IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

CHRISTOPHER FAIN; ZACHARY MARTELL; and BRIAN MCNEMAR, individually and on behalf of all others similarly situated,

Plaintiffs,

vs.

Case No.: 3:20-cv-00740
Judge Robert C. Chambers

WILLIAM CROUCH, in his official capacity as Cabinet Secretary of the West Virginia Department of Health and Human Resources; CYNTHIA BEANE, in her official capacity as Commissioner for the West Virginia Bureau for Medical Services; WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES; TED CHEATHAM, in his official capacity as Director of the West Virginia Public Employees Insurance Agency; and THE HEALTH PLAN OF WEST VIRGINIA, INC.,

Defendants.

DEFENDANT TED CHEATHAM'S MOTION TO DISMISS THE COMPLAINT

Defendant Ted Cheatham, in his official capacity as Director of the West Virginia Public Employees Insurance Agency ("this Defendant"), by and through counsel, Perry W. Oxley, David E. Rich, Eric D. Salyers, Christopher K. Weed, and the law firm of Oxley Rich Sammons, PLLC, pursuant to Rules 12(b)(1) and (6) of the Federal Rules of Civil Procedure, hereby moves this Honorable Court to dismiss all claims directed at this Defendant in Plaintiffs' Complaint for lack of subject matter jurisdiction and for failing to state a claim upon which relief may be granted. In support thereof, this Defendant submits the Memorandum of Law filed contemporaneously herewith.

WHEREFORE, this Defendant respectfully requests that this Court **GRANT** his Motion to Dismiss and **ENTER** an **ORDER** dismissing all claims in Plaintiffs' Complaint directed towards this Defendant, with prejudice. This Defendant further respectfully requests any other such relief, including costs and attorneys' fees, to which it may be entitled.

TED CHEATHAM, in his official capacity as Director of the West Virginia Public Employees Insurance Agency,

BY COUNSEL

s/ Perry W. Oxley
Perry W. Oxley (WVSB #7211)
David E. Rich (WVSB #9141)
Eric D. Salyers (WVSB #13042)
Christopher K. Weed (WVSB #13868)
Oxley Rich Sammons, PLLC
517 9th Street, P.O. Box 1704
Huntington, WV 25718-1704
Phone: (304) 522-1138
Fax: (304) 522-9528
poxley@oxleylawwv.com
drich@oxleylawwv.com
esalyers@oxleylawwv.com
cweed@oxleylawwv.com

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Defendants.

CERTIFICATE OF SERVICE

I hereby certify that, as undersigned counsel for Defendant Ted Cheatham, in his official capacity as Director of the West Virginia Public Employees Insurance Agency, I electronically filed the foregoing **"Defendant Ted Cheatham's Motion to Dismiss the Complaint"** on this **11th** day of **January, 2021,** with the Clerk of the Court using the CM/ECF system, which will send notification of filing, and a copy of the same, to the following CM/ECF participants:

Walt Auvil, WVSB No. 190
THE EMPLOYMENT LAW CENTER, PLLC
1208 Market Street
Parkersburg, WV 26101
Phone: 304-485-3058
Facsimile: 304-485-6344
auvil@theemploymentlawcenter.com
Counsel for Plaintiffs

Avatara Smith-Carrington, Visiting Attorney
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
3500 Oak Lawn Avenue, Suite 500
Dallas, TX 75219
Phone: 214-219-8585
Facsimile: 214-219-4455
asmithcarrington@lambdalegal.org
Counsel for Plaintiffs

Anna P. Prakash, Visiting Attorney
Nicole J. Schladt, Visiting Attorney
NICHOLS KASTER, PLLP
IDS Center, 80 South 8th Street
Suite 4600
Minneapolis, MN 55402
Phone: 612-256-3200
Facsimile: 612-338-4878
aprakash@nka.com
nschladt@nka.com
Counsel for Plaintiffs

