UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, et al., *ex rel.* SW CHALLENGER, LLC, et al., *Plaintiffs,* vs. EVICORE HEALTHCARE MSI, LLC, *Defendant.*	Case No. 19-cv-02501 (VM)

EVICORE'S REPLY TO RELATORS' OPPOSITION TO THE MOTION TO DISMISS RELATORS' SECOND AMENDED COMPLAINT, AND RESPONSE TO THE UNITED STATES' STATEMENT OF INTEREST

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PRELIMINARY STATEMENT

Relators' Opposition fails to rescue the SAC,[1] and instead confirms that the SAC's conclusory and internally inconsistent allegations fail to state any viable causes of action under the FCA or analogous state false claims acts. Among its other pervasive deficiencies, the SAC does not plausibly allege the essential FCA elements.[2]

First, the SAC identifies no "claims" for payment submitted *by anyone* or *to anyone.* Relators do not and cannot plausibly allege that eviCore caused MCOs to submit claims for medically unnecessary services to CMS, and the Opposition does not and cannot address eviCore's argument that MCOs do not submit claims to CMS for *medical services* under Medicare Part C ("Medicare Advantage"). Relators also identify no "claims" submitted by eviCore to MCOs, or that eviCore caused MCOs to submit to CMS, for any improper eviCore *prior authorization services*. The Statement of Interest ("SOI") filed by the U.S. Attorney's Office for the Southern District of New York does not contend Relators have identified any "claims" in the SAC, or that Relators have alleged any plausible basis for FCA liability.

Second, the SAC fails to plausibly allege "falsity." Relators do not identify any legal or contractual requirements that eviCore's review processes purportedly violated, and the SAC does not allege plausible facts that eviCore's services were worthless. Relators do not allege that eviCore provided no services of value under any specific contract with an MCO, and thus have no basis to allege a "worthless services" theory. *Third*, Relators identify no material false

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[1] Capitalized terms herein have the same meaning as defined in eviCore's Opening Brief. *See* ECF No. 22 ("MTD").

[2] To establish civil liability under the FCA against a contractor to Medicare Advantage plans, a relator must plausibly allege (1) that the company made a "claim," caused a claim to be made, or made a "statement" material to a claim, for payment by a federal program or with federal funds; (2) the claim or statement was "false"; (3) the company had "knowledge" that the claim or statement was false; and (4) the false claim or statement was material to the government's decision to pay or approve the false claim. *See U.S. v. Strock*, 982 F.3d 51, 58 (2d Cir. Dec. 2, 2020); *U.S. ex rel. Gray v. United Healthcare Ins. Co.*, No. 15-CV-7137, 2018 U.S. Dist. LEXIS 98195, at *9-10 (N.D. Ill. June 12, 2018) (dismissing a declined *qui tam* action against an MCO).

statements about eviCore's review process. *Fourth*, the SAC fails to satisfy Rule 9(b) as to any FCA element, and the Opposition does not demonstrate that the SAC has done so. As to the ancillary state law claims, Relators rely entirely on scant allegations limited to one state (Texas), which are not generalizable nationwide, and which do not plausibly allege a violation of any state law or the FCA. Relators also allege no adverse action supporting their retaliation claims.[3]

The Government, and each state, has declined to intervene and adopt any of Relators' allegations. But to protect its view of the law, the Government's SOI opines on what *could* be a "claim" (only one element of a potential FCA cause of action) involving a participant in the Medicare Advantage program.[4] The Government does not oppose dismissal of the SAC or argue that the SAC has plausibly alleged the elements or facts to support *any* FCA count against eviCore. Instead, the Government has stated that it "takes no position on the overall merit of eviCore's motion to dismiss." SOI at 2. In offering its view at this time, the Government seeks to avoid a ruling that would set forth broad legal principles that might narrow the Government's ability to assert theories of liability in *other* cases where it believes there "could" be "claims." *Id*.

But the issue before the Court is not whether, theoretically, there could be "claims" in a hypothetical case against a subcontractor. *See* SOI at 7. Rather, it is whether the SAC alleges plausible, particularized facts sufficient to state the elements of the asserted causes of action. It does not, and the SOI does not contend that it does, or otherwise preclude dismissal of the SAC. Given that Relators have already twice amended their complaint and any further amendment would be futile, the Court should dismiss the SAC with prejudice.

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[3] The Opposition does not respond to eviCore's argument that the conspiracy claims fails, and for this reason too, Count IV should be dismissed. Also, Count III fails because Relators have not identified any "obligation."

