

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)

**NOTICE OF DEFENDANT EVICORE HEALTHCARE MSI, LLC'S
MOTION TO DISMISS THE SECOND AMENDED COMPLAINT**

PLEASE TAKE NOTICE that, upon the accompanying Memorandum of Law, Defendant eviCore healthcare MSI, LLC (“eviCore”) will move this Court before The Honorable Victor Marrero, United States District Court, Southern District of New York, 500 Pearl Street, New York, New York 10007, for an order dismissing the Second Amended Complaint against eviCore pursuant to Rules 12(b)(6) and 9(b) of the Federal Rules of Civil Procedure.

PLEASE TAKE FURTHER NOTICE that opposition and reply papers shall be submitted pursuant to the briefing schedule entered by the Court.

Dated: New York, New York
November 23, 2020

Respectfully submitted,

/s/ David M. Siegal

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**MEMORANDUM OF LAW IN SUPPORT OF EVICORE'S
MOTION TO DISMISS RELATORS' SECOND AMENDED COMPLAINT**

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PRELIMINARY STATEMENT

SW Challenger, LLC (an entity apparently formed for purposes of bringing this case) and two of its members (collectively, the “Relators”), make speculative allegations that eviCore healthcare MSI, LLC (“eviCore”) violated the False Claims Act (“FCA”) and analogous state laws. EviCore is an industry leader in medical benefits management, and serves health plans around the country by improving patient care through intelligent, evidence-based solutions. Among other things, eviCore contracts with managed care health plans to review the medical necessity of requests for treatments and services that physicians¹ order for their patients (and certify as medically necessary) to determine if eviCore’s plan clients will pay for the treatment.² This process is called prior authorization.

Relators contend that eviCore approved physical and occupational therapy services that physicians ordered but were not medically necessary, and therefore caused eviCore’s health plan clients to submit fraudulent claims for services to the federal Medicare Advantage program and certain state Medicaid programs. Relators’ theory, however, relies on a misguided view of how managed care plans and eviCore operate. Neither the Department of Justice (“DOJ”) nor any state authority has intervened and taken over the litigation of this case, as the FCA and state analogs permit them to do.

Relators’ muddled allegations of fraud against eviCore fall far short of stating plausible, particularized allegations as required by the Federal Rules of Civil Procedure 8(a) and 9(b) in FCA actions. Relators contend that eviCore adopted prior authorization procedures to “auto-approve” physicians’ requests to treat their patients, and by doing so, (1) “failed to satisfy its contractual requirements” with Medicare Advantage Organizations (“MCOs”) (Second Amended

¹ “Physician” includes physicians or any other health care provider authorized to order clinical treatment.

² EviCore, “About eviCore”, available at: <https://www.evicore.com/about>.

Complaint (“SAC”) ¶ 31), or violated a Medicare Advantage statute or regulation, and (2) as a result, provided “worthless” prior authorization services to MCOs that provide government health care. *Id.* ¶¶ 31-32, 168.³ Relators speculate that “[i]f eviCore failed to provide” contracted-for prior authorization services, and eviCore approved treatments that were not reimbursable, this *could* “cost the Government a significant amount of taxpayer money.” *Id.* ¶ 16 (emphasis added). Based on speculation, Relators hypothesize that Medicare and Medicaid paid for medically unnecessary services. *Id.* ¶ 133. But Relators fail to set forth what services were medically unnecessary, cite any authority dictating what process MCOs must use to identify such services, or articulate any knowing approval of medically unnecessary services.

Relators’ claims fail because they are premised on a fundamental misunderstanding of the Medicare Advantage program, and they lack the most basic factual support necessary to support such claims. Contrary to Relators’ theory:

- **Medicare Advantage does not require prior authorization.** No Medicare Advantage related statute or regulation requires health plans to implement *any* prior authorization reviews. If a health plan decides to do so, the prior authorization requirements contained in eviCore’s contract with its health plan clients govern.
- **MCOs do not submit “claims.”** Contrary to Relators’ allegations, MCOs do not submit *any* claims to the Centers for Medicare & Medicaid Services (“CMS”) for *clinical services* they have provided to their members; CMS’s payments to MCOs are based on their members’ health status as determined by the members’ diagnosis / health condition information.
- **Physicians, not eviCore, are responsible for certifying that services are medically necessary.** Relators contend eviCore must second guess physicians’ clinical judgment about patient care, and that eviCore committed fraud by *approving payment for care that physicians ordered for their patients*. But federal and state guidelines in managed care programs are designed to ensure only that medically necessary services *will not be denied*.

In addition to these fundamental flaws in their theory, each of Relators’ causes of action fail for additional reasons: *First*, Relators fail plausibly to allege that eviCore caused MCOs to

³ Relators’ use the term “MCO” to describe federal Medicare Advantage Organizations (MAOs) and state Medicaid managed care plans, and for purposes of this brief, eviCore adopts the same usage.

submit *any* claims for clinical services and, even if MCOs submitted claims, fail to allege how any claims are “false.” Likewise, the SAC asserts that eviCore’s services were entirely “worthless” to the government, but articulates no basis for this claim (Count I). *Second*, Relators fail to allege any plausible, particular “false statements” to the federal government, or pinpoint any resulting false claims (Count II). *Third*, Relators have not alleged any eviCore “obligation” to pay money to the federal government, much less the “knowing” use of a “false record” material to any “obligation,” or any “knowing and improper” concealment of any “obligation,” sufficient to support their “reverse” FCA claim theory (Count III). *Fourth*, the conspiracy claim is wholly conclusory, and Relators have failed to allege the necessary elements of a conspiracy to violate the FCA (Count IV). *Fifth*, for the same reasons, there are also no plausible, particular factual allegations supporting the state law claims under the analogous state laws (Counts V-XX). *Sixth*, the FCA’s statute of limitations bars claims related to conduct before May 2014.⁴

Finally, Jane Doe 1 and 2 contend that eviCore retaliated against them. Yet, both voluntarily resigned. Not only have they failed to allege any adverse employment action, Jane Doe 1 and 2 have also failed to plausibly allege that eviCore took any action against them because they engaged in conduct protected under the FCA.

As this is the *third* attempt to allege claims against eviCore, any further amendment would be futile, and therefore the SAC should be dismissed with prejudice.

