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' MOTION TO DISMISS

TABLE OF CONTENTS

INTRODUCTION 1
BACKGROUND 4
I. MBB prior to its acquisition by Radiology Partners. 4
II. Radiology Partners acquires MBB and defrauds Aetna. 4
A. Radiology Partners acquires MBB and then immediately inflates MBB's billed charges. 5
B. The Contract Period scheme. 5
C. The Post-Contract Period scheme. 6
III. Defendants' efforts to conceal their schemes. 8
IV. Aetna files suit and Defendants move to dismiss. 8
LEGAL STANDARDS 8
ARGUMENT 9
I. Aetna properly states a claim for tortious interference with contract. 9
II. Aetna states claims for fraud, negligent misrepresentation, and violation of Florida's Deceptive and Unfair Trade Practices Act. 10
A. Defendants misinterpret the factual basis for these claims. 10
B. The Complaint contains well-pleaded factual allegations supporting Aetna's claims for fraud and negligent misrepresentation. 11
C. Aetna's FDUTPA claim is also well pleaded. 15
III. The Complaint states a claim for civil conspiracy. 17
IV. The Complaint properly pleads a claim for vacatur based on MBB's fraud during the NSA IDR process and because the arbitrators exceeded their powers. 19
A. Aetna states a claim for vacatur because of fraud. 20
1. The Complaint pleads fraud with particularity. 20
2. MBB's fraud was not discoverable upon the exercise of diligence prior to or during the NSA IDR arbitrations. 24
3. Defendants' fraud is materially related to the issues decided in the arbitrations. 25
B. The Complaint pleads that the NSA IDR entities exceeded their powers. 26

V. Aetna states a claim under ERISA § 502(a)(3). 28

VI. The Complaint properly states a claim for declaratory judgment, but Aetna partially withdraws its claim. 32

VII. The No Surprises Act does not shield Defendants from liability. 34

A. Defendants do not identify any exhaustion requirement applicable to Aetna's claims under the NSA. 34

B. The NSA does not foreclose Aetna's claims under Florida or federal law. 34

CONCLUSION 36

INTRODUCTION

In 2018, Defendant Radiology Partners, Inc. ("Radiology Partners") began acquiring radiology groups across Florida, including Defendant Mori, Bean and Brooks, Inc ("MBB"), which was then a relatively small radiology practice in Jacksonville. Each of these practices had its own in-network contract with Aetna. But, after acquiring the practices, Radiology Partners and MBB fraudulently billed Aetna for the services rendered by *all* the practices as if MBB had performed them. The purpose and effect of these actions was to cause Aetna and its plan sponsors to pay Defendants under the more lucrative contract between Aetna and MBB (the "Aetna-MBB Contract"), rather than the contracts between Aetna and the other practices. This was the "Contract Period" of Defendants' scheme.

Aetna terminated the Aetna-MBB Contract in 2022. Rather than reverting to billing for services rendered by the non-MBB practices under those practices' own billing identifiers and in-network contracts with Aetna, Radiology Partners continued to use MBB's billing identifiers. This meant the claims were billed on an out-of-network basis *even though the providers were in-network*. For thousands of such claims, Defendants went further and fraudulently initiated arbitrations under the No Surprises Act's ("NSA") Independent Dispute Resolution ("IDR") process, falsely certifying that the services were provided by non-contracted providers. This caused Aetna to incur tens of millions of dollars in fraudulent claims, NSA IDR awards, arbitration fees, and unnecessary overhead. This is Defendants' "Post-Contract Period" scheme.

Aetna filed this suit to seek recompense from Defendants and halt Defendants' scheme. Aetna asserted claims (1) against Radiology Partners for the claims billed during the Contract Period;[1] and (2) against MBB and Radiology Partners for the Post-Contract Period. In response, Defendants filed a motion to dismiss Aetna's claims against MBB and Radiology Partners only for the Post-Contract Period. D.E. 27 at 1 (limiting motion to Post-Contract Period).[2]

Aetna's claims for the Post-Contract Period fall into two categories. *First*, for the benefit claims that Defendants caused Aetna to pay improperly *independent* of the NSA IDR process, Aetna asserted causes of action under Florida and federal law (Counts 2-8, 10-11). For the benefit claims where Defendants fraudulently obtained NSA IDR awards, Count 9 seeks vacatur under 9 U.S.C. § 10.

The Complaint is factually detailed and states the claims asserted during the Post-Contract Period. Defendants' motion to dismiss, on the other hand, devotes nearly 20 pages to rhetoric, disputing the well-pleaded factual allegations in the Complaint, and other matters wholly outside of the four corners of the Complaint. *See* D.E. at 1-19. This choice speaks volumes about the strength of their arguments.[3]

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[1] Aetna has not asserted claims against MBB for the Contract Period, as Aetna has made clear. *See*, *e.g.*, D.E. 39 at 2 & n.1.

[2] Defendants moved to compel arbitration of Aetna's claims during the Contract Period rather than moving to dismiss them. D.E. 28. Accordingly, this opposition only addresses Aetna's claims relating to the Post-Contract Period, which are the subject of Defendants' motion to dismiss.

[3] Remarkably, Defendants even cite to delaydenydefend.com, a website touting a book which a title that matches the inscriptions on bullets used to kill the Chief

Defendants' other arguments are similarly unavailing. They argue that the NSA bars Aetna's claims (*see* D.E. 27 at 29-39) but there is a difference between claims where MBB obtained an NSA IDR award (which Aetna seeks to vacate under 9 U.S.C. § 10) and claims where Aetna simply relied on Defendants' misrepresentations and paid a claim that Defendants should not have ever billed independent of the NSA IDR process. The NSA does not preempt Aetna's state-law claims in the latter scenario, and Defendants present no authority that it does.

Defendants also take a shotgun approach to Aetna's state-law claims, largely ignoring the detailed factual allegations in the Complaint. For instance, Defendants argue *ad nauseum* that Aetna's fraud-based claims lack "particularity," even though Complaint has 354 detailed paragraphs identifying the who, what, when, how, and why of the scheme. The Complaint even includes *sworn discovery responses from a Radiology Partners-affiliated practice* that demonstrates how Defendants have been lying about the relationships between their providers and the various medical groups that Radiology Partners controls. *See* Compl. ¶¶ 67-85.

Defendants were caught engaging in a monumental fraud scheme. They have stolen tens of millions of dollars from Aetna and its plan sponsors and unnecessarily caused *thousands* of claims to be billed on an out-of-network basis. No relief is appropriate under Rule 12(b)(6). As a result, Aetna respectfully requests that the Court deny Defendants' motion to dismiss in its entirety.

Executive Officer of UnitedHealth Group. *See* D.E. 27 at 3 n.1. It was a striking, gratuitous, and inappropriate choice by lawyers from a well-regarded firm.

BACKGROUND

I. MBB prior to its acquisition by Radiology Partners.

MBB is a medical group formed in 1968 that, prior to its acquisition by Radiology Partners, was comprised of a few dozen radiologists in the Jacksonville area. D.E. 1 ("Compl.") ¶¶ 46–47. In 2001, Aetna and MBB entered into the Aetna-MBB Contract which reimbursed MBB, and only MBB, for services provided to Aetna's members at relatively higher rates. *See id.* ¶¶ 49, 54, 212–213. For almost two decades, MBB billed Aetna for services performed by a few dozen physicians at sites near Jacksonville. *Id.* ¶ 47.

