UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES OF AMERICA	)	
	)	
***ex rel*. DR. SUSAN NEDZA,**	)	
	)	
Plaintiff, Relator	)	
	)	
vs.	)	**No. 1:15-CV-6937 (JLA)**
	)	
AMERICAN IMAGING MANAGEMENT, INC., ET AL.,	)	**Hon. Judge Alonso** **Magistrate Judge Cox**
	)	
Defendants.	)	
	)	
	)	
	)	
	)	

DEFENDANT BLUE CROSS BLUE SHIELD OF MICHIGAN MUTUAL INSURANCE COMPANY'S MOTION TO DISMISS RELATOR'S SECOND AMENDED COMPLAINT

Defendant Blue Cross Blue Shield of Michigan Mutual Insurance Company ("BCBSM"), by and through its attorneys and pursuant to Rules 9(b) and 12(b)(6) of the Federal Rules of Civil Procedure, hereby moves this Court to dismiss both counts of the Relator's Second Amended Complaint, with prejudice, as to BCBSM. As set forth more fully in BCBSM's Memorandum in Support of its Motion to Dismiss Relator's Second Amended Complaint, which is being filed contemporaneously with this motion, Relator fails as a matter of law to state any claim under the False Claims Act against BCBSM. Furthermore, the False Claims Act's public disclosure bar precludes Relator's complaint as a matter of law.

WHEREFORE, BCBSM respectfully requests that the Court enter an Order dismissing Relator's Second Amended Complaint with prejudice, and awarding any other relief the Court deems just and proper.

Dated: March 13, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that all counsel of record who are deemed to have consented to electronic service are being served with a copy of this document via the Court's CM/ECF system on this 13th day of March, 2018.

/s/ Heather M. O'Shea

Heather M. O'Shea
An attorney for Blue Cross Blue Shield of Michigan Mutual Insurance Company

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DEFENDANT BLUE CROSS BLUE SHIELD OF MICHIGAN MUTUAL INSURANCE COMPANY'S MEMORANDUM IN SUPPORT OF MOTION TO DISMISS RELATOR'S SECOND AMENDED COMPLAINT

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Relator Susan Nedza's Second Amended Complaint ("SAC") should be dismissed as to Blue Cross Blue Shield of Michigan Mutual Insurance Company ("BCBSM") for the simple reason that Relator has no facts related to BCBSM, notably referencing BCBSM by name in only *five paragraphs* of the 169-paragraph SAC. And in no instance does Relator plead any facts about (1) BCBSM's purported relationship with the government or with American Imaging Management, Inc. ("AIM"), on whose conduct she bases her allegations; (2) any false claim for payment submitted by BCBSM; (3) any knowledge on the part of BCBSM of AIM's alleged fraudulent conduct; or (4) any conduct of BCBSM that would have been material to the government's decision to pay BCBSM's claims. Put simply, Relator does not provide a plausible factual basis for liability under the federal False Claims Act ("FCA"), let alone with the particularity required by Rule 9(b). Even if she did, Relator's allegations have already been publicly disclosed as the complaint itself describes at length. The complaint is thus precluded as a matter of law and should be dismissed, with prejudice.

BACKGROUND

Relator alleges that the 27 insurers named in the SAC contracted with the Centers for Medicare and Medicaid Services ("CMS") to provide Medicare Advantage ("MA") services. SAC ¶ 4. Under the MA program, the government, through CMS, pays each MA plan a capitated payment, i.e., a fixed monthly dollar amount for each Medicare beneficiary enrolled in that plan, based on factors such as the beneficiary's geographic location, gender, age, and health status. *Id.* ¶ 30. The MA plan then pays for that beneficiary's health care services. *Id.*

CMS permits MA plans to employ "utilization management," or UM, processes. "Pre-authorization" — by which insurers determine whether a particular medical procedure is medically necessary and appropriate for a patient before the insurer or the patient pays for the

procedure — is one of these accepted UM processes. *Id.* ¶ 40. Relator alleges that the 27 named "Defendant Insurance Plans" contracted with her former employer, AIM, to conduct pre-authorization assessments. *Id.* ¶ 6. According to Relator, AIM employed too strict a standard for determining which procedures to authorize, resulting in AIM denying too many procedures. *Id.* ¶ 53. Because of these higher-than-average denials, Relator alleges, each of AIM's customers violated their contract with CMS, resulting in false claims to the government. *Id.* ¶ 156. Notably, Relator bases her theory on the fact that CMS cited several of the Defendant Insurance Plans for noncompliance following audits of AIM's practices. *Id.* ¶¶ 16, 73, 107, 119, 120, 136, 137. She admits, however, that the audited plans continued to serve as MA providers. *Id.* ¶ 136.

