate for the populations to be covered and the services furnished under the contract. See 42 C.F.R. §438.6(c).

32. Kentucky Spirit has not offered, however, to pay ARH actuarially sound and appropriate rates for treating Kentucky Spirit Members in Eastern Kentucky.

33. The MCO contract entered between Kentucky Spirit and the Cabinet contained the following provision:

> 29.2 Payment to Out-of-Network Providers
>
> The Contractor shall reimburse Out of-Network Providers in accordance with Section 29.1 Provider Claims payments, if applicable, for the following Covered Services:
>
> A. Specialty care for which the Contractor has approved a authorization for the Member to receive services from an Out-of-Network Provider;

B. Emergency Care that could not be provided by the Contractor's Network Provider because the time to reach the Contractor's Network Provider would have resulted in risk of serious damage to the Member's health.

C. Services provided for family planning; and

D. Services for children in Foster Care.

Covered Services shall be reimbursed at no less than 100 percent of the Medicaid fee schedule/rate until January 1, 2012 and after January 1, 2012, no less than 90% of the Medicaid fee schedule/rate. Covered services except for emergency services provided to a Member from an Out-of-Network Provider that has not sought Prior Authorization within thirty (30) days need not be reimbursed.

For services not covered above, the Contractor shall submit to the Department for review and approval a process for Out-of-Network reimbursement.

34. The Medicaid rates for emergency room services are set by the Cabinet in accordance with 907 KAR 10:015. Laboratory services are reimbursed either at the Medicare-established technical component rate for the service in accordance with 907 KAR 1:029 or, if no Medicare rate exists for the particular service, the rate is determined by multiplying the hospital's current outpatient cost-to-charge ratio by its billed laboratory charges. Laboratory services reimbursements are final and not settled to cost at any later date. *Id.* Section 5.

35. The Medicaid rates for all other emergency services are reimbursed according to regulation on an interim basis at ninety-five percent of the hospital's specific, outpatient cost-to-charge ratio based on the hospital's most recently filed cost report and then settled to ninety-five percent of actual costs at year end. 907 KAR 10:015, Section 2.

36. When Kentucky Spirit has reimbursed ARH for ER services rendered to its Members since January 1, 2012, it has paid, however, only ninety percent of the Medicaid rate established in 907 KAR 10:015. In other words, it paid ninety percent of ninety-five percent of ARH costs for ER services or, in essence, eighty-five percent of costs.

i. <u>The Cabinet's Rates Are Inadequate.</u>

37. ARH has a Provider Agreement with the Cabinet and continues to be a Medicaid provider in good standing. As such, the Cabinet is liable to ARH for medical services rendered to Kentucky Medicaid beneficiaries.

38. The Cabinet is supposed to reimburse hospitals for "hospital care ...[on] bases which relate the amount of the payment to the cost of providing services or supplies." KRS 205.560(2).

39. The Cabinet has failed, however, since October 15, 2007, to reimburse ARH for inpatient, acute care services on any basis which relates the amount of the payment to the cost of providing services or supplies. Instead, in designing its diagnosis related group ("**DRG**") methodology effective October 15, 2007, the Cabinet first designed a methodology similar to the DRG methodology employed by CMS for Medicare reimbursements. After the Cabinet modeled what that methodology would pay it then arbitrarily applied a "budget neutrality factor" to its DRG methodology to reduce expected payments by approximately twenty percent.

40. The inadequacy of the Cabinet's Medicaid rates has been a source of constant litigation between the Cabinet and hospital providers since the federal district court decided in *Memorial Hospital v. Childers*, 896 F. Supp. 1427 (W.D. Ky. 1995), that

individual inequities should be addressed through the Cabinet's administrative appeal process. Despite subsequent numerous findings of inadequacy by administrative hearing officers, in state court decisions, and recognized through settlements including, most recently a $185 million "Global Settlement" paying "rate enhancements" to virtually every Kentucky hospitals in 2009 and 2010, the Cabinet's current inpatient DRG rates continue to be grossly inadequate. The Cabinet's "budget neutrality adjustment" basically perpetuates all of the inadequacies and inequities of the past.

j. **Administrative Remedies Are Inadequate and Futile.**

41. ARH has had rate appeals pending with the Cabinet concerning the inadequacy of the Medicaid DRG rates paid by the Cabinet since October 15, 2007, through the present time. Those rates only cover approximately 75 percent of the costs that ARH must incur in treating Medicaid patients. Although dispute resolution meetings were conducted almost two years ago for those appeals, dispute resolution decisions have never been rendered as required by 907 KAR 1:671, Section 8.