⁴ The FCA’s “public disclosure” bar also requires the dismissal of this lawsuit. 31 U.S.C. § 3730(e)(4); *see U. S. ex rel. Kreindler v. United Technologies*, 985 F.2d 1148 (2d Cir. 1993); *U.S. ex rel. Patriarca v. Siemens Healthcare Diagnostics, Inc.*, 295 F. Supp. 3d 186, 195 (E.D.N.Y. 2018). Under that provision, if there has been a “public disclosure” of the allegations the action is barred, unless the relator is an “original source.” 31 U.S.C. § 3730(e)(4)(B). There are ample public disclosures that trigger the bar, including the U.S. Attorney’s Office for the Southern District of New York’s own press release to announce a settlement with CareCore, which at that time was part of eviCore healthcare. *See* SAC ¶ 53. Moreover, SW Challenger, LLC, an entity formed on March 13, 2019, just before filing this case on March 20, 2019, is the sole relator and is not an “original source.” *See Federal Recovery Services, Inc. v. U.S.*, 72 F.3d 447 (5th Cir. 1996); *U.S. ex rel. Precision Co. v. Koch Industries, Inc.*, 971 F.2d 548, 552 (10th Cir. 1992). “Jane Doe 1” and “Jane Doe 2” are not proper parties and, even if they were, the SAC only includes them as parties to the retaliation counts, not any of the FCA causes of action.

BACKGROUND⁵

I. THE REGULATORY ENVIRONMENT IN WHICH EVICORE OPERATES

A. The Medicare Program, Including Medicare Advantage

The structure of Medicare proves why Relators' allegations are flawed. Medicare offers health insurance to individuals who are aged 65 or older or permanently disabled, among others. Medicare beneficiaries elect to receive benefits through Medicare "Fee for Service" ("FFS")⁶ or a Medicare managed care plan offered under the Medicare Advantage program.

Under the federal Medicare Advantage program, health plans contract with CMS to manage plan members' (*i.e.*, patients') care. Health plans that offer Medicare Advantage plans are referred to herein as "MCOs." MCOs receive payments from CMS, as administrators of the Medicare program, and from beneficiaries. Both types of payments are fixed in advance, and they are not set based on the clinical services that patients actually receive.

Instead, CMS pays an MCO a fixed amount per year to cover the cost of services, determined by a math formula that calculates the amount of financial risk associated with each plan member, and then adds all of those values together for each member in an MCO's plan. The per-member rate is established from an analysis of that same patient's *diagnoses* from the prior year. Importantly then, CMS *does not* pay MCOs based on *the medical services the patient/member actually receives (and that the MCO pays for)*. MCOs accordingly do not present "claims" to CMS on a service-by-service basis as they are paid a fixed amount to provide care for their members.⁷

⁵ While the Court must accept Relators' allegation as true for this motion, eviCore disputes the SAC's allegations. The Court may also take judicial notice of statutes, regulations, and prior lawsuits. *See, e.g., Staehr v. Hartford Fin. Servs. Grp., Inc.*, 547 F.3d 406, 425 (2d Cir. 2008). The Medicare Program is discussed to provide context.

⁶ In FFS, beneficiaries obtain services from health care providers who bill Medicare and are paid for each service.

⁷ *See* CMS, 2013 National Technical Assistance Risk Adjustment 101 Participant Guide § 4.2 (2013) ("Accurate risk-adjusted payments rely on the diagnosis coding derived from the member's medical record."). "Because

MCOs—*not* CMS—bear the entire financial downside if MCOs approve unnecessary services for its members. If the cost of patient care exceeds the pre-established fixed payment amount an MCO receives, then the MCO would incur a loss. Because of this, the MCO has an incentive to *reduce* the amount of unnecessary treatment it provides to its own members.

1. Utilization Management in Medicare

“Reasonable and necessary” medical services are not defined in the Medicare Act, and the treating physician determines when a service is “reasonable and necessary.” Physicians certify on the claim that they submit to MCOs and CMS that the claim “complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment” and that the “services on the [claim] form were medically necessary.”⁸ But both FFS Medicare and Medicare Advantage use tools to ensure that payments for services are in accordance with program coverage and other requirements.⁹

Though MCOs must have mechanisms to detect under- and over-utilization of services and to manage the costs of care,¹⁰ CMS does not require MCOs to use any tool other than audits. MCOs use different means to manage care and costs, including prior authorization. If an MCO uses prior authorization, it must do so in a manner that does not limit medically necessary services. Because MCOs are “at risk,” as described above, and they have a financial incentive to deny or limit care, the Social Security Act, as well as CMS regulations and guidance, are designed to prevent MCOs from inappropriately denying care. For example, CMS only allows an MCO to deny a request for service if a physician (or other appropriately licensed professional)

[Medicare Advantage] organizations offering coordinated care plans will not be paid for each additional service they provide, we believe that there is no risk of over-utilization of services.” 63 FR 34968, 35003 (June 26, 1998).

⁸ See e.g., CMS Claim Form 1500. For physical therapy, a provider must certify the patient needs or needed PT.

⁹ See 42 U.S.C. § 1862(a)(1)(A).

¹⁰ 42 C.F.R. § 422.152(b)(2).

reviews the request and determines it should be denied.¹¹ CMS has not, however, issued regulations specifying the process MCOs must follow to *approve* a prior authorization request.

B. The Medicaid Program

States offer Medicaid programs, which are jointly funded by that state and the federal government. While federal law sets the parameters for the operation of the states' Medicaid Programs, each individual state enacts, administers, and enforces the specific state laws and regulations governing the operations of that state's Medicaid Program. How these laws and regulations regulate MCOs and MCO subcontractors also varies significantly from state to state.

II. FACTUAL BACKGROUND

A. EviCore's Business and Prior Authorization Process

EviCore is a leading provider of medical benefits management that helps patients receive necessary and timely medical services, supports physicians by easing their administrative burdens, and helps health plans provide the most appropriate quality of care. EviCore contracts with health plan clients nationwide to conduct prior authorization. *See* SAC ¶ 10. When health plans contract with eviCore for prior authorization, the plans establish plan-specific requirements in their contracts with eviCore. *See e.g. id.* ¶ 18. Health plans sometimes direct eviCore to approve certain services or certain types of services to ensure that patient care is not denied.

EviCore's prior authorization process begins when the physician submits the request for treatment or service to eviCore. *Id.* ¶ 89.¹² The physician certifies to the government health care program that a treatment or service is "medically necessary." The physician must provide clinical and demographic information to eviCore as part of the prior authorization request. *Id.*

¹¹ 42 C.F.R. § 422.566(d).

¹² EviCore's utilization management program is accredited by URAC (the Utilization Review Accreditation Organization). As a result, when eviCore's MCO clients are audited by CMS for compliance, the MCO is "deemed" by CMS to comply with CMS Quality Improvement requirements applicable to utilization management.

