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

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| **UNITED STATES OF AMERICA** | ) | |
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| ***ex rel*. DR. SUSAN NEDZA,** | ) | |
| | ) | |
| **Plaintiff, Relator** | ) | **No. 1:15-CV-6937 (JLA)** |
| | ) | |
| **vs.** | ) | **Hon. Judge Alonso** |
| | ) | **Magistrate Judge Cox** |
| **AMERICAN IMAGING MANAGEMENT, INC., ET AL.,** | ) | |
| | ) | |
| **Defendants.** | ) | |
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**DEFENDANT BLUE CROSS BLUE SHIELD OF MICHIGAN MUTUAL INSURANCE COMPANY'S REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR'S SECOND AMENDED COMPLAINT**

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## INTRODUCTION

Relator's response to the Motion to Dismiss of Blue Cross Blue Shield of Michigan Mutual Insurance Company ("BCBSM"), even with her belated attempt to supplement the deficient allegations, still fails to satisfy the basic requirements of Rule 9(b). What's more, Relator cannot establish the requisite elements of any of the theories of liability she asserts the complaint alleges. Relator also fails to distinguish her allegations from the governmental audits into the exact behavior alleged, and as such, the public disclosure bar requires dismissal. For these reasons, and for the reasons cited in BCBSM's Motion to Dismiss the Second Amended Complaint and Memorandum in Support, BCBSM respectfully requests that this Court dismiss it, with prejudice, from Relator's Second Amended Complaint ("SAC").[1]

## ARGUMENT

### I. Relator Fails to Plead Fraud with Particularity Under 9(b).

BCBSM's motion to dismiss illustrated why the SAC fails to meet Rule 9(b)'s particularity requirements. Relator attempts to cure these deficiencies by improperly amending the SAC through argument and group pleading against separate defendants, still without alleging any submitted a specific false claim or made a specific false statement. The law requires more.

#### A. Relator fails to provide the factual bases for her allegations against BCBSM.

Relator admits in her Opposition that a complaint must "put each Defendant on notice of its role in the fraud." (Opp'n at 4.) Yet, in what can only be seen as an admission that her pleading does not satisfy this basic requirement, she attempts to bolster her allegations by attaching over thirty pages of exhibits not previously included with the SAC. Relator's attempt to replead is improper and should be disregarded as unverified, unsigned, and not referenced in

[1] BCBSM also incorporates into its Reply the arguments made by the Movants in their Reply in Support of their Motions to Dismiss (Dkt. 190), which Motion BCBSM previously incorporated.

the SAC. *See U.S. ex rel. McGinnis v. OSF Healthcare Sys.,* No. 11-CV-1392, 2014 WL 378644, at *2 n. 3 (C.D. Ill. Feb. 3, 2014) (refusing in an FCA case to consider material attached to plaintiff's opposition as an "improper attempt … to amend his Complaint").

Even if the Court were to consider the new material, the SAC still lacks any information about any contract *BCBSM* may have had with the government (or, for that matter, with AIM)—no details about signatories, dates, or Plan Years covered or about any BCBSM beneficiary allegedly denied services as a result of AIM's conduct—no names of patients or providers or dates of allegedly wrongful denials. Relator instead conjures up new purported facts she describes as "admissions" of AIM executives, and states that "AIM knew it was committing fraud, and that it was causing MA Plans to do so as well." (Opp'n at 6-7, 14.) These alleged admissions, however, give no notice to the Defendant MA Plans, BCBSM included, as to how they fit in the alleged fraud.[2] In fact, Relator's only allegations specific to BCBSM are that: (i) BCBSM opted for AIM's "Medicare-compliant" review platform (SAC ¶ 118); and then (ii) raised concerns about AIM's practices, which AIM explained away to "walk [BCBSM] off the cliff" (*id.* ¶ 146). Relator's own allegations show BCBSM properly monitored its claims and denials, raised its concerns to AIM, and was convinced by AIM that AIM's programs complied with Medicare regulations. They do not support an inference of fraud. (*Compare* with Opp'n at 9 (stating MA Plans in general were reckless for "not monitoring the situation").)