42. Administrative remedies are inadequate given the Cabinet's routine and habitual disregard for the time frames contained in 907 KAR 1:671, Section 8, for processing appeals.

43. Administrative remedies are also inadequate and futile here given the Cabinet's bias and complete intransigence regarding any administrative outcome that favors hospitals. *See e.g. RiverValley Behavioral Health, Inc. v. Cabinet for Health and Family Services*, Franklin Civil Action No. 09-CI-797; In Re: *Northkey Community Care*, Case No. AHB DMS 08-1212; *Samaritan Alliance, LLC d/b/a Samaritan Hospital v. Commonwealth of Kentucky*, Civil Action No. 08-CI-00294; *Commonwealth*

Health Corp. d/b/a The Medical Center, Case No. 03-CI-00108; *Jennie Stuart Medical Center, Inc. v. Commonwealth of Kentucky*, Civil Action No. 03-CI-1122; *Northkey Community Care v. Commonwealth of Kentucky*, Franklin Civil Action No. 03-CI-804; *Regional Medical Center v. Commonwealth of Kentucky*, Franklin Civil Action No. 03-CI-00387; *The Sisters of St. Francis Health Services, Inc. d/b/a St. Anthony .Hospital*, Franklin Civil Action No. 99-CI-01468; *Appalachian Regional Healthcare, Inc. d/b/a Harlan ARH Hospital*, Harlan Civil Action No. 09-CI-00458.

k. <u>The Inadequacies of the Past Are Being Perpetuated.</u>

44. The Cabinet's Data Book that it provided with its Request For Proposals ("**RFP**") giving "background information to enable interested MCOs to prepare their bids to DMS" and purporting to present "a summary of historical costs" does not, in fact, present the historical "costs" of providing care to Kentucky Medicaid beneficiaries. Rather the Data Book summarizes historical payments made to providers, which in the case of inpatient hospital services, by the Cabinet's own admission,[2] cover only eighty to eighty-two percent of hospital costs.

45. When Kentucky Spirit has paid for pre-authorized services provided by ARH prior to January 1, 2012, it has paid the inadequate DRG rates under appeal with the Cabinet.

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2 The Cabinet has been applying what it refers to as a "parity adjustment" of 80.5 to 82.5 percent to some types of hospital rates set by means other than the DRG methodology to reduce those other rates so they are on par (or in "parity") with the DRG rates. This is nothing less than a tacit admission that the Cabinet is, on average, paying 80.5 to 82.5 percent of Medicaid allowable costs with its budget driven DRG methodology.

46. When Kentucky Spirit has paid for DRG services provided by ARH since January 1, 2012, it has paid only ninety-percent of the inadequate DRG rates established by the Cabinet. Since the Cabinet's rates cover only approximately 75 percent of ARH's costs incurred in providing those services, then these payments are covering approximately 67 percent of ARH's DRG costs.

47. Kentucky Spirit is not acting pursuant to any statute or regulation or any other valid authority when it reimburses ARH with only ninety percent of the Medicaid rates for emergency services.

48. Kentucky Spirit is not acting pursuant to any statute or regulation when it reimburses ARH at either Medicaid rates or ninety percent of Medicaid rates for DRG services..

49. Kentucky Spirit is reimbursing ARH at ninety percent of Medicaid rates in retaliation for ARH's refusal to enter into a contract with Kentucky Spirit on the unfavorable, inadequate and oppressive terms offered by Kentucky Spirit.

COUNT I
(Prompt Pay Violations)

50. ARH realleges Paragraphs 1 through 49 as if fully set forth herein.

51. ARH has provided health care services to Kentucky Spirit Members and has submitted clean claims and otherwise performed as necessary to receive prompt reimbursement for those claims.

52. Kentucky Spirit has consistently failed to timely acknowledge receipt of original or corrected claims as required by KRS 304.17A-704; or to timely notify ARH of information missing from claims submitted or billing errors that Kentucky Spirit contends precludes claims from being clean claims.

53. Kentucky Spirit has consistently failed or refused to pay ARH's claims promptly on a timely basis as required by state Prompt Pay Statutes and has instead wrongfully delayed, denied or otherwise reduced or withheld payments owed to ARH.

54. Kentucky Spirit, through its violations of state Prompt Pay Statutes, has caused monetary damages to ARH.

55. ARH is entitled to receive interest for tardy payments for the time-periods and at the statutory interest rates specified in KRS 304.17A-730.

