UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,	:	
Plaintiff,	:	20 Civ. 2593 (ALC)
- v -	:	
ANTHEM, INC.,	:	
Defendant.	:	

THE GOVERNMENT'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANT ANTHEM, INC.'S MOTION TO TRANSFER VENUE, TO DISMISS IN PART, AND TO STRIKE CERTAIN ALLEGATIONS

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Plaintiff the United States of America (the "Government") respectfully submits this brief in opposition to the motion of defendant Anthem, Inc. ("Anthem") to transfer venue, to dismiss the Government's false attestation claims under the False Claims Act ("FCA"), and to strike paragraphs 99 through 105 in the amended complaint ("Am. Compl."). *See* ECF No. 37 ("Def. Br."). For the reasons set forth below, this motion should be denied in its entirety.

PRELIMINARY STATEMENT

In its combined motion, Anthem makes numerous assertions about three aspects of the amended complaint: (1) the significance to this case of witnesses in various locations, (2) the sufficiency of the Government's materiality allegations, and (3) the relevance of the Government's past enforcement efforts. *See* Def. Br. at 23–27, 41–48, 52–55. Instead of a fair summary of the amended complaint, however, Anthem presents an inaccurate and incomplete view of the Government's claims and allegations. Specifically, and contrary to Anthem's suggestion, the Government's claims in this case do not "fundamentally" turn on technical disagreements over how Anthem's operational staff in Columbus, Ohio, implemented "a specific business process, [namely, its] retrospective chart review program." *See id*. at 1-2. Rather, the crux of this case is about how the senior executives in charge of Anthem's Medicare business unit unlawfully structured and operated Anthem's risk adjustment data processes – including chart review – in blatant disregard of the obligation to ensure that the risk adjustment payments Anthem received from Medicare were based on accurate and truthful diagnosis data. As alleged, Anthem also repeatedly and falsely attested to the accuracy and truthfulness of its risk adjustment data submissions to Medicare to its "best knowledge, information, and belief" even while it had information – the chart review results – that showed otherwise. *See infra* at 4–8.

More specifically, Anthem simply ignores key allegations that bear directly on the FCA elements of falsity, scienter, and materiality — including allegations concerning its

executives' knowledge of significant inaccuracies in the diagnosis data submissions on which the Centers for Medicare and Medicaid Services ("CMS") relied to calculate risk adjustment payments to Anthem, their awareness that CMS expected Medicare Advantage Organizations ("MAOs") like Anthem to delete inaccurate diagnosis data based on information available to them, and those executives' failure to implement any procedure to fulfill that obligation. By ignoring these allegations, Anthem fails to confront the Government's claims at their core, instead attacking strawmen. *See infra* at 10–15.

Beside this crucial flaw at the base of all of its contentions, each aspect of Anthem's motion should be denied for additional reasons. *First*, insofar as Anthem seeks a transfer to the Southern District of Ohio on convenience grounds under 28 U.S.C. § 1404(b), it has failed to proffer "clear and convincing evidence" to overcome the strong presumption in favor of the plaintiff's choice of venue. *New York Marine & Gen. Ins. Co. v. Lafarge N.A., Inc.*, 599 F.3d 102, 113-14 (2d Cir. 2010) (recognizing that "the party requesting transfer [under § 1404(b)] carries the burden of making out a strong case for transfer"). As explained below, the claims at issue have material connections to this District. *See infra* Pts. I.B, I.C. Further, Anthem misstates key aspects of the § 1404(b) standard, disregards critical facts and significant witnesses discussed in the amended complaint, and fails to address the basis for the Government's choice of venue. Anthem's motion, thus, falls well short of "a strong case for transfer."

Second, the Court should reject Anthem's challenge to the sufficiency of the Government's allegations that the false attestations Anthem submitted to CMS in order to receive risk adjustment payments were material to payment. This aspect of Anthem's motion fails for four reasons. At the outset, Anthem not only ignores the "holistic approach" that applies to evaluating materiality under *Universal Health v. U.S. ex rel. Escobar*, 136 S. Ct. 1989 (2016) ("*Escobar*"), but also defies *Escobar*'s instruction that no one materiality factor is "automatically

dispositive." *See infra* Pt. II.A. Further, Anthem's brief fails to acknowledge, let alone address, most of the materiality allegations in the amended complaint. A fair assessment of these allegations under the "holistic approach" shows that they plausibly plead that Anthem's false attestations were material to payment. *See infra* Pt. II.B. In addition, Anthem also seriously mischaracterizes the amended complaint regarding the import of the false attestations to CMS. *See infra* Pt. II.C (noting that Anthem improperly equates "would" with "might" and "have the right to"). Lastly, Anthem pins most of its materiality arguments on an out-of-circuit district court decision — *U.S. ex rel. Poehling v. UnitedHealth Group*, CV-16-8697, 2018 WL 1363487 (C.D. Cal. Feb. 12, 2018). But Anthem misconstrues *Poehling* by ignoring key parts of its materiality analysis, whereas a careful reading of *Poehling* shows that it supports, rather than undercuts, the sufficiency of the materiality allegations in this case. *See infra* Pt. II.D.

Third, the Court should deny the motion to strike seven paragraphs in the amended complaint because Anthem falls far short of making the requisite showing under Rule 12(f) — that those allegations have no bearing on the relevant issues and no evidence in support of them would be admissible. *See Lipsky v. Commonwealth United Corp.*, 551 F.2d 887, 893 (2d Cir. 1976). Those allegations not only show the Government's efforts to enforce the accuracy requirement for the diagnosis data submitted to CMS by MAOs like Anthem, but also illuminate evidence of Anthem's internal discussions about such enforcement efforts. As courts in this District and elsewhere have repeatedly recognized, evidence of prior governmental enforcement is relevant to materiality under *Escobar* as well as scienter. *See infra* Pt. III.B. Anthem's brief makes no serious effort to address the relevance of the allegations it seeks to strike. Instead, it asks the Court to ignore the applicable legal standard and prematurely make evidentiary rulings at the pleadings stage based on plainly inapplicable case law. *See infra* Pt. III.C.

RELEVANT BACKGROUND

In contrast to Anthem's incomplete and inaccurate version of the Government's allegations and claims, we summarize below the Government's actual theories of fraud and the key supporting allegations. We next briefly explain how the claims and allegations in this case are connected to this District. We then describe three important respects in which Anthem's brief distorts the Government's theories, core allegations in the amended complaint, and the relevant regulatory history.

A. Senior Executives at Anthem Structured Its Risk Adjustment Data Procedures – Including Chart Review – in Contravention of Anthem's Attestations of Diagnosis Data Accuracy and Its Obligation to Correct or Delete Inaccurate Data

The FCA claims here arise from Anthem's operation of Medicare Advantage Plans, also known as Medicare Part C plans. Under Medicare Part C's risk adjustment payment system, Anthem submitted diagnosis data to CMS for the patients covered by its plans, and CMS relied on that data to determine how much to adjust the payment it made to Anthem on an interim basis each month for each patient. *See* Am. Compl. ¶¶ 27–37. Specifically, CMS used the diagnoses submitted by Anthem to calculate a "risk score" for each patient, which was then combined with the patient's demographic factors to compute the risk adjusted interim monthly payments to Anthem for that patient. *Id*. ¶¶ 29–30.

Further, when CMS undertook the final reconciliation process after the end of each year, Anthem's diagnosis data submissions again played a key role. *See id*. ¶ 44. Specifically, depending on whether Anthem submitted additional diagnoses or deleted previously-submitted diagnoses, CMS could either make additional reconciliation payments to Anthem or seek a recoupment due to the deletion of earlier-submitted diagnosis. *Id*.

Because the diagnosis data submitted by MAOs like Anthem directly affect the level of risk adjustment payments, *see id*. ¶ 35 (the addition of a leukemia diagnosis could increase

CMS's annual risk adjustment payments for a patient by $20,700), CMS imposed extensive regulatory and contractual requirements on MAOs to ensure the accuracy of their diagnosis data. As relevant here, these included requiring MAOs to follow the "medical record documentation" standard established by the International Classification of Disease ("ICD") coding guidelines, *see id*. ¶¶ 45–50, and requiring them to delete previously submitted diagnosis codes if the MAOs learned that those codes were not supported by the patients' medical record, *see id*. ¶¶ 51–56; *see generally id*. ¶¶ 58–70 (CMS incorporating these obligations into regulatory and contractual requirements on the MAOs). The obligation to delete inaccurate diagnoses was also specified in agreements that MAOs like Anthem executed with CMS, which required them to "research and correct risk adjustment data discrepancies," such as when a retrospective review of medical records revealed an inaccurate diagnosis that had been submitted previously. *See id*. ¶¶ 79–82.

To underscore the crucial importance of data accuracy, CMS required Anthem and other MAOs to expressly attest – on an annual basis – to the accuracy and truthfulness of their diagnosis data submissions as "a condition for receiving the monthly [risk adjustment] payments." *See id*. ¶¶ 83–90.[1] Specifically, a senior executive must make the attestation on behalf of each MAO and based on the MAO's "best knowledge, information, and belief." *See id*. ¶ 155, Ex. 9.[2] As Anthem itself recognized, the submission of the annual attestations was an essential component of the risk adjustment payment process — Anthem must do so "in order for

[1] *See generally U.S. ex rel. Swoben v. United Healthcare*, 848 F.3d 1161, 1166-68 (9th Cir. 2016) (noting that CMS recognized MAOs have "a financial incentive" to "report[] diagnosis codes" that are not "supported by [] medical records" and, thus, required MAOs to attest to the accuracy and truthfulness of their data submissions as a "bulwark" against fraud).

[2] While acknowledging that it was required to make good faith efforts to ensure data accuracy, Anthem makes the startling assertion that it is the arbiter of what constitutes good faith. *See* Def. Br. at 17 ("[t]he agency instead granted discretion to MAOs to determine what constituted 'good faith effort'…"). This contention demonstrates Anthem's proclivity to flout the rules and to treat the core requirements of Medicare Part C as merely advisory.

[its] Risk Adjustment data to be included" in CMS's calculations that determined final reconciliation payments. *Id*. ¶ 86.

From early 2014 to early 2018, executives overseeing Anthem's Medicare business – including Marc Russo, the then-president of that business unit – regularly attested to the accuracy and truthfulness of Anthem's diagnosis data submissions and signed agreements with CMS stating that Anthem would "research and correct" inaccurate data when it learned of a likely inaccuracy. *See id*. ¶¶ 87–88, 80–82. In practice, however, those executives disregarded the attestations and representations that they made to CMS regarding data accuracy; instead, they structured and operated Anthem's risk adjustment data procedures so that Anthem could improperly profit at Medicare's expense by systematically inflating risk scores based on inaccurate diagnosis data.

Specifically, Anthem relied on two separate sources for the diagnosis data it submitted to CMS — first, healthcare providers who treated patients and reported diagnoses to Anthem when they sought insurance coverage for the treatments; and, second, a coding vendor called Medi-Connect that Anthem paid to obtain medical records pertaining to those treatments and then extract diagnosis codes based on a review of the medical records. *See* Am. Compl. ¶¶ 106, 111. Executives overseeing Anthem's Medicare business understood – from their own experiences as well as result of audits conducted by CMS – that the diagnoses Anthem received from providers contained a significant percentage of inaccuracies. *Id*. ¶¶ 74–78, 96–97. For example, those executives knew that "improper dx[diagnosis] codes" was one of the "common errors" because "physicians do not always code accurately." *Id*. ¶ 75. In 2015, moreover, Anthem's own internal risk assessment alerted the senior executives in charge of its Medicare business to the fact that Anthem's profit-sharing relationships with certain healthcare providers – which gave those providers a financial incentive to over-report diagnoses – created a "High" risk

that Anthem was "submitting diagnosis data for risk adjustment that [was] not accurate and/or supported in the medical record." *Id*. ¶¶ 77–78. Nonetheless, those executives chose not to implement any procedure to identify inaccurate diagnoses and remove the unsupported diagnosis codes before forwarding the provider-reported codes to CMS. *Id*. at ¶ 110.

