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

UNITED STATES, ex rel. DR. SUSAN NEDZA, Relator, v. AMERICAN IMAGING MANAGEMENT, INC., et al., Defendants.	Case No. 15-cv-6937 Judge Alonso Magistrate Judge Cox

MOVANTS' REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR'S SECOND AMENDED COMPLAINT

Relator's Response in Opposition to Movants' Motion to Dismiss (the "Response") is based on exceedingly generous interpretations of her allegations in the SAC, along with allegations that were never made in the SAC at all. Despite her attempt to re-plead the SAC through argument, Relator still fails to plead a false claim allegedly submitted to the government, let alone with the particularity required by Fed. R. Civ. P. 9(b). To overcome this hurdle, Relator asserts she has alleged a fraudulent scheme from which false claims can be inferred; but in reality, all Relator has pled is her own disagreement with the essential nature of utilization management ("UM"), a process CMS itself has endorsed. Relator also fails to successfully plead any recognized theory of False Claims Act liability or to correctly apply the Supreme Court's holdings on materiality, and finally, does not explain how she can avoid her own allegations regarding CMS audits to escape the public disclosure bar.

The grounds Movants raised for dismissal are not merely technical defenses, but rather demonstrate Relator's fundamental failure to properly plead even the most basic elements of her claims. The SAC should be dismissed with prejudice.

I. RELATOR'S ARGUMENTS FAIL BECAUSE SHE STILL HAS NOT PLED THE SUBMISSION OF A FALSE CLAIM.

Relator's 53-page Response does not rectify her failure to plead in her 169-paragraph SAC the central requirement of an FCA claim—the existence of a false claim. Relator and her counsel know they must allege submission of false claims to proceed; the absence of these key allegations likely is an admission that no such facts exist (and a concession that amendment would be futile). The omission is fatal to this case because as this Court has made plain, actual submission of a false claim for payment to the government is "the *sine qua non* of a False Claims Act violation." *United States ex rel. Keen v. Teva Pharms. USA Inc.*, No. 15 C 2309, 2017 U.S. Dist. LEXIS 518, at *8 (N.D. Ill. Jan. 4, 2017) (citations omitted). In an effort to salvage her

SAC, Relator regurgitates various allegations from her SAC, and summarily concludes these allegations are sufficient to overcome the particularity requirements of Rule 9(b). Relator even goes so far as to informally amend her SAC through liberal drafting interpretations, *see, e.g.*, Resp. p. 30, despite the prohibition on using one's briefs to amend a Complaint. *Saverson v. Northeast Ill. R.R. Commuter R.R. Corp.*, 17-cv-6591, 2018 U.S. Dist. LEXIS 25234, at *2 (N.D. Ill. Feb. 15, 2018) (citation omitted) (on a motion to dismiss, courts may only consider allegations actually contained in the plaintiff's pleadings).

Even so, neither her lengthy (but general and vague) SAC nor her more detailed (but improper) Response, actually identifies the examples of false claims required by Rule 9(b). *Keen*, 2017 U.S. Dist. LEXIS 518 at *9-10 (Rule 9(b) requires "at least concrete examples of false statements and false claims") (citation and quotations omitted). Relator cites various purported "admissions" of AIM executives to support her view that AIM's review process was noncompliant with Medicare requirements, but she never provides support for the assertion in her Response that this supposedly fraudulent process caused any false claims.[1] All Relator has done is rework her telling of the same circumstances that failed—and still fail—to demonstrate a false claim in either of her first two complaints.