[4] Where the Government has declined to intervene, it may take "only a limited position" in an FCA case, by filing a statement of interest under 28 U.S.C. § 517, which, like an amicus brief, gives the United States "the ability to 'attend to the interests of the United States' in a pending lawsuit." *U.S. ex rel. Lynch v. Univ. of Cincinnati Med. Ctr., LLC*, No. 1:18-cv-587, 2020 U.S. Dist. LEXIS 48214, at *9 (S.D. Ohio Mar. 20, 2020) (citing *US. ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*, 892 F.3d 822, 833 n.6 (6th Cir. 2018)).

I. THE SECOND AMENDED COMPLAINT DOES NOT PLAUSIBLY ALLEGE THE ELEMENTS OF AN FCA VIOLATION.

A. Relators Have Not Plausibly Alleged "Claims" or "Falsity" (Count I).

In Count I, the SAC attempts to present two theories about how eviCore purportedly submitted false claims or caused false claims to be submitted.[5] Under one theory, the SAC appears to assert that eviCore's review methods approved clinical services that were not medically necessary, thus causing MCOs to submit false claims to CMS for payment of medically unnecessary clinical services. SAC ¶¶ 129-130. In its Opening Brief, eviCore identified the flaws in this theory, and the Opposition does not even address these flaws.

Under an alternate theory—which appears to be the focus of the Opposition—the SAC, as best as eviCore can discern, might be contending that eviCore submitted (unidentified) invoices under (unidentified) contracts to MCOs for purportedly deficient prior authorization services. This allegedly caused MCOs to submit (unidentified) false claims for *administrative* services to CMS. *Id.* ¶¶ 32-35. Relators allege eviCore's invoices were false either because (1) eviCore violated a contract or regulatory provision (none of which they identify), or (2) eviCore's prior authorization services were entirely "worthless." *Id.* Under any of these theories, Relators fail to plausibly allege the essential elements of an FCA violation. *See* MTD at 10-15.

1. The SAC Fails Plausibly to Allege False Claims for Medically Unnecessary Clinical Services.

The first theory fails as a matter of law because Relators do not assert *any facts* in the SAC about "claims" for approved medical services submitted by MCOs to CMS for payment. A "claim" is an essential FCA element. Neither the Opposition nor the SAC, however, identifies a single claim for payment for a purportedly medically unnecessary clinical service that eviCore

[5] The SAC's allegations of an FCA violation are vague and difficult to discern. For purposes of this Reply, eviCore articulates the SAC's potential theories well beyond the SAC's confused attempts to do so.

approved but was required to deny and that an MCO submitted to CMS for payment. As eviCore explained in its Opening brief—and which Relators cannot rebut—this theory of a "claim" is not grounded in factual reality because it is directly at odds with the structure and payment system of the Medicare Advantage program. In Medicare Advantage, eviCore *does not* submit claims for medical services to MCOs, and MCOs *do not* submit claims to CMS for the specific medical services that eviCore approves. *See* MTD at 10-11. Because of how MCOs are compensated by CMS, *no claim for reimbursement of individual medical services is ever made to CMS*. Unable to rebut eviCore's argument, Relators' Opposition ignores the argument and instead cites to cases involving contractor and subcontractor liability for Government procurement and services contracts. None of the cited circumstances involve fixed capitated payments under at-risk Medicare Advantage contracts or any remotely analogous context.[6]

The Government's SOI does not dispute eviCore's argument. The SOI acknowledges that CMS pays MCOs a fixed amount each year based on each MCO's members' health conditions and demographic profile. SOI at 3. That is, the Government pays Medicare Advantage organizations "a capitated (per enrollee) amount to provide medical benefits," and as numerous courts have explained "[t]he capitated amount is a fixed monthly payment *regardless of the volume of services an enrollee uses*." *U.S. v. DaVita Inc.*, No. 8:18-cv-01250, 2020 U.S. Dist. LEXIS 102981, at *3-4 (C.D. Cal. Apr. 10, 2020) (citing *U.S. v. United Healthcare Ins. Co.,* 848 F.3d 1161, 1167 (9th Cir. 2016)) (emphasis added); *see also U.S. ex rel. Gray v. United Healthcare Ins. Co.*, No. 15-CV-7137, 2018 U.S. Dist. LEXIS 98195, at *18-20 (N.D. Ill. June

[6] The government contracts cases upon which Relators rely bear no relation to Medicare Advantage contracts. *E.g.* Opp. at 4. These cases involve traditional government procurement and services contracts under which the prime contractor generally submits the subcontractors' claims to the government, or rolls them up into its claim to the government. *See e.g. U.S. v. Lagerbusch,* 361 F.2d 449, 449-50 (3d Cir. 1966); *U.S. ex rel. Luther v. Consol. Indus., Inc.,* 720 F. Supp. 919, 921-22 (N.D. Ala. 1989). By contrast, the Medicare Advantage program involves a different type of contract under which CMS pays MCOs fixed, capitated payments based on member heath status, among other things. The payments to MCOs in a given year do not vary based on medical services that eviCore approves.