As the amended complaint further alleges, by paying Medi-Connect to collect and review medical records, Anthem came into possession of information that showed which specific groups of diagnosis codes that Anthem had previously submitted to CMS were inaccurate and should be deleted. *See id*. ¶¶ 6–7, 120–133. Specifically, Anthem executives understood that comparing the diagnosis codes that Medi-Connect found as result of chart review could reveal mistakes and inaccuracies in the codes that Anthem had previously submitted to CMS, and they knew that Anthem could have readily written a computer algorithm to identify the inaccurately reported diagnosis codes by comparing the previously-submitted codes against the chart review results. *Id.* ¶¶ 7, 82, 130 (summarizing testimony by Anthem's chief compliance officer and the former data director for the Medicare business unit). Indeed, to convince healthcare providers to supply medical records to Medi-Connect, Anthem represented that Medi-Connect's review of the records would be an "oversight activity" intended to "help ensure that ICD9 codes had been reported by providers accurately" in terms of being "supported" by "medical record documentation" and in accordance with "proper coding guidelines." *Id*. ¶¶ 6, 112–113.

However, what Anthem told providers about its chart review program was a lie. As the amended complaint explains, the executives overseeing Anthem's Medicare business never directed either Anthem employees or Medi-Connect to design or execute chart review as "an oversight activity" to ensure diagnostic data accuracy. *See id*. ¶¶ 8, 141–152. Rather, Anthem treated it solely as a way to mine for additional diagnosis codes to increase revenue — or, as a senior executive noted in a 2017 internal e-mail, to be "a cash cow" for Anthem itself. *Id*.

More specifically, while the Anthem executives recognized that information generated by Medi-Connect's chart review gave Anthem an opportunity to fulfill its attestations and good faith obligation to ensure diagnosis data accuracy, they chose to disregard those obligations because finding and deleting inaccurate diagnosis codes based on chart review results would have significantly decreased – rather than "enhance[d]" – the revenue from Medicare. *Id.* ¶ 133. Instead, Anthem relentlessly tracked the profitability of its chart review program using the "ROI" (return on investment) metric. *See id.* ¶¶ 145–146 (by structuring chart review such that it only yielded more diagnoses and did not result in deletions, Anthem achieved an ROI of 6.00 in 2015 based on approximately $112 million in additional revenue versus $19 million in expenditures).

Finally, the amended complaint makes clear how the Anthem executives' conduct violated the FCA. As alleged, those executives knew that Anthem did not have any procedure to verify the accuracy of the diagnoses it received from providers before passing them on to CMS. *See id.* ¶ 110. Those executives also knew there were specific groups of diagnosis codes that Anthem had previously submitted to CMS – namely the codes coming from providers that Medi-Connect could not validate through chart review – that were inaccurate. *Id.* ¶ 154 (examples of inaccurate diagnosis code that Anthem could have corrected or deleted, but chose not to). The Anthem executives further understood that not correcting or deleting those inaccurate codes would result in Anthem receiving or retaining millions – possibly tens of millions – of dollars each year in Medicare risk adjustment payments based on inaccurate diagnoses. *See id.* ¶¶ 147–49 (two senior finance executives at Anthem discussing the estimate that deleting inaccurate diagnosis codes could translate to an $86 million reduction in Anthem's revenue in 2017). Thus, instead of ensuring the accuracy of its diagnosis data, as it promised CMS it would do, Anthem knowingly made false attestations and disregarded its obligation to correct and delete inaccurate data submissions. *See id.* ¶¶ 155–57.

B. Anthem Engaged in Conduct Relating to Its Risk Adjustment Fraud in This District

Contrary to its suggestion that the Government arbitrarily chose to file this case here, *see* Def. Br. at 3–4, 26–27, Anthem engaged in extensive activities in this District relevant to the risk adjustment fraud at issue.[3] As alleged, Anthem operated one of its largest Part C plans — Empire MediBlue Plus — in this District. *See* Am. Compl. ¶ 13. During the relevant period, Anthem enrolled thousands of residents in this District in that Part C plan. *See id*. In addition, to operate Empire MediBlue Plus, Anthem's Medicare business maintained a regional office at One Liberty Plaza in lower Manhattan. *Id*.

Beyond having generally carried out extensive business in this District, Anthem's Medicare business also engaged in specific conduct in this District that bear directly on the Government's FCA claims. In particular, Anthem had Medi-Connect obtain medical records from healthcare providers in this District for chart review purposes and made misrepresentations to those providers about its risk adjustment data procedures. *See id*. ¶¶ 13, 116–119. In 2010, for example, Anthem distributed a flyer to encourage healthcare providers with patients enrolled in Empire MediBlue Plus – *i.e.*, many hospitals, clinics, and doctors' offices in this District – to respond to Medi-Connect's request for medical records. In that flyer, Anthem falsely advised the providers that Medi-Connect would "perform oversight activities" relating to "whether diagnosis data reported to CMS were "supported by medical record documentation." *Id*. ¶ 116.

In addition, Anthem also made misrepresentations directly to providers in this District to pressure them to supply medical records to Medi-Connect. For example, when the Weill Cornell Medical Center ("Weill-Cornell") declined to give medical records to Medi-Connect in the fall of 2010, a regional vice presidents in Anthem's New York office met with staff at Weill-

[3] Before filing this case, the Government conducted an FCA investigation into Anthem's risk adjustment fraud in this District. That involved, *inter alia*, a subpoena enforcement proceeding to obtain testimony. *See United States v. Anthem Inc*., 18 Misc. 379 (GBD)(KMF).

Cornell. *Id*. ¶¶ 117–19.[4] At Anthem's instruction, the regional vice president misrepresented to Weill-Cornell that it needed to supply the records because Medi-Connect was performing "oversight activities" and "routine monitoring" for Anthem pursuant to CMS requirements. *Id*.

C. Senior Executives Overseeing Anthem's Medicare Business, Not Merely Local Operational Staff, Made Key Decisions Relating to the Risk Adjustment Fraud

In connection with its transfer request, Anthem tries to narrow the scope and focus of this case, wrongly asserting that this case is "fundamentally" about various operational details of its "chart review program." Def. Br. at 1-2. Specifically, Anthem suggests that the Government's claims turn on matters such as which medical records its operational staff in Ohio asked Medi-Connect "to collect from healthcare providers" and review, what steps its staff "implemented to confirm" Medi-Connect's chart review results, and how its staff assembled "Anthem's diagnosis coding manual." *Id*. at 23-24.

The Government's claims do not hinge on actions of Anthem's operational staff in Ohio, but rather on a fraudulent scheme designed and executed by the senior executives – mainly members of the "policy committee" for Anthem's Medicare business – who are located throughout the east coast and other parts of the country.[5] Tellingly, Anthem's brief only cites to a carefully selected set of paragraphs of the amended complaint, while ignoring key allegations in other paragraphs. *See id*. (failing to cite paragraphs 71–75, 77–78, 87–88, 117–119, 130-131, 133-135, 141-155). These skipped-over paragraphs allege, *inter alia*, what Anthem's chief compliance officer, who was a member of the policy committee for the Medicare business unit, knew about Anthem's obligation to delete inaccurate codes, *see* Am Compl. ¶ 73; the fact that a

[4] There is a typo in the amended complaint. The interaction between Anthem and Weill-Cornell occurred in November 2010, not November 2013.

[5] The amended complaint does not specifically allege those executives' membership in the policy committee for Anthem's Medicare business or their locations. If the Court deems it appropriate, the Government will amend its complaint to allege these additional facts.

2015 internal assessment by the policy committee found a "High" risk of "inaccurate" diagnosis data associated with "profit-sharing" arrangements, *id*. ¶ 77; how the president of Anthem's Medicare business, another member of the policy committee, submitted false attestations, *id*. ¶¶ 87–88; how the vice president heading the Medicare R&R group, also a member of the policy committee, viewed chart review as "a cash cow" due to its "high ROI," *id*. ¶¶ 145–147; and how Anthem failed to provide basic compliance training to the senior-most executives in charge of the policies and objectives of its Medicare business unit, *id*. ¶¶ 150–152.

Put simply, Anthem ignores the allegations highlighting that even though senior executives responsible for its Medicare business recognized that Anthem's risk adjustment data procedures were causing CMS to make risk adjustment payments based on diagnosis codes that Anthem's information showed to be inaccurate, they chose to maintain those procedures. *See id*. ¶¶ 5, 71–78, 130–133, 150. Anthem likewise ignores allegations showing that those executives contravened Anthem's annual attestations and good faith obligations to ensure data accuracy in order to improperly profit at Medicare's expense. *See id*. ¶¶ 6-9, 85–88, 110, 134-155.

In other words, this case is about the decisions made by the senior executives overseeing Anthem's Medicare business regarding the overall design, structure, and objective of Anthem's risk adjustment data operations. *See id*. ¶ 8 ("Anthem made 'revenue enhancement' the sole purpose of its chart review program, while disregarding its obligation to find and delete inaccurate diagnosis codes, because Anthem prioritized profits over compliance"). The Government's claims, thus, turn on what those executives knew about data inaccuracies and what they did, or failed to do, in light of that knowledge, and not ministerial acts like which specific medical records were collected as part of chart review or who at Anthem's Columbus office wrote a specific section of the "diagnosis coding manual." *See* Def. Br. at 23-24.

D. The Amended Complaint and Relevant Regulatory History Demonstrate That Anthem's False Risk Adjustment Attestations Were Material

The amended complaint sets out five sets of facts that illustrate how Anthem's false attestations regarding data accuracy were material to the Government. *First*, CMS promulgated regulations and contractual provisions to require MAOs like Anthem to attest to the accuracy of their risk adjustment diagnosis data every year. *See* Am. Compl. ¶¶ 83–85, Ex. 3. Indeed, the CMS regulations specify that submission of the annual attestation is "a condition for receiving the monthly [risk adjustment] payment." *Id*. ¶ 83 (quoting 42 C.F.R. § 422.504(l)). *Second*, the amended complaint details how the annual attestation requirement went to the essence of the bargain that CMS made with Anthem. Specifically, because CMS calculates risk adjustment payments based on diagnosis codes, and because CMS depends on MAOs to submit accurate diagnosis data, CMS advised Anthem and other MAOs that the annual attestations "place the responsibility on [them] to make 'good faith efforts [to] certify the accuracy'" of their data submissions. *Id*. ¶ 89 (quoting 65 Fed. Reg. 40,170, 50, 268 (June 29, 2000)). Anthem's false attestations thus "had a direct and foreseeable impact on CMS," including causing CMS to "disburse reconciliation payments [] during the relevant period." *Id*. ¶ 157.

Third, Anthem itself understood the import of the annual attestations. As alleged, Anthem's internal policy "recognized that submission of the attestation is a prerequisite [] 'in order for [Anthem's] Risk Adjustment data to be included in CMS's run of the Risk Adjustment model,' which determines the final payments to Anthem." *Id*. ¶ 86. Tellingly, Anthem also cited CMS's data accuracy requirement in its misleading statements to healthcare providers to pressure them into supplying medical records to Medi-Connect for chart review. *Id*. ¶¶ 90, 111–119; Ex. 10. *Fourth*, the amended complaint also describes the Government's long-standing and active efforts to "pursu[e] legal remedies against" violations of the data accuracy requirement. *See id*. ¶¶ 98-105. As alleged, the Government not only has obtained restitution for CMS, but also

mandated adoption of specific procedures for ensuring future compliance. *Id.* ¶ 100 (summarizing data accuracy procedures in a 2017 Corporate Integrity Agreement between an MAO and the Office of Inspector General for the Department of Health and Human Services).