Moreover, Relator still does not show (i) when, or through whom, BCBSM initiated its

[2] On page 16 of her Opposition, Relator identifies six bullets that allegedly put the Defendant MA Plans "on notice" of their role in the fraud, but not one includes details about any particular Plan contract with CMS or with AIM, any instance of medical care allegedly denied because of AIM's procedures, or any resulting false claim. (*See* Opp'n at 16.) Relator tries to save her conclusory allegations by citing to *Pirelli Armstrong Tire Corp. Retiree Med. Benefits Tr. v. Walgreen Co.*, 631 F.3d 436 (7th Cir. 2011) for the proposition that "pleading fraud does not require pleading 'specific misrepresentations made by particular [corporate defendant] *staffers*" (Opp'n at 16) (emphasis added). *Pirelli* does not, however, absolve Relator's burden to plead specific misrepresentations made by each corporate defendant. *See Pirelli*, 631 F. 3d at 447 (affirming dismissal for "insufficient" allegations).

relationship with AIM for UM services; (ii) what patients were allegedly improperly denied services as a result of AIM's processes and when (if at all); (iii) how BCBSM's monitoring processes were deficient; or (iv) what AIM said to "walk [BCBSM] off the cliff" when BCBSM raised concerns. Without these facts, Relator cannot show that BCBSM knew about AIM, its services, or any alleged conduct that rendered AIM's services improper or, fundamentally, that BCBSM submitted any false claims or certifications. Relator's allegations are a classic "fishing expedition" against 27 MA plans, with no actual details about their conduct. *Petri v. Gatlin*, 997 F. Supp. 956, 963 (N.D. Ill. 1997) (cited in Opp'n at 23) (explaining Rule 9(b)'s purposes).

Relator cannot excuse the SAC's deficiencies by arguing she could not access the underlying material. (*See* Opp'n at 12.) Relator repeatedly and consistently describes herself as a "top executive at AIM" in possession of "striking admissions and valuable insider information," and in fact touts her "insider" status as a reason the SAC should survive the public disclosure bar. (*Id.* at 4, 13, 48). Relator cannot have it both ways. She cannot be both a top executive, with access to information about the various levels of services AIM offered its MA Plan clients (*id.* at 8) and the "substance of AIM's procedures and policies governing the UM Process" (*id.* at 20); and yet claim she did not have access to information about services for which any MA Plan Defendant contracted with AIM or the requests denied by, or denial rates of, any MA Plan Defendant. Relator's "top executive" position (*id.* at 4) is a far cry from the low-level "position as a nurse practitioner" with which the court sympathized in *U.S. ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F. 3d 770, 778 (7th Cir. 2016) (cited in Opp'n at 4, 12-13, 18, 19, 25, 41); *see also Leveski v. ITT Educ. Servs., Inc.*, 719 F.3d 818, 839 (7th Cir. 2013) (cited in Opp'n at 23) (excusing relator for not producing documents due to her low-level status).

**B. Relator cannot group plead against defendants engaged in disparate conduct.**

Relator admits her complaint "pleads 'en masse'" but argues such group pleading is

appropriate because, according to Relator, "the role of each Defendant MA Plan is identical." (Opp'n at 16-17.) Relator is wrong. As Relator's own cases make clear, "[s]imply lumping defendants together," even where "they share a common nomenclature," "*is not enough.*" *U.S. ex rel. Zverev v. USA Vein Clinics of Chicago, LLC*, 244 F. Supp. 3d 737, 748 (N.D. Ill. 2017) (emphasis added) (allowing for group pleading only because the complaint alleged a single defendant "controlled each of the [] entities" and that "the entities were structured and operated as an integrated unit" connected to a "common computer system and common databases"). Here, the Defendant MA Plans are a far cry from an "integrated unit." Instead, they are separate companies, with separate beneficiaries and separate alleged contracts with both AIM and the government. What's more, BCBSM is a "non-Anthem insurance plan" with no corporate relationship with Anthem, or by extension, AIM. (SAC ¶ 23.)