Tara L. Borelli, Visiting Attorney
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
730 Peachtree Street NE, Suite 640
Atlanta, GA 30308
Phone: 470-225-5341
Facsimile: 404-897-1884
tborelli@lambdalegal.org
Counsel for Plaintiffs

Sasha Buchert, Visiting Attorney
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
Phone: 202-804-6245
Facsimile: 202-429-9574
sbuchert@lambdalegal.org
Counsel for Plaintiffs

Nora Huppert, Visiting Attorney
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
4221 Wilshire Boulevard, Suite 280
Los Angeles, CA 90010
Phone: 213-382-7600
Facsimile: 213-351-6050
nhuppert@lambdalegal.org
Counsel for Plaintiffs

Lou Ann S. Cyrus, Esquire
Roberta F. Green, Esquire
Caleb B. David, Esquire
Kimberly M. Bandy, Esquire
Shuman McCuskey Slicer PLLC
Post Office Box 3953
Charleston, West Virginia 25339
(304) 345-1400
Fax: (304) 343-1826
lcyrus@shumanlaw.com
rgreen@shumanlaw.com
cdavid@shumanlaw.com
kbandy@shumanlaw.com
Counsel for Defendants William Crouch, Cynthia Beane and West Virginia Department of Health and Human Resources

Stuart A. McMillan
BOWLES RICE LLP
600 Quarrier Street
Charleston, West Virginia 25301
(304) 347-1110
Fax: (304) 347-1746
smcmillan@bowlesrice.com

Aaron C. Boone
BOWLES RICE LLP
Fifth Floor, United Square
501 Avery Street, Post Office Box 49
Parkersburg, West Virginia 26102
(304) 420-5501
Fax: (304) 420-5587
aboone@bowlesrice.com
Counsel for Defendant The Health Plan of West Virginia, Inc.

s/ Perry W. Oxley
Perry W. Oxley (WVSB #7211)
David E. Rich (WVSB #9141)
Eric D. Salyers (WVSB #13042)
Christopher K. Weed (WVSB #13868)

15TH RENEWAL
WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY
THE HEALTH PLAN
HMO MANAGED CARE AGREEMENT

THIS AGREEMENT, effective the first day of July, 2015, by and between the WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY (hereinafter "PEIA"), an agency of the state of West Virginia, and The Health Plan (hereinafter, "HMO");

WHEREAS, the PEIA desires to contract with managed care plans to offer additional benefit choices to its insureds; and,

WHEREAS, the HMO is a licensed firm in the business of managed care, and has been selected by the PEIA through the Request for Proposals (RFP) process; and

WHEREAS, pursuant to that RFP process the parties had previously entered into contracts for HMO to provide its benefit plan to PEIA members and the initial contract was effective July 1, 1999, and expired on June 30, 2000; and

WHEREAS, a subsequent RFP process was conducted in September 2004 and HMO was again selected through that process; and

WHEREAS, the initial contract has been continuously renewed since subject to annual rate proposals; and

WHEREAS, PEIA and the HMO are desirous of entering into another renewal contract to make available to PEIA eligible insureds the HMO's benefit plan or plans, including a Medicare PFFS plan option available to members who become Medicare-eligible while enrolled in the HMOs other benefit plan or plans, all as approved by PEIA and on terms agreed to by the parties.

NOW THEREFORE, in consideration of the mutual promises, covenants, terms and conditions herein, the parties agree as follows:

1. The HMO agrees to provide to PEIA insureds enrolled in its plan the medical coverage specified and upon the terms and conditions as set forth in Addendums E and F hereto, and further to comply with all terms and conditions as set forth in this Agreement, in the RFP issued September 13, 2004, , and the HMO's proposal thereto. Where there is a conflict between the proposal and the RFP, the RFP will govern. Where there is a conflict between the Agreement and either the RFP or the HMO's proposal, the Agreement will govern. A copy of said RFP is attached hereto as Addendum A and incorporated into this Agreement. A copy of the HMO's proposal is attached hereto as Addendum B and is incorporated herein by reference. A copy of HMO's coverage forms and related Evidences of coverage are attached hereto and incorporated by reference as Addendums E and F, respectively.