EviCore may approve prior authorization requests in one of three ways. First, eviCore may approve a case “as requested” based on a health plan’s direction and business rules. These directives are sometimes called “auto-approvals.” But they are more accurately described as requests that eviCore approves at the direction of, or “as requested” by the health plan. *Id.* ¶ 22. For example, during a hurricane, health plans may direct eviCore to approve all requests.

Second, eviCore may approve physicians’ requests through eviCore’s electronic clinical “pathways.”¹³ EviCore’s “pathways” utilize the clinical and demographic information about the patient that physicians submit to eviCore. The clinical pathway used by eviCore for specialized therapy cases is known as “CorePath.”¹⁴ *Id.* ¶ 90. CorePath is not an automatic approval or artificial intelligence. Rather, CorePath asks physicians condition-specific clinical questions to obtain information to evaluate a recommended service. *Id.* ¶¶ 89, 94. If the information submitted meets the criteria for approval, the physician will receive a real-time approval decision and may treat the patient immediately.

Third, if eviCore does not approve the case through its electronic pathways, or if eviCore needs more information about the requested service, an eviCore clinical reviewer (such as a physical or occupational therapist) will review the clinical information provided to eviCore. *Id.* ¶ 96. Based on the clinical information provided, and health plan requirements, eviCore’s clinical reviewers can approve the services requested. *Id.* ¶ 86. Only a physician, or other licensed medical professional, may deny services, as determined by state and CMS regulations. When eviCore denies a prior authorization request, the physician is informed that eviCore’s health plan

¹³ CMS expressly encourages its FFS contractors to use automated review processes. CMS, Medicare Program Integrity Manual, Ch. 1 § 1.3.7, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c01.pdf>; see also Ch. 7 § 7.2.2.1, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c07.pdf>.

¹⁴ Relators’ allegations focus on specialized therapy (*e.g.*, physical and occupational therapy), and through conclusory allegations, try to sweep in more lines of care covered by eviCore’s business. See *id.* ¶¶ 24, 112.

client will not pay for the physician’s recommended services, and so the patient either will not receive the requested care, or must pay for the services herself. *See id.* ¶ 85.

B. Relators’ Allegations Against eviCore

Relators rely on conclusory allegations that eviCore adopted procedures to “auto-approve” authorization requests, (*id.* ¶ 21), and by using these procedures, eviCore (1) “failed to satisfy its contractual requirements [with MCOs] and thus failed to provide necessary medical review functions for CMS and the Qui Tam States,” (*id.* ¶ 31) and (2) as a result of this failure, provided “worthless” prior authorization services to MCOs who contract with CMS. *Id.* ¶ 32.

According to Relators’ hypothetical assertions, “[i]f eviCore failed to provide utilization management services and/or review prior authorization request as contracted-for” and eviCore approved a non-reimbursable treatment, this “could result in patient harm and cost the Government a significant amount of taxpayer money.” *Id.* ¶ 16 (emphasis added). As a result of this “scheme,” eviCore allegedly caused health plans to submit false “claims for payment of worthless services” to the government in violation of the FCA. *Id.* ¶¶ 131-32. The SAC also asserts that eviCore “conspired with others” to implement “auto-approval” procedures. *Id.* ¶ 185.

Relators Jane Doe 1 and 2 are parties only to the retaliation claims. They allege that eviCore retaliated against them in violation of the FCA. Jane Doe 1 contends that after she voiced concerns, eviCore “retaliated against [her]” by “targeting her with unreasonable and uncommon productivity requirements” and a verbal warning about productivity. *Id.* ¶¶ 148-49. Jane Doe 2 alleges that after she raised concerns to eviCore (*id.* ¶¶ 154, 160), she was “passed over for a managerial promotion” (*id.* ¶ 155) and received a “verbal warning.” *Id.* ¶ 162. Neither Jane Doe 1 nor Jane Doe 2 were terminated; they voluntarily resigned. *Id.* ¶ 135.

LEGAL STANDARDS

To survive a motion to dismiss under Rule 12(b)(6), “a complaint must contain sufficient

factual matter, accepted as true, to state a claim to relief that is plausible on its face.” *Wood ex rel. U.S. v. Applied Research Assocs.* (“ARA”), 328 F. App’x 744, 746 (2d Cir. 2009) (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009)). The plausibility standard “asks for more than a sheer possibility that a defendant has acted unlawfully.” *Id.* at 746–47. Allegations that “merely create[] a suspicion [of] a legally cognizable right of action,” are insufficient, *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007), and “stop[] short of the line between possibility and plausibility of entitlement to relief.” *ARA*, 328 F. App’x at 747.

FCA complaints must also comply with Rule 9(b). *See U.S. ex rel. Gelbman v. City of N.Y.*, 790 F. App’x 244, 247 (2d Cir. 2019).¹⁵ An FCA complaint must identify: the false or fraudulent statement, who made it, when they did so, and how the false statement caused the submission of a false claim. *Gelbman*, 790 F. App’x at 247. For causes of action based on personal knowledge, the complaint must allege the specific false claims that were submitted, and for those based on information and belief, the complaint must “adduce specific facts supporting a strong inference of fraud” with respect to claims. *Id.* at 248.¹⁶ The “complaint must be supported by more than ‘conclusory statements’ or ‘hypotheses’ and it must set forth ‘particularized allegations of fact.’” *U.S. ex rel. Tessler v. City of New York*, 712 F. App’x 27, 29 (2d Cir. 2017). Though scienter may be asserted generally under Rule 9(b), courts have “repeatedly required plaintiffs to plead the factual basis which gives rise to a strong inference of fraudulent intent.” *Id.* (quoting *O’Brien v. Nat’l Prop. Analysts Partners*, 936 F.2d 674, 676 (2d Cir. 1991)); *see also*

¹⁵ In “alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake.” Fed. R. Civ. P. 9(b).

¹⁶ A “plaintiff may allege that fraudulent claims were submitted based on information and belief where (i) the plaintiff make[s] plausible allegations that the bills or invoices actually submitted to the government were uniquely within the defendant’s knowledge and control, and (ii) the plaintiff adduce[s] specific facts supporting a strong inference of fraud.” *U.S. ex rel. O’Toole v. Cmty. Living Corp.*, No. 17 Civ. 4007, 2020 U.S. Dist. LEXIS 85443 at *25 (S.D.N.Y. May 14, 2020) (internal quotations omitted); *U.S. ex rel. Chorches v. Am. Med. Response, Inc.*, 865 F.3d 71, 83 (2d Cir. 2017). Relators make no such allegation.