Relator bases her claim of "identical conduct" on her allegation that each Defendant MA Plan "us[ed] the same procedures and forms established by CMS." (Opp'n at 17.) But her own complaint and Opposition highlight the differences among the MA Plans. For example, Relator explains that AIM offered MA Plans "review processes with different *levels* of compliance, to give each Defendant MA Plan the *choice* to follow Medicare coverage rules." (*Id*. at 8.) Relator never alleges the level of services for which any particular MA Plan contracted with AIM *or* that AIM provided the same services to each MA Plan. Instead, she admits that AIM offered different utilization management ("UM") review processes to different MA Plans and would make changes to review procedures to satisfy client requests. (SAC ¶¶ 118-119.) These individualized offerings, coupled with the distinct beneficiary needs each MA Plan serves, distinguish this case from all of the cases cited by Relator in support for her novel proposition that pleading "en masse" is appropriate in a situation like this. *Compare to Zverev*, 244 F. Supp.

3d at 748 (defendants all controlled by a common owner and operated as an "integrated unit"); *U.S. ex rel. Myers v. Am.'s Disabled Homebound, Inc.*, No. 14 C 8525, 2018 WL 1427171, at *1 (N.D. Ill. Mar. 22, 2018) (each defendant was an employee in the same organization or an entity with one of the individual defendants as its president); *Motorola, Inc. v. Lemko Corp.* No. 08 C 5427, 2010 WL 1474795, at *5 (N.D. Ill. Apr. 12, 2010) (same). Relator has not uncovered a single case where a court allowed a plaintiff to group together separate, and unrelated, legal entities and plead "en masse." And for good reason, as doing so undermines Rule 9(b)'s fundamental principle of providing each defendant "fair notice" of its alleged role in the fraudulent scheme. The principle applies especially here, where Relator has not otherwise pled the elements of an FCA claim.

## II. Relator Has Not Pled the Elements of a False Claim.

### A. Relator has not pled the existence of a false claim.

In addition to failing to identify specific conduct on the part of BCBSM, Relator still has not pointed to a single false claim for payment submitted by BCBSM—the "essential" element of any FCA action even under the cases Relator cites. *See U.S. ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 853-54 (7th Cir. 2009) (cited in Opp'n at 13, 19, 23) (declining to dismiss FCA complaint that identified "specific parts shipped on specific dates," details of payments and certifications made for those shipments, and facts showing those parts did not meet the certified specifications). Instead, Relator claims she does not have to identify a claim because "Defendants' MA plans are funded by monthly capitation payments from CMS." (Opp'n at 18.) Setting aside Relator's failure to plead any specifics about any claims for payment BCBSM may have submitted (such as the date, amount, or the subject services allegedly not provided), Relator admits the government bases its payments to MA Plans solely on the number and demographics of the Plan's beneficiaries, and not on any services offered to them. (*See id.*; *see also id.* at 35 &

35 n.21 ("monthly capitation payments do not vary with the amount of services provided").) Relator never alleges BCBSM misrepresented the number of beneficiaries or risk adjustment data—the only data the government uses to calculate payments. (*Id*. at 35 (quoting the certification contained in the payment request document but not alleging it was false); Ex. 1 at 9 (detailing the monthly certifications made to receive payment).) Accordingly, Relator points to nothing ***false*** in any claims BCBSM allegedly submitted. This failure alone defeats each of Relator's supposed theories. *See U.S. ex rel. Luckey v. Baxter Corp.*, 183 F.3d 730, 732 (7th Cir. 1999) (finding claim predicated on non-conforming goods theory not false where claims to the government did not specifically concern the allegedly fraudulent actions); *U.S. ex rel. McGee v. IBM Corp.*, No. 11-C-3482, 2017 WL 4467458, at *7 (N.D. Ill. Oct. 6, 2017) ("[Relator] would not have a cause of action under the FCA based on fraudulent inducement of a contract alone in the absence of a subsequent false claim.")[3]; *U.S. ex rel. Lisitza v. Par Pharm. Cos., Inc.*, 276 F. Supp. 3d 779, 797 (N.D. Ill. 2017) ("*Presser* reaffirmed that…. violations of the 'medically necessary' and 'economical' regulations … do not, without some 'specific representation,' make the submitted claims 'false'" under an implied representation theory.).[4]

