COURT OF APPEALS
DECISION
DATED AND FILED

February 5, 2014

Diane M. Fremgen
Clerk of Court of Appeals

Appeal No. 2012AP2495 **Cir. Ct. No. 2011CV1049**

STATE OF WISCONSIN **IN COURT OF APPEALS**
DISTRICT II

PROHEALTH CARE, INC.,

PLAINTIFF-APPELLANT,

V.

HEALTHEOS BY MULTIPLAN, INC.,

DEFENDANT-RESPONDENT.

APPEAL from a judgment of the circuit court for Waukesha County: JAMES R. KIEFFER, Judge. *Reversed and cause remanded.*

Before Brown, C.J., Reilly and Gundrum, JJ.

¶1 GUNDRUM, J. In this breach-of-contract case, ProHealth Care, Inc., appeals from a judgment that denied its motion for partial summary judgment and granted summary judgment to HealthEOS By Multiplan, Inc. ProHealth contends that HealthEOS breached the parties' Participating Provider Agreement

by failing to provide a material feature of the agreement, namely, automatic quarterly reports. HealthEOS contends that ProHealth's contract claim is barred both by the contract's Limitation of Liability provision and by the voluntary payment doctrine, which HealthEOS raised as an affirmative defense.

¶2 Based on the record before us, we conclude that neither the Limitation of Liability provision nor the voluntary payment doctrine apply. Accordingly, we reverse the judgment and remand the matter for further proceedings.

Background

¶3 ProHealth is an integrated health system that provides patient health care through its hospitals, clinics, and physicians. HealthEOS is a network of "Providers," like ProHealth, that deliver health care services to "Participants." "Participants" are patients eligible for coverage under specific health care benefit plans or worker compensation programs. Employers, insurance carriers, and other entities that sponsor or administer such benefit plans or programs and contract with HealthEOS to allow participants access to HealthEOS are HealthEOS' "Clients." In exchange for being included in the health network, providers agree to accept discounted rates for services rendered to participants covered by clients' health benefit plans. Providers benefit from patient "steerage," which generates more revenue, and from more timely and accurate payment of claims.

¶4 ProHealth and HealthEOS had a contractual agreement between 2003 and 2005. Effective November 1, 2005, the parties entered into a four-year Participating Provider Agreement that would renew automatically for consecutive one-year terms unless properly terminated. Under the agreement, HealthEOS agreed to provide ProHealth a Quality Management Program (QMP) that would

support improvement in the overall quality of health care provided to patients and a reduction in its overall cost.

¶5 The QMP included "CareEngine" services. CareEngine is a proprietary software program developed by ActiveHealth Management (AHM), a HealthEOS subcontractor. CareEngine would collect, integrate, and analyze health care data from medical records, insurance claims, and laboratory and pharmacy data. The analyzed data was used to identify gaps in care, medical errors, and quality issues, which AHM communicated directly to treating physicians. The communicated information was known as a "Care Consideration." Care Considerations provided information relative to an identified patient, prompting the physician perhaps to rethink a prescription or consider additional testing.

¶6 AHM also generated reports for clients—again, entities such as employers, insurers, or benefit program administrators. Client reports contained basic raw data that summarized activity of all providers in a particular network—HealthEOS, for instance—without identifying specific physicians or patients. Being "client-facing," AHM's software was not designed to generate reports for *providers* like ProHealth.

¶7 To be in the HealthEOS network, ProHealth, as a provider, was required to participate in the QMP. With the 2005 agreement, the parties agreed that ProHealth would pay HealthEOS a monthly fee of $77,172 to develop, administer, and maintain the QMP.[1] As a part of the package, ProHealth wanted

[1] The fee was approximately $33,000 under the 2003 contract. The new fee was subject to annual review and adjustment, by mutual consent, based on business volumes and use of the CareEngine services.

its corporate office to regularly receive patient-specific reports summarizing the Care Considerations its physicians received. After some negotiation, the parties inserted the following language, unique to the HealthEOS-ProHealth contract, into the agreement:

> HealthEOS is in the process of developing regular reporting capability for providers. Once this is developed (throughout 2005), it will be shared with Provider [ProHealth] during the first quarter of 2006, reflecting 2005 activity, and then each quarter thereafter. The report will be provided automatically on a quarterly basis.