Lastly, to dispel the erroneous claim in Anthem's pre-motion letter that the foregoing facts are somehow insufficient to show the import of its false attestations, *see* ECF Nos. 20, 23, the Government added several allegations in its July 2020 amendment to further clarify how Anthem's false attestations affected CMS. *See* Am. Compl. ¶¶ 161–162, 166–167. As alleged, the false attestations led CMS to believe that Anthem lacked awareness that "specific diagnosis codes it had submitted for payment and never deleted were inaccurate." *Id.* ¶ 162. Further, "if CMS had known" that Anthem had such awareness, then CMS "would have taken appropriate actions to ensure that Anthem did not receive or retain risk adjustment payments to which it was not entitled," such as by "recouping payments" administratively, "adjusting the reconciliation payments," or receiving restitution "in enforcement actions." *Id.*[6]

In addition, and in contrast to Anthem's suggestion, *see* Def. Br. at 46, 19-20, the relevant regulatory history of CMS's data accuracy requirement underscores the materiality of Anthem's risk adjustment fraud. As noted above, CMS promulgated regulations to require MAOs like Anthem to ensure data accuracy and issued public notice regarding the nature of the MAOs' obligations when they attest to the accuracy of their risk adjustment data. *See*, *e.g.*, Am.

[6] Anthem quarrels with the allegation that CMS was not aware of the falsity of Anthem's attestations. Specifically, Anthem incorrectly, and procedurally improperly, asserts that CMS knew the attestations were false because CMS had general knowledge about chart review programs conducted by MAOs. *See* Def. Br. at 46 (asserting, as a "fact," "that CMS necessarily learned of Anthem's chart review practices long before Plaintiff filed this suit"). However, as explained below, CMS did not know what Anthem's executives understood about the frequency of inaccurate diagnoses in its data submissions to CMS; if Anthem made efforts to verify the provider-reported diagnoses before submitting them to CMS; and, most importantly, whether Anthem had "information" that revealed the existence of specific groups of inaccurate diagnosis codes when it made the attestations to CMS. *See infra* Pt. II.C.

Compl. ¶¶ 45, 58, 89. Further, when CMS refrained in 2014 from imposing a mandate regarding how specifically MAOs should conduct chart review, CMS also – as the Ninth Circuit has recognized – expressly "reiterated" its "expect[ation] that [MAOs] implement … appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS." *Swoben*, 848 F.3d at 1169 (internal quotation marks omitted).

E. Allegations Concerning the Government's Prior Enforcement Activities Illustrate the Materiality of the Risk Adjustment Fraud and Anthem's Scienter

The amended complaint summarizes four instances where the Government took enforcement actions and obtained settlements for alleged risk adjustment frauds against CMS. In two instances, the Government's enforcement actions resulted in settlements based on allegations that two MAOs had knowingly submitted inaccurate diagnosis data to CMS. *See* Am. Compl. ¶¶ 99–100. In the other two instances, the Government resolved allegations that two healthcare providers had knowingly caused MAOs to submit inaccurate diagnosis data. *See id*. ¶¶ 101–02.

Notably, the first of these examples of the Government's risk-adjustment fraud enforcement efforts involved allegations that one of Anthem's peer MAOs, SCAN Health "had used outside vendors to review medical charts of [its] Part C beneficiaries to identify new diagnosis codes [] to submit to CMS, but had failed to disclose to CMS that chart review results also indicated that some of the previously-submitted diagnosis codes might need to be deleted." *Id*. ¶ 99. In other words, this enforcement action and settlement revealed that, as early as 2012, the Government had concerns about, and was "actively pursuing legal remedies" for, a key aspect of the risk adjustment fraud alleged here. *Id*. ¶ 98.

As further explained in the amended complaint, the examples of prior risk-adjustment fraud enforcement efforts not only shed light on how the Government publicly emphasized the importance of the data accuracy requirement, *see id*., but also illuminate Anthem's own understanding about *its* compliance obligations as an MAO. Anthem records show that its

"compliance staff … routinely monitored the status of the Government's enforcement activities relating to risk adjustment data accuracy." *Id.* ¶ 103.[7] For example, shortly after the Government announced the enforcement action and settlement against SCAN Health in 2012, "executives in Anthem's Medicare compliance group exchanged e-mails concerning the impact of the SCAN [] settlement on Anthem's Medicare 'risk adjustment reporting methodology.'" *Id.* ¶ 104. As alleged, a compliance manager at Anthem "highlighted a passage" in an analysis of the settlement noting that the SCAN enforcement action pointed to "greater scrutiny" by the Government as to the core issues at stake here— "how risk adjustment payments are calculated" and "how retrospective reviews are performed." *Id.* (internal quotation marks omitted).

ARGUMENT

POINT I

ANTHEM IS NOT ENTITLED TO A TRANSFER OF VENUE BECAUSE IT HAS NOT OFFERED CLEAR AND CONVINCING EVIDENCE THAT OHIO IS A MATERIALLY MORE CONVENIENT VENUE

Anthem's venue transfer request should be denied because it rests on a fundamentally misleading premise: that this case is "essentially" about local operational employees who played a role in carrying out Anthem's fraudulent scheme, *see* Def. Br. at 4, rather than — as the amended complaint makes clear — the executives who designed it. On the law, Anthem misstates the standard and fails to acknowledge the significant deference owed to the Government's venue choice. On the facts, Anthem disregards the strong connection between the claims at issue and this District. Further, Anthem's contentions on two of the § 1404(b) factors — convenience of witnesses and locus of operative facts — must be rejected because Anthem

[7] Notably, while Anthem is moving to strike paragraphs 99 through 105 of the amended complaint, *see* Def. Br. at 56, its brief focuses almost entirely on summaries of the four enforcement actions in paragraphs 99 through 102, *see id.* at 49, and barely mentions the next three paragraphs, which describe Anthem's internal discussions regarding the enforcement actions. This is of a piece with Anthem's overall strategy here — to tailor its arguments on the basis of misrepresentations and half-truths regarding the Government's allegations.

wholly ignores the crucial role played by the executives on the policy committee for Anthem's Medicare business. As none of the key witnesses are in Ohio or participated in the alleged fraud there, Anthem has not met its burden to demonstrate that this case should be transferred.

A. A Party Seeking Transfer Must Show That the § 1404(b) Factors Weigh "Strongly in Favor of" Overriding the Plaintiff's Venue Choice

Anthem's brief suggests that the Court should give little or no weight to the Government's choice to bring this case in this District — which Anthem does not dispute is appropriate — and conduct a *de novo* inquest to determine the best venue. *See, e.g.*, Def. Br. 29, 31-32. That, however, is not the law. Rather, the Second Circuit and courts in this District have repeatedly affirmed the basic principle that under 28 U.S.C. § 1404(b), "a plaintiff's choice of forum is presumptively entitled to substantial deference." *Gross v. British Broadcasting Corp.*, 386 F.3d 224, 230 (2d Cir. 2004); *accord In re Warrick*, 70 F.3d 736, 741 (2d Cir. 1995) (*per curiam*) ("[Plaintiff's] choice of venue [is] entitled to substantial consideration"); *Starr Indem. & Liab. Co. v. Brightstar Corp.*, 324 F. Supp. 3d 421, 433 (S.D.N.Y. 2018) (plaintiff's choice of forum "is generally entitled to considerable weight and should not be disturbed unless the balance of the factors is strongly in favor of the defendant") (internal quotation marks omitted); *see generally* Wright & Miller, 15 FED. PRAC. & PROC. JURIS. § 3848 (4th ed.) ("a motion to transfer under Section 1404(b) should not be granted lightly. After all, by definition, these are cases in which the plaintiff's choice of venue is proper under the applicable venue provisions.").

Given the deference owed to the plaintiff's choice of venue, a party seeking transfer, like Anthem, must make a "clear and convincing" showing that the balance of the § 1404(b) factors compels transfer. *See New York Marine & Gen. Ins. Co. v. Lafarge N. Am., Inc.*, 599 F.3d 102, 114 (2d Cir. 2010). In other words, "unless the balance is strongly in favor of the defendant, the plaintiff's choice of forum should rarely be disturbed." *Norex Petroleum Ltd. v. Access Industries, Inc.*, 416 F.3d 146, 154 (2d Cir. 2005).

Therefore, if in examining the § 1404(b) factors — "(1) the plaintiff's choice of forum, (2) the convenience of witnesses, (3) the location of relevant documents and relative ease of access to sources of proof, (4) the convenience of parties, (5) the locus of operative facts, (6) the availability of process to compel the attendance of unwilling witnesses, and (7) the relative means of the parties," *see Lafarge*, 599 F.3d at 112, as well as "(8) the forum's familiarity with the governing law, and (9) trial efficiency and the interest of justice," *Starr Indem.*, 324 F. Supp. 3d at 431 — this Court determines that the balance of those factors is "neutral" as between the two proper venues, it should deny transfer, because Anthem "ha[s] not provided the type of 'clear-cut showing' necessary." *Casper Sleep, Inc. v. Nectar Brand LLC*, 18 Civ. 4459 (PGG), 2019 WL 4727496, at *7 (S.D.N.Y. Sept. 27, 2019); *accord Starr Indem.*, 324 F. Supp. 3d at 433. However, as demonstrated below, the § 1404(b) factors tilt in favor of the Government's choice of venue in this District.

B. The Strong Connection of the Claims at Issue to This District Gives Substantial Weight to the Government's Choice of Venue

While Anthem concedes that venue in this District is permissible, it ignores allegations showing the strong connection this forum has to the misconduct at issue. As noted above, *see supra* at 9–10, Anthem's Medicare business contracted with CMS to operate a major Part C plan in this District affecting thousands of patients, maintained a regional office in lower Manhattan, and directed Medi-Connect to obtain medical records from healthcare providers in this District for chart review. *See* Am. Compl. ¶ 13.

More importantly, the amended complaint also alleges that Anthem engaged in conduct in this District that is at the core of the risk adjustment fraud and that shows Anthem carried out the scheme with scienter. Specifically, Anthem misrepresented the nature and objective of its chart review program to healthcare providers in this District to pressure them into supplying medical records to Medi-Connect. *See id.* ¶ 116, Ex. 11.

In one case, for example, a regional vice president in Anthem's New York office misrepresented to the staff at Weill-Cornell that Anthem's chart review program would verify the accuracy of previously submitted diagnosis codes, whereas Anthem's actual goal was to mine the records for additional diagnosis codes in order to improperly profit at Medicare's expense. *See id*. ¶¶ 117–19.

C. The Locus of Operative Facts and the Convenience of Witnesses Do Not Favor Transfer

As noted above, *see supra* at 6–8, 10–12, the amended complaint alleges that a group of senior executives – mainly members of the policy committee for Anthem's Medicare business – made the key decisions regarding Anthem's risk adjustment data procedures that are at the crux of this case. *See* Am. Compl. ¶¶ 5-9, 71–78, 85–88, 110, 130–155. Anthem, however, ignores these core allegations. In its telling, this case is "fundamentally" about the conduct of a group of operational staff in Columbus, Ohio. *See* Def. Br. at 1, 23–26.

Relying on this mischaracterization of the Government's allegations, Anthem argues that two of the § 1404(b) factors – locus of operative facts and convenience of witnesses[8] – favor a transfer of venue to the Southern District of Ohio. *See id*. at 29–32. In fact, though, Anthem wholly fails to show clearly and convincingly that these two factors tilt in its favor.