APPLICABLE PLEADING STANDARDS

Under Federal Rule of Civil Procedure 12(b)(6), a court must dismiss a complaint if it does not allege facts that, when "accepted as true … state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). The plaintiff must offer more than a "formulaic recitation of the elements" or "a sheer possibility that a defendant has acted unlawfully." *Id.* And where the complaint asserts claims against multiple defendants, the court must separately consider its adequacy as to each defendant. *See U.S. ex rel. Young v. Suburban Home Physicians*, No. 14-CV-02793, 2017 WL 2080350, at *8-9 (N.D. Ill. May 15, 2017).

Because the FCA is a fraud statute, a relator also must satisfy Rule 9(b), which "requires a plaintiff (or in this case, relator) to describe the 'circumstances' of the alleged fraud with 'particularity.'" *U.S. ex rel. Keen v. Teva Pharms. USA Inc.*, No. 15 C 2309, 2017 WL 36447, at *2 (N.D. Ill. Jan. 4, 2017) (Alonso, J.) (quoting *Windy City Metal Fabricators & Supply, Inc. v. CIT Tech. Fin. Servs., Inc.*, 536 F.3d 663, 668 (7th Cir. 2008)). An FCA complaint must also plead specific facts to support allegations that the defendant knew of the fraudulent conduct and that the fraudulent conduct was material to the government's decision to pay. *See Thulin v.*

Shopko Stores Operating Co., 771 F.3d 994, 1000 (7th Cir. 2014); *Universal Health Servs., Inc. v. Escobar*, 136 S. Ct. 1989, 2004 n.6 (2016).

ARGUMENT

Relator's five total mentions of BCBSM in an 160-plus paragraph complaint come nowhere near establishing the elements of her FCA claims against BCBSM, much less with the specificity Rule 9(b) requires. The SAC fails as a matter of law because it: (1) fails to satisfy 9(b), in that it does not identify any conduct of BCBSM in particular that could form the basis for an FCA violation; (2) fails to identify any false claim, knowledge on the part of BCBSM that any claim submitted was false, or that any statement (implied or express) was material to the government's decision to pay; and (3) triggers the FCA's public disclosure bar. This Court should therefore dismiss Relator's complaint against BCBSM, with prejudice.

I. RELATOR FAILS TO PLEAD FRAUDULENT CONDUCT BY BCBSM.

Rule 9(b) serves "three main purposes: (1) protecting a defendant's reputation from harm; (2) minimizing 'strike suits' and 'fishing expeditions'; and (3) providing notice of the claim to the adverse party." *Jepson, Inc. v. Makita Corp.*, 34 F.3d 1321, 1327 (7th Cir. 1994). Provision of fair notice is of "especial importance in a case involving multiple defendants." *Young*, 2017 WL 2080350, at *5 (internal citations omitted). Accordingly, only a complaint that "inform[s] each defendant of the specific fraudulent acts that constitute the basis of the action against the particular defendant" will satisfy Rule 9(b)'s rigorous notice standard. *Id.*

Measured against these heightened standards, Relator fails to satisfy 9(b) for several reasons. First, Relator fails to "provid[e] the 'who, what, where, when and how'" of any alleged false claim or statement; such as the dates, signatory, or content of any MA contract BCBSM may have had or the dates, content, or amount of claims allegedly made thereunder. *Keen*, 2017 WL 36447, at *2. Second, Relator offers no detail on the allegedly fraudulent conduct — no

claims denied, no beneficiaries affected, no money allegedly saved as a result. Third, Relator attempts to plead in the collective, and offers no examples of BCBSM's conduct. *See U.S. ex rel. Radke v. Sinha Clinic Corp.*, No. 12-cv-6238, 2015 WL 4656693, at *3 (N.D. Ill. Aug. 5, 2015).