Universal Health Servs., Inc. v. U.S. ex rel. Escobar, 136 S. Ct. 1989, 2002 (2016) (“*Escobar*”) (FCA’s scienter requirement is “rigorous”).

ARGUMENT

I. THE SAC FAILS TO ALLEGE ADEQUATELY ANY OF THE FCA CLAIMS, AND SHOULD BE DISMISSED WITH PREJUDICE.

A. The SAC’s Allegations Lack Plausibility and Particularity as to Every Necessary Element of the False Claims Cause of Action (Count I).

The SAC typifies the sort of conclusory and speculative allegations that Rule 12(b)(6) and Rule 9(b) foreclose. “The FCA is not a general ‘enforcement device’ for federal statutes, regulations, and contracts, but a narrow statute focused on fraud against the Government.” *U.S. ex rel. Kolchinsky v. Moody’s Corp.*, 238 F. Supp. 3d 550, 556 (S.D.N.Y. 2017) (internal quotations omitted); *Escobar*, 136 S. Ct. at 2004 (“the [FCA] is not a means of imposing...penalties for “insignificant regulatory or contractual violations”). To allege an FCA violation, Relators must plausibly allege the defendant “knowingly present[ed], or cause[d] to be presented, a false or fraudulent claim for payment or approval.” 31 U.S.C. § 3729(a)(1)(A). Relators must allege that eviCore “(1) made a claim [or caused a claim to be made], (2) to the United States Government, (3) that is false or fraudulent, (4) knowing of its falsity, and (5) seeking payment from the federal treasury.” *Coyne v. Amgen, Inc.*, 717 F. App’x 26, 28 (2d Cir. 2017). Relators fail to plausibly allege these essential elements.

1. The SAC Does Not Plausibly Allege Any eviCore Claim to CMS or Any Claim That eviCore Caused an MCO to Submit to CMS.

The “submission of a ‘claim’ is an essential element” of an FCA violation. *E.g., U.S. ex rel. Ramos v. Icahn Sch. of Med.*, No. 12 Civ. 5089, 2015 U.S. Dist. LEXIS 124090, at *11 (S.D.N.Y. Sep. 16, 2015) (dismissing *qui tam* action for failing to allege false claims, and denying leave to amend SAC as futile). But the SAC does not identify any specific false claims,

and thus lacks this essential element of an FCA cause of action. The SAC also utterly fails to allege any specific false claims that an MCO submitted to CMS that were caused by eviCore's approval for payment of clinical services. Because Relators have not, and cannot identify any false claims for services, Count I is fatally flawed.

Instead, Relators only make conclusory allegations that eviCore caused MCOs to submit claims for services that “were going to be paid ultimately by government healthcare programs.” SAC ¶ 63.¹⁷ Relators' allegations are not plausible because MCOs do not submit “claims” to CMS for any specific services that eviCore approves. *See id.* ¶ 4. The physician who orders the service submits an invoice for the service to the MCO—not to the government—and the MCO pays the physician. *See SAC* ¶ 129. CMS's per-beneficiary payments to MCOs depend on the projected costs to provide care for that beneficiary based on their *health conditions* (diagnoses) and other factors, *not the services provided to a specific beneficiary*. *See id.* ¶ 4. The SAC thus does not and cannot plausibly allege that eviCore's purported approval of medical services caused MCOs to submit false claims to the government.

Unable to plausibly connect eviCore's review of specific physician requests for services or treatment with any MCO claims to CMS, Relators are left to recite the elements of the FCA. *Id.* ¶ 169; *see also* ¶ 32. The SAC's reliance on “labels and conclusions” and “a formulaic recitation of the elements of a cause of action,” is precisely the type of pleading barred by *Iqbal/Twombly*. *Twombly*, 550 U.S. at 555; *Leeds v. Meltz*, 85 F.3d 51, 53 (2d Cir. 1996).

2. The SAC Identifies No Specific Claims Necessary to Meet Rule 9(b)'s Heightened Pleading Standard.

“Rule 9(b)'s particularity requirement applies not just to allegations of fraudulent

¹⁷The SAC also alleges that the “claims relevant to [Count I] include all claims for payment submitted by MCOs to CMS for the above-referenced *prior authorization services* . . . which were caused to be submitted by virtue of eviCore's scheme directly to CMS.” SAC ¶ 168 (emphasis added). Relators do not identify any such claims.

schemes, but also to the submission of false claims.” *O’Toole*, 2020 U.S. Dist. LEXIS 85443, at *24. Relators’ generalized conclusions that eviCore “submitted or caused to be presented” false claims to the government also do not meet Rule 9(b)’s requirements. Relators never identify (1) a single service that eviCore should have denied, (2) a single claim submitted to CMS for any such service, (3) who submitted the claim, (4) when it was submitted, or (5) what payment the MCO sought from CMS. *See ARA*, 328 F. App’x at 750 (dismissing claims that did not allege a single false “record or billing submission” or “when a purportedly false claim was presented for payment by a particular defendant at a specific time”).

3. The SAC Fails to Allege that Any Claim Submitted to the Government Was “False.”

Even if Relators could allege that eviCore caused MCOs to submit claims to the government based on the prior authorization of medical services, Relators fail to allege that any MCO claims are “false.”¹⁸ Relators’ theory of “falsity” relies on unspecified contractual and regulatory violations, or allegations with no factual support that eviCore provided “worthless services” to health plans. SAC ¶ 170; *see also* ¶¶ 32, 87, 132, 168. These conclusory allegations do not allege “falsity,” as Relators identify no statute, regulation, or contract eviCore violated.

i. The SAC Identifies No Statute or Regulation that eviCore Violated or Caused a Medicare Advantage Plan to Violate.

The SAC does not and cannot plausibly allege that eviCore’s prior authorization processes violated any statute or regulation (*id.* ¶ 171) *requiring* health plans to perform prior authorization, or mandating how prior authorization must be conducted. No statute or regulation requires a health plan to use prior authorization or prescribes how a health plan must structure

¹⁸ A false claim is one “aimed at extracting money the government otherwise would not have paid.” *U.S. ex rel. Colucci v. Beth Isr. Med. Ctr.*, 785 F. Supp. 2d 303, 310 (S.D.N.Y. 2011). For example, a claim to a federal program for payment is false if the services were not provided, or in extreme cases, the services were provided but were so grossly deficient as to be “worthless” to the federal program. *Kolchinsky*, 238 F. Supp. 3d at 557.

prior authorization. In fact, the Medicare guidance upon which Relators rely states that contracts between CMS and a Medicare Integrity Program “carrier” contractor (not plans) “*may* include any or all of the following functions” including “[c]onducting medical reviews [and] utilization reviews” among others.¹⁹ Contrary to Relators’ theory, the only mandate that CMS explicitly imposes about utilization management services is that MCOs “may not implement utilization management protocols that create inappropriate *barriers* to needed care,” *i.e.*, to deny care.²⁰ The SAC alleges the opposite—that eviCore violated the FCA by *not* denying care—but provides no statutory or regulatory support for this assertion, because there is none.

ii. The SAC Does Not Identify Terms of Any Contract Between an MCO and eviCore or How eviCore Violated that Contract.