Locus of Operative Facts. Anthem erroneously asserts that Ohio is the "locus of operative facts" because a group of operational staff in its Columbus, Ohio office processed diagnosis data that Anthem collected and then submitted to CMS for risk adjustment purposes. *See* Def. Br. at 4, 31–32. While the Government does not dispute that some relevant events relating to the implementation of Anthem's risk adjustment scheme occurred in Ohio, "the locus

[8] Courts often deem the "convenience of witnesses" to be the most important of the § 1404(b) factors, and the Government does not disagree. *See Starr Indem.*, 324 F. Supp. 3d at 437. Here, we address the "locus of operative facts" factor first because we believe doing so provides helpful background for the later discussion about the convenience of witnesses.

of operative facts" is ultimately about "where policy is determined." *Pippins v. KPMG LLP*, 11 Civ. 0377 (CM), 2011 WL 1143010, at *5 (S.D.N.Y. Mar. 21, 2011); *accord Dwyer v. Gen. Motors Corp*., 853 F. Supp. 690, 694 (S.D.N.Y. 1994) (denying transfer in part because the senior management decisions at issue in the design defect suit occurred in neither the plaintiff's chosen forum nor the proposed transferee forum).

Here, the key decisions were made not by the operational staff in Columbus, but instead by senior executives on the policy committee for Anthem's Medicare business. It was those executives who made the policy choice to structure Anthem's risk adjustment data procedures to focus on improperly profiting at Medicare's expense instead of ensuring accuracy. Specifically, those executives – who did not work in Ohio but instead in Anthem's offices in Connecticut, Colorado, Florida, and Pennsylvania – were aware of significant inaccuracies in the diagnosis data Anthem submitted to CMS, understood Anthem's obligation to correct and delete inaccurate data submissions, knew that Anthem could easily have done so by comparing previously submitted data against chart review results, and yet chose not to do so because they wanted to chart review to remain "a cash cow" for Anthem. *See* Am. Compl. ¶¶ ¶¶ 5-9, 71–78, 85–88, 110, 130–155. Year after year, moreover, Marc Russo – the president of Anthem's Medicare business unit who worked in Connecticut, not Ohio – falsely attested to the accuracy of Anthem's diagnosis data submissions to CMS. *See id*. ¶¶ 87–88, 155–57, Ex. 9.

The amended complaint also makes clear that this case involves a nationwide fraud scheme driven by decisions made by Anthem executives throughout the country, so there is more than one single locus of operative facts. *See Starr Indem.*, 324 F. Supp. 3d at 436 (recognizing that "venue analysis may determine that there are several loci of operative facts") (alterations omitted); *Tianhai Lace USA Inc. v. Forever 21, Inc.*, 16 Civ. 5950 (AJN), 2017 WL 4712632, at *4 (S.D.N.Y. Sept. 27, 2017) ("there may be several loci of operative facts in any action").

Thus, although Anthem carried out the data processing aspect of the alleged fraud in Ohio, it also took numerous steps *in this District* in furtherance of the fraud — such as having a regional vice president in its New York office make misrepresentations to staff at Weill-Cornell, and sending flyers to providers to convince them to supply medical records to Medi-Connect for its chart review. *See* Am. Compl. ¶¶ 112–19. Moreover, because Anthem operated one of its largest Part C plans – Empire MediBlue Plus – here, the fraud also had a significant impact on this District. *Id*. ¶ 13. In other words, Anthem is simply wrong to assert that "***no*** business operations relevant to this litigation have ever been based here." Def. Br. at 3-4 (emphasis in original).

Anthem, in short, has not shown – much less made a "clear and convincing" showing - that Ohio is *the* locus of operative facts or has a clearly "superior" claim than this District, *see Park v. McGowan*, 11-CV-3454 (JG), 2011 WL 6329797, at *4 (E.D.N.Y. Dec. 16, 2011); *Lafarge N. Am*., 599 F.3d at 114. Finally, insofar as Anthem asks the Court to ignore the Government's allegations and rely instead on how Anthem construes the amended complaint, that request is wholly at odds with the current procedural posture. Because this case is at the pleading stage, Anthem cannot rewrite the Government's claims as laid out in the operative complaint to suit its preference for another venue. *See* Wright & Miller, 15 FED. PRAC. & PROC. JURIS. § 3851 (4th ed.) (the Court's "evaluation [should be] based on the posture of the case at the time of the request for a change of venue.") (citing *In re Volkswagen AG*, 371 F.3d 201, 204 (5th Cir. 2004)).

Convenience of witnesses. The Government expects the discovery and trial for this case to involve four groups of witnesses — 1) the senior executives in Anthem's Medicare business whose decisions gave rise to the fraudulent scheme; 2) the staff at Weill-Cornell to whom Anthem made false statements about its risk adjustment and chart review procedures; 3) one or a handful of Anthem's operational staff whose day-to-day work involved implementation

of the executives' decisions; and 4) CMS employees with responsibilities relating to risk adjustment payments to MAOs.

Anthem's brief, however, largely ignores the first and second groups of likely witnesses and, instead, focuses mainly on witnesses in group 3 who work in the Columbus, Ohio area, which happens to be Anthem's preferred forum. *See* Def. Br. at 29–30. Indeed, disregarding the pertinent allegations in the amended complaint, Anthem wrongly claims that not a "***single witness***" likely to appear is in New York. *Id*. at 29. Further, while Anthem concedes that relevant CMS witnesses are located in Maryland, *see id*. at 26, it nonetheless contends – contrary to common sense – that Columbus, Ohio is equally convenient, or more so, as New York for those witnesses. *Cf. Starr Indemn.,* 324 F. Supp. 3d at 439 (even if a witness "does not live in this forum, this does not mean that the Court should ignore the fact that it would be easier for him to travel to New York than to Florida").

These assertions are meritless. As a starting point, the amended complaint expressly identifies several witnesses – the staff at Weill-Cornell and the Anthem regional vice president working at its office in Manhattan (who are in groups 3 and 4) – who are in the New York area. *See* Am. Compl. ¶¶ 117–19. For them, and especially the non-party witnesses at Weill-Cornell, this District will be a more convenient forum than Ohio. Under § 1404(b), this is significant because the "convenience of non-party witnesses is accorded more weight than that of party witnesses." *It's a 10, Inc. v. PH Beauty Labs*, 718 F. Supp. 2d 332, 336 (S.D.N.Y. 2010); *accord Starr Indemn.,* 324 F. Supp. 3d at 437; *Tianhai Lace*, 2017 WL 4712632, at *2-3.

Further, none of the witnesses with the most critical roles in the alleged fraud – the senior executives in group 1 who oversaw Anthem's Medicare business – is in Ohio. As enumerated below, two of the key witnesses in this group – both of them non-party witnesses because they no longer work for Anthem– are in Connecticut, and the others are spread across

different parts of the country:

- Marc Russo, the former president of Anthem's Medicare business unit, resides in Connecticut.[9] Mr. Russo not only signed the attestations that certified the accuracy of Anthem's risk adjustment data, but also led meetings of the policy committee for Anthem's Medicare business. *See* Am Compl. ¶¶ 87–88, 150–52.

- A staff vice president (SVP) of Medicare revenue at Anthem. Public records show that this witness resides in Florida. As the head of Anthem's Medicare Risk & Revenue group, the SVP was a member of Anthem's Medicare policy committee and responsible for risk adjustment data procedures. For example, after the policy committee concluded in 2015 that Anthem had a "High" risk of "submitting diagnosis data for risk adjustment that is not accurate," *see* Am. Compl. ¶ 78, the SVP was designated as the executive primarily responsible for mitigating that risk, *id*. ¶ 150. In 2016, moreover, the SVP refused to make changes to chart review in 2016 because she viewed it as "a cash cow" for Anthem. *Id*. ¶¶ 146.

- Anthem's vice president of finance. Public records show this witness resides in Nevada. She also was a member of Anthem's Medicare policy committee and is knowledgeable about Anthem's policies and procedures relating to risk adjustment data submissions, as evidenced by the fact that Anthem designated her as a Rule 30(b)(6) witness during the Government's pre-litigation investigation.

- The former vice president of Medicare revenue at Anthem. Public records show that this witness resides in Connecticut. As another member of the Medicare "policy committee," this witness participated in the 2015 internal assessment that identified the "High" risk of inaccurate diagnosis data submissions. *See id*. ¶¶ 78, 150. Further, in 2017, this witness told another executive that if Anthem were to start correcting and deleting inaccurate diagnosis codes that could not be validated by chart review, it would reduce Anthem's chart review revenue "by about two thirds." *Id*. ¶ 149.

- Anthem's chief compliance officer, who previously served as the compliance officer for the Medicare business unit. Public records indicate that this witness resides in Colorado. As alleged, this witness was involved with self-assessments that highlighted the likelihood of inaccurate diagnosis data submissions, and she also understood Anthem's obligations to delete inaccurate diagnosis codes and to "research and correct risk adjustment data discrepancies." *See id*. ¶¶ 73, 82.

- Former director of the data team for Anthem's Medicare business. Public records indicate that this witness resides in Pittsburgh, Pennsylvania. As the head of the data team, he executed electronic data interchange agreements that represented that

[9] Mr. Russo acknowledged his Connecticut residence in a late 2019 in the course of litigation relating to his departure from Anthem. *See* Answer ¶ 5, Dkt. No. 36, *Anthem, Inc. v. Marc Russo*, 1:19-cv-04312-JRS-MPB (S.D. Ind.) (Nov. 14, 2019).

Anthem would "research and correct" discrepancies between previously submitted diagnosis data and chart review results. *See id*. ¶¶ 79-82.[10]

- Former director of regulatory compliance for Anthem's Medicare business unit. Public records show that this witness resides in California. As another member of Anthem's Medicare "policy committee," she was among the executives assigned responsibility in Anthem's 2015 internal compliance plan for, as relevant here, the accuracy of the "risk adjustment diagnosis data [submitted] to CMS." *Id*. ¶ 150.

By contrast, the witnesses Anthem has identified in Ohio consist mainly of lower-level operational staff. While those employees may have played a role in carrying out the policies created by the executives identified above, their testimony will be less central because this case focuses on what decision-makers at Anthem knew and what choices they made.

Put simply, it is of little import how many staff-level witnesses from Ohio Anthem can list in its brief. Instead, what matters for § 1404(b) purposes is the materiality of the witnesses' testimony. *See Tianhai Lace*, 2017 WL 4712632, at *3-4 (considering the role of potential witnesses in proving elements of a claim to determine their importance in the case); *Herbert Ltd. P'ship v. Elec. Arts Inc.*, 325 F. Supp. 2d 282, 286 (S.D.N.Y. 2004) ("When assessing the convenience of witnesses, a court does not merely tally the number of witnesses who reside in the current forum in comparison to the number located in the proposed transferee forum; Instead, the court must qualitatively evaluate the materiality of the testimony that the witnesses may provide."); *accord Dwyer*, 853 F. Supp. at 693. Here, it will be the senior executives identified by the Government, rather than the staff-level witnesses identified by Anthem, who can speak to FCA elements like scienter and materiality. For those witnesses, as well as the New York-based witnesses and the CMS witnesses in Maryland, this District is at least equally convenient as, and perhaps more convenient than, the Southern District of Ohio.

[10] During the course of discovery and trial, the Government may decide to depose or call other Anthem witnesses, including, for example, one or more high-level executives at the company's headquarters in Indianapolis, Indiana.

Notably, three of the witnesses the Government has identified above are no longer Anthem employees, and their convenience is given more weight. *It's a 10*, 718 F. Supp. 2d at 336. Two of those witnesses, moreover, reside in Connecticut, which is indisputably within this Court's subpoena power and from where it is "easier [] to travel to New York than to [Ohio]," *Starr Indemn.*, 324 F. Supp. 3d at 439. This by itself weighs against transfer. *Id.; see also, e.g.*, *U.S. Commodity Futures Trading Com'n v. Wilson*, 27 F. Supp. 3d 517, 536 (S.D.N.Y. 2014).[11]

By contrast, Anthem has proffered potential witnesses who are apparently still its own employees. But because presumably it can ensure its own employees will be produced, their location is less significant. *See Hawley v. Accor N. Am., Inc.*, 552 F. Supp. 2d 256, 260 (D. Conn. 2008). That is especially so in this case, which involves the national practices of a large, nationwide business with witnesses throughout the country.