Relator generally alleges that MA plans certify that they will follow Medicare guidance as a condition of participation in the MA program. SAC ¶¶ 32, 156. But Relator offers *no information whatsoever* about any contract between *BCBSM* and CMS to participate in the MA program, or about any representations BCBSM allegedly made to obtain that contract. Nor does she allege when, or how, anyone at BCBSM made any misrepresentation, much less who made it. *See* SAC ¶¶ 23, 118, 130, 146, 147; *U.S. ex. rel. Grenadyor v. Ukrainian Vill. Pharm., Inc.*, 772 F.3d 1102, 1106 (7th Cir. 2014). Equally fatal, Relator pleads no facts about any allegedly false claims by BCBSM. *See U.S. ex rel. Dolan v. Long Grove Manor, Inc.*, No. 10 C 368, 2014 WL 3583980, at *3 (N.D. Ill. July 18, 2014) ("[Relator] must link specific allegations of deceit to specific claims for payment."). Relator also fails to identify any information, such as the "dates, amounts, or other details of actual payments" BCBSM allegedly received from the government, which would allow the Court to infer BCBSM requested payment. *See U.S. ex rel. McGinnis v. OSF Healthcare Sys.*, No. 11-CV-1392, 2014 WL 2960344, at *8 (C.D. Ill. July 1, 2014).

To conceal her deficient allegations as to BCBSM, Relator lumps it together with 26 other defendants and attempts to describe their conduct in the collective. The defendant insurers, however, are not one and the same. For one, unlike the bulk of the defendants, BCBSM is a "non-Anthem insurance plan" that has no corporate relationship with Anthem, or by extension, AIM. SAC ¶ 23. What's more, Relator fails to identify even a contract between BCBSM and AIM that could support her supposed fraudulent scheme, much less any dates of service,

signatories, or scope of work. Finally, even assuming there were some relationship between BCBSM and AIM, Relator does not identify a single example of a claim or benefit allegedly denied by AIM on behalf of BCBSM. *See* SAC ¶ 89. Indeed, the SAC *contains no allegations whatsoever* as to BCBSM's denial of coverage or rejection of pre-authorization requests.

Without particular allegations or a "representative example" of any fraudulent conduct by BCBSM, let alone any contract with or claim submitted to CMS by BCBSM, Relator does not provide close to adequate notice to BCBSM "of the nature of [its] alleged participation in the fraud," as Rule 9(b) requires. *Radke*, 2015 WL 4656693, at *3. Given these fundamental deficiencies, allowing the SAC to move forward against BCBSM would undercut Rule 9(b)'s purposes by permitting Relator to engage in a groundless fishing expedition without notice to BCBSM of the conduct in which Relator believes it engaged. *Jepson*, 34 F.3d at 1327; *Dolan*, 2014 WL 3583980, at *6 ("[R]elator is not entitled to embark on a fishing expedition against thirteen entities … based on the fraud he claims to have witnessed as an employee of one.").

II. RELATOR FAILS TO ESTABLISH ANY ELEMENT OF AN FCA VIOLATION.

Relator asserts two counts against BCBSM as part of the "Defendant Insurance Plans." Count I alleges that the Defendant Insurance Plans "repeatedly and knowingly presented, or caused to be presented, [a] false or fraudulent claim for payment or approval to [CMS]" in violation of 31 U.S.C. § 3729(a)(1)(A). SAC ¶ 163. Count II alleges that the Defendant Insurance Plans "repeatedly and knowingly made or used or caused false statements or records to be made or used that were material to a false or fraudulent claim" by falsely certifying compliance with Medicare guidance in violation of 31 U.S.C. § 3729(a)(1)(B). *See id.* ¶ 168.