2. The PEIA agrees to comply with all terms and conditions as set forth in the RFP and this Agreement and to remit to the HMO on the 25th day of each month for which coverage is in effect, all applicable premium as set forth in Addendum C which includes a Profit Sharing Agreement. PEIA further agrees to comply with the rates as set forth in Addendum C. Addendum C is attached hereto and incorporated into this Agreement.

3. The term of this Agreement shall be from July 1, 2015 through June 30, 2016. The HMO guarantees the rate levels and covered services for this initial term. The Agreement may be renewed for successive renewal periods of twelve (12) months, upon such terms and conditions as the parties may agree. Terms and conditions for renewal are to be negotiated no later than 90 days prior to the end of the current contract term.

EXHIBIT A

If this Agreement is not renewed, whether after the initial term or after any subsequent renewal period, the HMO shall nonetheless submit all required reports as required by the RFP, including the claims and encounter, quality measures, and quarterly summary reports, and such obligation shall survive nonrenewal or termination of this Agreement. If this agreement is not renewed, the HMO also agrees to give written notice to its members of such non-renewal prior to the next Open Enrollment period.

4. This Agreement may terminate upon any of the following events:

(a) Nonappropriation of funds by the West Virginia Legislature, in accordance with Section 20 of this Agreement;

(b) Default by either party on any obligation under the Agreement. Termination of the Agreement will occur only if the default is not remedied within ten business days after written notice to the defaulting party by the other party;

(c) Nonrenewal of this Agreement;

(d) Any date mutually agreed upon by the PEIA and HMO in writing.

If either party terminates this Agreement prior to the expiration of the original term of the Agreement for any reason other than termination as described in the preceding paragraph, the other party, in addition to any other remedies available to it under this Agreement or otherwise, may seek damages against the party who has terminated the agreement for breach of this Agreement.

In the event of termination of this Agreement, the HMO will assist PEIA in effecting an orderly transfer of all covered individuals to other plans offered by PEIA.

All claims data, eligibility information and any other data furnished by PEIA under this Agreement shall remain the exclusive property of PEIA. This material includes, but is not limited to, reports, data dictionaries, final (edited) databases, data, and other documentation (whether in printed or electronic form), collected or produced for the PEIA.

Upon termination of this Agreement and upon request of PEIA, the HMO will promptly deliver all files to PEIA. The HMO will provide such files in a format reasonable to PEIA, in accordance with any privacy provisions stipulated by HIPAA.

The HMO shall continue to provide care under the coverage terms and limits of this Agreement, and be financially responsible for enrollees who are confined in an inpatient acute care facility at the time of termination of this Agreement until the discharge of such enrollees from the inpatient acute care facility. The termination of this Agreement shall in no way affect the quality or continuity of care rendered to those enrollees. If an enrollee is in a non-acute care facility (i.e., skilled nursing facility) at the time of the termination of this Agreement, the HMO shall continue coverage for such enrollee through the end of the month in which the Agreement terminates.

5. The HMO will have agreements in place which hold members harmless from charges in excess of amounts paid by the HMO for "covered" services to the HMO's participating or authorized providers. This paragraph does not affect copayments or deductibles.

If a participating hospital, primary care physician, or OB/GYN is terminated from the HMO plan's network, the HMO must notify the affected Members and the PEIA within 10 days of such termination. The HMO will use its best efforts to communicate to Members that if a Member continues seeing a terminated provider, the HMO is not responsible for payment.

The HMO will require network providers to agree that, if they are terminated, the provider shall communicate to any HMO Member prior to the delivery of service that services are no longer covered by the plan. If the Member elects to use the provider and subsequently files a grievance for the non-reimbursed expense, the provider must demonstrate proof that the Member was informed of his/her financial responsibility or the Member will be held harmless for the expense.