Finally, given the strong connections to this District and the absence of connections to the Southern District of Ohio (including the absence of key witnesses there), Anthem's heavy reliance on *United States v. Nature's Farm Prod., Inc.*, 00 Civ. 6593 (SHS), 2004 WL 1077968 (S.D.N.Y. May 13, 2004), *see* Def. Br. at 28-35, is wholly misplaced. In *Nature's Farm*, the court found that the key events of a fraudulent scheme had allegedly occurred in California; the two natural person defendants resided there; and the corporate defendant was headquartered there. *Id*. at *4-5. The *Nature's Farm* court concluded that "the facts giving rise to the litigation bear little material connection to the [plaintiff's] chosen forum [in New York]." *Id*. at *3.

Here, by contrast, Anthem's Medicare business not only engaged in the misconduct alleged in this District, but also made misrepresentations in furtherance of the fraud to non-party

[11] Section 3731(a) of the FCA provides for nationwide service of process. In the Government's view — and the view of the majority of courts to address the issue — this provision empowers a trial court to issue subpoenas to witnesses throughout the United States. *See, e.g.*, *U.S. ex rel. Lutz v. Berkeley Heartlab, Inc.*, No. CV 9:14-230-RMG, 2017 WL 5624254, at *3 (D.S.C. Nov. 21, 2017) (providing overview and explaining majority view).

witnesses at Weill-Cornell. *See* Am. Compl. ¶¶ 117–19. The connection this District has to the allegations and claims at issue therefore gives substantial weight to the Government's choice to bring this case here. *See Starr Indem.*, 324 F. Supp. 3d at 433. Likewise, the allegations in the amended complaint squarely refute Anthem's erroneous claim that "***every single witness*** … will need to travel [here] from some other location." Def. Br. at 29 (emphasis in original). Not so — for example, both the Anthem regional vice president at its New York office and the staff at Weill-Cornell to whom she made misrepresentations are in the New York area. Furthermore, the proposed transferee district is home to no parties, none of the most crucial witnesses, and (based on the Government's current understanding of the fraudulent scheme) is not the location where any of the principal events relating to the fraud occurred.

Nature's Farm is therefore clearly distinguishable and inapposite. Anthem, in short, has fallen well short of showing – let alone making a "clear and convincing" showing – that the locus of operative facts or the convenience of witnesses favors transfer under § 1404(b).

D. The Other § 1404(b) Factors Likewise Do Not Favor Transfer

Location of documents. Because we live in a "technological age" with "widespread use of, among other things, electronic document production," *Tlapanco v. Elges*, 207 F. Supp. 3d 324, 331 (S.D.N.Y. 2016), the location of documents is generally insignificant. Courts therefore give "little weight" to this factor "unless [the movant] makes a detailed showing of the burden it would incur absent transfer." *Starr Indem.*, 324 F. Supp. 3d at 441. Anthem's presentation on this score is not detailed, *see* Def. Br. 31, and instead rests on the same incorrect premise as its argument about witnesses: that because the case is essentially about the actions of low- and mid-level employees in Columbus (it is not), hardcopy records of those employees will be most relevant (they will not be). Thus, even if Anthem had demonstrated that producing any such records would be significantly burdensome, this factor would not support transfer, because those

records (while potentially relevant) are not the most salient ones with respect to the Government's allegations in this case.

Additional factors. Anthem claims that several of the § 1404(b) factors are neutral. *See* Def. Br. 32-33. As noted above, however, the case law instructs that neutral factors weigh *against* transfer. *See, e.g.*, *Casper Sleep*, 2019 WL 4727496 at *7. First, with regards to the ability to compel unwilling witnesses, the Government has already pointed out that two non-party former high-level executives of Anthem are unquestionably within this Court's regular subpoena power. *See supra* at 24–25. Second, the Government agrees there is no meaningful distinction between the parties' means. Third, although the Government agrees that federal courts throughout the country are familiar with the FCA, the parties — and this Court — have already invested significant time litigating this case in this District. The Government was compelled to litigate a subpoena enforcement proceeding here, *see supra* at 9 n.3 (discussing *United States v. Anthem Inc.*, 18 Misc. 379 (GBD)(KMF)), and the parties have now submitted multiple filings pursuant to Rules 12(b)(6) and 12(f). While it is true that Anthem promptly stated its intention to seek to transfer the case, *see* ECF No. 15, it would be inefficient to transfer it now: although it is at an early stage, the case will have been pending for more than seven months by the time Anthem's threshold motions are fully briefed. *See, e.g.*, *Khing v. Nay Lin*, 14 CV 4004 SJ RLM, 2015 WL 4523238, at *2 (E.D.N.Y. July 27, 2015) (denying motion to transfer to avoid delay).

* * *

Considering the Government's allegations in full, Anthem has fallen well short of the "clear and convincing" showing it must make to overcome the Government's original choice of venue and transfer this matter. Accordingly, the Court should deny Anthem's transfer motion.[12]

[12] Anthem also suggests that the Government's unopposed motion to transfer in the *Poehling* case somehow supports its transfer request. This is highly misleading because, in *Poehling*, the

POINT II

THE AMENDED COMPLAINT SUFFICIENTLY ALLEGES THE MATERIALITY OF ANTHEM'S FALSE RISK ADJUSTMENT ATTESTATIONS

Anthem does not contest that the Government has sufficiently alleged that the risk adjustment attestations Anthem submitted to CMS were false because Anthem attested that the diagnostic data that it had submitted for payment was accurate and truthful even though it was in possession of information showing that many of the diagnoses were in fact inaccurate and untruthful. Anthem also does not challenge the sufficiency of the Government's allegations that Anthem "knowingly" submitted these false attestations.[13] Anthem's only argument is that the Government did not sufficiently allege that its knowing submission of false attestations about the accuracy and truthfulness of its data was "material," that is, had "a natural tendency to influence, or [was] capable of influencing, the payment or receipt of money" by CMS. 31 U.S.C. § 3729(b)(4) (FCA's definition of the term "material").

The Supreme Court's *Escobar* decision provides a framework for "evaluating materiality" under the FCA. *See* 136 S. Ct. at 2002-04. In accordance with that framework, the amended complaint presents detailed factual allegations that demonstrate the materiality of Anthem's false attestations. *See supra* at 10-11. Specifically, the amended complaint describes how those false attestations "had a direct and foreseeable impact" by "caus[ing] CMS to … disburse reconciliation payments to Anthem." Am. Compl. ¶¶ 155–157. The amended

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Government sought transfer, with the *qui tam* relator's consent, principally because that case appeared to be legally and factually related to an earlier-filed *qui tam* action – *Swoben* – already pending in California, and the Government planned to seek to have the cases related or consolidated after transfer. Further, unlike here, the original district chosen by *Poehling* relator was home to none of the key witnesses. The *Poehling* transfer motion, thus, has no bearing here.

[13] Anthem appears to quarrel with the FCA's scienter requirement by suggesting that the Government must allege that Anthem had actual knowledge that the diagnostic data it submitted to CMS was inaccurate and untruthful. This cannot be squared with the statutory text, as the FCA defines the required scienter to include "deliberate ignorance" and "reckless disregard" as well as actual knowledge. *See* 31 U.S.C. § 3729(b)(1). In any event, the amended complaint alleges that Anthem "knowingly" violated the FCA, *see* Am. Compl. ¶¶ 161, 165, and details how it had actual knowledge of falsity of its attestations or recklessly disregarded this fact, *id*. ¶¶ 153–57.

complaint also expressly avers that CMS "would have taken appropriate actions" to recover "payments to which [Anthem] was not entitled" by several possible means if it "had known that [the] attestation was false." *Id.* ¶¶ 162, 167. Together, these allegations show that Anthem's false attestations were "sufficiently important to influence the behavior of [CMS]" and, therefore, material under the framework set forth by *Escobar*. *See U.S. ex rel. Escobar v. Universal Health Servcs.*, 842 F.3d 103, 109 (1st Cir. 2016) (*Escobar II*); *accord U.S. ex rel. Grubea v. Rosicki, Rosicki & Assocs., P.C.*, 318 F. Supp. 3d 680, 702 (S.D.N.Y. 2018).

Anthem does not seriously attempt to address these allegations under the appropriate legal framework. At the outset, Anthem fails to follow the "holistic approach" to materiality that courts have developed in the wake of *Escobar*. Instead, it focuses exclusively on a single issue — CMS's payments to MAOs despite its alleged general knowledge about the MAOs' chart review programs. This singular focus defies *Escobar*'s admonition that no single materiality factor is "automatically dispositive." This is especially true where, as here, CMS's alleged general knowledge about chart reviews is irrelevant to materiality. Further, when Anthem purports to analyze CMS's response, it engages in a sleight-of-hand — rather than addressing actions that the amended complaint alleges CMS "***would have taken***" if it had known about the false attestations, Am. Compl. ¶ 162 (emphasis added), Anthem pretends that the Government only alleges "actions that CMS ***might have taken***" or "***had the right to***" take, *see* Def. Br. at 44 (emphasis added). In addition, Anthem purports to dispute the factual allegation that CMS did not know Anthem's attestations were false. However, neither attacking a strawman nor creating factual disputes at the pleading stage entitles Anthem to dismissal. *See infra* Pt. II.C.

Finally, Anthem also relies extensively on *U.S. ex rel. Poehling v. UnitedHealth Group*, 2018 WL 1363487. *See* Def. Br. at 38–40, 43–45. However, Anthem cites only one section of *Poehling*'s materiality analysis and ignores sections that are at odds with its position, *see* 2018 WL 1363487, at *12. Read in its entirety, *Poehling* shows that the allegations here regarding CMS's lack of actual knowledge of Anthem's fraud and what actions CMS would

have taken if it had actual knowledge sufficiently plead materiality. *See infra* Pt. II.D.

A. Anthem Ignores the "Holistic Approach" for Assessing Materiality under *Escobar*

In *Escobar*, the Supreme Court held that "a misrepresentation of compliance … must be material to the Government's payment decision in order to be actionable under the [FCA]." *Escobar* at 2002. *Escobar* next delineated a framework for assessing materiality that focuses on "the effect on the likely or actual behavior of the recipient of the misrepresentation." *Id*. at 2002. The Supreme Court then provided several examples to illustrate what types of evidence constitute "proof of materiality" under this framework. *Id*. at 2003. Finally, *Escobar* rejected the suggestion that materiality should depend solely on whether "the Government would have the option to decline to pay." *Id*. at 2003.

After the Supreme Court decided Escobar in 2016, lower courts have developed a "holistic approach" to apply Escobar's materiality framework and specific materiality factors. *See generally Escobar II*, 842 F.3d at 109; *United States v. Brookdale Senior Living Cmtys., Inc.*, 892 F.3d 822, 831 (6th Cir. 2018); *U.S. ex rel. Lemon v. Nurses To Go, Inc*., 924 F.3d 155, 162 (5th Cir. 2019); *U.S. ex rel. Lacey v. Visiting Nurses Svcs. of NY*, 14 Civ. 5739 (AJN), 2017 WL 5515860, at *6 (S.D.N.Y. Sept. 26, 2017); *U.S. ex rel. Raffington v. Bon Secours Health Sys*., 405 F. Supp. 3d 549, 569 (S.D.N.Y. 2019). Under this "holistic" approach, courts examine the materiality allegations in their totality based on the three factors enumerated in *Escobar* — 1) whether the misrepresentation went to the "essence of the bargain" or, conversely, was "minor or insubstantial," *Escobar* at 2003; 2) whether the misrepresentation relates to a requirement designated as "a condition of payment," *id*.; and 3) whether the Government takes action when it becomes aware of violations of the requirement about which defendant made misrepresentations, *id*. at 2003–4. *See Escobar II*, 842 F.3d at 109; *Lemon*, 924.3d at 161–62. Finally, courts following the "holistic approach" are also mindful of Escobar's admonition that no single

materiality factor is "automatically dispositive," *Escobar* at 2003. *See Brookdale Senior Living*, 892 F.3d at 834; *accord Lemon*, 924 F.3d at 162 ("no one factor is dispositive"); *see also* 26 R. Lord, WILLISTON ON CONTRACTS § 69:12 (4th ed. 2003) (noting that materiality is "intensely fact-dependent" and "cannot be determined in a vacuum").