II. Radiology Partners acquires MBB and defrauds Aetna.

Radiology Partners is a private equity–backed aggregator of radiology practices founded in 2012 that carries out its operations through local groups that it acquires and controls. *See id.* ¶¶ 2, 3, 45. Radiology Partners today claims $3 billion in annual revenue, employs more than 3,900 radiologists at 3,400 sites in all 50 states, and handles more than 10% of the country's imaging volume. *Id.* ¶ 38. Radiology Partners' rapid growth follows from its founders' core business plan: to consolidate the radiology market. *Id.* ¶ 39. The private equity firms that have backed this growth through billions of dollars of investment exert considerable control, influence, and direction over the operations of Radiology Partners. *Id.* ¶ 40. In exchange for this private equity investment, the company's funders demanded growth and a sizable return on investment. *Id.* ¶ 44. To accomplish that goal, Radiology Partners turned to the scheme set forth herein with MBB. *Id.*

A. Radiology Partners acquires MBB and then immediately inflates MBB's billed charges.

In 2018, Radiology Partners acquired MBB for over $130 million. *See id.* ¶¶ 48–49. Immediately after, Radiology Partners began trying to find ways to gin up revenue. *Id.* ¶ 53. In doing so, Radiology Partners observed that the Aetna-MBB Contracted reimbursed MBB for certain services at 70% of MBB's billed charges. *Id.* ¶ 54. Radiology Partners caused MBB to inflate its billed charges by, on average, over 60%. *Id.* ¶ 55. For example, MBB began charging $147 for a particular x-ray read that MBB had historically charged only $41 for. *Id.* ¶ 56.

B. The Contract Period scheme.

Radiology Partners was not content with simply inflating MBB's billed charges. *Id.* ¶ 58. It decided to bill services rendered by its *other* Florida-based radiology groups though MBB, making it appear as though MBB rendered the services and that they were eligible for payment under the Aetna-MBB Contract. *See id.* ¶¶ 59, 65. This caused Aetna to overpay. *Id.* ¶¶ 67–111.

For instance, Dr. Navid Nouri has worked for Radiology Associates of South Florida ("RASF"), a radiology group in Florida that has its own in-network contract with Aetna, since 2014. *Id.* ¶¶ 67–68. RASF billed for services provided by Dr. Nouri using its own Tax Identification Number ("TIN") for years. *Id.* ¶ 69. However, after acquiring RASF and MBB, Radiology Partners directed that services provided by RASF be billed using MBB's TIN. *Id.* ¶¶ 70–71. Claims for services rendered by Dr. Nouri were then billed by MBB. *Id.* ¶ 72. This resulted in

claims for Dr. Nouri's services being reimbursed at dramatically higher rates. *See id.* ¶ 77 (1638.76% increase for x-ray read). Notwithstanding his services being billed by MBB, (1) Dr. Nouri still appears on RASF's website, (2) Dr. Nouri publicly identifies himself as working for RASF, and (3) both Dr. Nouri and RASF recently admitted in sworn discovery in a malpractice case that he "was an employee of [RASF]" on the same day MBB billed Aetna for his services. *Id.* ¶¶ 78–82.

The scope of Defendants' scheme is staggering. Prior to MBB being acquired by Radiology Partners, MBB was submitting claims to Aetna for services rendered by about 50 physicians. *Id.* ¶ 60. Since Radiology Partners acquired MBB, MBB has submitted claims to Aetna for *more than 1,000 different physicians*. *Id.* ¶ 62.

C. The Post-Contract Period scheme.

Aetna terminated the Aetna-MBB Contract in July of 2022. *Id.* ¶¶ 118, 130. Defendants then pivoted to using MBB to bill claims on an out-of-network basis for medical groups that had (and still have) active in-network agreements with Aetna. *Id.* ¶¶ 131–133. This, too, caused Aetna to overpay MBB. *Id.* ¶ 9.

Defendants still were not content. They went even further by improperly submitting some of these claims into the NSA IDR process, a statutory mechanism for payment disputes between certain out-of-network providers and health plans. *Id.* ¶¶ 10, 121, 130–179; *see also* 42 U.S.C. §§ 300gg-111, *et seq*. The NSA IDR process begins when a provider initiates a dispute and attests that the services underlying a claim are "qualified item(s) and/or service(s) within the scope of the Federal IDR process." Compl. ¶¶ 122–23; *see* 45 C.F.R. § 149.510(b)(2)(iii)(A)(6).

Notably, the NSA IDR process is only available to "nonparticipating provider[s]"—*i.e.*, a provider "who does not have a contractual relationship with the plan or issuer" for the services at issue. Compl. ¶¶ 125–26 (quoting 42 U.S.C. § 300gg-111(a)(3)(E)(v)(G)(ii)).

Notwithstanding the NSA's limitations on the applicability of the IDR process, Defendants began initiating NSA IDR arbitrations for services rendered by "participating provider[s]" from the other medical groups it acquired in Florida that had active contracts with Aetna. Compl. ¶¶ 131–133. Each time it initiated an arbitration, MBB provided false attestations to the Department of Health and Human Services, the arbitrators, and Aetna. *Id.* ¶ 135. This was all done so that Defendants could extract large awards and force Aetna to incur needless fees and expenses. *Id.* ¶ 134.

By way of one example, MBB initiated an NSA IDR on claims for services rendered by Dr. Juan Carlos Diez—a provider with RASF, a group that had and still has an active agreement with Aetna—which resulted in Aetna being forced to pay $1,117 on a claim that never should have been billed by MBB and for which MBB was not entitled to payment. *Id.* ¶¶ 140–151. Defendants then tried to use these results to coerce Aetna into signing a new, extremely lucrative in-network contract. *Id.* ¶¶ 184–186; *see also* D.E. 27 at 14 ("Aetna could have avoided its alleged victim status in the NSA IDR process by negotiating a new contract with MBB.").

III. Defendants' efforts to conceal their schemes.

Radiology Partners and MBB knew their conduct was wrong, so they went to great lengths to conceal their actions. *Id.* ¶ 188. For instance, employees were directed to move physicians from other medical groups to MBB's TIN slowly to avoid raising any red flags with payors. *Id.* ¶ 191. Radiology Partners also gave its employees strict guidelines for dealing with payors like Aetna, which were designed to avoid actions that might tip them off to the scheme. *Id.* ¶¶ 189-190. Employees that raised concerns were disciplined. *Id.* ¶ 192.

IV. Aetna files suit and Defendants move to dismiss.

Aetna filed its Complaint in December 2024. D.E. 1. In response, Defendants filed the present motion to dismiss, D.E. 27, which only addresses Aetna's claims during the Post-Contract Period. *Id.* at 1 (limiting motion to "the NSA Period").

LEGAL STANDARDS

"To survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* All factual "allegations in the complaint are taken as true and construed in the light most favorable to the plaintiffs." *Rivell v. Priv. Health Care Sys.* 520 F.3d 1308, 1309 (11th Cir. 2008).