Relator attempts to excuse her fundamental failure by citing to *U.S. ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016) for the principle that a false certification can create liability when it is a prerequisite to obtaining a government benefit. (Opp'n at 21-22 (citing *Swoben*, 848 F.3d at 1183).) Relator, however, fails to recognize the

[3] *See also U.S. ex rel. Kennedy v. Aventis Pharms., Inc.*, No. 03 C 2750, 610 F. Supp. 2d 938, 946 (N.D. Ill. 2009) (dismissing FCA claim where relator failed to allege a certification made "in connection with a Medicare claim" and instead alleged hospitals "promised they would comply" then failed to do so).

[4] While Relator argues that the Court in *Universal Health Services, Inc. v. United States ex rel. Escobar* did not limit the universe of implied certification claims (Opp'n at 33), all courts in the Northern District of Illinois faced with the question have interpreted *Escobar* as setting forth specific conditions for such claims. *See id.*; *U.S. ex rel. Gray v. United Healthcare Ins. Co.*, No. 15-cv-7137, 2018 WL 2933674, at * 5 (N.D. Ill. June 12, 2018).

distinction: The certifications at issue in *Swoben* involved risk adjustment data submitted *in their actual claims* to the government for risk adjustment payments. There is no such analog here: MA Plans do not certify the services they provide to receive government payments.[5] Indeed, in a recent MA case in this District, the Court rejected Relator's FCA claim for the precise reason that Relator did not allege that beneficiary information or risk adjustment data was not "accurate, complete, and truthful," the only requirement under 42 C.F.R. § 422.504. *Gray*, 2018 WL 2933674, at * 4; (*see* Opp'n at 35 (detailing "requests for payment under the [MA] contract").)

In an effort to create a prerequisite certification where one does not exist, Relator cites for the first time in her Opposition a supposed "Benefit Attestation" (Ex. 2 to Opp'n) never once mentioned in the SAC.[6] This can easily be dismissed. First, Relator cannot rely on a form document—she must plead particularized allegations regarding any false statement she alleges BCBSM made. Moreover, Relator's attempt to bolster her deficient complaint by identifying for the first time new information—even if only an unsigned form not specific to BCBSM and covering a single Plan Year for which Relator does not even allege BCBSM contracted with AIM—violates the "basic principle" that a complaint may not be amended by the briefs in opposition to a motion to dismiss. *Thomason v. Nachtrieb*, 888 F.2d 1202, 1205 (7th Cir. 1989).

But even if the Court were to consider the forms Relator now attaches, this case mirrors

[5] Relator also fails to acknowledge that following the Ninth Circuit's remand, the District Court for the Central District of California dismissed all claims except those based on a reverse false claim theory (not raised here) based on insufficient pleading of materiality under *Escobar*. *See United States v. Scan Health Plan,* No. CV 09-5013, 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017).