12, 2018) (explaining that CMS "pays Medicare Advantage plans a set, monthly payment regardless of the number of uncovered, unnecessary, or excessive services provided"; finding "[t]he government is not harmed" if MCOs cover medically unnecessary services; and dismissing FCA claims). Relators ignore this point because they cannot rebut it.[7]

2. The SAC Fails Plausibly to Allege False Claims for eviCore's Prior Authorization Services.

Under a second theory, it appears Relators contend that eviCore caused MCOs to submit "claims" for payment to CMS for eviCore's purportedly deficient prior authorization services. SAC ¶ 32. Relators have not made any plausible, specific allegations that eviCore submitted any "claims" or invoices for its contracted services to MCOs, much less that any MCO submitted any false eviCore invoices to CMS. Relators also fail to allege that any eviCore invoices were "false" for the following two reasons.

i. The SAC Identifies No Regulatory or Contractual Violations.

Although Relators contend that eviCore's prior authorization processes violated legal and contractual requirements, and thus invoices for eviCore's review services were false, the SAC does not identify any regulatory or statutory provision, or any contract term, that eviCore violated, or that forbids automated prior authorization processes or "auto-approvals." *See* SAC ¶¶ 31, 171. This is no surprise because there are no regulatory or statutory provisions that prohibit automated review, or that would require eviCore to have a human clinician manually review every approval of a physician request for treatment. This is fatal to the SAC because, to prove "falsity," Relators must make a plausible and specific factual allegation as to the

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[7] The SOI suggests that if "an improper approval results in a healthcare provider billing [an MCO] for [a] medically unnecessary treatment," that request for payment is a "claim." SOI at 7. It also posits a highly attenuated mechanism by which claims for medically unnecessary treatments could, in theory, result in an MCO's transmission of incorrect diagnosis codes that affects CMS's capitated payments and thus amounts to a "false claim." *Id.* at 8–9. But as discussed below, Relators do not articulate these theories and have not alleged any facts to plausibly support them. *See infra* Part II.

contractual, regulatory, or statutory requirements that eviCore violated. *See e.g. U.S. ex rel. Kolchinsky v. Moody's Corp.*, 238 F. Supp. 3d 550, 558 (S.D.N.Y. 2017).[8]

The Opposition wrongly contends that eviCore violated regulations that apply to Medicare Integrity Program ("MIP") contractors. *See* Opp. at 8. But these regulations do not apply to eviCore. MIP contractors enter into written contracts with CMS to conduct oversight of the Medicare Fee for Service and/or Medicare Advantage program. *See* 42 C.F.R. § 421.300, 421.304. EviCore and its MCO clients are not MIP contractors. *See id.*[9]

Despite the SAC's conclusory accusations of "auto-approvals," automated reviews are not prohibited. To the contrary, CMS encourages its contractors to use automated review processes and in some cases requires it. *See e.g.* CMS, Medicare Program Integrity Manual, Ch. 1 § 1.3.7[10] ("Whenever possible, [contractors] are encouraged to automate [the medical review] process"). CMS has also proposed rules to make electronic prior authorization more available.[11]

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[8] The SOI does not address this pleading failure, or attempt to identify any applicable statutory, regulatory, or contractual provisions that eviCore violated. The SOI instead refers to the allegations in *U.S. ex rel. Nedza v. AIM*, No. 15-6937, 2020 U.S. Dist. LEXIS 52415 (N.D. Ill. Mar. 26, 2020). The allegations in *Nedza* are the *exact inverse* of the allegations here. That relator contended that a prior authorization company *denied* too many services, while here, Relators allege eviCore *approved* too many requests. *Id.* at *15-20. This distinction is critical because, as eviCore explained in its Opening Brief, while Medicare regulations prohibit MCOs from inappropriately *denying* services and establish processes that MCOs must follow to *deny* service requests, Medicare regulations do not establish a process that MCOs must follow when they *approve* service requests. MTD at 5-6. It is therefore not surprising that unlike *Nedza*, Relators have not plausibly alleged that eviCore violated any "Medicare requirement." According to relator Nedza, MA plans must (1) "pay for all the medical care that would be covered under Original Medicare" and (2) make "individualized coverage decisions" for requested treatments. 2020 U.S. Dist. LEXIS 52415, at *11-12. Relators here do not allege that eviCore violated the first requirement, nor could it, because Relators allege that eviCore approved "all treatment requests." Opp. at 4. Relators do not rely on the second Medicare requirement either, much less allege that eviCore violated it. Unlike in *Nedza*, Relators here also fail to allege even one specific instance where eviCore approved a request that should have been denied in violation of these, or any other, Medicare rules. *See* 2020 U.S. Dist. LEXIS 52415, at *32-33. Indeed, *Nedza* demonstrates that Relators' allegations here—that eviCore did not *deny* enough services—lacks plausibility, and explains why Relators have not and cannot point to any regulation that was violated. *Id.* at *16 (alleging certain Medicare-compliant prior authorization review "would have a denial rate of 0.5 to 1.5 percent," essentially what Relators allege occurs at eviCore).

