

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

UNITED STATES OF AMERICA,)	
)	Case No. 15-cv-06937
<i>ex rel.</i> DR. SUSAN NEDZA)	
)	
Plaintiff, Relator)	Judge Alonso
)	
v.)	Magistrate Judge
)	
AMERICAN IMAGING MANAGEMENT, INC., ET AL.,)	
)	

Defendant.

**DEFENDANT HEALTH FIRST HEALTH PLANS, INC.’S REPLY TO RELATOR’S
OMNIBUS OPPOSITION TO DEFENDANTS’ MOTIONS TO DISMISS THE SECOND
AMENDED COMPLAINT**

Relator’s Omnibus Opposition to Defendants’ Motions to Dismiss the Second Amended Complaint (“SAC”) (Dkt. 187) entirely fails to address the SAC’s fundamental failure to allege *any* conduct at all by Health First. While the SAC fails for many reasons applicable to many of the Defendants, as fully laid out in Defendants’ Joint Reply, which Health First joins in full, Health First writes separately as to this failure, which is fatal as to Relator’s case against Health First. Relator does not and cannot point to anything in her SAC, nor to any case law, that supports allowing her case to proceed against Health First in the face of this total dearth of pleading. Therefore, this Court should dismiss the SAC, in its entirety and with prejudice, at a minimum as to Health First.

I. The SAC Alleges No Conduct at All Particular to Health First

As detailed in Health First’s Motion to Dismiss the SAC, Dkt. 130, the SAC contains only two references to Health First in its 169 numbered paragraphs. Neither of these references describes any conduct by Health First, or even any knowledge by Health First of any of AIM’s

alleged conduct. Rather, these references allege only two facts with respect to Health First: Paragraph 23 alleges that Health First is a party to this case and a non-Anthem insurance plan, and Paragraph 118 alleges that AIM made a temporary change to its review process for certain Medicare Advantage (“MA”) plans, one of which was Health First Health Plans in Florida. Clearly, even if taken as true, these allegations would fall far, far short of satisfying Rule 9(b) or Rule 8.

In arguing that “[t]he SAC sets forth each Defendant’s role in the systemic fraud,” Dkt. 187 at 14, Relator points to six sets of allegations that she claims “are more than sufficient to provide notice of [Defendant Insurance Plans’] alleged wrongdoing.” Dkt. 187 at 24. However, not a single one of the SAC paragraphs referenced in Relator’s recitation of these allegations makes a specific mention of Health First. Rather, each of these paragraphs contains only *en masse* pleading against Defendant Insurance Plans as a group, which is radically insufficient to satisfy the particularity requirements of Rule 9(b) as to Health First.

Relator has not made a single allegation that provides any basis for accusing Health First of fraud. *See Uni*Quality, Inc. v. Infotronix, Inc.*, 974 F.2d 918, 924 (7th Cir. 1992) (explaining that “Rule 9(b) ensures that a plaintiff have some basis for his accusations of fraud before making those accusations...”). Effectively, Relator seems to adopt the position that she should be allowed to proceed against any MA plan that – like Health First - she believes contracted with AIM, without any particular supporting allegation as to the plan’s relationship with AIM, the particular services AIM provided to the plan, the impact of these services, the plan’s knowledge of AIM’s alleged conduct, or the plan’s relationship or representations to the government. This position would render Rule 9(b) a virtual nullity and cannot be sustained. As Relator has failed to make a single

particular allegation as to Health First's conduct, or evince any ability or intention to do so, this Court should dismiss the SAC with prejudice as to Health First.

II. Relator's *En Masse* Pleading Is Inappropriate and Insufficient

While Relator argues that her *en masse* pleading against Defendant Insurance Plans in her SAC is permitted, she provides no support for this proposition, nor meaningful rebuttal to the myriad Seventh Circuit and Northern District of Illinois cases, many of which are cited in Defendants' Motions to Dismiss, that hold exactly the opposite. None of the cases she cites analyzes facts at all similar to the facts here; rather, each of these opinions addresses a situation in which combined pleading was against a set of closely related entities and/or individuals. Relator's *en masse* pleading in this case is inappropriate and obscures exactly the details that would be required to sustain a complaint under Rule 9(b). Lacking any pleading as to any specific Health First conduct, the SAC must be dismissed as to Health First.