¶8 The automatic quarterly reports to ProHealth never came to fruition. HealthEOS was not "in the process of developing regular reporting capability for *providers*," as the agreement stated. (Emphasis added.) Rather, as HealthEOS's former vice president of network development, Paul Sabin, acknowledged at his deposition, HealthEOS was working with AHM to try to develop this capability solely for ProHealth. AHM never developed a "provider-facing" product capable of compiling the data necessary to generate the reports called for in the agreement.

¶9 On two occasions, Sabin undertook the "cumbersome process" of manually preparing summary reports of ProHealth Care Consideration activity from raw data AHM supplied. The summaries contained no patient-specific information and, according to ProHealth, were of little-to-no use or value. Despite ProHealth's repeated inquiries and expressed concerns regarding HealthEOS's failure to provide the reports, HealthEOS did not apprise ProHealth that AHM had not developed the software capable of producing the desired reports, but instead repeatedly communicated to ProHealth that the reports would be forthcoming.

¶10 Sabin left HealthEOS in 2007, and ProHealth received no further reports from HealthEOS, manual or automated. Sabin's successors were unaware

until 2010 that the contractual obligation existed. According to ProHealth, as averred by its chief financial officer in her affidavit, HealthEOS never informed ProHealth that it was incapable of providing the reports as required by the agreement until a meeting between ProHealth and HealthEOS representatives in mid-2010.

¶11 In a series of adjustments, the monthly QMP fee was reduced to $30,000, effective November 1, 2008, through September 30, 2010. As of October 1, 2010, the agreement was amended to eliminate the monthly fee altogether. ProHealth asserts that it paid HealthEOS more than $2.6 million "for QMP reporting that HealthEOS never delivered."

¶12 ProHealth commenced this action seeking damages for HealthEOS's alleged breach of contract, as well as misrepresentations and unfair trade practices in violation of WIS. STAT. §§ 100.18 and 100.20 (2011-12),[2] and seeking a constructive trust over QMP payments it previously made. The circuit court granted HealthEOS's motion to dismiss ProHealth's §§ 100.18 and 100.20 claims.

¶13 Both parties subsequently moved for summary judgment. ProHealth argued that the undisputed facts showed that HealthEOS failed to provide the promised QMP services despite having been paid millions. HealthEOS contended that ProHealth's claim was barred by the voluntary payment doctrine as well as language in the Limitation of Liability clause within the agreement. At the hearing on the motions, ProHealth contended that, as to HealthEOS's voluntary payment doctrine defense, a material fact dispute remained as to the applicability

[2] All references to the Wisconsin Statutes are to the 2011-12 version unless noted.

of the doctrine. The circuit court granted HealthEOS's summary judgment motion and denied ProHealth's.

¶14 ProHealth appealed the circuit court's grant of summary judgment to HealthEOS. This court ordered oral argument.[3] We now reverse and remand, because issues of fact remain.

Discussion

¶15 We review a grant of summary judgment de novo, applying the same methodology as the circuit court. ***Paskiewicz v. American Family Mut. Ins. Co.***, 2013 WI App 92, ¶4, 349 Wis. 2d 515, 834 N.W.2d 866. Summary judgment is appropriate when the facts relevant to the case are undisputed and only a question of law remains. ***Id.***

Limitation of Liability Provision

¶16 On appeal, as before the circuit court, HealthEOS claims subsections (d) and (e) of the Limitation of Liability clause in the agreement preclude its liability. The full clause provides:

> 3.3 Limitation of Liability. The parties acknowledge and agree as follows: (a) any reports generated by the CareEngine® and any references to published materials forwarded to treating physicians or to Providers with respect to CareEngine® Services do not represent a medical diagnosis by HealthEOS or by AHM and do not prescribe a mandatory course of patient care; (b) all ultimate decisions regarding patient care are strictly and solely the responsibilities of the Provider; (c) HealthEOS provides access to CareEngine® Services solely as an information service to Providers; *(d) HealthEOS has not*

[3] This court commends both counsel for their preparedness and excellent presentations.