6. In the event the HMO loses the services of a Primary Care Physician (PCP) or an OB/GYN during the first six months of any contract term, and the loss of the service of said PCP or OB/GYN affects more than two percent of the PEIA insured patients enrolled with the plan or 50 PEIA insureds, whichever is greater, the HMO shall notify the PEIA insured patients of the PCP or OB/GYN and shall allow such insureds the opportunity to (i) change PCPs or OB/GYNs, or (ii) change plans. If the PEIA insured elects to change plans, he or she must change plans within the first six months of the contract term and may only change plans at the beginning of the next calendar month after the loss of service of the PCP or OB/GYN. If a PEIA insured changes to the PEIA PPB plan, the HMO shall pay PEIA one hundred dollars ($100.00) for each contract holder, or if a PEIA insured changes to another HMO plan, the HMO shall pay PEIA twenty dollars ($20.00) for each contract holder; provided that the maximum amount the HMO will be required to pay PEIA during the term of the contract for such change of plans will be twenty-five thousand dollars ($25,000.00). Nothing in this paragraph shall apply to (i) any PCP or OB/GYN who either (a) relocates from the area serviced by the HMO, (b) retires from the practice of medicine, (c) is disqualified from receiving payments from the Medicaid or Medicare programs, (d) dies, (e) loses his license to or is otherwise prohibited from practicing medicine, (f) fails to renew their contract with the HMO or withdraws from the HMO based on unreasonable requests for reimbursement by the PCP or OB/GYN, or (g) otherwise is removed from the panel of the HMO for cause, or (ii) any PEIA insureds affected by any PCP or OB/GYN referred to in (i)(a)-(g) above. In addition to the situations described in (i)(a)-(g) above, the Director of the PEIA (Director), at the request of an HMO, shall have the discretion to determine that this paragraph does not apply to other situations in which the PCP or OB/GYN leaves the plan.

7. The HMO agrees to allow PEIA insureds, after exhausting the appeal process established by the HMO, to appeal any decision of the HMO to the Director of the PEIA. The decision of the PEIA Director shall be appealable by either party to the State Insurance Commissioner in accordance with W. Va. Code §33-25A-12.

8. The HMO agrees to allow PEIA to determine eligibility for coverage for all members. PEIA will provide eligibility data to the HMO on a weekly basis. Coverage for a member will cease on the last day of the month in which the member is eligible for coverage. PEIA will make every effort to notify the Plan of terminations on a timely basis; however, in no event will the HMO be required to terminate coverage retroactively by more than 90 days. Any prescription drug claims paid beyond the eligibility date provided by PEIA shall be the responsibility of the HMO if the drug claim was paid beyond 48 hours of receipt of eligibility information properly provided by PEIA.

The HMO further agrees to enroll only those members and their dependents who live in a county where the plan has a Certificate of Authority.

9. The HMO agrees to comply with the modified reporting requirements as set forth in Addendum D, which is attached hereto and incorporated into this Agreement. The HMO also agrees that it will respond to all PEIA staff inquiries in a thorough and timely fashion, and in any event within 20 calendar days. PEIA and HMO acknowledge that they are part of an Organized Health Care Arrangement (OHCA), as defined by HIPAA.

10. The HMO agrees to pursue both Coordination of Benefits (COB) and Subrogation on all appropriate claims.

(a) The HMO shall identify COB opportunities and pursue those opportunities that may lead to a net recovery of funds. To identify COB opportunities, the HMO shall utilize data supplied by the PEIA as well as its own resources to investigate potential opportunities. Independent investigation by an HMO should include, but not be limited to, actions such as verification of insurance coverage for the working spouse of an enrollee.

(b) The HMO shall identify subrogation opportunities and pursue those opportunities that may lead to a net recovery of funds. Th HMO shall establish screening criteria for claims, approved by the PEIA, to access the merit of pursuing subrogation. To identify

these subrogation opportunities, the HMO shall utilize relevant data supplied by the PEIA as well as its own resources to investigate potential opportunities. Independent investigation by an HMO should include establishing a procedure by which it can identify through claim information inquiries that may be the result of an accident. In such circumstances, the HMO should contact the enrollee to determine whether a third party may be liable for the injuries. In cases where subrogation is appropriate, the HMO shall attempt to recover from third parties.