Relator cites *United States ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770 (7th Cir. 2016), to support the assertion that her deficient pleading does not warrant dismissal. But in that case, the only allegations surviving dismissal were those where the relator

[1] These alleged "admissions" of fraud also do not satisfy Rule 9(b). Relator cites *United States ex rel. Howard v. KBR, Inc.*, 139 F. Supp. 3d 917 (C.D. Ill. 2015), but the *Howard* relators provided much more detail as to the alleged fraud—including specific examples of how relevant regulations were allegedly violated—than Relator does here. Moreover, the *Howard* relators' claims were allowed to proceed due to the issue of reasonableness of costs under the Federal Acquisition Regulations being a "highly contestable and fact-specific inquiry" inappropriate for a 12(b)(6) motion to dismiss, none of which is at issue here. *Id.* at 943 (citations omitted). Further, while the admissions in *Howard* actually described *why* submitted information would be false, the alleged admissions here are merely conclusory. *See, e.g.*, SAC ¶ 115.

pled *specific* circumstances regarding the defendants' misuse of a particular billing code (which the relator specifically identified) and representations to the government "that a certain treatment was given by certain medical staff when in fact it was not." *Id.* at 778-79. Similarly, *Lusby* does not advance plaintiff's cause, because there, the relator named specific allegedly non-conforming parts shipped on specific dates, and related "details of payment." *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854 (7th Cir. 2009). These allegations provide far more detail than has been pled by Relator, who does not identify any specific beneficiaries who allegedly did not receive services to which they were purportedly entitled, or even any AIM guideline that was allegedly improper. Indeed, Relator makes repeated reference to Defendants' alleged noncompliance with "Medicare coverage rules," *see, e.g.,* Resp. at 9-10, but she fails to plead even a single specific Medicare coverage rule Defendants allegedly violated.[2]

Relator also cites *Presser* for the proposition that relators should not be penalized "for not pleading details that can be reasonably inferred but as to which they have no access." Resp. at 12. Her argument is unavailing, however, since Relator declares she personally was "responsible for development of clinical guidelines and regulatory compliance for Medicare programs" at AIM. SAC ¶ 16. Taking Relator's own allegations as true, including her assertion that she was "a well-placed insider," Resp. at 20, Relator cannot credibly assert that she did not have access to information about AIM's clinical guidelines, their alignment with Medicare guidelines, or their application; and the information she does plead is insufficient. *See Keen*, 2017 U.S. Dist. LEXIS

[2] Relator lists four categories of requests for which "Defendants categorically refused coverage." Relator, however, fails to connect these alleged request categories to any particular Medicare coverage rule, any particular denial by any Defendant, or any particular claim. Further, Relator provides no "medical, technical, or scientific context which would enable a reader of the complaint to understand why" allegedly denying these requests amounted to improper conduct. *Presser*, 836 F.3d at 779 (dismissing claims where complaint did not provide reasons why treatments were medically unnecessary other than Relator's personal view). As in *Presser*, these denials could have entirely innocent explanations, and Relator's "subjective evaluation, standing alone, is not a sufficient basis for a fraud claim." *Id.* at 780-81.

517 at *9 (Relator had not pled FCA claims with particularity where she did not "so much as 'set forth the circumstances of any particular false statement or cite a single example of a false claim or a provider that made a false claim[.]'") (citations omitted). Relator had access to information that would have allowed her to meet Rule 9(b)'s requirements if she had a case to plead; her failure to include it is a telling and inarguable basis to dismiss the SAC.

Nor does the capitated payment model do away with the pleading strictures of the FCA and Rule 9(b). Instead of pleading a false claim, Relator asserts only that "Defendant MA Plans exist by virtue of government payments and thus all necessarily submitted claims for payment." Resp. at 11; *see also* Resp. at 18 ("claims inevitably result from operating a Medicare Advantage plan.") But the Defendant MA Plans' existence, without more, does not mean Defendant MA Plans submitted a false claim. This case is not like *Trombetta*, where the relator pled "specific disparities between [the] defendants' coding practices and the Medicare guidelines" that resulted in systematic fraud. *United States ex rel. Trombetta v. Emsco Billing Servs.*, No. 96 C 226, 2002 U.S. Dist. LEXIS 28463, at *4 (N.D. Ill. Dec. 5, 2002); *see also Presser*, 836 F.3d 770 (only claims permitted to proceed were those for which relator had provided details of the specific claim type at issue and the wrongdoing in which the defendant was engaged, as well as detailed allegations outlining how bills were submitted and that claims must have gone to the government). Here, simply because AIM and the MA Plan Defendants use the UM processes and the MA Plan Defendants are paid under the capitated payment model does not mean that false claims were submitted. Even giving Relator the benefit of reasonable inferences, there is no valid basis for inferring the submission of a false claim when Relator does not allege any details of AIM guidelines, requested medical treatment or claims, or beneficiaries affected. Notably, Relator does not cite any authority for the assertion that "where the certainty of