> *created or participated in the development of the CareEngine® and assumes no liability or responsibility for the content of the information generated or the services provided by AHM with respect to the CareEngine®; (e) HealthEOS shall not be liable in any way with respect to any reports, published materials or in any other respect relating to the provision of CareEngine® Services and the rendition of health care services to Client/Payors and Participants;* and (f) each party disclaims any right to indemnification from the other for any reason hereunder, whether arising by contract or by operation of law. (Emphasis added.)

¶17 Relying upon subsections (d) and (e), HealthEOS contends ProHealth's claims are barred because "Section 3.3 clearly encompasses the nature of the claim being made by ProHealth"—that ProHealth was not provided with the automatic quarterly reports as required elsewhere in the contract. ProHealth argues that Section 3.3 limits HealthEOS's liability with respect to use of certain information related to the treatment of patients, but "does not immunize HealthEOS from *all* liability for failing to comply with specific contractual promises contained elsewhere in the agreement, including HealthEOS's promise to provide ProHealth with automatic, quarterly QMP reporting." Our reading of Section 3.3 is more in line with that of ProHealth.

¶18 The construction of a written contract generally is a question of law we review independently on appeal. ***Jones v. Jenkins***, 88 Wis. 2d 712, 722, 277 N.W.2d 815 (1979). We ascertain the meaning of a particular contract provision with reference to the contract as a whole. ***Tempelis v. Aetna Cas. & Sur. Co.***, 169 Wis. 2d 1, 9, 485 N.W.2d 217 (1992).

¶19 HealthEOS essentially asks us to treat subsections (d) and (e) as exculpatory clauses. Courts closely scrutinize exculpatory clauses and strictly construe them against the party that seeks to rely on them. ***Mettler ex rel. Burnett v. Nellis***, 2005 WI App 73, ¶13, 280 Wis. 2d 753, 695 N.W.2d 861.

¶20 HealthEOS argues that these subsections preclude liability for its failure to provide the reports required by the agreement. However, reading subsections (d) and (e) in the context of the entire Limitation of Liability provision and the agreement as a whole, as we must, HealthEOS's interpretation cannot stand. Section 3.3 relates to the *substance* of reports (or services) provided and does not suggest that the failure to even provide the required reports in the first instance is excused. A more reasonable reading is that these subsections were intended to preclude liability for errors or omissions within the reports HealthEOS was supposed to provide. Our interpretation is further guided by the significant fact that elsewhere in the agreement HealthEOS specifically promised to provide these reports "automatically on a quarterly basis," beginning "during the first quarter of 2006 … and then each quarter thereafter." If subsections (d) and (e) could exculpate HealthEOS from liability with regard to this promise, it would take much clearer language to that effect to do so. The Limitation of Liability provision does not apply to ProHealth's claims, and it is for a fact finder to decide whether HealthEOS materially breached the contract.

Voluntary Payment Doctrine

¶21 The voluntary payment doctrine provides that, as between two parties, "money paid voluntarily, *with knowledge of all the facts*, and without fraud or duress, cannot be recovered merely on account of ignorance or mistake of the law." ***Putnam v. Time Warner Cable of Se. Wis., Ltd., P'ship***, 2002 WI 108, ¶13, 255 Wis. 2d 447, 649 N.W.2d 626 (citation omitted; emphasis added). A mistake of fact goes to the "unconscious ignorance" of a fact "material to the contract," ***id.***, ¶19 n.6 (citation omitted), and "work[s] to negate the true voluntariness of payments," ***id.***, ¶29.

¶22 HealthEOS contends the voluntary payment doctrine bars ProHealth's claims because ProHealth voluntarily paid the QMP fee for years with no objection. ProHealth provides several reasons why the doctrine should not apply in this case; however, our reversal on this point is driven by our agreement with ProHealth's contention that a genuine issue of material fact remains regarding whether it made the payments "with knowledge of all the facts."