To plausibly allege a violation of 31 U.S.C. § 3729(a)(1)(A), a complaint must allege that each individual defendant (1) presented "for payment or approval by the government"; (2) "a false or fraudulent claim"; (3) "know[ing] the claim [wa]s false." *Grenadyor*, 772 F.3d at 1105

(internal quotation marks omitted) (quoting 31 U.S.C. § 3729(a)(1)(A)). A violation of 31 U.S.C. § 3729(a)(1)(B), requires allegations that (1) each defendant made a statement in order to receive payment from the government; (2) the statement was false; and (3) the defendant knew the statement was false. *Thulin*, 771 F.3d at 998. Relator pleads none of these elements.

A. Relator Pleads No False Claim or False Statement.

It is well-established that statutory, regulatory, or contractual violations, like those alleged here, cannot form the basis of an FCA violation unless the defendant falsely certifies compliance with the statute, regulation, or contract as a condition of payment, *and* compliance is material to the government's payment decision. *See U.S. ex rel. Lisitza v. Par Pharm. Cos., Inc.*, 276 F. Supp. 3d 779, 797-98 (N.D. Ill. 2017); *U.S. ex rel. Yannacopoulos v. Gen. Dynamics*, 652 F.3d 818, 836 (7th Cir. 2011) ("[A] mere breach of contract does not give rise to liability under the False Claims Act."). Relators generally pursue two false certification theories: (1) express certification, in which the defendant expressly certifies that its conduct complies with a particular statute, regulation, or contractual term as a prerequisite to payment, knowing the certification is false, *Grenadyor*, 772 F.3d at 1105; and (2) implied certification, in which a bill submitted to the government acts as an implicit assurance that it presents a lawful claim for payment, *id.* at 1106. Relator here appears to rely solely on an implied certification. The Supreme Court has limited implied certification to situations where a defendant submits a claim containing "specific representations" about the goods and services for which it requests payment and fails to disclose material noncompliance with statutory, regulatory, or contractual requirements. *Escobar*, 136 S. Ct. at 2001. The complaint fails to satisfy this test.

1. Relator cannot imply a false certification by BCBSM.

Relator's theory that alleged deficiencies in BCBSM's pre-authorization reviews rendered its claims for payment false fails both prongs of the implied certification test. Relator's

claims should be dismissed because she alleges neither: (1) that any claim of BCBSM "makes specific representations about the goods or services provided," nor (2) that BCBSM's "failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths." *Escobar*, 136 S. Ct. at 2001.

As to the first prong, Relator does not allege facts about any BCBSM claims for payment, much less that such claims "make[] specific representations about the goods or services provided." *Id*. And for good reason. MA plans do not make representations about the services they provide, or deny, a beneficiary in claims they submit to CMS. Rather, MA plans submit demographic and medical diagnosis information about their enrollees, and receive capitated payments that do not vary based on the services provided. 42 C.F.R. § 422.504; SAC ¶ 32; *see also Lisitza,* 276 F. Supp. 3d at 797 (regulatory "violations [that] might lead to 'unauthorized billing' … do not, without some 'specific representation,' make the submitted claims 'false'").

Relator also fails the second prong for implied certification, as she cannot make out a breach by BCBSM of any statutory, regulatory, or contractual requirement. Without a violation, there can be no misleading half-truth. *See Escobar*, 136 S. Ct. at 2001.

As explained above, Relator offers no information about any contract between BCBSM and CMS to participate in the MA program, nor about where, or when, or to whom, or how BCBSM allegedly certified compliance with the SAC's distorted definition of "Medicare Rules."[1] *See* SAC ¶ 32. Nor does she does allege a single instance in which BCBSM rejected a pre-authorization request or denied a beneficiary any Medicare benefit because of AIM's

[1] Relator defines "Medicare Rules" in the SAC as including "the Medicare statute, Medicare regulations, and *all Medicare non-regulatory guidance, procedures, and policies regarding coverage and treatment of beneficiaries*." *Id.* (emphasis added). For the reasons discussed below, Relator has no factual support for her definition, which she invented out of whole cloth.

reported pre-authorization process. Thus, Relator pleads no facts showing that *BCBSM specifically* violated a statutory, regulatory, or contractual requirement.