ARGUMENT

I. Aetna properly states a claim for tortious interference with contract (Count 2).

Aetna has contracts with the relevant non-MBB radiology practices in Florida to pay specified rates for services provided by those practices' providers. *See*, *e.g.*, Compl. ¶¶ 226-229, 234-236, 243-245. When Radiology Partners purchased or otherwise became affiliated with these non-MBB practices, it was aware of those contracts but required that all services rendered by the non-MBB practices instead be billed by MBB under the Aetna-MBB Contract. *Id.* ¶¶ 59-65. These actions breached Aetna's contracts with the non-MBB providers. *Id.* ¶¶ 226-251. The Complaint provides examples of the financial impact of these actions. *See*, *e.g.*, *id.* ¶¶ 66-77 (1,638% increase in reimbursement by billing through MBB instead of RASF); *see also id.* ¶¶ 78-117.

Defendants' only argument why the Court should dismiss Aetna's claim for tortious interference with contract is that Radiology Partners is not a "stranger" to the business relationship between Aetna and the non-MBB practices. *See* D.E. 27 at 29-30. But "'even for 'non-strangers' to a contract, the privilege to interfere is a valid defense only to the extent the interference was done in good faith.'" *Reliance Pro Rehab, LLC v. Atkins*, No. 8:16-cv-3287, 2017 WL 11665358, at *2 (M.D. Fla. Aug. 3, 2017) (quoting *CSDS Aircraft Sales & Leasing, Inc. v. Lloyd Aereo Boliviano Airlines*, No. 09-cv-22274, 2011 WL 1559823, at *5 (S.D. Fla. Apr. 22, 2011)). The Complaint details Radiology Partners' bad faith, malice, and conspiratorial motives in detail. *See*, *e.g.*, Compl. ¶ 5 (Radiology Partners

motivated by greed); *id.* ¶ 287 (actions were malicious). Radiology Partners acted with full knowledge of Aetna's contracts with the non-MBB practices, yet "knowingly and deliberately" caused the non-MBB practices to breach their contracts with Aetna and bill under the Aetna MBB Contract so that Defendants could take more than the non-MBB practices and Aetna had contracted for the same services, by the same providers, at the same locations. *See* Compl. ¶¶ 220, 231, 240, 248. Radiology Partners' bad faith is also reasonably inferred from its efforts to conceal its conduct. *See id.* ¶¶ 188-201. No matter how you slice it, the privilege to interfere "does not encompass the purposeful causing of a breach of contract." *Reliance Pro*, 2017 WL 11665358 at *2-3; *see also Making Ends Meet, Inc. v. Cusick*, 719 So.2d 926, 928 (Fla. Dist. Ct. App. 1998) (quoting *McCurdy v. Collis*, 508 So.2d 380, 384 (Fla. Dist. Ct. App. 1987)) (same). The Complaint alleges Radiology Partners purposefully caused a breach of Aetna's contracts with the non-MBB practices in Florida. Accordingly, the Complaint properly states a claim for tortious interference with contract.

II. Aetna states claims for fraud, negligent misrepresentation, and violation of Florida's Deceptive and Unfair Trade Practices Act (Counts 3, 4, and 8).

A. Defendants misinterpret the factual basis for these claims.

Defendants argue that Aetna's claims for fraud, negligent misrepresentation, and violation of Florida's Deceptive and Unfair Trade Practices Act ("FDUTPA") "are based on its allegations that claims were submitted to the IDR process using MBB's TIN for providers who worked for other medical groups."

See D.E. 27 at 30-31 (citing Compl. ¶¶ 256, 269, 273, 274, 279); *id.* at 35-36 (describing the same "fraud-based narrative"). This is incorrect. For claims fraudulently submitted to the NSA IDR process Aetna filed a separate claim seeking vacatur of the resulting awards. *See* Compl. ¶¶ 319-333 (Count 9). Aetna's claims for fraud, negligent misrepresentation, and FDUTPA during the Post-Contract Period relate to the claims fraudulently billed by Defendants using MBB's TIN that were paid independent of the NSA IDR process.[4] *See supra* at 2-3; *see also infra* § VII.B. These claims do not rely on the NSA IDR process.[5] *See* Compl. ¶¶ 253-281, 307-318.

B. The Complaint contains well-pleaded factual allegations supporting Aetna's claims for fraud and negligent misrepresentation.

Defendants argue superficially that Aetna's claims for fraud and negligent misrepresentation were not pleaded with particularity. *See* D.E. 27 at 30–33. But they do not even attempt to grapple with the hundreds of fact-specific allegations in the Complaint. Instead, they recite the elements of these claims and assert in conclusory fashion that there are no allegations sufficient to satisfy certain elements. Their arguments are meritless.

[4] There are tens of thousands of claims billed by Defendants using MBB's TIN on an out-of-network basis that were *not* the subject of an NSA IDR proceeding.

[5] Defendants argue that the NSA prohibits or preempts Aetna's claims for fraud, negligent misrepresentation, and violation of FDUTPA. *See* D.E. 27 at 31, 35-36. Because Defendants raise the same argument as to numerous claims, Defendants respond below. *See infra* § VII.B.

The Complaint pleads Defendants' false statements with particularity. It is disingenuous for Defendants to say that Aetna has not identified "*any* specific false statement made by MBB for any specific billed claim." D.E. 27 at 32 (emphasis original). The Complaint alleges that the "submission of a claim for reimbursement to Aetna constitutes a certification and representation that the information on the claim is true, accurate, and complete." Compl. ¶ 254. And, "each time MBB and Radiology Partners submitted a claim or caused a claim to be submitted, they represented that MBB performed the services being billed." *Id.* ¶ 255. Aetna alleges in no uncertain terms that this was false, because for every claim at issue, the rendering provider's claim was billed under MBB's TIN even though the provider "worked for medical groups other than MBB." *Id.* ¶ 50. Aetna's Complaint further provides specific, detailed examples of claims that were fraudulently billed. *Id.* ¶¶ 67–118, 130. In addition to these representative examples, Aetna alleges Defendants improperly billed more than 110,000 claims using MBB's TIN, causing more than $20 million in damages to Aetna.[6] *Id.* ¶ 111. This is sufficient to meet Aetna's burden under Rule 9(b). *Gov't Employees Ins. Co. v. Landau & Assoc, P.A.*, No. 8:17-cv-02848-EAK-TGW, 2019 WL 12493609, at

[6] In cases where "the alleged fraud occurred over an extended period of time and the acts were numerous, the specificity requirements are applied less stringently." *Lawrence Holdings, Inc. v. ASA Int'l, LTD.*, No. 8:14-CV-1862-T-33EAJ, 2014 WL 5502464, at *11 (M.D. Fla. Oct. 30, 2014). "This is true where defendants possess factual information about the ongoing conduct of their business." *Cont'l 332 Fund, LLC v. Albertelli*, 317 F. Supp. 3d 1124, 1141 (M.D. Fla. 2018) (citing *Lawrence*).

*6-7 (M.D. Fla. Mar. 29, 2019) (denying motion to dismiss and finding complaint satisfied Rule 9(b) by identifying specific examples of alleged scheme).