56. As a direct and proximate result of Kentucky Spirit's continuing Prompt Pay violations, ARH has sustained damages in an amount to be determined at trial.

57. Under KRS 446.070, ARH is entitled to recover the damages it has sustained by reason of Kentucky Spirit's violations of the Prompt Pay Statutes.

COUNT II
(Contract)

58. ARH realleges Paragraphs 1 through 57 as if fully set forth herein.

59. Kentucky Spirit entered into an MCO contract with the Cabinet in which it obligated itself to pay providers promptly for medical services provided to Kentucky Spirit Members.

60. ARH is a third-party beneficiary of Kentucky Spirit's MCO contract with the Cabinet.

61. Alternatively, ARH's provision of emergency and/or pre-authorized services to Kentucky Spirit Members creates an express and/or implied

contract between ARH and Kentucky Spirit obligating Kentucky Spirit to pay ARH promptly for medical services provided to Kentucky Spirit Members.

62. ARH is entitled to be promptly reimbursed at Medicaid rates for Emergency Room services, and at its normal charges for all other health care services provided to Kentucky Spirit's Members.

63. As a direct and proximate result of these breaches, ARH has sustained damages in an amount to be determined at trial.

COUNT III
(Declaratory and Injunctive Relief)

64. ARH realleges Paragraphs 1 through 63 as if fully set forth herein.

65. An actionable and justiciable controversy and dispute now exists between ARH and Kentucky Spirit.

66. Kentucky Spirit has not complied with applicable laws in reimbursing ARH causing great harm to ARH.

67. ARH desires a judicial determination and declaration of Kentucky Spirit's obligations and duties in reimbursing ARH for medical services provided Kentucky Spirit Members.

68. ARH desires preliminary and permanent injunctive relief causing Kentucky Spirit to immediately comply with applicable laws and contractual provisions and to prevent it from disregarding and breaching those laws and provisions in the future.

COUNT IV
(Bad Faith)

69. ARH realleges Paragraphs 1 through 68 as if fully set forth herein.

70. Kentucky Spirit owes ARH the duty of good faith and fair dealing.

71. To the extent Kentucky Spirit retained any discretion to determine the manner and format in which claims were to be submitted and whether claims submitted were "clean claims", it has abused that discretion with the result that the contractual rights of ARH are being injured and destroyed.

72. While Kentucky Spirit has been arbitrarily and unreasonably refusing or failing to pay ARH's claims promptly or otherwise delaying payment through pretextual means, Kentucky Spirit has continued to collect its monthly capitated payments from KMAP, amassing for itself millions of dollars.

73. Kentucky Spirit's actions complained about herein have been taken to build up or supplement its own working capital and increase its own profits even while causing serious harm and detriment to ARH and ARH's ability to provide needed health care services to Eastern Kentucky residents. By its actions Kentucky Spirit has acted in bad faith breaching its duty of good faith and fair dealing owed to ARH.

74. As a result ARH has and will continue to suffer substantial damages in an amount to be proven at trial.

COUNT V
(Unjust Enrichment)

75. ARH realleges Paragraphs 1 through 74 as if fully set forth herein.

76. ARH has conferred benefits upon Kentucky Spirit by providing health care services to its Members. In conferring these benefits ARH was acting either upon compulsion of law (EMTALA) or pursuant to pre-authorization of the services by Kentucky Spirit.

77. Kentucky Spirit has not adequately reimbursed ARH for services provided to its Members and is being unjustly enriched and is retaining benefits for which it has not and is refusing to pay reasonable value.

78. Under the circumstances Kentucky Spirit was reasonably notified that ARH was expecting to be paid by Kentucky Spirit for the reasonable value of its services.

79. Kentucky Spirit has refused, however, to reimburse ARH for the reasonable value of its services and as a result ARH has and will continue to suffer substantial damages in an amount to be proven at trial.

COUNT VI
(Breach By Cabinet)

80. ARH realleges Paragraphs 1 through 79 as if fully set forth herein.

81. The Cabinet has failed to reimburse ARH for hospital services in accordance with state statute and in breach of its Provider Agreements.

82. The DRG rates established by the Cabinet since October 15, 2007, are inadequate and unreasonable and were not set on bases that relate to the cost of providing these services in violation of KRS 205.560(2).

83. By failing to pay ARH rates that are adequate and reasonable and in compliance with the law and by failing to provide ARH with a prompt administrative appeal of those rates, the Cabinet has breached the Provider Agreements it entered into with ARH.