government payment is evident," concrete examples of false claims do not need to be pled. Resp. at 22. Nor have the courts interpreted the FCA in this manner. Relator's failure to identify any situations whatsoever in which a purportedly improper AIM denial was left undisturbed, and a plan nonetheless included that beneficiary in a monthly claim for capitation payment, undermines her liability theory altogether.

In *Uni*Quality, Inc. v. Infotronx, Inc.*, 974 F.2d 918, 924 (7th Cir. 1992), which Relator cites, the Seventh Circuit highlighted the "important purpose" of Rule 9(b)'s particularity requirement given that "[a]ccusations of fraud can seriously harm a business," and then dismissed the plaintiff's claims, pled on information and belief, that failed to state the "who, what, when, and where" of the alleged fraud.[3] Here, Relator has fallen far short of that standard: even generously interpreted, the SAC alleges only that 29 Defendants, at some point in time and at some location, violated some unidentified Medicare coverage rules. These highly general allegations do not provide the who, what, when, or where of any false claim or claims, and certainly fail to provide the "concrete examples of false statements and false claims" required to satisfy Rule 9(b). *Keen*, 2017 U.S. Dist. LEXIS 518 at *9-10.

II. RELATOR HAS NOT PLED A SCHEME OF INTENTIONAL FRAUD.

Relator also has not adequately pled a scheme of intentional fraud. Simply because Relator's SAC contains many paragraphs does not mean she has successfully outlined a fraudulent scheme, or that the SAC passes muster under Rule 9(b). In reality, the only "scheme" Relator describes is the decision to use UM or pre-authorization review—a practice which CMS

[3] *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016), a case outside this Circuit, is inapposite. The *Swoben* relator outlined a much more detailed scheme, and though he did not plead specific diagnoses codes that were allegedly intentionally underreported, there was no need for specific codes to be identified for the larger scheme to be made clear as to the defendants. Here, it is not clear how Movants did anything other than provide UM services, since Relator has not identified any Medicare coverage rules that were allegedly violated when care allegedly was denied.

already has confirmed is appropriate. CMS, Medicare Managed Care Manual, Pub. No. 100-16, Ch. 4 § 110.1.1. Absent any particulars about a scheme of intentional *fraud*, there is no possible basis for the Court to infer the submission of any false claim (even if such inference were appropriate in the absence of representative examples), and therefore no basis for allowing the SAC to proceed.

Indeed, Relator's fundamental mischaracterization of the laws and regulations governing the larger Medicare Advantage process is evident in both her SAC and her Response. To hear Relator tell it, AIM and the MA Plan Defendants were required to approve *any* "medical services that were requested . . . ." Resp. at 28. This assertion cannot be correct or UM would serve no function at all. According to Relator, because the MA Plan Defendants used AIM to deny medically unnecessary requested services through UM processes, "Defendants were not providing the government what it bargained for[.]" *Id.* But the relevant regulations require only that MA plans *cover* beneficiaries for the types of services that would be covered by traditional fee-for-service Medicare, not that they provide whatever clinical services a beneficiary demands, regardless of a Plan's medical necessity determinations. Likewise, these regulations do not limit the processes MA Plans can employ to make individualized medical necessity determinations. 42 U.S.C. § 1395w-22(a)(1)(A); *see also* 42 U.S.C. § 1395y(a)(1)(A) (except for certain preventive services, Medicare does not cover items and services that are "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member[.]").