Even setting aside this fundamental failure, Relator's collective allegations fare no better. Her allegations do not establish that AIM's practices caused *any* MA organization to violate any Medicare statute, regulation, or contractual requirement. As Relator admits, Medicare regulations expressly authorize MA plans to use their own internal policies and procedures (which may include pre-authorization services) to make coverage determinations. 42 C.F.R. § 422.112(a)(6)(ii); SAC ¶ 40. Relator further acknowledges that AIM did comply with Medicare regulations requiring that a medical professional review adverse decisions. *See* 42 C.F.R. § 422.566(d); SAC ¶ 56 (alleging that both a nurse and a physician reviewer had to approve denials of pre-authorization requests).

Without any specific statutory or regulatory breach to cite, Relator relies solely on alleged deviations by the collective "Defendant Insurance Plans" — none specifically by BCBSM — from the Medicare Managed Care Manual. *See, e.g.*, SAC ¶¶ 33, 35, 36, 37, 38, 39, 43, 71, 72, 75, 79, 82, 84, 93 (citing Medicare manuals as sources of alleged violations of law). But such Medicare guidance does not have the force and effect of law. *See Shalala v. Guernsey Mem'l Hosp.*, 115 S. Ct. 1232, 1239 (1995) (labeling Medicare manuals as a forum for "the promulgation of interpretive rules and general statements of policy" that do not have the force and effect of law).[2] Nor can Relator credibly say BCBSM ever certified that it would comply with this nonbinding guidance. Instead, MA plans agree in their contracts with CMS to provide

[2] The government, the real party in interest, recently confirmed "[g]uidance documents" cannot create binding requirements that do not already exist by statute or regulation. *See* DOJ Office of the Assoc. Attny. Gen., Memo: Limiting Use of Agency Guidance Documents in Affirmative Civil Enforcement Cases, Jan. 25, 2018, *available at* https://www.justice.gov/file/1028756/download (last visited March 12, 2018). The court may take judicial notice of the memorandum, which is a matter of public record. *See, e.g., Cause of Action v. Chi. Transit Auth.* ("*CTA*"), 815 F. 3d 267, 277 n.13 (7th Cir. 2016).

basic Medicare benefits "[i]n a manner consistent with professionally recognized standards of health care," and to comply with the U.S. Code and the Code of Federal Regulations. *See* 42 U.S.C. § 1395w-27; 42 C.F.R. § 422.101; *id.* § 422.504(a). Relator's attempt to bind MA plans to "Medicare non-regulatory guidance, procedures, and policies regarding coverage" is a nonstarter. *See* SAC ¶ 32 (alleging the Defendant Insurance Plans certified compliance with "Medicare Rules," including nonbinding guidance); *U.S. ex rel. Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 732-33 (7th Cir. 1999) (granting summary judgment where regulations cited by relator did not require what relator pled). Moreover, this guidance is capable of multiple different, but reasonable, opinions based on the medical judgment of the reviewing physician. The fact that Relator disagrees with how AIM's reviewing physicians interpreted the guidelines does not make certifications of compliance with those guidelines "objective[ly] false[]." *Yannacopoulos*, 652 F.3d at 836; *U.S. ex rel. Lamers v. City of Green Bay*, 168 F.3d 1013, 1018 (7th Cir. 1999) ("differences in interpretation growing out of a disputed legal question are [] not false under the FCA").

Relator's five examples of services allegedly denied by AIM — none for BCBSM —- fare no better in establishing a violation of the SAC's version of "Medicare Rules." *See* SAC ¶ 89. Apart from the fact that not one of the identified examples is specific to BCBSM, they all fail to identify any actual beneficiary who was allegedly denied access to any services as a result of AIM's policies, a physician reviewer who allegedly denied a beneficiary services, or the basis for Relator's belief that the services would have been medically appropriate. *See Dolan*, 2014 WL 3583980, at *5 (dismissing FCA complaint for failing to "identify any patients allegedly referred," the referring physician, the therapy provided, or the "basis for relator's belief that the therapy was unnecessary"). This information is necessary to provide BCBSM notice of the

allegedly fraudulent conduct in which Relator alleges it engaged. *See id.*; *Grenadyor*, 772 F.3d at 1106 (dismissing complaint that failed to plead that specific patients received kickbacks).