Rather than engage with the allegations in the Complaint, Defendants resort to complaining that Aetna failed to *disprove* various hypotheticals that they may (or may not) argue in the future to defend their billing practices. *See* D.E. 27 at 32 (faulting Aetna for not pleading the absence of staffing contracts between MBB and hospitals or between MBB and the other medical groups at issue). But at the motion to dismiss phase, a plaintiff has no obligation to anticipate and disprove defenses that have not yet been raised. *See Tyler v. Hennepin Cnty.*, 598 U.S. 631, 637 (2023) ("At this initial stage of the case, Tyler need not definitively prove her injury or disprove the County's defenses."). This is true even for fraud claims. *See, e.g.*, *Mycone Dental Supply Co. v. Creative Nail Design, Inc.*, No. CIV.A. 11-4380 JBS, 2012 WL 3599368, at *5 (D.N.J. Aug. 17, 2012) ("Even Rule 9 does not require plaintiffs to disprove defendants' possible theories; it simply requires a party to 'state with particularity the circumstances causing fraud[.]'" (quoting Fed. R. Civ. P. 9(b)). Defendants are welcome to raise their defenses at the appropriate procedural juncture; at this stage, however, it does not matter that Defendants can imagine facts that would be helpful to them. Aetna's purported failure to address any such theoretical facts in its Complaint is thus not a basis for dismissal.

The Complaint adequately pleads Defendants' intent to defraud. Defendants argue without citation that dismissal is warranted because the Complaint does not plead with specificity that "Defendants intended to knowingly

defraud Aetna." D.E. 27 at 32. Rule 9(b) expressly says otherwise: "[m]alice, intent, knowledge, and other conditions of a person's mind may be alleged generally[,]" Fed. R. Civ. P. 9(b), so this is not a basis for dismissal. Even setting aside Defendants' misstatement of the law, Aetna has levied detailed accusations that demonstrate Defendants' specific intent to defraud, including allegations concerning their motives for executing the scheme, the influence from their private equity backers, and the great lengths they took to conceal and justify the scheme. *See* Compl. ¶¶ 259–61, 273–75.

The Complaint alleges that Aetna reasonably relied on Defendants' misrepresentations. Defendants contend that Aetna did not plead specific reliance on any fraudulent statements, but again make no effort to examine the allegations in the Complaint. *See*, *e.g.*, Compl. ¶¶ 254, 257-264 (alleging that Aetna relied on the use of MBB's TIN in its decision whether and how much to pay for the claims); *id.* ¶¶ 268, 272-278 (same). The Complaint alleges reliance with particularity by explaining how payors like Aetna process more than one million claims every day and how it is a standard industry practice for payors to rely on providers like MBB to submit claims for reimbursement that are true, accurate, and complete. *See* Compl. ¶¶ 34, 257, 260–61.

The real thrust of Defendants' argument on reliance is their improper attempt to dispute the well-pleaded allegations in the Complaint, even though they admit such facts must be accepted as true. *See* D.E. 27 at 19. Specifically, Defendants ask the Court to take judicial notice of certain documents from an

arbitration between Aetna, Radiology Partners, and Radiology Partners-affiliated practice in Texas *and to conclude from those filings that* "Aetna knew, or could have known through due diligence, the facts that it now alleges are 'fraud.'" D.E. 27 at 32-33. Aetna is separately responding to Defendants' request for judicial notice and articulated its theory of why judicial notice would be wholly improper. *See* D.E. 49. But Defendants' request for an inference to be drawn in their favor from a judicially noticed document is particularly inappropriate.[7] Defendants' reliance on the Texas arbitration as proving their innocence is also odd: the *arbitrator awarded Aetna $14.1 million* on its counterclaim against the radiology practice for improper pass-through billing in breach of the parties' in-network agreement. D.E. 29-4 at 30.

C. Aetna's FDUTPA claim is also well pleaded.

Defendants recycle their arguments on fraud and negligent misrepresentation in response to Aetna's FDUTPA claim. *See* D.E. 27 at 36–37. They generically argue that Aetna "fails to identify any specific deceptive or unfair act for any specific bill at issue, that Aetna detrimentally relied on any specific false statements, was misled, or that it would be reasonable to have been misled" by the deceptive act. D.E. 27 at 37. Defendants again refuse to engage with the Complaint.

[7] Even if documents from the Texas arbitration were a proper subject for judicial notice, the documents do not establish that Aetna knew or should have known about Defendants' fraudulent scheme *in Florida*. Defendants' argument rests on the premise that, having identified misconduct by Radiology Partners in Texas, Aetna *knew or should have known the same misconduct was happening in Florida*. This is illogical.

The allegations that support Aetna's fraud and negligent misrepresentation claims likewise support its FDUTPA claim. *See, e.g.*, *State Farm Mut. Auto. Ins. Co. v. Performance Orthopaedics & Neurosurgery, LLC*, 278 F. Supp. 3d 1307, 1327 (S.D. Fla. 2017) (first analyzing common-law fraud claim and confirming that same allegations gave rise to FDUTPA claim). Aetna plausibly alleged that it is objectively unfair and deceptive under FDUTPA for Defendants to submit claims under MBB's TIN for reimbursement when the healthcare provider who rendered the care was affiliated with a different medical group with a separate in-network agreement with Aetna. *See* Compl. ¶¶ 4–13, 316. Aetna also pleaded specific examples of MBB and Radiology Partners carrying out the scheme, including the amounts of each claim, the name of the provider, and the medical group the providers were actually affiliated with. *Id.* ¶¶ 67–116. Aetna even provided discovery responses from a physician and a Radiology Partners-affiliated medical group admitting that the provider (who MBB was billing Aetna for) was employed by a different medical group on precisely the same day. *Id.* ¶¶ 67-85. And Aetna pleaded reasonable reliance on Defendants' deceptive conduct and resulting damages by alleging that it is standard in the industry for payors to rely on providers' representations (due to the millions of claims billed each day) and that Defendants' conduct caused Aetna to pay more than it was obligated to on MBB's claims. *Id.* ¶¶ 260–61, 314. Aetna states a claim under FDUTPA.

III. The Complaint states a claim for civil conspiracy (Count 5).

In response to Aetna's claim for civil conspiracy, Defendants say that Radiology Partners and MBB are not separate economic groups that are necessary to state a civil conspiracy claim. D.E. 27 at 33. But Aetna has alleged that the conspiracy included not only Radiology Partners and MBB, but also the other Florida medical groups and the "[p]rivate-equity firms such as New Enterprise Associates, Starr Investment Holdings, and others" who funded Radiology Partners' acquisitions and demanded the returns that motivated the scheme. *See* Compl. ¶¶ 5, 37-44, 283-285. Thus, the conspiracy is not limited to a corporate parent and subsidiary, as Defendants contend, and the claim is properly stated. *See, e.g.*, *Charr v. King*, No. 21-cv-61654-WPD, 2022 WL 18458126, at *4 (S.D. Fla. Oct. 31, 2022) (denying motion to dismiss civil conspiracy claim where defendant company and its principal were alleged to have conspired with two others because "the multiplicity of actors necessary for the formation of a conspiracy" was alleged); *Rossi v. Darden*, NO. 16-21199-CIV-ALTONAGA/O'Sullivan, 2016 WL 11501449, at *8 (S.D. Fla. July 19, 2016) (exception to intracorporate conspiracy doctrine "manifests where separate legal entities are involved in the alleged conspiracy" (citation omitted)).[8]