[9] Even if eviCore was governed by a contract under the MIP—and it is not—that Program's requirements upon which Relators rely merely state that contracts between CMS and its MIP contractors "*may* include" functions such as "[c]onducting medical reviews." 42 C.F.R. § 421.304 (emphasis added); 42 C.F.R. § 421.200 (same).

[10] The Medicare Program Integrity Manual, Chapter 1 is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c01.pdf.

[11] *See* 85 Fed. Reg. 82586 at 82606- 82607 (December 18, 2020).

Relators also do not identify any specific contract terms or identify eviCore's purported violation of any contract terms. Rather, Relators make only general, conclusory statements that eviCore "contracts with MCOs" to provide prior authorization services. *See* Opp. at 8-9. These generic allegations do not (i) identify any term of any contract between an MCO and eviCore, (ii) pinpoint any eviCore obligation under any contract to conduct human review of every physician request (or prohibiting automated review), or (iii) explain how any so-called "auto-approval" violated any contract. *See e.g.* SAC ¶ 31. This cannot prove a contract violation, much less fraud. *See U.S. ex rel. Ladas v. Exelis, Inc.*, 824 F.3d 16, 27 (2d Cir. 2016) (affirming dismissal of claims where relator failed to plausibly allege "any of the devices delivered to the government failed to meet Contract specifications").[12]

ii. The SAC's "Worthless" Services Claim Fails.

Relators further fail to satisfy the falsity element under the demanding "worthless services" standard.[13] Under this doctrine, a claim is "false" if it seeks federal payment for services that, for all practical purposes, were not provided. *Mikes v. Straus*, 274 F.3d 687, 703 (2d Cir. 2001). The law is clear that no liability exists under this doctrine unless the service, in its

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[12] Relators try to brush aside the dispositive cases cited in eviCore's Opening Brief by contending that Relators have alleged "specific factual allegations." Opp. at 10 & n.6. But this attempt fails because Relators' pleading deficiencies are nearly identical to the cases eviCore cites. *See e.g. Ameti ex rel. U.S. v. Sikorsky Aircraft Corp.*, No. 3:14-cv-1223, 2017 U.S. Dist. LEXIS 93481, at *16 (D. Conn. June 19, 2017) (dismissing claim where relator failed to plead "the specific contract involved, [or] the specific date on which a violation occurred…"); *U.S. ex rel. Youssef v. Tishman Constr. Corp.*, No. 12-cv-03862, 2017 U.S. Dist. LEXIS 42376, at *9-11 (E.D.N.Y. Mar. 23, 2017) (dismissing claim where, despite "personal knowledge," relator "failed to identify any specific fraudulent claims made by the Defendants, [or] any contract provision that was violated").

[13] The Opposition is internally inconsistent about Relators' worthless services theory: on the one hand, Relators contend that eviCore "is providing worthless services (i.e., fraudulent 'auto-approval' utilization management) to MCOs." Opp. at 3. But on the other hand, they argue that the *medical services* for which physicians sought approval—rather than *eviCore's* pre-approval services—were worthless because the physicians' services were not medically necessary. *Id.* at 7 ("eviCore violated the FCA by causing fraudulent claims to be submitted to the Government, for services eviCore knew to be medically unnecessary and worthless"); *id.* at 10 (eviCore "adopted policies to ensure that unnecessary medical services were approved and ultimately paid by the Government").

entirety, was so deeply deficient that it was "worthless" to the federal payor. *See id.*; *see also* Opp. at 12 (citing *Mikes*, 274 F.3d at 703).