Relators also have not alleged “falsity” based on any eviCore failure to comply with a contract. CMS states that if MCOs decide to implement prior authorization, and engage a third-party to perform it, the MCOs set the terms of the prior authorization services by contract.²¹ Even though Medicare Advantage leaves it entirely up to MCOs to determine whether to use prior authorization and to implement any prior authorization process via contract, the SAC nowhere identifies any specific contracts at issue, nor the terms of any contracts. Relators, never *once* identify a contract, describe any terms of any contract between eviCore and an MCO that eviCore allegedly violated, or explain *how* eviCore’s authorization of services that any patient’s

¹⁹ 42 C.F.R. § 421.304 (emphasis added); SAC ¶ 69. The SAC alleges that MCOs are “carrier contractors” that are required to perform functions under the Medicare Integrity Program. SAC ¶¶ 69-71. This assertion is incorrect. Medicare Program Integrity contractors are under separate contracts with CMS for oversight of the Medicare FFS and Medicare Advantage program. *See* 42 C.F.R. § 421.304. Also, CMS *may* include some of these functions in contracts with its Medicare FFS contractors (known as “Medicare Administrative Contractors”), “carriers,” and “intermediaries.” 42 U.S.C. § 1395kk-1. MCOs and their service providers, such as eviCore, are neither carrier contractors nor Medicare Program Integrity contractors. 42 C.F.R. § 421.304.

²⁰ CMS, Medicare Managed Care Manual, Ch. 4 § 110.1.1 (emphasis added), available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>.

²¹ *See id.* Ch. 11 § 100.5 (requiring contract between vendor and MCO to “clearly state the responsibilities of the administrative services provider and its reporting arrangements”), available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c11.pdf>; *see also* SAC ¶ 11.

treating physician certified as medically necessary violated the terms of any contract. Instead, the SAC merely asserts the conclusion that eviCore failed to provide its “contracted-for” prior authorization services. *See, e.g.*, SAC ¶¶ 33, 35.

Relators’ allegations that eviCore did not provide “contracted-for services” also fall far short of Rule 9(b)’s heightened standard. The utter lack of particularity in Relators’ allegations to allege or describe what contracts, with which plans, covering what services, over what time period, that eviCore purportedly violated cannot possibly provide eviCore with fair notice of Relators’ alleged fraud, and do not satisfy Rule 9(b). *Ameti ex rel. U.S. v. Sikorsky Aircraft Corp.*, No. 14-cv-1223, 2017 U.S. Dist. LEXIS 93481, at *24 (D. Conn. June 19, 2017) (dismissing claims lacking any details identifying a governing contract or false claims); *U.S. ex rel. Youssef v. Tishman Constr. Corp.*, No. 12-cv-03862, 2017 U.S. Dist. LEXIS 42376, at *10 (E.D.N.Y. Mar. 23, 2017) (dismissing claims where relator failed to identify “any contract provision that was violated”).²² The SAC’s conclusory allegations that eviCore “failed to satisfy” some unknown contracted-for services (*see, e.g.*, SAC ¶ 31), does not satisfy Rule 9(b)’s demands. *U.S. ex rel. Ladas v. Exelis, Inc.*, 824 F.3d 16, 26- 27 (2d Cir. 2016).

Even if Relators could allege a specific contract or contract term, Relators identify not one single specific instance where eviCore approved a prior authorization request that should have been denied under the contract with a health plan, and an MCO submitted a claim to CMS for that service. The SAC contains no specific example of prior authorization requests that eviCore should have denied because it (1) was a medically unnecessary service, or (2) violated health plan rules for approval.²³ Absent such allegations, Relators’ claims fail.

²² Relators make the generalized statement that eviCore contracts with “third-party insurance companies, such as WellCare, to perform utilization management services.” SAC ¶ 85. That is not enough to satisfy Rules 8(a) or 9(b).

²³ The only specific prior authorization request alleged is that eviCore had to approve 200 visits for an ankle sprain. SAC ¶ 111. Relators do not allege this request violated any health plan rules for approval of treatment requests.

Indeed, all Relators allege is a mere *possibility* that the failure to comply with unspecified contractual obligations *could* cause a loss to the government. SAC ¶ 16. Courts have held that the “mere possibility of misconduct” cannot show “the pleader is entitled to relief.” *ARA*, 328 F. App’x at 747. The Court should dismiss Count I.

4. The SAC Fails to Allege that eviCore Caused False Claims to be Submitted by Performing Worthless Services.

Relators also try to generally contend that eviCore provided “worthless” services to health plans as their theory of “falsity.” The SAC alleges no plausible, particular facts to support the inflammatory claim that eviCore provided no services of value to any health care plan client.

In the Second Circuit, services are “worthless” where “the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all.” *Mikes v. Straus*, 274 F.3d 687, 703 (2d Cir. 2001), *abrogated on other grounds by Escobar*, 136 S. Ct. 1989. In other words, a “worthless services claim asserts that the knowing request of federal reimbursement” for a service with no value violates the FCA. *Id.* at 702. The SAC simply fails to meet this demanding standard and cannot plausibly allege that eviCore, which provides prior authorization services to health plans and over 100 million members nationwide, managed all prior authorization requests for its health plan clients in a manner *so deficient* that the services were “equivalent to no performance at all.” The SAC alleges no *facts* to support this outrageous claim, and simply stating the conclusion is insufficient as a matter of law.

In addition, Relators only allege that eviCore performed “auto-approvals” on a subset of the prior authorization reviews. SAC ¶¶ 22, 23, 25. These discrete allegations do not establish eviCore performed “no services at all” for MCOs, much less that “no services” were performed from the perspective of a federal program. Relators do not—and cannot—meet the high bar to allege worthless services. *Kolchinsky*, 2018 U.S. Dist. LEXIS 41117, at *14 (holding relator

failed to demonstrate defendant's ratings service was worthless where he acknowledges only some of defendant's ratings were erroneous); *U.S. v. Dialysis Clinic, Inc.*, No. 5:09cv00710, 2011 U.S. Dist. LEXIS 4862, at *62 (N.D.N.Y. Jan. 19, 2011) (dismissing claims that did "not allege that defendant failed to provide *any* services") (emphasis in original).