[8] That there was some overlap with the leadership of Radiology Partners and some of the private equity firms does not affect the inquiry. *See State Farm Mutual Automobile Insurance Co. v. LaRocca*, No. 8:21-cv-2536-SCB-AEP, 2023 WL 9062996, at *2 (M.D. Fla. Oct. 29, 2023) (finding that the defendants were separate entities, despite overlap in their ownership and employees); *Collier HMA*

Finally, an independent claim for civil conspiracy exists if "the conduct complained of would not be actionable if done by one person, but by reason of force of numbers or other exceptional circumstances, the defendants possess some peculiar power of coercion . . . ." *Am. Diversified Ins. Servs., Inc. v. Union Fid. Life Ins. Co.*, 439 So. 2d 904, 906 (Fla. 2d DCA 1983). "The result of the defendants' concerted action must be different from anything that could have been accomplished separately." *Kee v. Nat'l Reserve Life Ins. Co.*, 918 F.2d 1538, 1542 (11th Cir. 1990) (citation and internal quotation marks omitted). The Complaint contains allegations that plausibly state such a claim. Each member of the conspiracy played a vital role in injuring Aetna that could not be duplicated by the others: the private equity firms provided the funding for Radiology Partners' rapid expansion and demanded the returns that motivated the fraudulent scheme; Radiology Partners acquired the medical groups and served as the central organizer of the scheme across its medical groups; MBB provided the Aetna-MBB Contract and its TIN, the vehicles for the conspiracy; and physicians from the other medical groups provided the services billed under MBB's TIN. *See* Compl. ¶ 284. Acting alone, none of the co-conspirators could have inflicted the harm Aetna suffered, and their malicious intent can be inferred by their actions, including their misrepresentations in civil discovery about the relationships between the medical groups and the healthcare providers. *See* id. ¶ 287. In fact, MBB has argued that it

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Physician Management, LLC v. NCH Healthcare System, Inc., No. 2:18-cv-408-FtM-38MRM, 2019 WL 277733, at *10 (M.D. Fla. Jan. 22, 2019) (same).

was only able to take certain acts relevant to Aetna's claims *due to the financial support of Radiology Partners*. *See*, *e.g.*, D.E. 27 at 4. Aetna also alleges this scheme was the plan all along—"to achieve such a dominant share of the radiology market that it could bully and extort above-market contracts." *Id.* ¶ 187. The combination, relationship, size, and economic influence of the conspirators all converged to harm Aetna, plausibly alleging an independent, actionable tort of conspiracy.

IV. The Complaint properly pleads a claim for vacatur based on MBB's fraud during the NSA IDR process and because the arbitrators exceeded their powers (Count 9).

Defendants respond to Aetna's claim seeking vacatur of the improperly obtained NSA IDR awards by repeatedly noting that both judicial review and vacatur of arbitration awards are extremely rare and disputing Aetna's well-pleaded facts. D.E. 27 at 22—29.

The "NSA invokes the FAA" in "only one specific aspect," by adopting "the four scenarios in which a court may vacate an arbitration award." *Med-Trans Corp. v. Capital Health Plan, Inc.*, 700 F. Supp. 3d 1076, 1082 (M.D. Fla. 2023) (citing 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II)). Specifically, the NSA allows judicial review of IDR decisions only as prescribed "in any of paragraphs (1) through (4) of section 10(a) of [the FAA]." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). Section 10(a) of the FAA allows a court to vacate an award "where the award was procured by corruption, fraud, or undue means," 9 U.S.C. § 10(a)(1), and "where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite

award upon the subject matter submitted was not made." *Id.* § 10(a)(4). As explained below, Aetna has pleaded facts that support vacatur under both subparts.

A. Aetna states a claim for vacatur because of fraud.

To vacate an arbitration award for fraud or undue means under Section 10(a)(1) of the FAA, the movant must fulfill a test articulated by the Eleventh Circuit in *Bonar v. Dean Witter Reynolds, Inc.*, 835 F.2d 1378 (11th Cir. 1988). There, the Eleventh Circuit found that a claimant's expert had committed perjury at an arbitration hearing and vacated the award under Section 10(a)(1). The court set out three factors necessary to vacate an award procured by fraud: (1) "the movant [must] establish fraud by clear and convincing evidence"; (2) "the fraud must not have been discoverable upon the exercise of due diligence prior to or during the arbitration"; and (3) "the fraud [must have] materially related to an issue in the arbitration." *Id.* at 1383. All three elements are satisfied here.

1. The Complaint pleads fraud with particularity.

Aetna alleges that Defendants initiated tens of thousands of arbitrations under the NSA's IDR process for services that were not performed by MBB and were instead performed by medical groups who were contracted with Aetna. *See* Compl. ¶¶ 7–13, 130–80, 322–27. Each time Defendants initiated one of these IDR proceedings using MBB's TIN for a non-MBB provider, they knowingly and falsely certified to Aetna, the IDR entity, and to the Department of Health and Human Services that "the item(s) and/or service(s) at issue are qualified item(s)

and/or service(s) within the scope of the Federal IDR process." Compl. ¶¶ 135, 323. The certification was false because the claims were rendered by contracted providers who had no right to invoke the IDR procedures set forth in the NSA. *See id.* ¶¶ 136, 322–326. But for this false certification and the submission of an IDR-ineligible claim, none of the awards ever would have been issued.

Defendants spill considerable ink describing *Guardian Flight, LLC v. Aetna Health Inc.*, a decision dismissing an air ambulance provider's claim seeking to vacate an award arising from an NSA IDR arbitration with Aetna. 711 F. Supp. 3d 662, 673 (S.D. Tex. 2024); *see* D.E. 27 at 23-25. They suggest it disposes of Aetna's request for vacatur here. But *Guardian Flight* is not analogous. In that case, the air ambulance alleged that Aetna did not calculate the "qualifying payment amount" ("QPA") properly and thereby misrepresented it to the NSA IDR entity. 711 F. Supp. 3d at 667. The court ruled the facts alleged did not give rise to judicial review because the allegations about bad faith were "conclusory, at best, and are not factually supported." *Id.* at 673. The court also relied on the fact that federal agencies were responsible for monitoring the accuracy of QPA calculations. *Id.* *Guardian Flight* involved facts more analogous to a dispute between parties in an arbitration about whether particular facts are true. In this case, on the other hand, Aetna has alleged that Defendants falsely certified *the eligibility of the claims to be arbitrated at all*. Such allegations are squarely within the scope of review under the Federal Arbitration Act endorsed in *Guardian Flight*. *Id.* 672.