Relators' empty, conclusory assertions that eviCore's services were "worthless" do not meet their pleading burden for several reasons. *First*, Relators would have to allege that eviCore provided no services of value at all under an identified contract with an MCO (even before getting to the issue of whether such a contract violation was material to a federal payment or caused any federal damages). *See Mikes*, 274 F.3d at 703; *Universal Health Servs. v. U.S. ex rel. Escobar*, 136 S. Ct. 1989, 1996 (2016). The SAC alleges no plausible facts that eviCore's services violated any legal or contractual requirements, much less that they violated all such requirements and were entirely worthless. *Second*, the mere conclusory allegation that eviCore "auto-approved" cases without human review of clinical information does not suffice to plead "worthless services." *See* Opp. at 5. Relators do not plead—and cannot show—that human review of every approval of a request is required, or that, absent human review of every request, eviCore's services are worthless. *Third*, Relators have conceded that eviCore's algorithms considered clinical information (ECF No. 36, Compl. ¶ 114),[14] rendering their allegations that eviCore did not review any clinical information implausible. *Fourth*, Relators have not alleged facts to show that eviCore's review processes failed to meet any terms of a specific contract with an MCO. To the contrary, Relators have conceded that some of eviCore's processes "were agreed to by MCOs." Opp. at n.1. *Finally*, the SAC excludes the possibility of a worthless services claim since Relators only allege that eviCore performs "auto-approvals" on *some* of

[14] When Relators' statements in the SAC differ from or contradict prior allegations within the original Complaint, Relators are "bound by [their] prior allegations." *Delaney v. Farley*, No. 13-CV-9183, 2014 U.S. Dist. LEXIS 158191, at *12-13 (S.D.N.Y. Nov. 7, 2014) (dismissing retaliation claim as time barred based on contradictory statements made in plaintiff's original complaint, which were "abandoned" within the SAC); *see also U.S. v. McKeon*, 738 F.2d 26, 31 (2d Cir. 1984) ("A party thus cannot advance one version of the facts in its pleadings, conclude that its interests would be better served by a different version, and amend its pleadings to incorporate that version, safe in the belief that the trier of fact will never learn of the change in stories.").

eviCore's prior authorization reviews. SAC ¶¶ 22-25. Accordingly, Relators fail to allege falsity under the worthless services theory and the FCA causes of action should be dismissed. *See U.S ex rel. Kolchinsky v. Moody's Corp.*, No. 12cv1399, 2018 U.S. Dist. LEXIS 41117, at *14 (S.D.N.Y. Mar. 13, 2018) (failing to show ratings service was worthless where "only some" ratings were allegedly erroneous).

B. Relators Have Not Plausibly Alleged That eviCore Made "False Statements" About Its Prior Authorization Services (Count II).

Relators also fail to plausibly allege in Count II that eviCore violated the FCA under the second theory by making false statements to its client MCOs, which were "adopted by the MCOs in communications with the Government in carrying out the scheme." SAC ¶ 176. Here too, Relators cannot rebut eviCore's argument.

Relators rely on broad, conclusory statements that eviCore "made false or fraudulent records or statements" that eviCore knew "would be material to the payment decision of the Government," yet fail to plausibly allege facts supporting their assertions. *Id.* at ¶ 177.[15] The SAC contends based on generalized conclusions that eviCore made "false statements" to MCOs when it "initiated auto-approvals without MCO approval." *See e.g.* SAC ¶ 102. Relators' allegations are implausible because Relators admit that eviCore's review processes were "*agreed to by MCOs*." Opp. at n.1 (emphasis added); *see also* Compl. ¶¶ 10, 86. Relators' contradictions in these fundamental assertions show that their allegations are implausible and that Count II should be dismissed.[16] *Ashcroft v. Iqbal,* 556 U.S. 662, 663 (2009); *Alexander v. The Bd. of*

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[15] As discussed in note 2 *supra*, liability under the FCA is premised on a "claim" or "statement" to obtain federal funds, "falsity" of the claim or statement, "knowledge" of the false claim or statement, and the "materiality" of the false claim or statement to the government's decision to pay or approve the false claim. *Gray*, 2018 U.S. Dist. LEXIS 98195, at *9-10. The "materiality" element requires that the alleged contractual or regulatory violation must be material to the government's payment decision. *Escobar*, 136 S. Ct. at 1996. The SAC does not allege any specific violation, and thus nothing is alleged that could be material to the government's payment decision.