Here, Anthem's brief fails to cite, let alone engage with, the circuit and district court cases that apply the holistic approach to materiality. Anthem also effectively asks this Court to reject the prevailing standard for assessing materiality by ignoring most of the Government's materiality allegations. Further, by focusing its arguments exclusively on the issue of CMS conduct in light of its alleged general awareness about chart reviews by MAOs, Anthem misconstrues *Escobar*.

As the Supreme Court explained, an agency's reaction to fraudulent conduct or noncompliance can be relevant to materiality if the agency has actual knowledge of the fraud or noncompliance. *See Escobar* at 2003–4. Here, the amended complaint alleges that CMS did not have actual knowledge that Anthem's risk adjustment attestations were false. *See* Am. Compl. ¶¶ 155–67. Accordingly, any general awareness CMS had regarding chart reviews is irrelevant and, in any event, not "dispositive" under *Escobar*. *See* 136 S. Ct. at 2003. Because Anthem offers no basis for its proposed approach to materiality, the Court should reject Anthem's suggestions and, instead, follow the "holistic approach" and examine what the amended complaint alleges regarding what CMS would have done it if had actual knowledge of the fraud.

B. Under the "Holistic Approach," the Amended Complaint Plausibly Allege That Anthem's False Attestations Would Have Affected CMS's Payment Decisions

As summarized above, the amended complaint offers a plethora of allegations as to the materiality of Anthem's false attestations. *See supra* at 10-11. Analyzed according to the three *Escobar* factors, these allegations plausibly allege that the false attestations had an "effect on the likely or actual behavior of the recipient of the misrepresentation," *i.e.*, CMS. *Escobar* at

2002; *see also U.S. ex rel. Hussain v. CDM Smith, Inc.*, 14 Civ. 9107 (JPO), 2017 WL 4326523, at *8 (S.D.N.Y. Sept. 27, 2017) (denying motion to dismiss because it was "plausible" that misleading claim "would have affected the government's payment decision").

"Essence of the Bargain." *Escobar* drew a distinction between material requirements that go "to the very essence of the bargain" and immaterial ones "where noncompliance is minor or insubstantial." *See Escobar* at 2003. Following *Escobar*, courts have interpreted this distinction to turn on facts such as whether the misrepresentation had a direct influence on government payment, *see Lemon*, 924 F.3d at 163; *U.S. ex rel. Streck v. Bristol-Myers Squibb Co.*, CV 13-7547, 2018 WL 6300578, at *18 (E.D. Pa. Nov. 29, 2018); whether the requirement at issue is one that "the government has consistently emphasized in its guidance regarding [program requirements]," *see Brookdale Senior Living*, 892 F.3d at 836–37; and whether the Government would alter its payment decision or seek recovery if it knew of the misrepresentation or noncompliance, *see United States v. Spectrum Painting Corp.*, 2020 WL 5026815, at *12 (S.D.N.Y. Aug. 25 , 2020).

Here, the amended complaint makes clear that Anthem's false attestation undermined the "very essence of the bargain" between the Government and Anthem because compliance with rules that directly affect the accuracy of payments goes to the core of Medicare Part C. As in *Lemon* and *Streck*, the amended complaint alleges that Anthem's "ongoing submission of the false annual attestations [] had a direct and foreseeable [financial] impact on CMS." *Id.* ¶ 157. Specifically, the false attestations "caused CMS to … disburse reconciliation payments to Anthem." *Id.* The false attestations also caused the reconciliation payments to be inflated because Anthem did not withdraw the unsupported diagnosis codes and falsely attested to the accuracy and truthfulness of those codes. *Id.* ¶¶ 49, 154.

Further, as in *Brookdale Senior Living*, the Government alleges here that CMS

"repeatedly notified MAOs since June 2000" regarding the importance of their data accuracy attestations to the integrity of the Medicare Part C's risk adjustment system. *See* Am. Compl. ¶ 89. Finally, the amended complaint clearly states that CMS "would have taken appropriate actions" to recover "payments to which [Anthem] was not entitled" by various means if it "had known that [the] attestation was false." *Id*. ¶¶ 162, 167.

These factual allegations show that the attestation requirement went to the very "essence of the bargain" between Anthem and CMS. *See Lemon*, 924 F.3d at 163; *Brookdale Senior Living*, 892 F.3d at 836–37; *Streck*, 2018 WL 6300578, at *18; *see generally Swoben*, 848 F.3d at 1168 (recognizing that the attestation requirement is "a bulwark against fraud"). Indeed, even *Poehling* – on which Anthem relies for most of its materiality arguments – specifically concluded that the risk adjustment attestations "go to the 'essence of the bargain' between CMS and [MAOs]" under Medicare Part C. *See* 2018 WL 1363487, at *9.

Express Condition of Payment. *Escobar* also held that although "not automatically dispositive," "the Government's decision to expressly identify a provision as a condition of payment is" nonetheless "relevant to the materiality inquiry." *Escobar* at 2003. Following *Escobar*, lower courts have clarified that the key to applying this materiality factor is whether the regulation or contractual provision designating a requirement as a condition of payment is central to, or merely peripheral to, the overall regulatory or contractual scheme.

In *Escobar II*, for example, the First Circuit determined that Massachusetts Medicaid's designation of mental health providers' "compliance with licensing and professionalism" rules as a condition of payment was "central" to the Medicaid program and, therefore, material. *See* 842 F.3d at 111-12. This was because the designation by Medicaid was embedded in "a series of regulations … in place to ensure" proper qualification of providers rendering mental health care to Medicaid patients. *Id*. Similarly, in *Lacey*, another court in this

District found that Medicare designation of "plan of care" compliance as a condition of payment, along with "CMS's guidance and manuals" emphasizing that requirement, demonstrated materiality under *Escobar*. *See* 2017 WL 5515860, at *9-10. Specifically, *Lacey* held that the volume of government instructions showed that following the "plan of care" was "a central component of the Medicare program." *Id*.

Here, the Government alleges that CMS's designation of the risk adjustment attestation as a condition of payment is central to the integrity of the Medicare Part C risk adjustment payment system. *See* Am. Compl. ¶¶ 83–89. The amended complaint also details how the attestation was not a minor requirement as to which the agency paid little attention. Rather, CMS included the attestation in its Part C regulations and all of its Part C contracts with all MAOs. It also discussed the requirement in its Part C manuals and training documents focused on MAOs' compliance with their obligation to ensure data accuracy. *See id*. ¶¶ 45–82. Further, Anthem's internal policy and communications to providers show that it understood the import of the attestation requirement. *See id*. ¶¶ 86, 90. Accordingly, as in *Escobar II* and *Lacey*, the allegations in this case regarding the regulatory designation of the attestation of data accuracy as a condition of payment are sufficient to show the materiality of Anthem's false attestations. See *Escobar II*, 842 F.3d at 111-12; *Lacey*, 2017 WL 5515860, at *9-10.

The Government's Reaction to Noncompliance. In *Escobar*, the Supreme Court recognized that how the Government reacts to violations of a requirement when it has actual knowledge of noncompliance can be "very strong evidence" of whether that requirement is material. *See Escobar* at 2003. Thus, evidence that the Government "consistently refuses to pay claims in the mine run of cases based on noncompliance with [a] . . . requirement" supports materiality. *Id*. By contrast, it can be "strong evidence" of a lack of materiality "if the Government regularly pays a particular type of claim in full despite actual knowledge that certain

requirements were violated, and has signaled no change in position[.]" *Id.* at 2003-04.

In applying *Escobar*, courts recognize that the evidence of the Government's enforcement of a given requirement is not confined to a binary choice of payment versus refusal to pay. Instead, such efforts can take other forms such as criminal and civil enforcement actions, *Lemon*, 924 F.3d at 164; *U.S. ex rel. Arnstein v. Teva Pharm.*, 13 CIV. 3702 (CM), 2019 WL 1245656, at *29 (S.D.N.Y. Feb. 27, 2019); *U.S. ex rel. Wood v. Allergan, Inc.*, 246 F. Supp. 3d 772, 818 (S.D.N.Y. 2017) *rev'd and remanded on other grounds*, 899 F.3d 163 (2d Cir. 2018); imposing corrective action and other remedial measures, *U.S. ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1021–22 (9th Cir. 2018)*; Arnstein*, 2019 WL 1245656, at *30; and audits and administrative recoupment, *see Raffington*, 405 F. Supp. 3d at 569; *Rose*, 909 F.3d at 1021–22. As the Ninth Circuit explained in *Rose*, a record of the Government having pursued enforcement actions and obtained recovery for past violations of a program requirement indicates that the Government is "not prepared to pay claims 'in full' despite knowing of violations [of the requirement]." 909 F.3d at 1021–22 (noting that Department of Education "reached settlement agreements with 22 additional schools," which yielded "more than $59 million in payments" recouped, based on violations of a ban on incentive compensation); *accord Lemon*, 924 F.3d at 162 ("criminal and civil enforcement actions" for similar noncompliance "raised a reasonable inference that the Government would deny payment if it knew about Defendants' alleged violations").

Here, the amended complaint unequivocally states that "CMS would have taken appropriate action" to ensure that Anthem did not retain payments to which it was not entitled if "CMS had known that Anthem's [risk adjustment] attestation was false." *See* Am Compl. ¶¶ 162, 167. This also comports with the Government's extensive allegations about its efforts to enforce the MAOs' obligation to ensure the accuracy of their diagnosis data submission to CMS.

As in *Lemon*, *Arnstein*, *Allergan*, the amended complaint here offers examples of the civil actions that the Government has pursued against MAOs like Anthem when it became aware of violations of the data accuracy requirement as well as the recoveries obtained on CMS's behalf. *See* Am. Compl. ¶¶ 98–100. Further, as in *Rose* and *Arnstein*, the Government also has described how an MAO was required to take forward-looking corrective actions pursuant to a "Corporate Integrity Agreement" after settling past violations of the data accuracy requirement. *See id*. ¶ 100. The allegations here regarding the Government's past enforcement efforts, therefore, demonstrate that Anthem's false attestations of compliance with the data accuracy requirement were material. *See Arnstein*, 2019 WL 1245656, at *29-30 (a jury could reasonably find that defendants' false certification of compliance with the Anti-Kickback Statute was material based on evidence of the Government pursuing FCA claims against another defendant for similar conduct and Corporate Integrity Agreements that addressed similar conduct); *Allergan*, 246 F. Supp. 3d at 818 (same).

C. Anthem Mischaracterizes Allegations Regarding the Actions That CMS Would Have Taken If It Had Known of Anthem's False Attestations and Improperly Seeks to Dispute Factual Allegations as to CMS's Lack of Knowledge

As noted above, Anthem directs its materiality arguments exclusively to the issue of how CMS has reacted to MAOs' false attestations of data accuracy. Specifically, Anthem wrongly claims that the Government has not plausibly pled the materiality of the false attestations because the amended complaint "alleges ***only*** that CMS ***had the right to*** deny payment to Anthem" or that CMS "***might have done so***." *See* Def. Br. at 44-45 (emphasis added). Anthem also incorrectly – and improperly – suggests that CMS had actual notice of Anthem's false attestations "long before [the Government] filed this suit." *Id*. at 46. In both cases, Anthem is trying to mischaracterize the amended complaint with a sleight-of-hand.

In the first regard, the Government readily acknowledges that in *Escobar*, the

Supreme Court rejected defining materiality solely in terms of whether the Government is entitled to deny payment based on a misrepresentation. Indeed, if the materiality allegations in this case consisted *only* of statements about what CMS is entitled to do or might have done, that would not be sufficient under *Escobar*.