When they do finally get to the substance of Aetna's allegations, rather than confront them head-on, Defendants again resort to misconstruing the Complaint to suggest that Aetna has not pleaded fraud sufficient to vacate the IDR awards. Specifically, Defendants contend that the "only alleged 'facts'" in the Complaint are that: "(1) MBB grew, and (2) MBB submitted bills where the doctors listed allegedly were or are also employed by other practices." D.E. 27 at 26. Defendants' myopic and self-serving view of the facts is inconsistent with the actual allegations of the Complaint as discussed above. Most tellingly, Defendants address Aetna's allegations about the false certifications they submitted to initiate each of NSA IDR proceedings at issue. *See* Compl. ¶¶ 135, 323. Nor do they address that the medical services were provided by medical groups who had contracts with Aetna. Instead, Defendants state that Aetna "provides no support for its theory that doctors *cannot* provide services as employees or contractors of MBB, at hospitals MBB staffs."[9] D.E. 27 at 26 (emphasis in original). Again, this argument ignores the relevant standard under Rule 12(b)(6) that the allegations in the Complaint are accepted as true, and instead distorts Aetna's theory, which clearly alleges that MBB had no valid employment relationship with the more than 1,000 providers whose claims

[9] Defendants' theory that the doctors were "also employed by other practices" is indefensible. When Aetna presents the Court with the claims data for the Radiology Partners-affiliated practices the Court will see that claims volume for all the practices other than MBB dropped off a cliff. It was a wholesale switch to billing under MBB, but Defendants did not close the other practices or terminate their contracts with Aetna. Nor was it dual employment. Defendants simply jumped to billing under the more lucrative medical group, MBB.

MBB improperly and falsely submitted for reimbursement. *See, e.g.*, Compl. ¶¶ 66–110, 193–196. Defendants' efforts to contradict the facts alleged in great detail in the Complaint do not entitle them to relief under Rule 12(b)(6).

The level of detail in the Complaint is exceptional for not having access to discovery. For example, Aetna identified discovery responses in an unrelated matter by a provider and a non-MBB medical group admitting that the provider "was an employee of Radiology Associates of South Florida, LLC" when he performed services at "Baptist Hospital of Miami, Inc, on May 5, 2022." Compl. ¶¶ 81-82. Yet, the same day, Defendants used MBB to bill three claims to Aetna for services provided by that provider. How do Defendants square these inconsistencies? They don't address them at all. Instead, they demand that Aetna plead facts that are uniquely in Defendants' possession.

The Complaint contains numerous well-pleaded factual allegations that collectively assert fraud with particularity. The false certifications of NSA IDR eligibility are even *more* material than perjury by a witness in an arbitration hearing, which is "just the type of fraud envisioned by the provision of the FAA allowing for vacation of an arbitration award." *Nuvasive*, 642 F. Supp. 3d at 1332 (citing *Bonar*, 835 F.2d at 1383–84). This is one of the rare circumstances where vacatur is appropriate and, thus, the motion to dismiss should be denied.

2. MBB's fraud was not discoverable upon the exercise of diligence prior to or during the NSA IDR arbitrations.

Next, the Complaint details why the scheme was not discoverable prior to the NSA IDR arbitrations. *Bonar*, 835 F.2d at 1383. Aetna receives more than one million claims per day, meaning it must rely on healthcare providers' truthfulness as to the information they submit; it cannot investigate each claim. Compl. ¶ 260. The same is true with respect to the NSA IDR submissions, particularly due to Defendants batch filings. *Id.* ¶ 138 ("MBB initiated NSA arbitrations for approximately *5,603 claims* on March 7, 2024. The next day, MBB initiated NSA arbitrations for at least *another 4,856 claims*.").[10]

In addition, Defendants went to great lengths to avoid the detection of their scheme. They concealed critical facts from Aetna by: (1) giving their employees strict guidelines on their communications with Aetna that were designed to avoid actions that might tip Aetna off; (2) lying to Aetna about providers being hired into MBB; (3) misleading hospitals staffed by Radiology Partners about the medical groups and physicians who were actually performing the services; (4) creating sham agreements between physicians and MBB to give the claims the appearance of legitimacy; and by (5) retroactively covering up their tracks by suggesting that the contracted, non-MBB medical groups were actually "divisions" of MBB. *See* Compl. ¶¶ 112-117, 188–201.

[10] Even if Aetna knew MBB was "growing" during the Contracted Period, that does not mean Aetna knew about Defendants' misrepresentations. *See* D.E. 27 at 28 (arguing knowledge of growth forecloses vacatur).

Defendants again argue that their fraudulent certification of IDR eligibility was discoverable by Aetna because of the Texas arbitration between Aetna, Radiology Partners, and its Texas-based affiliate, Singleton Associates ("Singleton"). Their argument is literally that, because Aetna knew Radiology Partners was engaging in fraud with one practice in Texas (which was contracted with Aetna, unlike MBB), Aetna was obligated to "exercise due diligence during the NSA IDR process, which Aetna did not do." D.E. 27 at 27-28. Again, that Radiology Partners engaged in one fraudulent scheme in one state does not mean Aetna was on notice of all other fraudulent schemes that Radiology Partners was engaging in.

Defendants' motion also never explains how Aetna could have discovered MBB's submission of non-eligible claims through the NSA IDR process "prior to or during" the IDR proceedings by the exercise of due diligence based on the Texas Arbitration. *Bonar*, 835 F.2d at 1383. It could not have: the Texas arbitration "pre-dates the NSA Period" in this case. D.E. 27 at 27.

Because Aetna has asserted facts demonstrating that MBB's fraud was not discoverable upon the exercise of diligence prior to or during the NSA IDR arbitrations, Defendants' motion to dismiss should be denied.

3. Defendants' fraud is materially related to the issues decided in the arbitrations.

Finally, the third element of the vacatur analysis—that "the fraud materially related to an issue in the arbitration"—is obviously met here. *Bonar*, 835 F.2d at 1383. Importantly, "this last element does not require the movant to establish that

the result of the proceedings would have been different had the fraud not occurred." *Bonar*, 835 F.2d at 1383; *see also NuVasive, Inc. v. Absolute Medical, LLC*, 71 F. 4th 861, 879 (11th Cir. 2023) (same). But there can be no doubt that Defendants' fraud was materially related to an issue in the arbitration. Absent Defendants' fraudulent misrepresentation—that the claims were within the scope of the NSA IDR process (*i.e.*, were rendered by a non-contracted provider)—there would not be any arbitrations or awards. Notably, Defendants do not address this prong beyond a brief footnote stating in conclusory fashion that, because there was no fraud, the fraud could not have materially related to an issue in the arbitration. *See* D.E. 27 at 25 & n.39.

Because the Complaint satisfies the three *Bonar* factors, Aetna has stated a valid claim for vacatur of the NSA IDR awards based on Defendants' fraud.

B. The Complaint pleads that the NSA IDR entities exceeded their powers.

Aetna's Complaint also details how the NSA IDR entities exceeded their powers, justifying vacatur of the resultant NSA IDR awards under 9 U.S.C. § 10(a)(4). Under § 10(a)(4), a court's "review is quasi-jurisdictional: a check to make sure that the arbitration agreement granted the arbitrator authority to reach the issues it resolved." *Gherardi v. Citigroup Glob. Mkts. Inc.*, 975 F.3d 1232, 1238 (11th Cir. 2020). Typically, "[b]ecause 'arbitrators derive their powers from the parties' agreement,' [courts] look to the terms of the governing arbitration clause to determine the powers of the arbitration panel." *White Springs Agric. Chems.,*

Inc. v. Glawson Inv. Corp., 660 F.3d 1277, 1281 (11th Cir. 2011). Here, however, because the NSA's IDR "is statutorily compelled," *Med-Trans*, 700 F. Supp. 3d at 1083, the "IDR entities' powers are derived from the language of the NSA and its related guidance." *Guardian Flight*, 711 F. Supp. 3d at 674.