84. By using its DRG rates as the "costs" of treating Kentucky Medicaid patients in its Data Book used in its RFP, the Cabinet has only perpetuated the inadequacies of its system.

85. ARH is entitled to damages for the Cabinet's breach in such amounts as are determined at trial.

COUNT VII
(Breach By Cabinet)

86. ARH realleges Paragraphs 1 through 85 as if fully set forth herein.

87. The Cabinet is responsible, both statutorily and by contract, for reimbursing ARH for medical services provided to Kentucky Medicaid beneficiaries.

88. Although the Cabinet has tried to assign or delegate that duty to Kentucky Spirit, the Cabinet remains responsible for reimbursing ARH for medical services provided Kentucky Medicaid beneficiaries and for any violations of Prompt Pay laws or violations of any other laws by Kentucky Spirit acting as the Cabinet's agent.

89. ARH has refused to participate in Kentucky Spirit's managed care plan under the terms offered and has not waived any of its rights against the Cabinet under the Provider Agreements or law.

90. Since Kentucky Spirit has not reimbursed ARH promptly and in the amounts ARH is entitled to receive then ARH is entitled to recover those damages from the Cabinet in such amounts as are determined at trial.

WHEREFORE, Plaintiffs pray for the following relief:

A. That the Court enter a declaration that Kentucky Spirit is required to comply with applicable Prompt Pay laws and provisions;

B. That the Court enter a declaration that Kentucky Spirit is required to reimburse ARH as an out-of-network provider at the current Medicaid rates for emergency services, and at ARH's normal charges for all other services provided Kentucky Spirit Members;

C. That the Court grant ARH preliminary and permanent injunctive relief directing Kentucky Spirit to comply with all applicable Prompt Pay laws and provisions;

D. That the Court grant ARH preliminary and permanent injunctive relief directing Kentucky Spirit to reimburse ARH for emergency services at Medicaid rates, and at ARH's normal charges for all other services provided Kentucky Spirit's Members, unless and until such time as ARH and Kentucky Spirit agree otherwise;

E. That the Court award ARH such damages, including punitive damages, as may be established at trial for Kentucky Spirit's failure to promptly pay claims for Medicaid services provided to Kentucky Spirit Members, for its breach of express and/or implied contractual rights, for unjust enrichment, and for its breach of its duty of good faith and fair dealing;

F. That the Court award ARH interest at the statutory rates of twelve (12%), eighteen (18%) and twenty-one (21%) percent as provided in KRS 304.17A-730 for Kentucky Spirit's delays in making payments;

G. That the Court enter a declaration that the Cabinet is jointly and severally liable with Kentucky Spirit for reimbursements for Medicaid services provided by ARH to Kentucky Spirit Members;

H. That the Court enter a declaration that the Cabinet has failed to set reimbursement rates that are in compliance with the law since October 15, 2007;

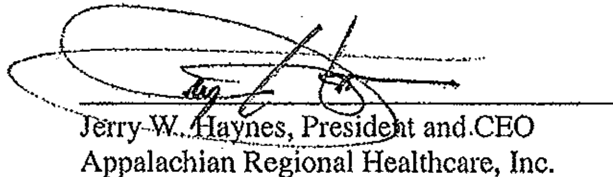
I. That the Court award ARH such damages as may be established at trial for the Cabinet's failure to set adequate rates or to reimburse ARH in accordance with the law since October 15, 2007;

J. That the Court enter a judgment awarding ARH its reasonable attorneys' fees, costs and expenses incurred herein; and

K. That the Court enter judgment awarding ARH all further legal, equitable and other relief to which it may appear to be entitled.

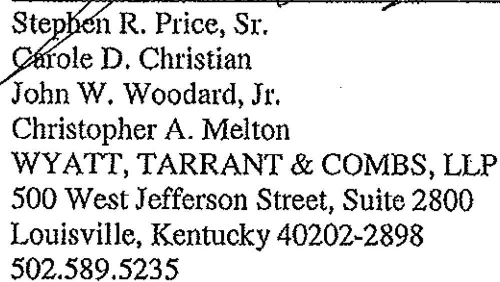
VERIFICATION

I, Jerry W. Haynes, President and CEO of Appalachian Regional Healthcare, Inc. hereby verify under penalty for perjury that the factual allegations set forth herein are true and correct to the best of my knowledge, information and belief this 12th day of April 2012.



Jerry W. Haynes, President and CEO
Appalachian Regional Healthcare, Inc.

Respectfully submitted,



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