[6] As discussed in BCBSM's motion to dismiss (*see* Dkt. No. 153 at 10), and not addressed by Relator, certifications in BCBSM's alleged MA Plan contract *cannot* form the basis of an FCA claim, for without any evidence of when BCBSM allegedly contracted with the government or with AIM, Relator cannot allege BCBSM falsely certified anything in its MA Plan contract. *See U.S. ex rel. Grenadyor v. Ukrainian Vill. Pharm., Inc.*, 772 F.3d 1102, 1105 (7th Cir. 2014). This pleading failure defeats entirely Relator's "fraudulent inducement" theory, which requires a showing that a defendant knew about a specific rule and promised the government it would comply *while planning at the time to do otherwise*. (Opp'n at 29 (citing *U.S. ex. rel. Main v. Oakland City Univ.*, 426 F.3d 914, 917 (7th Cir. 2005).)

the facts analyzed by the Seventh Circuit in *U.S. ex rel. Gross v. AIDS Research Alliance Chi.*, 415 F.3d 601 (7th Cir. 2005). In *Gross,* as here, the relator attempted to hold a defendant liable under the FCA for purportedly false certifications of compliance with regulatory requirements. Yet the "false statements on which his claim [wa]s grounded [were] identified only by a categorical and essentially undecipherable listing of various 'forms, written reports and study results' the defendants are alleged to have filed with the government at some point – the pleading [did] not say when—during the course of the study." *Gross*, 415 F.3d at 604-05. Instead, the relator merely made "conclusory allegations" that the forms "constitute[d] 'certification of regulatory compliance.'" On those allegations, the Seventh Circuit held, dismissal was appropriate. *Id.*

**B. Relator has not pled non-compliance with laws, regulations, or contractual requirements necessary to succeed under any falsity theory**.

Relator bases her entire "falsity" argument on the premise that the Defendant MA Plans employed UM practices not used by traditional, "fee-for-service," Medicare, and that those practices allegedly resulted in a higher percentage of denials of services. Relator misses the point. While traditional Medicare generally does not employ UM practices, the government specifically endorses MA Plans' use of such practices in the Medicare regulations. *See* 42 C.F.R. § 422.112(a)(6)(ii); (SAC ¶ 40 (requiring MA Plans to establish written "[p]olicies and procedures (coverage rules, practice guideline, payment policies, *and utilization management*) that allow for individual medical necessity determinations") (emphasis added)). Because traditional Medicare does not require prior authorization for most services, denials of prior authorization requests using AIM's processes would *necessarily* be higher than under traditional Medicare, and yet Medicare still allows MA Plans to use such processes. (*See* SAC ¶ 58.)

Moreover, as in *Presser*, cited by Relator throughout her Opposition, Relator here "offers

no medical, technical, or scientific context which would enable a reader of the complaint to understand why" the services allegedly denied as a result of AIM's UM practices were medically necessary. *See* 836 F.3d at 779 (affirming dismissal of claim that clinic provided "unnecessary care forbidden by the [Medicare] statute" because the relator's allegations did not provide the "medical, technical, or scientific context" to enable the reader to understand why the care was unnecessary). The complaint in *Presser*, unlike in this case, identified four specific individuals who allegedly received medically unnecessary care. Even with these details, the Seventh Circuit found the complaint failed to show the treatments were unnecessary and dismissed most claims.

Further, while focusing her Opposition solely on the first stage of AIM's prior authorization review (Opp'n at 9), Relator admits in the SAC that if AIM's initial process denied a request for PA, AIM then elevated the request to "AIM nurse review" (SAC ¶ 55); and if still not approved by a nurse reviewer, then a physician from AIM would discuss the denial with prescribing physician and make the final determination. (*Id*. ¶ 56.) Medicare regulations, and even its non-binding guidance,[7] require no more. *See* 42 CFR § 422.566(d); CMS, Medicare Managed Care Manual § 13.40.1.1 (organization determination must be reviewed by a physician before a denial); 42 CFR § 422.112(a)(6)(ii); CMS, Medicare Managed Care Manual § 4.10.16 (organization must have written policies for "individual medical necessity determinations"). While Relator may take issue with some of AIM's decisions (none she specifically identifies), she acknowledges that written policies and procedures governed those decisions, and that a physician ultimately made the decisions on an individual basis, just as Medicare requires. (*See*

[7] As BCBSM noted in its Motion to Dismiss, the government has 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).