A. Cases Allowing Limited Grouping of Closely Related Defendants Provide No Support for Relator's Attempt to Lump Health First With Twenty-Six Other Wholly Unaffiliated Entities

Relator cites three cases in support of her *en masse* pleading, none of which has any application to her brazen collapse of all twenty-seven Defendant Insurance Plans into a single group. For instance, *United States ex rel. v. Am.'s Disabled Homebound, Inc.*, No. 14 C 8525, 2018 WL 1427171 (N.D. Ill. Mar. 22, 2018), involved pleadings against a company, one of its employees, its COO, its president, and a second company that shared the same president. Relator cites to a footnote to that case, which states that in the particular complaint at issue there is "no such lack of clarity" as to which defendants allegedly committed which wrongful acts or were liable for which counts. She ignores the context in the body of the opinion, which explains that

plaintiff in that case was “alleging that all Defendants are liable for all the alleged claims.” *Id.* at *7. In contrast, in this case, Relator cannot possibly be alleging that all twenty-seven Defendant Insurance Plans were liable for all the alleged claims; certainly Health First cannot plausibly be liable for claims submitted by twenty-six other wholly separate entities in which it has no involvement. While pleading against a group of closely related defendants who were all responsible for all of the alleged conduct in a complaint may have been acceptable, it is not acceptable for Relator to attempt to proceed against Health First solely on the strength of allegations levied against twenty-seven combined Defendants, the others of which have no relationship whatsoever to Health First.

Likewise, in *United States ex rel. Zverev v. USA Vein Clinics of Chicago*, 244 F. Supp. 3d 737 (N.D. Ill. 2017), the Court addressed the combination of a defendant individual and six entities that he owned and controlled, and which were operated in an integrated, uniform manner. In fact, the Court is clear that “[s]imply lumping defendants together because they share a common nomenclature is not enough” and that the combination of defendants in that case was acceptable because “the complaint specifically alleges that Katnelson controlled each of the USA Vein entities, that the entities were structured and operated as an integrated unit, and that Katnelson caused the entities to submit fraudulent billing submissions while practicing at each of the USA Vein clinics named in the complaint.” *Id.* at 748. Health First has no such commonality with the other Defendant Insurance Plans named in this case – they share no common ownership or control, are not integrated in any way, and do not operate in a uniform manner. Allegations about the conduct and knowledge of these wholly disparate entities as if they were a uniform group does not provide the particularity required as to the conduct and knowledge of Health First.

And in *Motorola, Inc. v. Lemko Corp.*, No. 08 C 5427, 2010 WL 1474795 (N.D. Ill. Apr. 12, 2010), a non-False Claims Act dispute between Motorola and several of its former employees, the six defendants grouped for the purposes of Motorola’s fraud claim were all former employees who had allegedly made the same misrepresentation. While these defendants were grouped within the fraud count of the complaint, specific allegations against each defendant were laid out above in the complaint’s body. *See Motorola, Inc. v. Lemko Corp.*, No. 08 C 5427, Dkt. 290 (N.D. Ill. Dec. 18, 2009). Moreover, the Court ultimately dismissed Motorola’s fraud count for failure to meet Rule 9(b)’s requirements, in part because the complaint did not “identify when defendants are claimed to have made the misrepresentations constituting the fraud.” *Id.* at 5; *see also Midwest Grinding, Inc. v. Spitz*, 976 F.2d 1016, 1020 (7th Cir. 1992) (“explaining that “the complaint must, at minimum, describe the predicate acts with some specificity and ‘state the time, place, and content of the alleged communications perpetrating the fraud.’”) (internal citation omitted). As in this case, in grouping defendants, plaintiff omitted critical information about the “when” of the alleged misrepresentations, without which its fraud pleading was inadequate. Similarly, Relator’s complaint in this case fails to allege when Health First made any statement that could have constituted a misrepresentation – or any other information about any particular alleged misrepresentations by Health First.

B. Relator’s Attempt to Collapse Health First Into a Large Group of Unrelated and Potentially Dissimilar Entities Omits Exactly the Particularity Required by Rule 9(b)

In fact, it is difficult to imagine that many of the allegations that Relator has pled *en masse* could be appropriately directed wholesale against twenty-seven unrelated entities. For instance, Relator claims that she has alleged that each of the Defendant Insurance Plans “contracted with

AIM to increase profits through denial of pre-authorization of services for MA beneficiaries, knowing AIM violated Medicare rules.” Dkt. 187 at 16. In so doing, Relator lumps together twenty-seven separate contractual relationships, as well as the knowledge of twenty-seven separate entities, as though they were one and the same. Yet, she has not pointed to a single provision in any contract between Health First and AIM to support this allegation, nor has she pointed to any fact that provides any support for her allegation that Health First knew that AIM allegedly violated Medicare rules.