5. The SAC Fails to Allege Knowledge by eviCore that It Was Violating Contract Requirements by Denying Too Few Claims.

Relators also do not plausibly allege the required element of knowledge under the FCA. The Supreme Court has emphasized that the scienter requirement under the FCA is a "rigorous" one, and that complaints may be dismissed at the pleading stage for failure to allege knowledge adequately. *Escobar*, 136 S. Ct. at 2002. To survive a motion to dismiss, Relators must allege facts sufficient to establish a strong inference that the defendant acted "knowingly." 31 U.S.C. § 3729(b)(1)(A). For this element too, Relators rely on wholly conclusory allegations that "eviCore knowingly provided worthless services of no value to MCOs" and "thus knowingly failed to provide the medical review services that it was subcontracted to perform." SAC ¶¶ 32-33.

Here again, Relators offer no supporting facts that, if true, would show that eviCore knew that, by approving certain physician requests using processes permitted in their client contracts, it would violate its contract requirements with the plans or any regulatory requirements, or that it would cause any plan to submit purportedly false claims. As with the other FCA elements, this pleading failure dooms the FCA claims to dismissal. *Twombly*, 550 U.S. at 555.

B. The SAC Fails to State a Claim for Making False Statements Material to a False Claim (Count II).

Relators include even fewer allegations in Count II. Section 3729(a)(1)(B) provides for liability when the defendant "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(B). To prove a claim under this subsection, a "plaintiff must show that: (1) the defendant made (or caused to

be made) a false statement, (2) the defendant knew it to be false, and (3) the statement was material to a false claim. *U.S. ex rel. Kester v. Novartis Pharm. Corp.*, No. 11 Civ. 8196, 2014 U.S. Dist. LEXIS 81180, at *17 (S.D.N.Y. June 10, 2014). Thus, under this subsection, the plaintiff must plead both a false statement *and* a corresponding false claim.” *Id.*

1. Relators Fail to Plausibly Allege that eviCore Made Any False Statements to Managed Care Plans or Any False Claim, or That Any eviCore Statement Was Material to any False Claim.

Relators identify no specific eviCore false statement. Instead, as with Count I, they rely on conclusory allegations and empty recitations of the cause of action elements, without plausible, particular facts. Relators make the extraordinarily vague assertion that the “false or fraudulent records or statements underlying the false claims relevant to [Count II] include all false or fraudulent records or statements regarding eviCore’s prior authorization approval process made by eviCore to its client MCOs and adopted by the MCOs in communications with the Government in carrying out the scheme.” SAC ¶ 176. There are no facts alleged to support the conclusory allegations of eviCore false statements.

Count II also fails because the SAC lacks any allegations about how any (unidentified) false statement is “material” to any false claim (and as explained above, there are no false claims alleged). Again, it is indisputable that CMS pays MCOs based on members’ diagnosis codes—not approved medical services. So Relators’ allegations that eviCore “auto-approved” medical services are immaterial to CMS’s payments to MCOs as a matter of law. *See e.g. U.S. v. Am. Imaging Mgmt.*, No. 15 C 6937, 2019 U.S. Dist. LEXIS 53899, at *21-25 (N.D. Ill. Mar. 29, 2019) (granting motion to dismiss where “[g]iven the capitated payment scheme of the [Medicare Advantage] program,” allegations that defendant’s review process violated Medicare Rules was immaterial to the government’s decision to pay). For this reason, the SAC fails.

2. Relators Identify No Specific Statements, as Required By Rule 9(b).

The heightened standard of Rule 9(b), which applies equally to Section 3729(a)(1)(B) claims, requires that Relators “(1) specify the statements that the plaintiff contends were fraudulent, (2) identify the speaker, (3) state where and when the statements were made, and (4) explain why the statements were fraudulent.” *Gelbman*, 790 F. App’x at 247. In addition to other deficiencies of the SAC discussed above, Relators meet none of these essential 9(b) pleading requirements. Relators fail to identify any statements made or records provided to any MCOs, beyond a single statement to a Texas Medicaid plan—a single plan in one state, at that. SAC ¶ 127.²⁴ The rest of the SAC is devoid of any statements made or record provided by eviCore to any federal or state health care program at all, much less any details alleging who made the statement, where and when the statement was made and how the statement was fraudulent. Instead, Relators focus on alleged internal communications among eviCore employees, with no allegation any were provided or made to any MCOs or to CMS. These allegations are insufficient under Rule 9(b), *ARA*, 328 F. App’x at 750, and so the Court should dismiss Count II.

C. The SAC Fails to State a “Reverse False Claim” Cause of Action (Count III).

Relators identify no eviCore obligation to pay money to the government, as required to sustain Count III. Section 3729(a)(1)(G) is often called the “reverse false claims” provision because it covers claims concerning money *owed to* the government, rather than payments *made by* the government. To survive a motion to dismiss, Relators must specifically allege that eviCore knowingly (1) made a false record or statement material to an obligation to pay money to the government, or (2) concealed or improperly avoided an obligation to pay money to the

²⁴ Relators allege that on October 3, 2019, an eviCore representative stated to a [Medicaid plan] personnel that a “review decision granting full approval (made because of eviCore’s auto-approval policy) was based on an appropriate medical necessity review” when, according to Relators, “it was not.” SAC ¶ 127. Relators fail to cite to any facts to support these allegations in support of Relators’ personal belief.

government. 31 U.S.C. § 3729(a)(1)(G); *U.S. ex rel. Foreman v. AECOM Gov't Servs.*, 454 F. Supp. 3d 254, 268 (S.D.N.Y. 2020).

Relators do not make any plausible and particularized allegations satisfying any of these elements of their cause of action. As discussed above, the SAC identifies no false record or statement made by eviCore that could form the basis for this fraud claim. Relators fail to allege that eviCore received any money from any federal or state health care program, and that eviCore had an obligation to pay money to the government. *Id.* at 68-69. Rather, Relators' "reverse false claim" cause of action relies on the same conduct alleged with respect to the direct false claim, and simply recites the elements of a "reverse false claims" cause of action. *See* SAC ¶¶ 181-83. Because the SAC does not identify any eviCore financial obligation to the government, Count III should also be dismissed. *Foreman*, 454 F. Supp. 3d at 268 (holding complaint that does not identify "any financial obligation that the [defendant] owed to the government" or "any false records or statements used to decrease such an obligation must be dismissed").