The language of the NSA provides that the IDR process applies only to "an item or service furnished . . . by a nonparticipating provider . . . ." 42 U.S.C. § 300gg-111(c)(1)(A). The statute specifies in relevant part that nonparticipating provider means, in pertinent part, "a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law *and who does not have a contractual relationship with* the . . . issuer . . . for furnishing such item or service . . . ." *Id.* § 300gg-111(a)(3)(G)(i) (emphasis added). The difference between a nonparticipating and participating provider under the NSA is that the latter "has a contractual relationship with the . . . issuer. . . ." *Id.* § 300gg-111(a)(3)(G)(ii).

Aetna alleges that the services at issue were rendered by participating providers—that is, that Aetna had at least one contract with the providers for the services they furnished. *See* Compl. ¶¶ 131–32, 136, 140–181, 326, 330. Indeed, the exemplary providers that Aetna identifies in the Complaint previously had their services billed under these contracts. *Id.* at ¶¶ 140-178. Aetna has alleged that the claims at issue were never "qualified IDR item[s] or service[s]," *id.* § 300gg-111(c)(2)(A), and that the IDR entities thereby exceed their authority.

In response, Defendants again insist that Aetna must plead facts that are uniquely in Defendants' possession—specifically, that "MBB lacked the radiology department staffing contract at any hospital or lacked a contract for the radiologists to provide services for MBB at that hospital, for any bill." D.E. 27 at 29. This distorts the Rule 8 and Rule 12(b)(6) standards; a plaintiff is not required to anticipate and plead around every factual defense a defendant may or may not raise. *See Tyler*, 598 U.S. at 637.

Even if Defendants' argument was proper for a motion to dismiss, it would still be wrong. The NSA's definitions for participating and nonparticipating providers focus on the "physician or other health care provider" who rendered the service and whether that physician does or does not have "a contractual relationship with the . . . issuer." 42 U.S.C. § 300gg-111(a)(3)(G). Defendants' hypotheticals about contractors and subcontractors do not matter; if a radiologist has a contractual relationship with Aetna (as Aetna has alleged), that physician "has a contractual relationship" with Aetna. *Id.* § 300gg-111(a)(3)(G)(ii).

V. Aetna states a claim under ERISA § 502(a)(3) (Count 10).

In response to Aetna's claim for declaratory and injunctive relief under ERISA § 502(a)(3), Defendants argue that Aetna seeks an impermissible legal remedy. *See* D.E. 27 at 37-38. Specifically, Defendants describe this as a claim for "overpayments," but it is nothing of the sort; the claim seeks specific injunctive and declaratory relief, not the return of overpayments. *See* Compl. ¶ 344 (request for injunction barring Defendants from billing for non-MBB providers using MBB's

TIN and from transferring or dissipating funds that Defendants caused Aetna to pay that were not owed under the ERISA plans); *id.* ¶ 347 (request for declaration that claims billed for non-MBB providers using MBB's TIN are not covered benefits under the ERISA plans). Aetna is not seeking damages, only injunctive and declaratory relief authorized by 29 U.S.C. § 1132(a)(3).

The sole case cited by Defendants, *Cook v. Campbell*, involved a claim for breach of fiduciary duty brought by participants in an employee stock ownership plan ("ESOP"), where the plaintiffs sought the "diminished value" of their shares in the ESOP from certain fiduciaries, which the court held were essentially money damages. 482 F. Supp. 2d 1341, 1357-62 (M.D. Ala. 2007). Defendants' argument is premised on their abject mischaracterization of the relief sought by Aetna in its ERISA claim. None of the relief requested seeks the return of funds, directly or indirectly. The injunctive and declaratory relief Aetna seeks is appropriate under ERISA § 502(a)(3) and Defendants' motion should be denied.

Defendants also argue that Aetna's claim for injunctive and declaratory relief under ERISA § 502(a)(3) does not plead the relevant ERISA plans or their terms "with any particularity." D.E. 27 at 38-39. But "particularity" is not required; Aetna need only provide a "short and plain statement of the claim showing [it] is entitled to relief" Fed. R. Civ. P. 8(a)(2). Aetna alleged that certain benefit plans impacted by Defendants' conduct were governed by ERISA and quoted plan terms that are "reasonably representative" of the hundreds of ERISA-governed benefit plans at issue. *See* Compl. ¶¶ 335 (some at-issue benefit plans governed by ERISA), 340-

342 (plans exclude services a member has no obligation to pay; Aetna may deny benefits or recover funds overpaid due to fraud; plans have right to pursue overpayments). The sole case Defendants rely on is inapposite: it did not evaluate the pleadings because it was an appeal of an order granting summary judgment and involved only a single benefit plan. *See Green. v. Holland*, 480 F.3d 1216, 1216–28 (11th Cir. 2007). Where hundreds of benefit plans are at issue, the pleading of reasonably representative terms is consistent with Rule 8's directive that Aetna provide a "short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). *See Sanctuary Surgical Ctr., Inc. v. Aetna, Inc., No. 11–80799–CV, 2012 WL 993097, at *3 (S.D. Fla. Mar. 22, 2012) (*"While Plaintiffs are not necessarily required to quote provisions from each of the plans involved, the allegations must give the Court some sense of the actual language of the agreements and the degree to which the language provided represents the provisions in the other plans."*); Unitedhealthcare Services, Inc. v. Team Health Holdings, Inc.*, No. 3:21-cv-00364, 2022 WL 1481171, at *8 (E.D. Tenn. May 10, 2022) ("TeamHealth is correct that United does not specify which ERISA plans are at issue in its claim seeking injunctive relief under § 1132(a)(3). That, however, is not enough to dismiss United's ERISA claims at this stage of litigation.").

Finally, Defendants ask the Court to dismiss Aetna's ERISA claim for allegedly failing to plead that it exhausted its administrative remedies under that statute. D.E. 27 at 21. But this requirement is not applicable to Aetna's ERISA

claim, unlike a claim by a plan participant or beneficiary against plans or plan fiduciaries following an adverse benefit determination.[11] *See Florida Health Scis. Ctr., Inc. v. Total Plastics, Inc.*, 496 Fed. Appx. 6, 10 (11th Cir. 2012) ("[P]articipants in an ERISA plan to whom benefits have been denied must exhaust their administrative remedies before challenging the denial in court."). Courts have consistently rejected Defendants' argument that Aetna has an obligation to exhaust any administrative remedies before asserting its claims here. *See, e.g.*, *Conn. Gen. Life Ins. Co. v. True View Surgery Ctr. One, LP*, 128 F. Supp. 3d 501, 512 (D. Conn. 2015) ("The court concludes, therefore, that neither ERISA nor the ERISA regulations require Cigna to . . . exhaust administrative remedies prior to filing a lawsuit to recover overpayments."); *Advanced Reimbursement Sols. LLC v. Aetna Life Ins. Co.*, No. 19-cv-05395, 2022 WL 889058, at *4 (D. Ariz. Mar. 25, 2022) ("Multiple district courts have determined that attempts to recover overpayments are not adverse benefits determinations subject to administrative exhaustion."); *Nutrishare, Inc. v. Conn. Gen. Life Ins. Co.*, No. 2:13-CV-02378-JAM-AC, 2014 WL 1028351, at *3 (E.D. Cal. Mar. 14, 2014) ("Neither the relevant ERISA

[11] The cases cited by Defendants reinforce this distinction. *See Tindell v. Tree of Life, Inc.*, 672 F. Supp. 2d 1300, 1305–06 (M.D. Fla. 2009) ("[B]efore a plaintiff may bring an ERISA action in federal court, she must exhaust the *administrative remedies provided for in the ERISA plan for challenging the administrator's denial of benefits*." (emphasis added)); *Manorcare Potomac v. Understein*, No. 8:02-cv-1177-T-23EAJ, 2002 WL 31426705, at *1 (M.D. Fla. Oct. 16, 2002) ("[T]he Medicare Act, 42 U.S.C. § 1395w–22(g), obligate a Medicare claimant to exhaust administrative remedies before resort to litigation in federal court.").

provisions nor rulings from other federal courts indicate any such exhaustion requirement for the equitable claims in the Counterclaim.").