But that is not the case here. Instead, in addition to the other *Escobar* factors discussed above, the amended complaint expressly alleges that if CMS had actual knowledge of Anthem's false attestations, it "***would have taken*** appropriate actions" – such as administrative recoupment, adjusting reconciliation payments, or recovering damages under the FCA – to ensure that Anthem does not receive or keep ill-begotten gains from Medicare. *See* Am Compl. ¶¶ 162, 167. Further, contrary to Anthem's presentation, the amended complaint alleges numerous facts relevant to the actions CMS would have taken if it had actual knowledge of Anthem's fraud. For example, the amended complaint describes how the Government has repeatedly recovered overpayments for CMS from MAOs that knowingly violated their obligation to ensure data accuracy. *See id*. ¶¶ 98–102. The Government's ability to obtain those recoveries reflects the fact that CMS has placed the risk adjustment data attestation requirement at the core of a full range of regulations, contractual requirements, guidance, and training promulgated to ensure risk adjustment data accuracy. *See id*. ¶¶ 83–84, 45–56, 58–65. As another Court in this District recently held, these types of "specific factual allegations" plausibly support the Government's statement regarding the actions an agency "would have" taken if it had known about the fraud. *See Spectrum Painting*, 2020 WL 5026815, at *12–13. Thus, Anthem's claim that the amended complaint "alleges only that CMS had the right to deny payment" or "might have done so" is simply untrue. *See* Def. Br. at 44-45

Anthem's brief also suggests that CMS was on notice of the false attestations well before the filing of this case, in direct contradiction to what is alleged in the amended complaint.

See id. at 46-47. This is both wrong and procedurally improper. At the outset, Anthem's misleading assertion is premised on a false equivalence between CMS being generally aware that some MAOs conduct so-called one-sided chart reviews and CMS having actual knowledge that the risk adjustment attestations submitted by Anthem were false because Anthem attested to the accuracy of its diagnosis data when it possessed information that many of those diagnoses were in fact inaccurate. However, as courts have recognized, this false equivalence does not comport with the very language of Anthem's attestations. *See Swoben*, 848 F.3d at 1175 ("By holding that one-sided [chart] review *can* result in false [attestations], we do not suggest that they necessarily always do") (emphasis in original).

Specifically, the claims at issue allege that Anthem violated the FCA by seeking and obtaining payments from CMS based on false attestations. *See* Am. Compl. ¶¶ 158–166. And the attestations say absolutely nothing about chart review or how or why Anthem may have had "knowledge, information or belief" that its diagnosis data submissions were inaccurate; instead, the attestation focuses on whether, at the time it submitted the attestation, Anthem had such "knowledge, information or belief." *See id*. ¶ 155, Ex. 9.

Indeed, by making false attestations and not disclosing that it had information showing that many diagnosis codes it had submitted were inaccurate, Anthem precluded CMS from having the kind of actual knowledge that matters for materiality purposes. In other words, Anthem is suggesting that whenever CMS had suspicions that an MAO may be falsely attesting to the accuracy of some proportion of its diagnosis data, CMS must stop all payments in order to satisfy the materiality standard under *Escobar*. But that is not the law — "[a]s *Escobar* makes clear, the misrepresentation does not have to be so grievous that the government would have completely denied payment upon discovering the truth — it is enough that the omission would have affected the government's payment decision." *CDM Smith, Inc*., 2017 WL 4326523, at *8.

Instead, CMS could seek to determine whether the attestations are false by, as it did so here, coordinating with the Department of Justice or the Office of Inspector General for the Department of Health and Human Services to investigate the matter and, if appropriate, identify and recover the specific overpayments.[14]

In any event, Anthem's attempt to impute actual notice of the false attestations to CMS conflicts with the well-established Rule 12(b)(6) standard. On a motion to dismiss for failure to state a claim, the Court must "accept[] all factual allegations in the complaint and draw[] all reasonable inferences in plaintiff's favor." *ATSI Commc'ns, Inc. v. Shaar Fund, Ltd.*, 493 F.3d 87, 98 (2d Cir. 2007). Here, the Government alleges, *inter alia*, that Anthem's false attestations caused CMS "to disburse reconciliation payments to Anthem." Am. Compl. ¶ 157. It is therefore plainly improper for Anthem to dispute, at this stage, the Government's allegation regarding CMS's lack of knowledge of false attestations.

D. Anthem Ignores Key Parts of *Poehling*'s Materiality Analysis That Supports the Government's Position

Anthem pins most of its materiality arguments on the Central District of California's *Poehling* decision. *See* Def. Br. at 38–41, 43–45. According to Anthem, *Poehling* makes clear that the materiality requirement under *Escobar* can only be satisfied if the Government specifically alleges that CMS "would have refused to make risk adjustment payments to Anthem" if it had knowledge of the false attestations. *Id*. at 41–44.

As a starting point, and to state the obvious, *Poheling* – an out-of-circuit district court decision – is not binding on this Court. A careful review of *Poehling*, moreover, refutes how

[14] For example, it is possible that an MAO may not have had knowledge of the frequency of inaccuracies in its diagnosis data submissions or may have had processes outside of chart review to validate its diagnosis data submissions. Here, however, the amended complaint alleges that Anthem's senior executives *did* know about the inaccuracies in their diagnosis data submissions and *did not* validate previously-submitted codes using chart review results or otherwise.

Anthem has characterized its import for this case. In *Poehling*, the Government alleged "reverse false claims" violations against UnitedHealth and affiliated defendants for failing to delete inaccurate diagnosis codes and direct false claims violations for making false attestation claims. *See Poehling*, 2018 WL 1363487, at *6. When the defendants sought dismissal under *Escobar*, the district court first determined that their attestations were "assurances that CMS could rely on the data [d]efendants submitted" and, therefore, did "go to the 'essence of the bargain" between defendants and CMS. *Id*. at *9.[15]

The district court nonetheless concluded, however, that the attestation claims did not satisfy *Escobar* because the Government did not allege "that the [a]ttestations are material to the Government's course of action, specifically, [its] payment decision." 2018 WL 1363487, at *10 (quoting *Escobar* at 2001, 2002) (internal alterations omitted). As *Poehling* makes clear, this was not because the court found an inherent flaw with the theory that the risk adjustment attestations are material. *See id*. at 9-10. Indeed, the district court recognized a "logical" link between the truth or falsity of the attestations and the accuracy, *vel non*, of diagnosis codes — namely, that "false [a]ttestations were one of the ways in which [d]efendants concealed their fraudulent scheme from the Government." *Id*. at 10.

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[15] Anthem also relies, albeit to a lesser extent, on the district court's decision on remand in the *Swoben* case. *See* Def. Br. at 38-39. Like *Poehling*, the district court decision in *Swoben* is also not controlling. In any event, that decision incorrectly concluded that the Government must allege that CMS would have refused to make payments if it had known about the defendants' chart review practices. This not only is directly at odds with decisions from this District like *CDM Smith, Inc.*, but also conflicts with *Escobar*'s holding that materiality focuses on an agency's conduct when it has actual knowledge of the fraud at issue, *i.e.*, the false attestations.

In addition, it is worth noting that Anthem presents a misleading account of the resolution in the *Swoben* case. The voluntary dismissal noted in Anthem's brief, *see* Def. Br. at 39, resulted from a settlement that included the payment of damages for the defendants' failure to delete the diagnoses that its chart reviews showed were inaccurate. In other words, the Government obtained recovery for CMS even in the face of the adverse ruling.

Rather, the materiality problem was a pleading issue — the district court could not find in the Government's complaint "the key allegation that the [a]ttestations have a direct impact on CMS' risk adjustment payments." *Id*. at 9. To overcome this pleading hurdle, *Poehling* further explained, the Government needed to add allegations regarding the attestations that "suggest they are likely to influence the payment of money." *Id*.

Notably, the materiality analysis in *Poehling* did not end here. Instead, the district court also considered an argument that Anthem has advanced here, *see* Def. Br. at 41-44 — that because CMS had an "awareness of [defendants'] 'one-way' chart reviews," the Government cannot therefore demonstrate materiality. *See* 2018 WL 1363487, at *12. *Poehling* made short shrift of this argument. It held that even if the "Government may have had general suspicions" about defendants' compliance "with requirements for submitting diagnostic data," those suspicions were obscured due to defendants' "allegedly fraudulent representations." *Id*.

Put simply, the *Poehling* court did not hold – as Anthem suggests – that false attestations are only material if CMS immediately starts to refuse to make payments upon becoming aware that the attestations were false. Instead, *Poehling* clearly shows that the Government can satisfy *Escobar* by alleging, first, that false attestations of data accuracy "have a direct impact on CMS' risk adjustment payments," and, second, that the attestations "are likely to influence the payment of money." *See* 2018 WL 1363487, at *9. Here, the amended complaint makes both allegations. *See* Am. Compl. ¶ 157 (Anthem's "ongoing submission of the false annual attestations to CMS had a direct and foreseeable impact on CMS," including by "caus[ing] CMS … to disburse reconciliation payments to Anthem"), ¶ 162 ("If CMS had known that Anthem's attestation was false," CMS "would have taken appropriate actions to ensure that Anthem did not receive or retain risk adjustment payments to which it was not entitled"). Likewise, *Poehling* does not support Anthem's argument that any awareness CMS had regarding

Anthem's one-sided chart review translates to actual notice of false attestations. As Poehling recognized, the making of "false [a]ttestations [is] one of the ways" by which defendants like Anthem can "conceal[] their fraudulent scheme from the Government," even where the Government may have some reason to suspect an MAO's non-compliance with the data accuracy requirement. 2018 WL 1363487, at *10.[16]

POINT III

ANTHEM'S REQUEST TO STRIKE PARAGRAPHS 99 THROUGH 105 OF THE AMENDED COMPLAINT SHOULD BE DENIED.

As Anthem recognizes, motions to strike are "generally disfavored" and should be granted only when "the matter asserted clearly has no bearing on the issue in dispute." *Correction Officers Benevolent Ass'n v. Kralik*, 226 F.R.D. 175, 177 (S.D.N.Y. 2005); *see also Lipsky*, 551 F.2d at 893 (a motion to strike allegations from a pleading should be granted only where "no evidence in support of the allegation would be admissible."). Accordingly, to prevail on a motion to strike, a defendant "must show that (1) no evidence in support of the allegation

[16] In the background section of its brief, Anthem devotes numerous pages to disputes and litigation over how the statutory concept of "actuarial equivalence" – which relates to the average payments Medicare expects to make for a given beneficiary under traditional Medicare and under Medicare Part C, *see* 42 U.S.C. § 1395w-23(a)(1)(C)(i) – applies to the risk adjustment payment system. *See* Def. Br. at 12–16, 19–22. In the argument section of its brief, however, Anthem makes no meaningful mention of actuarial equivalence, let alone draw any genuine connection between that concept and any aspect of its pending motion.