Making this deficit even more problematic, the SAC itself acknowledges that there were relevant differences between AIM’s contracts with different MA plans. For instance, Relator alleges that “in many of [AIM’s] contracts with insurance plans, AIM promised to deny requests at specific rates to hit cost savings goals.” SAC 46. The clear implication of this allegation is that other of AIM’s contracts did *not* contain such promises, yet Relator nowhere alleges anything about the contents of Health First’s particular alleged contract with AIM or whether or not such promises were included. Likewise, Relator alleges that “AIM also agreed to hold harmless certain insurance plans for any shortfall in the guaranteed cost savings,” implying that contracts with other plans did not have such provisions. SAC 47. The SAC provides no indication as to whether Health First’s alleged contract with AIM did or did not contain a hold harmless provision.¹ Relator goes on to allege that “contracts between AIM and many of its insurance plan clients were clear that AIM would review and deny requests based on the ‘AIM guidelines and health plan medical policy,’” again implying that some AIM contracts were not clear on this point; the SAC does not explain into which category Health First’s alleged contract with AIM may have fallen. SAC 144.

¹ In fact, Health First has never entered into a contract with AIM containing any such provision.

Similarly, Relator’s wholesale assertion that all of the Defendant Insurance Plans “denied medical care upon AIM’s denial of pre-authorization”, Dkt. 187 at 24 (*citing* SAC 51, 150), inappropriately and implausibly lumps together the internal processes of twenty-seven separate entities, wholly unaffiliated with Health First. To imagine that each of these separate entities adopted identical policies with respect to the review and implementation of AIM’s pre-authorization decisions is implausible, at best – certainly this type of *en masse* pleading about the policies of so many unaffiliated defendants does not satisfy the strictures of Rule 9(b).

The SAC does not speak at all to which of AIM’s services Health First contracted for, the provisions of any such contract, or if or how Health First implemented the decisions it received from AIM. It therefore fails to allege if or how Health First was involved in or related to the scheme it purports to describe. Nor does it indicate whether or what type of care was allegedly denied to Health First enrollees, or how such denials impacted any claim from Health First to the government, let alone the particulars of any such claim. As Relator would have it, merely alleging that Health First is one of twenty-seven insurance plans that contracted with AIM is insufficient to inform Health First of its alleged role in the scheme she purports to describe; in fact, this broad brush pleading leaves Health First in the dark as to what wrongful act she believes it committed and falls far short of a justification for subjecting Health First to continued litigation.

This Court has been clear that – even in the case of related entities – “relator 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 of them.” *U.S. ex rel. Dolan v. Long Grove Manor, Inc.*, No. 10 C 368 (N.D. Ill. Jul. 18, 2014); *see also Suburban Buick v. Gargo*, No. 08 C 0370 (N.D. Ill. May 29, 2009) (where “the amended complaint is replete with references to ‘Defendants Gargo’ and ‘Gargo’ when discussing the conduct of, and counts alleged against, each of the four Gargo

defendants” and “contains many broad references to ‘Defendants,’” the “style of pleading is wholly inadequate to put defendants on notice of the conduct alleged.”). Here, Relator has proposed a fishing expedition into the affairs of twenty-seven separate Defendant Insurance Plans, based on conduct she claims to have witnessed as an employee of one non-Insurance Plan Defendant. Disallowing this type of baseless attack is at the heart of Rule 9(b). *See Jepson, Inc. v. Makita Corp.*, 34 F.3d 1321, 1327 (7th Cir. 1994) (affirming that minimizing fishing expeditions, protecting a defendant’s reputation from harm, and providing notice of the claim are the three main purposes of Rule 9(b)). This Court, therefore, should not credit Relator’s *en masse* pleading and should dismiss the SAC as to Health First.

III. Conclusion

Relator has not and cannot plead any particular conduct by Health First. Rather, Relator’s current allegations already exhaust the whole of her supposed grievance against Health First – specifically, that it was one of many companies that entered into some unspecified contract for some unspecified set of preauthorization review services with AIM. Merely contracting with a company for preauthorization services is a far cry from fraud – in fact, it is a regular and legitimate part of the business model of most Medicare Advantage plans nationwide. Certainly the mere fact of having contracted with AIM is a painfully frail basis for having accused Health First of fraud and dragged it into this Court. Therefore, Health First respectfully requests that this Court put an end to Relator’s transparent fishing expedition and dismiss the SAC, with prejudice, at least as to Health First.

July 6, 2018

Respectfully Submitted,

s/Kevin M. Cloutier

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on July 6, 2018, the foregoing was filed through the Court's CM/ECF system, which shall send notification of such filing to all counsel of record at their e-mail addresses on file with the Court.

s/Mikela T. Sutrina

One of the Attorneys for Health First Health
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