Relator does not allege (nor is it the case) that the MA Plan Defendants did not provide any coverage for the types of services at issue. Rather, she evidently finds fault with AIM and the MA Plan Defendants for denying specific *instances* (of which she fails to identify even a

single example) of services for specific *beneficiaries* (whom she does not name). This is merely a description of how the UM process is intended to operate. Based on the facts presented, not every treatment requested by a provider can appropriately be deemed medically necessary; indeed, claims can later be denied as unnecessary with traditional Medicare or any other payor.[4] The very purpose of the UM process is to help ensure patients receive medically necessary care at an appropriate time. *Steedley v. McBride*, Civil Action No. 10-215-GMS, 2015 U.S. Dist. LEXIS 94328, at *5 (D. Del. Jul. 20, 2015). The cost-savings aspect of UM is realized not only by MA plans, but by the government itself, because future capitation payments are calculated in part based on the previous amounts MA plans spent to care for their members. 42 C.F.R. § 422.254. There is no fraudulent scheme implicit in UM or the preauthorization process, and merely pleading that Defendants employed such processes cannot sustain Relator's claims. CMS, Medicare Managed Care Manual, Pub. No. 100-16, Ch. 4 § 110.1.1 (noting that prior authorization is a UM approach "frequently used by plans" and stating that MA plans are required to establish provider networks that establish and maintain "utilization management protocols that allow for individual medical necessity determinations"). As Judge Durkin recently explained, MA plans that provide the same coverage as traditional Medicare, but more efficiently, do not violate the False Claims Act. *United States ex rel. Gray v. UnitedHealthcare Ins. Co.*, 2018 U.S. Dist. LEXIS 98195, at *19-20 (N.D. Ill. June 12, 2018) ("the government is

[4] Traditional fee-for-service Medicare by definition has a very low denial rate, as there is no medical review on the front end. Using UM, as is common for MA plans, inevitably results in a higher denial rate than using traditional Medicare's "pay and chase" system. Any reliance on a comparison of denial rates as supposed evidence of fraud is nonsensical, and tellingly, Relator fails to offer any support for her assertion that a mere difference in denial rates is supportive of her conclusory assertions of fraud. Nor is there necessarily any correlation between denial rates and profit. Because CMS' capitation payments are calculated in part based on the previous amounts spent by MA plans to care for their beneficiaries, reducing the number of medically unnecessary claims that are approved results in *lowering* the future capitation payments those plans receive. *See* Memorandum in Support of Movants' Motion to Dismiss, Dkt.145, p. 3 (discussing bid process).

harmed only when the [MA] plans make false diagnoses and report that information, causing CMS to pay [MA] plans a greater capitated amount than it would otherwise pay.").

III. RELATOR CANNOT JUSTIFY HER IMPERMISSIBLE GROUP PLEADING.

Relator's Response does not remedy the impermissible group pleading found throughout her SAC. *See, e.g.,* SAC ¶¶ 4, 6, 8, 155. Relator's assertion that it would be nonsensical for her to repeat in 27 separate paragraphs, for each of the insurance plan Defendants, the "conduct engaged in by all," belies her lack of knowledge of any details of any impermissible conduct on the part of any of the separate MA Plan Defendants.[5] In *United States ex rel. Myers v. Am's Disabled Homebound, Inc.*, No. 14 C 8525, 2018 U.S. Dist. LEXIS 47087, at *1 (N.D. Ill. Mar. 22, 2018), group pleading was permitted where there were only five different defendants, only two of which were corporate entities – unlike the 29 different Defendants here that Relator attempts to lump together. *Motorola v. Lemko Corp.*, No. 08 C 5427, 2010 U.S. Dist. LEXIS 35602, at *15-16 (N.D. Ill. Apr. 12, 2010), also does not support Relator's argument, as in that case, the court allowed group pleading only as to six individual defendants who were expressly alleged to have made precisely the same misrepresentation about devoting their best efforts to their employer. Here, there are 29 corporate entities involved, not six individuals, and far more variation as to the extent to which these 29 Defendants, including the 27 insurance plan Defendants, allegedly violated Medicare rules or committed fraud.