Without any facts as to coverage denied, beneficiaries affected, or how regulations were allegedly violated, Relator fails to show how AIM's pre-authorization process caused BCBSM to violate its supposed contractual or legal obligations. *See Dolan*, 2014 WL 3583980, at *6.

2. Relator does not allege facts establishing a false express certification.

Although Relator's complaint appears to be premised on an implied certification, it would also fail under an express certification theory. As noted, Relator rests her claims solely on an alleged *contractual* promise she asserts the 27 MA plans made to comply with supposed "Medicare Rules," as participants in the MA program. SAC ¶¶ 32. At best, this is a "forward-looking statement—a promise or undertaking—not a false representation." *U.S. ex rel. Kennedy v. Aventis Pharms.*, 610 F. Supp. 2d 938, 946 (N.D. Ill. 2009). Crucially, Relator does not allege any facts showing the supposed promise was false *when it was made*. *See Grenadyor*, 772 F.3d at 1105 ("The problem with this part of [the] complaint lies ... in an insufficient showing that the 'I agree' statement was false when the pharmacy made it."). Relator does not allege when BCBSM first initiated either its relationship with CMS or its relationship with AIM, much less that BCBSM knew about AIM, its services, or its alleged noncompliance at the time of any alleged certification. *See U.S. ex rel. Garst v. Lockheed-Martin Corp.,* 328 F.3d 374, 378 (7th Cir. 2003) (what matters is whether a defendant "said something knowing at the time that the representation was false (or not intending to perform)"). Accordingly, Relator fails to allege any actionable certification of compliance or other false statement. Thus, she cannot sustain an FCA claim. *See Kennedy*, 610 F. Supp. at 946 (dismissing FCA complaint for its failure to allege "any specific certification by a [defendant], in connection with a Medicare claim, that it had

acted in compliance" with Medicare laws and regulations).[3]

B. Relator Fails to Allege BCBSM Knew of AIM's Alleged Conduct.

Not only does the SAC fail to identify any false claim submitted by BCBSM, it also fails to allege that BCBSM knew of any alleged fraud. Plausible allegations of knowledge under the FCA require specific facts showing that the individual making the false statement acted with actual knowledge, deliberate ignorance, or reckless disregard to the possibility that submitted claims were false. *Thulin*, 771 F.3d at 1000 ("vague allegations" do not suffice). To meet this test for a false certification, a complaint must allege that someone at the defendant's organization knew: (i) of non-compliant conduct, (ii) the conduct did not comply, and (iii) the submission of claims amounted to a certification of compliance; and (iv) still decided to engage in the non-compliant conduct. *See U.S. ex rel. Berkowitz v. Automation Aids*, No. 13 C 08185, 2017 WL 1036575, at *7 (N.D. Ill. Mar. 16, 2017). Relator alleges none.

Relator attempts to allege knowledge through sweeping allegations that *all* Defendant Insurance Plans knew or recklessly disregarded the fact that AIM allegedly violated "Medicare Rules." SAC ¶¶ 149, 157. As an initial matter, these allegations fail to show, or even allege, that BCBSM knew its requests to CMS for capitation payments impliedly or expressly certified compliance with Relator's distorted definition of "Medicare Rules" on the part of both BCBSM and AIM. Without any such allegations, Relator cannot plausibly allege BCBSM *knew* any claims it may have submitted were false.

Moreover, Relator must allege that BCBSM knew of the alleged noncompliant conduct

[3] Relator's false certification theory also should be dismissed because, for the reasons stated above, she has provided no support for her allegations (1) that BCBSM entered into a contract with CMS in which it promised to comply with the entire universe of Medicare rules in order to receive payment; or (2) that BCBSM failed to live up to that promise. *See supra* pages 6-9; *Yannacopoulos*, 652 F.3d at 827 (no false certification where defendant complied with the contract with which it certified compliance).