[16] The SAC states expressly that the "claims relevant to" Count II are those claims for payment that MCOs submitted "directly to CMS" (SAC ¶ 175)—that is, *Medicare* claims. By contrast, claims by MCOs under state

Educ. of City of New York, 648 F. App'x 118, 120-21 (2d Cir. 2016) (affirming dismissal of contradictory, inconsistent allegations as implausible).[17]

C. Relators Have Not Satisfied Rule 9(b).

Unable to point to plausible, particular facts supporting their claims, Relators ask the Court to permit this case to go forward to discovery so Relators can hunt for any support for their speculative claims. Opp. 1-2. But the Court should not "unlock the doors of discovery for a plaintiff armed with nothing more than conclusions." *Iqbal*, 556 U.S. at 678-79; *see also Main St. Legal Servs. v. Nat'l Sec. Council*, 811 F.3d 542, 567 (2d Cir. 2016).

Beyond their failure to allege the specific facts with respect to the necessary elements of an FCA cause of action, as detailed above, Relators also have not met the heightened pleading requirements of Rule 9(b), which require them to plead the "who, what, when, where and how of the alleged fraud." *Chen v. EMSL Analytical, Inc.,* 966 F. Supp. 2d 282, 301 (S.D.N.Y. 2013). Relators have failed to meet their heightened pleading burden:

- Relators contend that eviCore approved too many services, *but* the SAC contains no specific allegations about services that must be denied but were approved.
- Relators argue the "who" is eviCore, which "adopted policies to ensure that unnecessary medical services were approved" (Opp. at 10), *but* they neither identify nor describe specific "policies" purportedly "adopted" with such purpose.
- Relators assert the "what" is that eviCore instituted an auto-approval "scheme" to "meet the high volume of prior authorization requests and to avoid contractual [turnaround time (TAT)] penalties" (Opp. at 10), *but* Relators fail to allege facts establishing that auto-approval processes were used to avoid TAT penalties, or were otherwise improper.

Medicaid plans are submitted to the states or their agents. Accordingly, by Relators' own formulation of Count II, any alleged false statements made to an MCO in the Texas *Medicaid* program are irrelevant to, and thus cannot save, Count II.

[17] *See also AJ Energy LLC v. Woori Bank*, No. 18-CV-3735, 2019 U.S. Dist. LEXIS 164961, at *9-14 (S.D.N.Y. Sept. 26, 2019) (dismissing inconsistent allegations as implausible), *aff'd*, 829 F. App'x 533 (2d Cir. 2020).

In sum, the SAC does not state plausible allegations of a fraudulent scheme, and thus fails to meet the rigorous Rule 9(b) pleading standard. *See e.g. U.S. ex rel. Gelbman v. City of N.Y.*, 790 F. App'x 244, 247-48 (2d Cir. 2019).

D. Relators Have Not Alleged "Knowledge" Sufficiently.

Relators also do not allege "knowledge" by eviCore as required under the FCA. Relators must "allege facts that give rise to a *strong* inference of fraudulent intent." *U.S. ex rel. Grubea v. Rosicki, Rosicki & Assocs., P.C.*, 318 F. Supp. 3d 680, 694 (S.D.N.Y. 2018) (emphasis in original).[18] The Opposition, instead, relies on conclusory and hypothetical statements that eviCore had "motive," but these allegations fail because they lack essential supporting facts:

- Relators allege that eviCore revised internal documents to remove "auto-approval" language (Opp. at 13), *but* do not allege a single fact supporting a nefarious reason for the revision. The more plausible explanation for this change is that eviCore was trying to more accurately describe its automated prior authorization processes.

- Relators argue that eviCore had motive to institute "auto-approval" processes to "reduce costs associated with staffing and thereby increase company profits" (Opp. at 14), *but* the mere fact that a company seeks to increase profits does not establish knowledge of false claims.[19]

Accordingly, the SAC fails to plausibly allege knowledge.

II. THE SOI DOES NOT OPPOSE OR PRECLUDE DISMISSAL OF THE SAC.

The SOI does not save the deficient SAC. In the SOI, the "Government takes no position on the overall merit of eviCore's motion to dismiss." SOI at 2. Rather, the SOI simply seeks to protect the Government's view of a generic "claim" within the Medicare Advantage program against a potential ruling that would be adverse to its enforcement interests. The Court need not, and eviCore respectfully submits *should not*, address the SOI's theorizing about "claims," and

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[18] Under the FCA, "a person acts knowingly when he 'has actual knowledge of the information; acts in deliberate ignorance of the truth or falsity of the information; or acts in reckless disregard of the truth or falsity of the information.'" *U.S. ex rel. Pervez v. Beth Isr. Med. Ctr.*, 736 F. Supp. 2d 804, 814 (S.D.N.Y. 2010).