D. The SAC Fails to State a Claim for Conspiracy Under the FCA (Count IV).

Section 3729(a)(1)(C) imposes FCA liability on anyone who conspires to commit an FCA violation. 31 U.S.C. § 3729(a)(1)(C). To allege conspiracy under the FCA, Relators must plausibly allege: "(1) an unlawful agreement by the defendant to violate the FCA, and (2) at least one overt act performed in furtherance of that agreement." *U.S. ex rel. Scharff v. Camelot Counseling*, No. 12-cv-3791, 2016 U.S. Dist. LEXIS 133292, at *26 (S.D.N.Y. Sept. 28, 2016). "Under the intracorporate conspiracy doctrine, the officers, agents, and employees of a single corporate entity, each acting within the scope of [his] employment, *are legally incapable of conspiring together.*" *Reich v. Lopez*, 38 F. Supp. 3d 436, 463 (S.D.N.Y. 2014)(emphasis added); *Farbstein v. Hicksville Pub. Library*, 254 F. App'x 50, 50-51 (2d Cir. 2007).

Relators do not allege an agreement to violate the FCA, but rely only on non-specific allegations of an eviCore conspiracy with unnamed “others.” SAC ¶ 185. Under the intracorporate doctrine, Relators’ conspiracy claim must fail because the SAC does not allege an agreement with any individual outside eviCore. *Farbstein*, 254 F. App’x at 51; *White v. City of N.Y.*, No. 13 Civ. 7156, 2014 U.S. Dist. LEXIS 123255, at *45 (S.D.N.Y. Sep. 3, 2014) (“[p]laintiff’s claim fails due to the ‘legal impossibility of pleading conspiracy by exclusive reference to actions of employees of a single corporation’”).

Relators’ boilerplate allegations that “eviCore conspired with others to implement ‘auto-approval’ procedures” (SAC ¶ 185), falls far short of meeting Relators’ pleading allegations under both Rules 8(a) and (9)(b). *See, e.g., Ladas*, 824 F.3d at 27 (upholding dismissal of FCA conspiracy claim that failed “to identify a specific statement where [defendants] agreed to defraud the government”); *Scharff*, 2016 U.S. Dist. LEXIS 133292 at *26 (dismissing conspiracy claim that failed to allege any agreement to violate the FCA).

Relators also make no plausible factual allegations of any “overt act” in furtherance of any agreement to violate the FCA, let alone with the sufficient particularity demanded by Rule 9(b). For these reasons, Count IV should be dismissed.

II. THE ANCILLARY STATE LAW CLAIMS FAIL TO ALLEGE ANY PLAUSIBLE CLAIMS UNDER ANY STATE FCA (COUNTS V-XX).

A. For the Same Reasons, Relators Do Not Plausibly Allege State Claims.

Relators’ state law claims must meet the same pleading standards that apply to the federal claims, and their viability (or lack thereof) rests on the same empty assertions that Relators offer to support their federal FCA counts. *See, e.g., U.S. ex rel. Blaum v. Triad Isotopes, Inc.*, 104 F. Supp. 3d 901, 912–13 (N.D. Ill. 2015); *U.S. ex rel. NPT Assocs. v. Lab. Corp. of Am. Holdings*, No. 1:07-cv-05696, 2015 U.S. Dist. LEXIS 155601, at *19 (S.D.N.Y. Nov. 17, 2015). For the

same reasons, the Court should dismiss all the state law counts. *NPT Assocs.*, 2015 U.S. Dist. LEXIS 155601, at *21 (“Where Relator has not sufficiently pled its allegations in any state, it would be illogical to allow those deficient allegations to support state-law claims.”).

B. All of the State Medicaid Claims Lack Plausible, Particularized Allegations.

Relators’ state law claims are no better supported than the federal claims. Relators allege that by entering into contractual arrangements with MCOs to provide prior authorization services for Medicaid Plans, and charging MCOs for those services, “eviCore was obligated to provide the contracted-for service” (SAC ¶ 27), and by failing to do so “thus failed to provide necessary medical review functions for CMS and the Qui Tam States by instituting [its] auto-approval policies.” *Id.* ¶ 31. The state law claims are insufficient for four reasons.

First, Relators do not allege *any* claims to *any* state Medicaid Plan that eviCore caused to be submitted, much less that any such claims were false. Relators have alleged only a boilerplate statement and conclusion of law that eviCore “submitted or caused to be presented” false claims to the *Qui Tam* states (*id.* ¶ 132), which is not enough. *Leeds*, 85 F.3d at 53.

Second, the SAC does not establish that eviCore violated any state-specific Medicaid requirements. Beyond a list of state statutory provisions in the SAC, which Relators baldly assert governs “subcontractor requirements” (SAC ¶ 83), the SAC fails to specifically allege any requirement that applies to eviCore in the performance of its prior authorization services or to identify any specific statute or regulation that eviCore purportedly violated. The SAC’s list of Medicaid laws and regulations (*see e.g., id.*) does not inform eviCore of the state law provisions eviCore allegedly violated when it comes to Medicaid managed care in the individual state.

Third, the SAC does not allege any facts showing the eviCore breached any contracts with Medicaid MCOs. Relators hypothetically assert that, as with Medicare, “state Medicaid agencies *can* delegate their duties to private insurance carrier contractors, including MCOs”

which “duties *may* include the determination as to whether services requested by a physician are medically necessary and appropriate.” *Id.* ¶ 82 (emphasis added). That there *could* be a contract is not sufficient. The SAC lacks any allegations about (1) which Medicaid MCOs contracted with a state Medicaid agency; (2) what state the MCO contracted with; (3) if the MCO subcontracted with eviCore for its Medicaid beneficiaries; (4) what services eviCore was contracted to provide; and (5) the terms of those contracts. The utter lack of any factual allegations concerning which subcontracted services eviCore allegedly provided to which Medicaid MCO recipients in which states is fatal to the SAC’s Medicaid claims. *N.Y. ex rel. Khurana v. Spherion Corp.*, No. 15 Civ. 6605, 2017 U.S. Dist. LEXIS 61158, at *27 (S.D.N.Y. Apr. 21, 2017) (“Rule 9(b) requires that a plaintiff set forth the who, what, when, where and how of the alleged fraud.”).

Finally, if the Court dismisses the federal law claims, but declines to address the alleged state law claims, in the alternative, the Court should dismiss the state law claims for lack of supplemental jurisdiction. *Giurca v. Orange Reg’l Med. Ctr.*, 2019 U.S. Dist. LEXIS 209198, at *8 (S.D.N.Y. Dec. 3, 2019); 28 U.S.C. § 1367(c)(3) (district court “may decline to exercise supplemental jurisdiction” if it “has dismissed all claims over which it has original jurisdiction”).