VI. The Complaint properly states a claim for declaratory judgment, but Aetna partially withdraws its claim (Count 11).

Defendants make two arguments in support of their motion to dismiss Aetna's claim for declaratory judgment.

First, Defendants contend that the requested declaratory relief is "superfluous" to its other claims. D.E. 27 at 39. But the claim for declaratory relief is unique in comparison to most of Aetna's claims because it seeks forward-looking relief. *See Restless Media GmbH v. Johnson*, 704 F. Supp. 3d 1288, 1302 (S.D. Fla. 2023) (denying dismissal of "declaratory relief claim" that seeks "forward-looking remedies that would not be available were Plaintiff to prevail on the breach of contract and fraud claims alone"); *see also* Compl. ¶ 354(a) (seeking declaration that Aetna is not obligated to pay services billed by MBB that were rendered by non-MBB providers, including prospectively). Moreover, "even assuming [Aetna's] declaratory judgment claims are redundant . . . , a motion to dismiss tests a claim's plausibility—not redundancy." *KOVA Com. of Naples, LLC v. Sabin*, No. 2:23-CV-614-JES-KCD, 2024 WL 964195, at *10 (M.D. Fla. Mar. 6, 2024) (quotations and citations omitted). And "the federal Declaratory Judgment Act and Rule 57 allow for a declaratory judgment even if there is another adequate remedy." *Id.* (quotations and citations omitted).

Second, Defendants contend that "the NSA only provides for post-award review, and even then, it restricts judicial review to the very limited circumstances for challenging awards under the" FAA. D.E. 27 at 19-20. This argument appears to relate principally to the second prong of Aetna's claim for declaratory relief, which seeks a declaration that certain acts violate the NSA. From Aetna's perspective, this dispute is unnecessary. Accordingly, Aetna notifies the Court and Defendants that it withdraws the second request for declaratory relief in Count 11 which seeks a declaration that Defendants are violating the NSA. Compl. ¶¶ 352, 354(b). Recognizing that under Eleventh Circuit precedent, single causes of action (and, presumably, portions of single causes of action) cannot be dismissed under Rule 41, *see Perry v. Schumacher Grp. of La.*, 891 F.3d 954, 958 (11th Cir. 2018), Aetna notifies the Court and Defendants that it hereby withdraws that portion of Count 11. Given the resources dedicated to the pending briefing, Aetna respectfully submits that both judicial economy and Federal Rule of Civil Procedure 1 favor a ruling on the pending motion to dismiss for all issues unrelated to this prong of Aetna's claim for declaratory relief. When the Court rules on Defendants' motion to dismiss it may permit Aetna to file an amended complaint, or Aetna may seek leave to do so, at which time Aetna will remove the second prong of its claim for declaratory relief. Aetna's hope is that this will avoid burdening the Court or Defendants with further briefing on an issue that is now moot.

VII. The No Surprises Act does not shield Defendants from liability.

A. Defendants do not identify any exhaustion requirement applicable to Aetna's claims under the NSA.

Defendants contend that "dismissal" is required because Aetna supposedly "failed to plead facts to support it exhausted its administrative remedies" under the NSA. D.E. 27 at 21. They do not identify which purported "administrative remedies" Aetna failed to plead satisfaction of or which claims should be dismissed. *See id*. Nor do Defendants cite supportive authority. *Id*. This leaves Aetna and the Court guessing about the basis for Defendants' argument, but "[u]ndeveloped arguments are abandoned." *Doe v. Baker Cnty*., 3:23-cv-00609-CRK-LLL, 2025 WL 834317, at *10 (M.D. Fla. Mar. 17, 2025). To the extent this argument relates to Aetna's request for vacatur of the NSA IDR awards, Defendants do not explain how Aetna could have been expected to satisfy unidentified "administrative remedies" when it was unaware of Defendants' fraud until after the issuance of the arbitral awards. *See* Compl. ¶ 332. Moreover, the NSA expressly provides for "judicial review" as set forth in "paragraphs (1) through (4) of section 10(a) of [the FAA]."42 U.S.C. § 300gg-111(c)(5)(E)(i)(II). No aspect of this judicial review is, or has been interpreted to be, based on any preconditions.

B. The NSA does not foreclose Aetna's claims under Florida or federal law.

Defendants repeatedly contend that Aetna's claims are preempted by the NSA. *See, e.g.*, D.E. 27 at 31 (fraud and negligent misrepresentation); *id*. at 35 (unjust enrichment and money had and received); *id*. at 35-36 (FDUTPA); *id*. at 37

(ERISA); and *id.* at 39 (declaratory judgment). This argument *appears* to flow from the mistaken belief that these claims relate only to "allegations that claims were submitted to the IDR process using MBB's TIN for providers who worked for other medical group." *See*, *e.g.*, D.E. 27 at 30-31 (arguing preemption of fraud claims); *id.* at 35 (arguing unjust enrichment and money had and received are preempted because they seek to overturn NSA IDR awards). But this is not correct.

For claims fraudulently submitted to the NSA IDR process, Aetna seeks only vacatur of such awards related to those claims. *See* Compl. ¶¶ 319-333 (Count 9). On the other hand, Aetna's claims for fraud, negligent misrepresentation, unjust enrichment, money had and received, FDUTPA, ERISA, and declaratory judgment relate to the claims fraudulently billed by Defendants using MBB's TIN that were paid *independent of* the NSA IDR process. *See* Compl. ¶ 10 (alleging that the fraudulent NSA IDR awards were only a portion of the disputed claims in the Post-Contract Period). These claims do not rely on the NSA IDR process. *See* Compl. ¶¶ 253-265 (fraud); *id.* ¶¶ 266-281 (negligent misrepresentation); *id.* ¶¶ 290-297 (money had and received); *id.* ¶¶ 298-306 (unjust enrichment); *id.* ¶¶ 307-318 (FDUTPA); *id.* ¶¶ 334-347 (ERISA); *id.* ¶¶ 348-354 (declaratory judgment, as narrowed in Section VI, *supra*). If, with the benefit of this clarification, Defendants still contend that the NSA preempts these claims the argument should be rejected as it is undeveloped and Defendants have not cited any supporting authority. "Undeveloped arguments are abandoned." *Baker Cnty.*, 2025 WL 834317 at *10.

CONCLUSION

Because the Complaint contains hundreds of well-pleaded factual allegations supporting the causes of action asserted therein, Aetna respectfully requests that the Court deny Defendants' motion to dismiss in its entirety.

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