11. The HMO will indemnify and hold harmless the State of West Virginia and the PEIA, its directors, officers, agents and employees, from any and all claims arising from the provision of services by the HMO or any of its participating providers.

12. Any data or information pertaining to the diagnosis, treatment (including medications), or health of a Member or to any other personal information obtained from such person or from any provider by the HMO shall be held in strict confidence and shall not be disclosed to any person except as provided for in West Virginia Health Maintenance Organization Act (W.Va. Code §33-25A-1, et seq.) or other applicable laws including, but not limited to, HIPAA. The HMO shall provide to the Director, at least thirty (30) days prior to the commencement of this Contract, a copy of the HMO's confidentiality policy which shall include, but not be limited to, procedures to train new employees on identifying and handling confidential information, an annual class on confidentiality to be provided to all employees and the HMO's procedures addressing breaches of confidentiality. In addition, the HMO will provide a confidentiality provision in all of its Network provider contracts.

13. The validity, interpretation and performance of the provisions of this Agreement between PEIA and the HMO, shall be governed by the laws of the State of West Virginia.

Within ten (10) days of receipt of notification of any determination of non-compliance with state or federal laws, rules, regulations, or guidelines made by any agency charged with the responsibility to make such a determination, the HMO shall provide the PEIA with a copy of such notification with corrective action it has taken or plans to take. At least monthly thereafter until such time as the appropriate state or federal authority determines that the HMO is again in compliance, the HMO shall, upon request, provide a written report detailing corrective measures taken and the status of its negotiations with the state or federal authority.

14. This Agreement is subject to modification, at the discretion of the PEIA, to conform or comply with any state or federal law or regulation enacted during the term of the Agreement. In such circumstances, the PEIA shall notify the HMO as provided for in Section 17 of this Agreement, identifying the law or regulation, the sections of the Agreement affected, and any proposed modifications that it feels would be necessary to come into compliance. Within thirty (30) days of receipt of the notice by the HMO, the parties shall meet in order to attempt to agree on the necessary Agreement modifications. If the enacted law or regulation requires that a modification be made prior to this thirty (30) day period, a shorter period may be designated by the PEIA. If the parties are unable to agree on the modifications, and the proposed modifications by the PEIA would result in a cost increase to the HMO of more than one (1%) percent of the total premium collected from the PEIA, the matter shall be submitted for dispute resolution in accordance with Section 21 of this Agreement. However, nothing in this section shall be construed to require either the PEIA or the HMO to violate any applicable law or regulation, and if the parties are unable to agree to the modifications prior to the effective date of the law or regulation, that portion of the Agreement affected shall be severed in accordance with Section 19, and the parties shall continue to attempt to resolve their differences.

15. Any taxes to be paid by the HMO shall be the responsibility of the HMO or its participating providers.

16. The HMO, at its sole expense, agrees to maintain insurance or other risk coverage for professional liability and comprehensive general liability in amounts of at least $1 million per occurrence. Prior to the effective date of this Agreement, the HMO shall provide to PEIA a certificate of insurance or evidence of self-insurance required herein. The HMO shall notify PEIA in writing 30 days prior to any such insurance coverage being terminated for any reason whatsoever.

17. Any notice required or permitted to be given pursuant to this Agreement shall be in writing and shall be either hand-delivered or deposited in the United States mail, by registered or certified mail, return receipt requested, addressed as follows:

Director Public Employees Insurance Agency 601 57th Street SE, Suite 2 Charleston, West Virginia 25304	Jim Pennington, President and CEO The Health Plan 52160 National Road, East St. Clairsville, Ohio 43950

Notice shall be effective upon receipt. Either party may change the address to which notices are to be delivered by giving written notice to the other party as provided in this Section.