¶23 ProHealth asserts that it paid the required monthly QMP fee in part because it relied upon HealthEOS's representation in the agreement that it was "in the process of developing regular reporting capability for *providers*." (Emphasis added.) It points out that Sabin testified in his deposition that, at the time HealthEOS entered into the agreement, HealthEOS in fact was not in the process of developing this capability for health care providers generally but was attempting to develop it solely for ProHealth. ProHealth further points to emails between itself and HealthEOS, deposition testimony of ProHealth personnel who communicated with HealthEOS regarding the reports, and averments in the affidavit of its chief financial officer, all of which support its assertion that it was operating under a mistake of fact when it made monthly payments because HealthEOS continued to represent that the reports would be forthcoming and

failed to inform ProHealth of HealthEOS's lack of progress in developing the ability to provide the reports.[4]

¶24 When asked at his deposition if he had "any reason to believe that ProHealth Care was told by anybody that [AHM] was incapable of generating the information needed for the reports called for by the contract," the senior HealthEOS representative responsible for the ProHealth account responded, "I don't believe so." When further asked, "Based on your experience and your knowledge of this industry, do you believe that ProHealth Care should have been informed prior to this revelation meeting that occurred in 2010 about all the challenges that were being faced by HealthEOS and AHM together trying to generate this provider reporting?" the same HealthEOS representative responded, "My opinion would be yes."

[4] ProHealth personnel testified during depositions that: discussions with HealthEOS took place "throughout the term of the contract" about "when [ProHealth] would receive reports"; when renegotiating, in 2009, the monthly dollar amount ProHealth would pay, HealthEOS personnel again told ProHealth it "would be receiving reports"; and that ProHealth was "continually … led to believe that we were going to be getting more, that being at least the one report that we had received previously, plus a more robust reporting package." In response to the deposition question, "So it's fair to say to the best of your knowledge ProHealth Care believed in good faith that the reports would eventually be developed and that they would come at some point in time, correct?" a HealthEOS representative responded, "I believe so."

An example of email correspondence cited to by ProHealth is a ProHealth email to HealthEOS in October 2007 asking, "Will you be sending the report soon?" with an email from HealthEOS to ProHealth three hours later stating, "I do apologize.… I am moving in many different directions at one time. I will request that these be run by someone else so that it isn't sitting on my plate. I will have them to you quickly."

ProHealth's chief financial officer averred that "a number of ProHealth's representatives, including me, were told by [HealthEOS's] representatives that [HealthEOS] would provide ProHealth with the … reporting required under the … Agreement … at various times during the years ProHealth was making its monthly … payments."

¶25 Pointing to the record, ProHealth asserts that

> [i]n November 2005 [when it signed the agreement], [it] did not know (or have reason to know) HealthEOS could not develop or deliver the promised reporting. Thus, at a minimum, QMP fee payments made by ProHealth in late 2005 and early 2006 were clearly mandated by the agreement and were not voluntary in any sense.

We agree with ProHealth's contention that there is a material question of fact regarding "when ProHealth obtained full knowledge (or reasonably should have known) that HealthEOS was incapable of developing and delivering the required reporting."

¶26 Based on the record before us, it appears at a minimum as if ProHealth's decisions to initially pay and to continue paying the monthly QMP fee to HealthEOS as required by the agreement may have been based, at least in part, upon ProHealth's continued but mistaken belief that HealthEOS was close to having the capability to provide it with the reports. Considering representations made by HealthEOS in the agreement and through communications by HealthEOS's representatives to ProHealth personnel, that belief may have been reasonable, at least for some number of months or years. Thus, a material factual dispute remains as to whether ProHealth made payments voluntarily or instead based upon mistake of fact. Preclusion of ProHealth's claims based on the voluntary payment doctrine is inappropriate at this time.

By the Court.—Judgment reversed and cause remanded.

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