Because Anthem makes no argument about actuarial equivalence in support of its motion, and because Anthem cannot put forth such arguments for the first time in reply, *see DoubleLine Capital LP v. Odebrecht Finance, Ltd*., 323 F. Supp. 2d 393, 450 (S.D.N.Y. 2018) ("Defendants have waived the argument raised in their reply" for the first time); the Government will not devote space here to address this irrelevant issue, except to note that, as the Northern District of California recently held, *first*, actuarial equivalence does not shield Medicare Part C participants from FCA liability when they knowingly violate Part C's data accuracy requirement and does not require the Government to prove that a participant's fraud resulted in a specific difference between the "error rates" in the Part C risk adjustment data and the traditional Medicare data, *see U.S. ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1073 (N.D. Cal. 2020); and, *second*, there is no basis for believing that "CMS inevitably pays [MAOs] less .., than for traditional Medicare beneficiaries, thereby violating the 'actuarial equivalence' provision, *id*. at 1064–67.

would be admissible; (2) the allegations have no bearing on the relevant issues; and (3) permitting the allegations to stand would result in prejudice to the movant." *M'Baye v. World Boxing Ass'n*, 05 Civ. 9581, 2007 WL 844552, at *4 (S.D.N.Y. Mar. 21, 2007) (citing *Roe v. City of New York*, 151 F. Supp. 2d 495, 510 (S.D.N.Y. 2001)). The burden of making this showing is a "heavy" one, *Guzman v. News Corp.*, 09 Civ. 9323 (BSJ) (RLE), 2011 WL 13340378, at *3 (S.D.N.Y. April 26, 2011), and the court should not strike a portion of a pleading if there is "any possibility that the pleading could form the basis for admissible evidence." *Eskofot A/S v. E.I. Du Pont De Nemours & Co.*, 872 F. Supp. 81, (S.D.N.Y. 1995) (declining to strike portions of complaint because, although the court "view[ed] with skepticism" the plaintiff's explanation for why the corresponding evidence would be admissible, the issue would be "more easily determinable after adequate discovery" and it would thus be "improper" to strike the allegations at that stage).

Here, Anthem has fallen far short of making the requisite showing because, far from having no bearing on the issues to be decided in the case, the allegations Anthem seeks to strike are relevant to the materiality of Anthem's alleged conduct, as well as Anthem's knowledge of its duty to use chart review results to delete inaccurate diagnosis codes. *See Arnstein*, 12019 WL 1245656, at *30 (evidence of the Government's past efforts to "enforce[] the FCA against [firms] for similar behavior" is directly relevant to materiality); *U.S. ex rel. Tutante-Luster v. Broker Solutions, Inc.*, CV 19-1630 PSG (JPRx), 2019 WL 6972689, at *11 (C.D. Cal. July 8, 2019) (allegations about "instances in which the Government has either sanctioned or pursued legal allegations against various companies for similar violations" satisfied materiality requirement). Anthem's arguments to the contrary rely on inapplicable case law and mischaracterizations of the allegations at issue and should be rejected.

A. The Case Law Anthem Cites Regarding Prior Settlements with Defendants Is Inapplicable

Anthem first attempts to rely on case law involving prior settlements by defendants, which courts have held are inadmissible to show that the defendant in fact engaged in the conduct alleged and settled in those cases. *See* Def. Br. at 50-51. These cases are not relevant here because the Government is not citing prior settlements by Anthem or arguing that Anthem must have engaged in the alleged conduct simply because other entities settled similar allegations.

In *Lipsky*, the court considered a motion to strike allegations regarding a case previously brought by the Securities Exchange Commission against the defendant and a consent decree entered into in that case. The court held that the consent decree was "a consent judgment between a federal agency and a private corporation which is not the result of an actual adjudication of any of the issues," and thus could "not be used as evidence in subsequent litigation between that corporation and another party" to establish that the defendant committed the conduct alleged in the SEC case. 551 F.2d at 894-5. Because the SEC consent decree would not be admissible to show that the defendant engaged in the conduct alleged by the SEC, the court struck the pleadings regarding that action. The other cases Anthem cites reflect the same principle. *See, e.g.*, *Low v. Robb*, 11 Civ. 2321 (JPO), 2012 WL 173472, at *9 (S.D.N.Y. Jan. 20, 2012) (striking references to other disputes and lawsuits defendant was involved in, which plaintiff intended to show that defendant engaged in a similar "pattern of conduct" in other cases); *Gotlin v. Lederman*, 367 F. Supp. 2d 349 (E.D.N.Y. 2005), a*ff'd sub nom. Gotlin ex rel. Cty. of Richmond v. Lederman*, 483 F. App'x 583 (2d Cir. 2012) (striking allegations about settled enforcement actions against and government investigation of defendants that were intended to "reveal . . . unflattering things about" defendant's conduct in other contexts).

Those cases are, by their terms, inapplicable, because the Government has not made any allegations regarding prior suits against, or settlements by, Anthem, or implied that Anthem

is liable simply because other entities have settled similar allegations. It is simply not the case, moreover, that, as Anthem contends, "[t]he logic of those decisions applies with equal (if not greater) force to allegations regarding prior settlements or proceedings involving non-defendants." See Def. Br. at 51. *Lipsky* and its progeny found allegations about prior settlements by defendants improper precisely because those settlements could not be used to establish the culpability of those defendants—a rationale that is absent when cases against other defendants are cited for an entirely different purpose. Anthem has cited no case that supports the proposition that a prior settlement involving a different defendant is inadmissible for the purpose of showing that the Government has actively enforced the requirements at issue in the past, or that the defendant was aware of those efforts, and indeed the relevant case law in this Circuit and others is to the contrary. *See Teva*, 2019 WL 124565, at *30 (recognizing relevance of prior enforcement efforts to materiality); *Tutante-Luster*, 2019 WL 6972689, at *11 (same). To the extent Anthem attempts to suggest that a settlement agreement is always inadmissible and thus cannot be cited in a complaint for any purpose, moreover, that argument is directly at odds with Second Circuit precedent. *See, e.g.*, *Brady v. Wal–Mart Stores, Inc.*, 531 F.3d 127, 136 (2d Cir. 2008) ("A consent decree may properly be admitted to demonstrate that a defendant was aware of its legal obligations.").[17]

B. The Allegations at Issue Are Relevant and There Is No Basis To Strike Them

Anthem next argues that the allegations at issue should be stricken because they "are not relevant and are highly prejudicial." Def. Br. at 52. This argument also fails.

[17] Notably, Anthem does not even attempt to argue, nor could it, that its internal discussions regarding the Government's enforcement efforts – which form the basis for the allegations regarding Anthem's scienter in paragraphs 103 to 105 of the amended complaint – would not be admissible. *See supra* at 15 n.7 (noting Anthem's failure to address these allegations, despite the fact it ostensibly seeks to strike them). Accordingly, while ultimately irrelevant because Anthem's motion to strike fails in its entirety, Anthem's admissibility argument would not, even if meritorious, warrant striking paragraphs 103 through 105.

As discussed above, the allegations regarding the Government's prior enforcement efforts are relevant to the materiality of Anthem's conduct. *See Arnstein*, 2019 WL 124565, at *30, 34 (denying defendant's motion for summary judgment as to materiality of alleged violations because "Relators have introduced evidence that the Government pursues FCA cases against pharmaceutical companies based on [similar] violations"); *Tutante-Luster*, 2019 WL 6972689, at *11 (denying motion to dismiss as to materiality because the complaint "allege[d] several instances in which the Government has either sanctioned or pursued legal action against various companies for similar violations, to the tune of billions of dollars returned to the public fisc" and "[t]hat the Government cares enough to initiate significant enforcement actions weighs in favor of materiality").[18]

Anthem argues that these enforcement actions are not relevant because "two of the settlements do not involve chart review practices" and, while the other two do, they also "involved other business practices" which Anthem suggests "appear to have driven the settlements." Def. Br. at 52. As alleged in the complaint, each of the cited cases involved allegations that an MAO or healthcare provider knowingly submitted to CMS diagnoses that were not supported by the medical records, *see* Am. Compl. ¶¶ 99-102 — as Anthem is alleged to have done in this case. Further, as Anthem acknowledges, two of the cases involved allegations that MAOs like Anthem failed to ensure the accuracy of their risk adjustment data in relation to chart review programs — the very situation at issue here. *See id.* ¶¶ 99, 101. Anthem, therefore, has not come close to meeting its burden of showing that such allegations have "*no* bearing on the relevant issues" and "*no* evidence in support of" the allegations "would be admissible." *M'Baye*, 2007 WL 844552, at *4 (emphasis added).

[18] Anthem's argument that prior enforcement efforts are irrelevant to materiality is, as discussed above, based on an inappropriately narrow reading of *Escobar*. *See supra* at 31–32.

The prior government enforcement actions also are relevant because they factored into Anthem's internal discussions and, therefore, bear directly on the element of scienter. As alleged, internal communications show that compliance executives at Anthem's Medicare business unit discussed the Government's settlement with SCAN Health, which involved allegations that SCAN conducted chart review to identify new diagnoses to submit but failed to disclose that chart review results also indicated that some previously-submitted diagnosis codes might be invalid. *See* Am. Compl. ¶¶ 103-05. This allegation cuts against any effort by Anthem to disclaim awareness of its duty to use chart review results to delete inaccurate diagnoses codes.

Anthem disingenuously suggests that these allegations do not bear on scienter because "a general awareness of government oversight . . . falls far short of specific knowledge by Anthem that its own chart review program violated a particular CMS requirement." Def. Br. at 54. This borders on the frivolous. First, Anthem's internal discussions about specific enforcement actions involving the precise type of conduct at issue here involves more than "general awareness of government oversight." Further, the relevant inquiry is not whether the allegations would, standing alone, suffice to prove scienter, but whether they "have *no bearing* on the relevant issues," *M'Baye*, 2007 WL 844552, at *4 (emphasis added), and they plainly do.

Anthem also argues that the allegations regarding settlements should be stricken "because any potential relevance of those settlements is substantially outweighed by the unfair prejudice and waste of time and resources that would result if they remain." Def. Br. at 54. Anthem's arguments in this regard again rely on mischaracterizations of the Government's allegations and it would in any event be inappropriate to strike allegations at the pleading stage based on the sort of cost-benefit analysis Anthem proposes.

First, Anthem claims that it will suffer prejudice from the allegations because "[t]he effect of these allegations is to 'bootstrap' Plaintiff's Claims by suggesting that Anthem is liable

because other defendants have settled purportedly similar suits before." Def. Br. at 54. However, as discussed above, and as the amended complaint itself makes clear, that is not the import of the allegations at issue. *See supra* at 14–15. Anthem has not identified any unfair prejudice it would suffer from the actual allegations, which describe the Government's prior enforcement efforts and Anthem's knowledge thereof.

Second, Anthem suggests that, if the allegations are not struck, "extensive discovery" from both the Government and the opposing parties in the referenced cases would be necessary in order to "know the basis for the prior settlements," and that Anthem will "be forced to challenge" the Government's "refus[al]" to waive privilege over its privileged communications and materials pertaining to those other cases. Def. Br. at 53, 55. These assertions again misconstrue the relevance of the allegations at issue, as the relevance of the Government's prior enforcement efforts to the materiality of Anthem's conduct, or its scienter, is readily apparent without needing to, as Anthem proposes, conduct a "mini-trial" into the "motivations of the settling parties," or review the Government's privileged communications. *See* Def. Br. at 53

At any rate, Anthem has cited no support for the proposition that the Court should, at the pleading stage, attempt to assess the cost and burden of taking discovery into issues raised in the amended complaint and strike relevant allegations on that basis. To the contrary, the case law makes clear that pleadings should not be struck unless the defendant can show that they have "no bearing" on the issues in dispute. *Kralik*, 226 F.R.D. at 177; *see M'Baye*, 2007 WL 844552, at *4; *see also* cases cited Def. Br. at 55 n.17 (*MC1 Heathcare, Inc. v. United Health Grp., Inc.*, 2019 WL 2016949, at *11 (D. Conn. May 7, 2019) (striking allegations that were "irrelevant" where their "*only* intended effect" was to prejudice the defendant (emphasis added)); *Reiter's Beer Distribs., Inc. v. Christian Schmidt Brewing Co.*, 657 F. Supp. 136, 144 (E.D.N.Y. 1987) ("only effect" of allegations was to prejudice the defendant). Anthem has fallen far short of

making that showing here, and its motion to strike should be denied.

CONCLUSION

For the reasons set forth above, Anthem is not entitled to a transfer of venue, to dismissal of the Government's FCA claims based on false attestations, or to strike paragraphs 99 through 105 of the amended complaint. Accordingly, the Government respectfully requests that the Court deny Anthem's motion in its entirety.

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Respectfully submitted,

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