18. No delay or failure of either party to exercise any right hereunder and no partial or single exercise thereof shall be deemed of itself to constitute a waiver of such right or any other rights hereunder.

19. If any section, portion of a section, or provision in this Agreement is determined to be invalid, illegal, or unenforceable, by any court, any state or federal board or agency responsible for regulating matters or areas addressed in this Agreement, any federal or state law enacted during the term of this Agreement, or for any other compelling reason as determined by PEIA, said section, portion of a section, or provision shall be severed from this Agreement and the remaining portions of the Agreement shall remain in full force and effect and be binding on the parties, unless such action would make it impossible for either party to comply with or fulfill their obligations under the then existing Agreement or render the Agreement meaningless. Any dispute as to modifications to the Agreement that may be required as a result of actions taken pursuant to this section shall be resolved in accordance with Section 21 herein.

20. Pursuant to Article 10, Section 4 of the West Virginia Constitution, the State of West Virginia or its subdivisions may not enter into any contract or agreement which would obligate the State beyond the current fiscal year. Therefore, goods to be delivered and/or services to be performed under this Agreement are to be continued in succeeding fiscal years for the term of this Agreement, contingent upon funds being appropriated by the Legislature for such goods and/or services, the payments, including any interest, and the services hereunder, shall be canceled in whole without penalty to the State at the end of the then current fiscal year, with the Agreement becoming null and void after June 30th of such year. The PEIA will make reasonable efforts to obtain the necessary funds to avoid cancellation of this Agreement, and will make all reasonable efforts to provide written notice to the HMO in the event of non-appropriation forty-five (45) days prior to the end of the fiscal year in which such non-appropriation for the next fiscal year occurs.

21. If a dispute arises out of this Agreement, any modifications made to the Agreement pursuant to Sections 14 (subject to the one percent provision contained therein) or 19 herein, the performance of either party, or for any reason that effects the business relationship of the parties, the parties agree to meet and attempt to resolve the dispute by negotiation. If negotiation is not successful, the parties shall in good faith explore the use of mediation using the American Arbitration Association as the mediator, or such other firm or association as agreed upon by the parties. The parties agree to make a good faith attempt to resolve the dispute prior to litigation. This section shall not prevent a party from terminating the Agreement for the failure of the other party to cure a breach of a material duty pursuant to Section 4 herein.

22. PEIA and the HMO enter into this agreement as independent contractors. Nothing in this Agreement or otherwise is intended to create or shall be deemed or construed to created any other relationship between the parties, including one of employment, agency, partnership, or joint venture.

23. No person or entity is intended to be or shall be construed or deemed to be a third party beneficiary of this Agreement.

24. Neither PEIA nor the HMO shall be liable to third parties for acts or omissions of the other party hereto or its agents. The responsibility for determining and providing appropriate health care

services in a competent manner to enrollees shall remain with the HMO and the enrollees; treating physicians and other health care professionals and facilities, not PEIA. By entering into this Agreement, PEIA makes no representations, warranties or guarantees regarding the outcome, appropriateness or degree of skill exercised in making any diagnosis or providing any course of treatment to enrollees.

25. To the extent that Federal statutes or rules governing Medicare Private Fee For Service (PFFS) plans are in conflict with the provisions of the Agreement those Federal statutes and rules shall prevail with respect to the HMOs Medicare PFFS plan.

26. The terms and conditions as set forth in the RFP and in this Agreement shall define and control the relationship between the parties and any deviation, deletion, expansion, or clarification of the terms and conditions as set forth in the RFP and this Agreement shall not be binding on the parties unless agreed to in writing.

This Agreement, executed in duplicate originals, represents the full and complete understanding of the parties.

THE HEALTH PLAN

By: _____

Jim Pennington, President and CEO
52160 National Road, East
St. Clairsville, Ohio 43950

WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY

By: _____

Ted Cheatham, Director
West Virginia Public Employees Insurance Agency
601 57th Street SE, Suite 2
Charleston, West Virginia 25304

EXHIBIT A