[19] *See U.S. ex rel. Gudur v. Deloitte Consulting LLP*, 512 F. Supp. 2d 920, 954 (S.D. Tex. 2007) ("evidence of profit motive alone is insufficient to demonstrate FCA liability").

should dismiss the SAC because it fails to articulate coherent, plausible, and particularized facts upon which any FCA claims could be premised. Indeed, to adopt the Government's legal theories here would be to issue an advisory opinion on issues not in dispute in this case.[20]

The SOI has no bearing on eviCore's Opening Brief. The SOI consists of two parts: Part I explains an aspect of the FCA statute, "presentment," not disputed in this matter or raised by eviCore, by explaining that the direct submission of false claims to the Government "is not necessary for stating an FCA claim, and that a request made to a contractor like a Medicare Part C plan is encompassed within the meaning of 'claim' under the FCA." SOI at 7. To the extent such "request" is a request for payment to the Government or its contractors, and the request meets the definition of "claim" under the FCA, eviCore does not dispute this general statement.[21]

Part II of the SOI narrowly explains the Government's opinion about what "*could*" be a "claim" under the FCA in the Medicare Advantage program. SOI at 7-9 (emphasis in original). Here, the SOI goes far beyond the SAC, the Motion to Dismiss, and the Opposition, and discusses potential theories *not even alleged* in this case. This discussion does not reference allegations in the SAC or argue that the SAC has asserted plausible claims.

For example, the SOI declares that if a treating provider billed an MCO for medically unnecessary treatment, that payment request *could* give raise to a false claim. SOI at 7. The SAC does not plausibly make this allegation, and the SOI does not contend it does. Similarly, the SOI states that a subcontractor's invoices to MCOs for its prior authorization services, if it conducted

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[20] "[T]he oldest and most consistent thread in the federal law of justiciability is that the federal courts will not give advisory opinions. . .This means that federal courts may not give an opinion advising what the law would be upon a hypothetical state of facts." *Ass'n of Car Wash Owners Inc. v. City of N.Y.*, 911 F.3d 74, 85 (2d Cir. 2018) (internal quotations and citations omitted).

[21] The SOI misconstrues eviCore's argument, asserting that eviCore contends the SAC "fails to allege the 'submission of a claim'" on the basis that eviCore's submitted invoices to a contractor, not directly to the federal program. SOI at 5. EviCore's statement, in context, argued accurately that the SAC fails to allege the submission of a claim by an MCO to CMS for medically unnecessary services. EviCore did not argue in its Opening Brief that "presentment" is required, as the government contends. *Id*.

no meaningful review, could be a "claim." SOI at 7. Again, the SOI does not argue that Relators have plausibly alleged such a claim in the SAC. Further, the SOI posits that theoretical claims might arise out of a health plan's "inaccurate diagnosis codes" or its "bid" to CMS, but neither theory is alleged or even hinted at in the SAC, as the SOI all but acknowledges.[22] SOI at 8-9 (expressing no view as to whether "Relators have sufficiently alleged that eviCore's improper approval of medically unnecessary treatments resulted in [MCOs'] transmission of inaccurate diagnosis codes to CMS"). Because none of these three scenarios is alleged in the SAC, the Court need not address these hypothetical theories or grant Relators the opportunity to piggyback on them by repleading new conclusory allegations echoing such "theories."

Finally, the SOI does not discuss any additional FCA elements (*i.e.*, "knowledge", "materiality" and "falsity"). The SOI does not analyze or argue a hypothetical basis in support of alleging FCA *liability* against eviCore. For these reasons, the SOI does not breathe life into the SAC, and Relators cannot evade dismissal of *this case* simply because the Government filed a SOI seeking to cordon off Government theories of potential "claims" under the FCA.

III. RELATORS' STATE LAW CLAIMS FAIL (COUNTS V- XX).

Relators' state law claims suffer the same pleading deficiencies as their federal FCA claims. The few factual assertions relating to state laws only reference Texas Medicaid; there are no facts alleged as to any other state law. In the Opposition, Relators summarize the Texas Medicaid Fraud Prevention Act ("TMFPA"), without tying their allegations to specific violations of Texas law or substantively responding to eviCore's argument that all state-law claims should be dismissed. Opp. at 17-19.

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[22] EviCore does not concede that the Government's theoretical positions regarding what could be a "claim" have merit.