SAC ¶¶ 55-56, 62-63, 9, 100.)[8] Under established Seventh Circuit law, "[i]t is not enough" for an FCA claim "to offer evidence that the defendant provided services that are worth some amount less than the services paid for." *U.S. ex rel. Absher v. Momence Meadows Nursing Ctr., Inc.*, 764 F.3d 699, 710 (7th Cir. 2014); *see also Luckey*, 183 F.3d at 732 ("The principal difficulty with [relator]'s position is its equation of ineffective testing with no testing.").

**C. Relator fails to plead BCBSM knew, or recklessly disregarded, any alleged noncompliance**.

Relator continues her practice of group pleading when she alleges the Defendant MA Plans were reckless to the falsity of their statements to CMS. (Opp'n at 43.) In support, Relator cites to: (i) Plans' receipt of information on AIM's denial rates; (ii) CMS's requirement that Plans provide "actuarial certifications of the MA plans benefits based on utilizations"; and (iii) Plans' supposed choice of "AIM's unlawful UM review process over other more compliant review products that AIM offered." (*Id*. at 42-43.) As explained above, Relator's reliance on the MA Plans' UM denial rates is misleading: because traditional Medicare does not require UM, the MA Plans had no comparator for the denial rates. (*See* SAC ¶ 58.) Moreover, Relator does not plead that the Defendant MA Plans falsely certified the actuarial information reported to CMS. The Defendant MA Plans had the same level of knowledge about the utilization of their services as the government itself. And finally, Relator fails to identify *what* AIM services each MA Plan Defendant chose, or whether the Plans' choices were identical, so as to impart the same

[8] While Relator alleges AIM "case-aged" certain requests when treating providers did not return AIM's messages, she only alleges AIM's nurse reviewers employed this practice before sending the claims to physician reviewers to conduct a final review. (*See* SAC ¶¶ 56, 74.) Moreover, Relator does not allege the "case-aging" prevented a provider from re-submitting the request when it returned AIM's message, thereby artificially increasing AIM's denial rate while not actually resulting in the denial of any services. To the contrary, Relator admits that AIM's denials sometimes were reversed on appeal. (*Id.* ¶ 119.) And Relator's allegations as to the "one contact limit" also do not support her claim, as she herself admits that AIM changed its practices but does not provide the timeframe for the change, or whether that change predated the MA Plans' alleged contracts with AIM. (*See id.* ¶ 73.)

level of knowledge on each. Indeed, in a lone reference to BCBSM, Relator even admits that BCBSM used AIM's "Medicare-compliant" model, yet she still attempts to generalize other Plans' choices to it. (*See id*. ¶¶ 118, 129 (alleging BCBSM used AIM's "Medicare-compliant model" until AIM pulled the program, but not alleging BCBSM knew of AIM's actions).)

Relator's attempt to group plead is problematic with respect to BCBSM in other ways as well. While Relator attempts to argue the Defendant MA Plans "purport[ed] to be ignorant," her allegations reveal just the opposite for BCBSM. Rather than bury its head in the sand, Relator admits BCBSM monitored its UM processes and "raised concerns" to AIM about AIM's UM determinations. (*See id*. ¶ 146.) Relator further alleges that BCBSM told AIM it would self-report to CMS until AIM "walked them off the cliff" and convinced BCBSM that AIM's processes did not amount to violations or warrant self-reporting. (*See id.*) Far from recklessness, Relator's allegations paint a picture of BCBSM as a conscientious consumer of AIM's services who, at worst, was duped by AIM executives into a sense of compliance.

### D. Relator falls well short of the demanding materiality threshold affirmed by the Supreme Court in *Escobar*.

Relator's materiality argument is equally fated. She makes two arguments in her attempt to establish materiality: First, Relator argues "Defendants' alleged fraud goes to the heart of the bargain" because MA plans, Relator alleges, are to provide Medicare beneficiaries the same benefits as traditional Medicare. (Opp'n at 43.) Second, Relator, attempts in vain to analogize the certifications at issue here to those the Supreme Court assessed in *Escobar*. (*Id*. at 34, 44.) Neither argument is availing.