by AIM, and she has not. *Berkowitz*, 2017 WL 1036576, at *7. *First*, Relator alleges Anthem executives knew of AIM's policies through their conversations with AIM executives, *id.* ¶¶ 133, 134, 140, 141, but Relator acknowledges that BCBSM has no affiliation with Anthem, *id.* ¶ 23. *Second*, while Relator describes internal discussions among AIM executives related to BCBSM, strikingly, Relator provides no detail that BCBSM knew of those discussions. *See id.* ¶¶ 130, 146. *Third*, while Relator generally alleges that MA plans "pledge to monitor the performance of all subcontractors 'on an ongoing basis,'" she does not allege that BCBSM did not monitor AIM's performance, or that BCBSM's monitoring procedures were reckless. *See id.* ¶ 33. In fact, Relator's own allegations suggest BCBSM did monitor AIM's processes, and was convinced by AIM that its decisions were reasonable: Relator's sole reference to actual communications between BCBSM and AIM describes how AIM "walked them off the cliff" and assured BCBSM that AIM's process for assessing pre-authorization requests ***did not*** violate any applicable statutes and regulations. *See id.* ¶ 146. Relator fails to allege any facts that could give rise to a plausible inference that BCBSM knew otherwise. *See Thulin*, 771 F.3d at 1000-01.

C. Relator Does Not Allege Any Certifications Were Material to the Government's Decision to Pay.

In addition to failing to allege that BCBSM made a knowingly false statement to obtain payment, Relator also fails to plead any facts supporting her bald assertion that the government paid for claims that it would not have allowed had it been aware of the purported falsity. *See* SAC ¶¶ 165, 169. Supreme Court precedent compels the dismissal of a complaint that does not allege factual support for an assertion of materiality. *See Escobar*, 136 S.Ct. at 2001.

In *Escobar*, the Supreme Court clarified that the government's past practices were key to determining materiality. *Id.* at 2002. As the Supreme Court explained:

> [I]f the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements

> are not material. Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.

Id. at 2003-04.

Relator's allegations perfectly mimic the hypothetical posed by the Supreme Court in *Escobar*. She describes multiple instances where CMS allegedly identified issues with AIM's guidelines and processes during audits of MA plans. SAC ¶¶ 73, 107, 119. But Relator does not allege that CMS terminated those plans' participation in the MA program or required them to pay back any funds they received from the government during that time. Nor does Relator allege that CMS declined to pay those plans going forward, after the audits. Instead, Relator describes "CMS audit findings prior to 2008 that criticized a [health] plan (through AIM) for ignoring Medicare Rules in the AIM review process," and then concedes that the same plan continued to use AIM, with no "change in position." *Id.* ¶ 136; *Escobar*, 136 S. Ct. at 2004.[4]

Relator attempts to allege materiality by citing certain regulations covering MA plan contracts (42 C.F.R. §§ 422.101 and 422.504(a)), but these regulations do not condition payment on a plan's compliance with them. SAC ¶ 32. To the contrary, the applicable statute and regulations provide a range of remedies other than denying payment for MA plans that "fail[] substantially to provide medically necessary items and services." 42 U.S.C. § 1395w-27(g); 42 C.F.R. § 422.510 (offering an opportunity to cure). And even if those regulations *did* condition payment upon compliance (which they do not),"[a] misrepresentation cannot be deemed material merely because the government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment." *Escobar*, 136 S. Ct. at 2003.

[4] If CMS's own audits were not sufficient to put it on notice of AIM's practices, it is difficult to imagine how Relator could allege "the [government] remained unaware that the claims were false after the lawsuit was filed." *City of Chi. v. Purdue Pharma L.P.*, 211 F. Supp. 3d 1058, 1079 (N.D. Ill. 2016) (Alonso, J.).

III. THE FCA'S PUBLIC DISCLOSURE BAR REQUIRES DISMISSAL

Finally, even if Relator could make out the basic elements of an FCA violation as against BCBSM — which she cannot — this Court would nevertheless be required to dismiss the action under the FCA's public disclosure bar. *See* 31 U.S.C. § 3730(e)(4)(A) (encompassing disclosures in a "congressional, Government Accountability Office, or other Federal report, hearing, *audit*, or investigation"). Determining whether a qui tam claim is barred involves three steps: (1) Have plaintiff's allegations been publicly disclosed? (2) Is the lawsuit "based upon, *i.e.*, substantially similar to" that publicly disclosed information? (3) Is the plaintiff an original source of the information? *CTA*, 815 F.3d at 274.[5] The relator bears the burden of proof. *Id.*