In particular, even where Relators allege some detail with respect to their Texas allegations, they fail to specify how any of that detail establishes a violation of the TMFPA. Relators do not allege any purportedly false statement or misrepresentation made by eviCore that could satisfy the TMFPA even under Relators' own articulation of the statute—*i.e.,* they describe no "information required to be provided" by an applicable law, rule, regulation, or Medicaid-related provider agreement that was not provided, and fail to allege any TMFPA "obligation" to which a statement might be material. *See* Opp. at 17-18 (quoting TMFPA). In fact, for Texas and elsewhere, Relators fail to cite *any* requirement that eviCore perform prior authorization on Medicaid claims, or allege any invoices under any contracts with MCOs for purportedly deficient prior authorization services, in Texas or anywhere, to support any claim under the TMFPA.

Relators then rely on various inapplicable cases that neither contain nor address any state law claims, to argue that they have alleged a *nationwide* scheme that rescues all of their state law claims. *Id*. at 19-20.[23] But Relators' scant allegations relating to conduct relative to one state (Texas) can hardly be said to be generalizable to the entire nation, much less justify the Court's retention of jurisdiction over such claims, absent viable federal claims.[24]

Because the SAC lacks factual allegations sufficient to state a claim under the Texas statute or any other state statute, the Court should not retain supplemental jurisdiction over these claims if the FCA claims are dismissed. 28 U.S.C. § 1367(c)(3) (district court "may decline to exercise supplemental jurisdiction" if claims with "original jurisdiction" are dismissed).[25]

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[23] For example, in *U.S. ex rel. Spay v. CVS Caremark Corp.* 913 F. Supp. 2d 125, 139, 174-75 (E.D. Pa. 2012), the relator filed no state law claims and the court did not even address whether an alleged nationwide scheme rescues state-law claims. *See also U.S. ex rel. Duxbury v. Ortho Biotech Prods., L.P.*, 579 F.3d 13, 31 (1st Cir. 2009) (no state law claims); *U.S. ex rel. Hudalla v. Walsh Constr. Co.,* 834 F. Supp. 2d 816, 823 (N.D. Ill. 2011) (same).

[24] Relators include one paragraph that simply lists several states, with no specific allegations. SAC ¶ 122. That is not enough to allege a "nationwide scheme" as Relators contend.

[25] *Giurca v. Orange Reg'l Med. Ctr.*, No. 19 Civ. 1096, 2019 U.S. Dist. LEXIS 209198, at *8 (S.D.N.Y. Dec. 3, 2019) (holding "no satisfactory basis for the exercise of supplemental jurisdiction over the state law claims" where federal FCA claim was being dismissed, and declining to do so); *see also Bridgeman Art Library, Ltd. v. Corel*

IV. RELATORS HAVE NEITHER PLAUSIBLY ALLEGED AN ADVERSE EMPLOYMENT ACTION NOR CONSTRUCTIVE DISCHARGE (COUNTS XXI-XXII).

Relators have not alleged adverse employment action. Relators resigned from eviCore. SAC ¶ 135. Relators must therefore allege "constructive discharge," which is "a demanding standard." *U.S. v. N. Metro. Found. for Healthcare, Inc.,* No. 13-CV-4933, 2019 U.S. Dist. LEXIS 63958, at *37 (E.D.N.Y. Apr. 14, 2019). Allegations that Relators were subject to productivity metrics (Opp. at 21), and received a verbal warning (SAC ¶¶ 149, 162) do not meet such standard; a reasonable person would not be compelled to resign under these circumstances. *See e.g. Hiralall v. Sentosacare, LLC,* No. 13 Civ. 4437, 2016 U.S. Dist. LEXIS 35781, at *38 (S.D.N.Y. Mar. 18, 2016) (denial of "vacation request and [a] written warning" were "too trivial" to establish adverse action). The retaliation claims should therefore be dismissed.

V. THE SAC SHOULD BE DISMISSED WITH PREJUDICE.

Despite multiple opportunities to do so, Relators have not brought forward new facts and have still failed to allege an FCA violation, or any necessary element of one. The Court may deny leave to amend for "undue delay, bad faith…repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, [and/or] futility of amendment." *U.S. ex rel. Gelbman v. City of N.Y.,* No. 14-CV-771, 2018 U.S. Dist. LEXIS 169435, at *23 (S.D.N.Y. Sep. 30, 2018). Relators' pleading continues to suffer from incurable pleading deficiencies, and any further leave to amend would be both futile and unfair to eviCore. The Court should dismiss it, with prejudice.

VI. CONCLUSION

For the reasons above, the entire SAC should be dismissed with prejudice.

Corp., 25 F. Supp. 2d 421, 431 (S.D.N.Y. 1998) ("When, as here, the federal claim is dismissed early in the litigation process, 'the presumption to decline jurisdiction is strong.'").

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Respectfully submitted,

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