As to Relator's first argument, the alleged contractual promises here are a far cry from the "heart of the bargain" between the government and MA plans, nor is that the test for materiality, as affirmed in *Escobar*. To be clear, Relator does not allege that the Defendant MA

Plans failed to offer their members *any coverage benefits* for advanced diagnostic imaging or other services for which they allegedly required prior authorization. (*See* SAC ¶¶ 51-52; Opp'n at 5 n.3.) Nor does she allege that AIM's nurse and physician reviewers did *not make* individualized coverage determinations based on the patient's available medical history. (*Id.* ¶¶ 55, 56.) MA plans' "bargain" requires no more. (*See* statutes cited in Opp'n at 5.) Moreover, Relator fails to show any alleged misrepresentation related to the government's decision to pay, as *Escobar* requires. *Universal Health Servs., Inc. v. U.S. ex rel. Escobar*, 136 S. Ct. 1989, 2002 (2016); *see United States v. Strock*, No. 15-CV-0887-FPG, 2018 WL 647471, at *9 (W.D.N.Y Jan. 31, 2018) (dismissing FCA claim where false certifications were not connected to the government's "decision to pay [the defendant's] for work performed under the contracts."). In fact, Relator's newly-introduced exhibits show just the opposite: the form MA contract Relator attaches to her Opposition as Exhibit 1 confirms that the only data MA plans submit to receive monthly government payments are beneficiary information and risk adjustment data. (*See* Opp'n Ex. 1 at 9.)

Relator's strained analogy to *Escobar* fares no better. True, in both *Escobar* and in this case, defendants allegedly submitted claims for payment by reference to specific numeric codes. But the similarities end there. In *Escobar*, those codes were the diagnostic codes for the services provided and the provider providing those services: the very substance of the claim. Here, the code is purportedly the MA Plans' identification number, which only links a request for payment to an approved MA Plan. (Opp'n at 34.)[9] Moreover, Relator neglects to mention that CMS requires a qualified actuary to certify each plan's projected monthly costs for servicing the plan's

[9] As far as MA plans' monthly "claims" go, Relator admits they are based solely on "the number of Medicare enrollees" the plan serviced, not the individual services provided (or denied) for each enrollee. (Opp'n at 34.)

beneficiaries contained in these bid submissions, *which projected costs are calculated using claims data and denial rates*. 42 C.F.R. §§ 422.254(b)(5), (c) and 422.256(b) (CMS can only accept bids supported by actuarial bases); (*see also id.* at 42-43 (citing same).)

Relator is, however, correct in one respect: the government has spoken on the issue of materiality in this case. (*See id.* at 45.) ***First***, Relator admits that the government has repeatedly accepted the MA Plans Defendants' bids despite the claims information and denial rates reported in their actuarial submissions. (*Id.* at 30-31.) ***Second***, Relator alleges that the government noted instances of non-compliance of AIM's UM processes after auditing Defendant MA Plans but took no action whatsoever. (SAC ¶¶ 107, 119-120, 136.)[10]

The Supreme Court emphasized that the government's payment of a claim despite actual knowledge that certain requirements were violated is "very strong evidence that those requirements are not material." *Escobar*, 136 S. Ct. at 2003. For this reason, in the MA context, courts have dismissed as immaterial allegations that the government would not have made risk adjustment payments had it known defendants submitted false annual certifications to receive more each year in capitated payments. *U.S. ex rel. Poehling v. Unitedhealth Group, Inc. et al.,* No. 2:16-cv-08697, 2018 WL 1363487, at *8 (C.D. Cal. Feb. 12, 2018) (dismissing allegations based on annual certifications where "CMS [] continued to pay Defendants based on their submitted Attestations … [d]espite doubts about the validity … including based on CMS's own audits of Defendants' diagnoses"); *Scan Health Plan*, 2017 WL 4564722, at *6 (dismissing, following remand, FCA action where government failed to "allege that CMS would have refused