III. THE STATUTE OF LIMITATIONS BARS CLAIMS BEFORE MAY 21, 2014.

The FCA’s statute of limitations provides that a civil action under section 3730 may not be brought (1) more than 6 years after the violation is committed, or (2) more than 3 years after facts material to the right of action are known or reasonably should have been known by the government, but not more than 10 years after the violation is committed, whichever occurs last. 31 U.S.C. § 3731(b). As it applies to this case, when calculating the statute of limitations under subsection (b)(1), eviCore does not contest that the SAC reasonably relates back to the conduct alleged in the FAC filed on May 21, 2020, and thus the six-year statute of limitations extends

back to May 21, 2014. Because the initial complaint was filed under seal in this matter, was not provided to eviCore, and remains under seal today, eviCore has no basis to determine if the SAC relates back to the allegations in the initial complaint under Rule 15(c)(1)(B). For these reasons, all claims prior to May 21, 2014—six years before the FAC was filed in this matter—are barred.

IV. THE SAC FAILS TO PLAUSIBLY ALLEGE THAT EVICORE RETALIATED AGAINST RELATORS (COUNTS XXI-XXII).

The FCA’s anti-retaliation provision only applies to employees who engage in protected FCA conduct from being “discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment” because of such protected conduct. 31 U.S.C. § 3730(h). Jane Doe 1 and 2 must demonstrate that “(1) [they] engaged in conduct protected under the statute, (2) that defendants were aware of [their] conduct, and (3) that [they were] terminated in retaliation for [their] conduct.” *U.S. ex rel. Sasaki v. N.Y. Univ. Med. Ctr.*, No. 05 civ 6163, 2012 U.S. Dist. LEXIS 8672, at *33 (S.D.N.Y. Jan. 25, 2012).

Relators “Jane Doe 1” and “Jane Doe 2” were added as putative parties in the SAC. In the first place, Jane Doe 1 and 2 should not be permitted to proceed anonymously as they have alleged no facts supporting anonymity. *See e.g. Doe v. N.Y. State Dep’t of Health*, No. 1:20-cv-04817, 2020 U.S. Dist. LEXIS 170560, at *3 (S.D.N.Y. Sep. 17, 2020). The Court should dismiss their retaliation claims on that basis. *E.g., U.S. ex rel. Doe v. Janssen Pharm. N.V.*, No. CV 16-06997, 2018 U.S. Dist. LEXIS 226049, at *7 (C.D. Cal. Apr. 19, 2018) (dismissing FCA retaliation claims where anonymous relator “fails to meet her burden to show why the Court should let her proceed anonymously”).

A. The SAC Fails to Allege That eviCore Took Any Adverse Action.

Relators have also not plausibly alleged that eviCore took adverse employment action against them. Both Relators *voluntarily resigned* from eviCore. They have not alleged that

eviCore discharged them, demoted or suspended them, or took other action that impacted the terms or conditions of their employment. *See* 31 U.S.C. § 3730(h). In many employment contexts, adverse employment actions “include ‘termination of employment, a demotion evidenced by a decrease in wage or salary, a less distinguished title, a material loss of benefits, significantly diminished material responsibilities, or other indices that might be unique to a particular situation.’” *Fahrenkrug v. Verizon Servs. Corp.*, 652 F. App’x 54, 56 (2d Cir. 2016). None of these factors are present. Disruptions in the workplace, including “petty slights, minor annoyances, and simple lack of good manners,” fail to qualify. *Burlington Northern*, 548 U.S. 53, 68 (2006); *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 a “vacation request and [a] written warning” were “too trivial” to establish adverse action).²⁵

Relators rely on conclusory allegations that they were “forced to resign,” (SAC ¶¶ 150, 163), which is effectively a constructive discharge claim. “[A]n employee is constructively discharged when his employer, rather than discharging him directly, intentionally creates a work atmosphere so intolerable that [s]he is forced to quit involuntarily.” *Terry v. Ashcroft*, 336 F.3d 128, 151-52 (2d Cir. 2003). “[C]onditions are intolerable when, viewed as a whole, they are so difficult or unpleasant that a reasonable person in the employee’s shoes would have felt compelled to resign.” *Id.* at 152 (internal citation and quotations omitted); *U.S. v. Bank of Am. Corp.*, No. 12-cv-08399, 2016 U.S. Dist. LEXIS 44279, at *38 (S.D.N.Y. Mar. 31, 2016). Plaintiffs alleging constructive discharge “face 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) (citing *Miller v. Praxair, Inc.*, 408 F. App’x 408, 410 (2d Cir. 2010).

²⁵ Federal courts refer to Title VII case law when analyzing retaliation claims under the FCA. *See, e.g., Harrington v. Aggregate Indus.-Northeast Region, Inc.*, 668 F.3d 25, 32 (1st Cir. 2012).

Relators have not, however, alleged facts showing constructive discharge. They contend that they (1) were subject to productivity requirements (SAC ¶¶ 148, 162), and (2) received a verbal warning about low productivity metrics. *Id.* ¶¶ 149, 162. They allege a generalized concern about speaking up to management that is not tied to any type of protected conduct or any adverse employment action. *Id.* ¶ 136. Relators do not plausibly allege that a reasonable person would be compelled to resign under these circumstances. Being subject to productivity metrics, and receiving a verbal warning, do not plausibly show adverse employment action. *See Bank of Am. Corp.*, 2016 U.S. Dist. LEXIS 44279, at *39.

B. The SAC Fails to Allege Facts Plausibly Showing That eviCore Took Any Adverse Employment Action “Because Of” Protected Conduct.

Relators also have not plausibly alleged that eviCore took adverse employment action “because of” any protected conduct. While the Second Circuit has not defined the standard of causation for FCA retaliation claims, the Supreme Court has clarified that the term “because of” typically “imports, at a minimum, the traditional standard of but-for causation.” *Lawrence v. Int’l Bus. Mach. Corp.*, No. 12CV8433, 2017 U.S. Dist. LEXIS 120804, at *37 (S.D.N.Y. Aug. 1, 2017).²⁶ Here, Relators have not alleged that “but for” protected conduct, they were subject to performance metrics, received a warning for low metrics, or needed to ask permission to attend meetings. The retaliation claims should therefore be dismissed.

V. CONCLUSION

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

²⁶ Relators have not alleged that they were engaged in activities that would have given “the employer reason to believe that the employee was contemplating a *qui tam* action against it.” *U.S. ex rel. Vallejo v. Investronica, Inc.*, 2 F. Supp. 2d 330, 339 (W.D.N.Y. 1998).

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Respectfully submitted,

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