Seventh Circuit precedent holds that disclosure of facts exposing a scheme as fraudulent to a government official, including in an administrative audit or investigation, bars an FCA action predicated on those facts unless the relator is an original source. *See U.S. ex rel. Lisitza v. Par Pharm. Cos., Inc.*, No. 06 C 06131, 2017 WL 3531678, at *9 (N.D. Ill. Aug. 17, 2017) (quoting *CTA*, 815 F.3d at 275). Relator alleges that CMS audited multiple MA plans, and that those audits revealed the very conduct on which she bases her FCA claims. SAC ¶¶ 53, 107, 120, 136. Thus, based on Relator's own allegations, the conduct at issue was publicly disclosed.

Not only has there been a "public disclosure," Relator's allegations are also "substantially similar" to the publicly disclosed allegations." *CTA*, 815 F.3d at 281. Relator bases her allegations that AIM's processes violated Medical Rules, and that defendants knew of the violations, on the findings of CMS audits. *See, e.g.*, SAC ¶¶ 73, 107, 119, 120, 136. There can be no question that the allegations in the SAC are "based upon," and thus "substantially similar

[5] The pre-2010 version of the public disclosure bar applied if the action were "based upon" the public disclosures. The Seventh Circuit has explained that "this change is not significant," as "[t]he current version of the statute expressly incorporates the 'substantially similar' standard" applied under the old version. *Bellevue v. Universal Health Servs. of Hartgrove, Inc.*, 867 F.3d 712, 718 (7th Cir. 2017).

to," the publicly disclosed conduct. *See U.S. ex rel. Ziebell v. Fox Valley Workforce Dev. Bd. Inc.*, 806 F.3d 946, 952 (7th Cir. 2015) (where a "claim rests on … precisely what [a government agency] found in its audit … [it] is plainly 'based on' the [agency's] public disclosure").

The last inquiry is whether Relator qualifies as an "original source" — one who either (1) "voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based" prior to the public disclosure, or (2) "has knowledge that is independent of and materially adds to the publicly disclosed allegations." 31 U.S.C. § 3730(e)(4)(B). Relator meets neither criterion. First, Relator could not have voluntarily disclosed information to the government prior to CMS's audits, as the audits Relator describes occurred more than seven years before Relator filed her original complaint and at a time when Relator worked for CMS. SAC ¶¶ 18, 136. Second, Relator's allegations do not materially add to the publicly disclosed allegations. To the contrary, Relator freely admits that her allegations parrot the conclusions formed by CMS after multiple audits of AIM's practices. *Id.* ¶¶ 119-20, 136; *Bellevue*, 867 F.3d at 712 (allegations that were "'substantially similar to' the publicly disclosed allegations … did not 'materially add' to the public disclosure"). Relator does not qualify as an original source.

CONCLUSION

The SAC's *five* vague references to BCBSM do not come close to adequately alleging an FCA violation under any theory. Even if they did, the FCA's public disclosure bar precludes any iteration of the complaint. For these reasons, as further explained above, BCBSM respectfully requests that this Court grant BCBSM's motion and dismiss the SAC, with prejudice.[6]

[6] Because Relator will not be able to cure the defects in her allegations against BCBSM through amendment, Relator's claims should be dismissed with prejudice. *See J.D. Marshall Int'l, Inc. v. Redstart, Inc.*, 935 F.2d 815, 819 (7th Cir. 1991) (leave to amend may be denied for "futility"). In further support of its motion, BCBSM also incorporates the arguments raised by the AIM and Anthem Health Plan Defendants in their Motions and Memorandum in Support to the extent applicable and not raised.

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Respectfully Submitted,

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CERTIFICATE OF SERVICE

The undersigned certifies that all counsel of record who are deemed to have consented to electronic service are being served with a copy of this document via the Court's CM/ECF system on this 13th day of March, 2018.

/s/ Heather M. O'Shea

Heather M. O'Shea

An attorney for Blue Cross Blue Shield of Michigan Mutual Insurance Company