[10] Relator limits her discussion of the results of the government's own audits, conducted over the course of ten years, to an uncited footnote, and instead focuses her argument on how the SAC's unproven allegations do not provide the government with "actual knowledge" or a basis to terminate payment. (*See* Opp'n at 46-47.) The government's actual knowledge, through its audits of AIM's processes used by MA Plans, makes this case squarely analogous to *City of Chi. v. Purdue Pharma L.P.*, 211 F. Supp. 3d 1058 (N.D. Ill. 2016), where the City continued to pay claims with actual knowledge of the alleged fraud.

to make risk adjustment payments to [] Defendants if it had known the facts"). Here, the government's extensive knowledge of the review processes and resultant denial rates compels the same result.

**III. The Public Disclosure Bar Precludes Relator's Claims as a Matter of Law**.

Finally, Relator cannot avoid application of the public disclosure bar. She makes only two arguments in response: (1) defendants did not provide the Court with copies of the public disclosures; and (2) she "materially add[ed]" to the public disclosures and thus is an original source. (Opp'n at 49, 50-51.) Neither is availing.

As to her first argument, Relator does not argue the government audits do not qualify as public disclosures. She merely argues that defendants "provided no actual evidence" of those public disclosures that would allow the Court to compare whether they are "substantially similar" to Relator's allegations. (*Id*. at 49-50.) But this misses the point. As Relator states throughout her Opposition, in deciding a motion to dismiss such as those now before the Court, *a court must accept the complaint's allegations as true*. Here, the SAC alleges that CMS audits criticized the Defendant MA Plans "for ignoring" and "violat[ing] Medicare Rules" by, among other things, using AIM's alleged "case-aging" and "one contact" practices —the precise basis of Relator's FCA claims against the Plans. (SAC ¶¶ 107, 119, 120, 136.)

In arguing second that she is an original source, Relator focuses on "information 'independent' of the prior public disclosure" she allegedly gained through her "personal observations and insider information" received *as an employee of AIM*. (Opp'n at 48, 51.) But Relator alleges no insider information or observations about any of the Defendant MA Plans, including BCBSM. (*See id.* 51 (identifying "information about AIM's practices and role of key executives, the scope, mechanics and methods of fraud, and scienter" as the "additional information" Relator added to the public disclosure).) To the contrary, Relator repeatedly tries to

save her conclusory allegations against the MA Plans from dismissal by arguing she *did not have access* to information about MA Plans' claims, contracts, or coverage determinations. (*Id.* at 6, 20.) Relator has not offered a single additional basis for her claim against the Defendant MA Plans beyond those CMS allegedly expressed in its audits. (*See* SAC ¶¶ 107, 119, 120, 136.)

Finally, a public disclosure bars lawsuits "even partially based on the public information." *Lisitza*, No. 06 C 06131, 2017 WL 3531678, at *12 (N.D. Ill. Aug. 17, 2017). Thus, the Seventh Circuit has barred lawsuits based on publicly disclosed information where, as here, a complaint identifies another participant in the publicly disclosed scheme. *U.S. ex rel. Bogina v. Medline Indus., Inc.*, 809 F.3d 365, 369-70 (7th Cir. 2016) (affirming dismissal of suit adding a new party, identifying new governmental programs allegedly affected by the scheme and alleging the fraud was continuing). While Relator may identify new defendants—for whom she provides no unique details—she cannot deny that the fundamental aspects of the alleged scheme, including the role of AIM and of MA Plans, are based upon (and substantially similar to) numerous audits conducted by CMS.

For these reasons, and for the reasons expressed in BCBSM's Motion to Dismiss, BCBSM respectfully requests this Court dismiss, with prejudice, all claims against it.

Dated: July 6, 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 6th day of July, 2018.

*/s/ Heather M. O'Shea*

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