Similarly, in *United States ex rel. Zverev v. United States Vein Clinics of Chi., LLC*, 244 F. Supp. 3d 737 (N.D. Ill. 2017), group pleading was permitted for clinics controlled by a single individual defendant, where all the clinics "were structured and operated as an integrated unit,"

[5] To the extent Relator points to Defendants' decision to make arguments "on behalf of various groupings" of Defendants, Resp. at 18, this is but a symptom of the problem: Where Relator failed to allege separate conduct by each of the MA Defendants, Movants had no choice *but* to refer to the groups of MA Plan Defendants together. Moreover, Relator's pleading failures are common to the various Defendants.

and the same individual defendant practiced at each of the clinics and caused them to submit fraudulent bills. The 29 Defendants in this case do not share a single parent entity, *see* SAC ¶ 23, let alone are they controlled by a single individual, or operated as an integrated unit.

Each of the 27 insurance plan Defendants[6] are distinct entities, with different executives and leadership, different plan coverage terms, different membership populations, different bids, different internal processes, different contracts with AIM, and different denial rates. Yet Relator implausibly asserts that her generic, repeated allegations as to "Defendant Insurance Plans" are sufficient to put these 27 distinct entities on notice of their allegedly individualized fraudulent conduct.

Astonishingly, the *only* separate allegations made about 13 of the MA Plan Defendants, Anthem Health Plans of Kentucky, Inc., Anthem Health Plans of New Hampshire, Inc., Anthem Health Plans, Inc., Anthem Insurance Companies, Inc., Blue Cross of California, Blue Cross and Blue Shield of Georgia, Inc., Blue Cross Blue Shield Healthcare Plan of Georgia, Community Insurance Company, Compcare Health Service Insurance Corp., Empire HealthChoice HMO, Inc., Empire HealthChoice Assurance, Inc., HMO Colorado, Inc., and HMO Missouri, Inc., are that Anthem, Inc. is their parent company, and they "hired AIM to increase profits by utilizing the AIM UM review process[.]" SAC ¶ 23. Hiring the same, specialized contractor—without more—is not a fraudulent act causing the submission of specific false claims. Similarly, the *only* allegation made about Blue Cross of Idaho Care Plus, Inc. and Moda Health Plan, Inc., is that they are "non-Anthem insurance plans[.]" *Id.* That characteristic also is not unlawful. Such allegations fail to adequately plead fraud against these defendants and cannot be described as

[6] This group includes the 16 MA Plan Defendants, which are listed in Movants' Motion to Dismiss Relator's Second Amended Complaint, Dkt. 144, p. 1.

providing notice to these defendants of any fraud in which they are alleged to have been involved.

As for PacificSource Community Health Plans (PacificSource), Relator alleges only that it is not an Anthem insurance plan, that a 2014 audit of PacificSource made AIM aware that AIM's practices violated Medicare rules, and that PacificSource was cited for AIM's practices. *Id.* at ¶¶ 23, 72, 120. Relator makes no other allegations as to separate conduct by PacificSource.[7]

Even if the 16 MA Plan Defendants used the same forms and made the same allegedly false statements in contracts and attestations—facts that themselves are not sufficiently pled in the SAC—they would have had different discussions and contracts with AIM, and would have covered different beneficiaries for different treatment by different providers. The idea that each of these many Defendants engaged in identical conduct with respect to AIM, UM processes, denials, or otherwise is unsupportable, as therefore is the assertion that these Defendants can be lumped together for the purposes of virtually the entire SAC. Relator's impermissible group pleading does not satisfy Rule 9(b) and mandates dismissal of the SAC. *United States ex rel. Gross v. Aids Research All.-Chicago*, 415 F.3d 601, 605 (7th Cir. 2005).

IV. RELATOR'S THREE THEORIES OF LIABILITY FAIL.

Relator's Response dramatically overstates her allegations in an attempt to shoehorn them into three different rubrics for FCA liability. First, she claims she has properly pled that Defendants submitted false claims for nonconforming services, and that Defendants claimed full payment from the government despite providing "deficient Medicare insurance coverage." Resp. at 25. As previously discussed, Relator never pled, either in her SAC or Response, which

[7] Relator alleges even less about any specific conduct by other MA Plan Defendants than these patently insufficient allegations.

particular Medicare coverage guidelines any Defendants violated, or even a single example of care that *any* Defendant failed to provide. Certainly her allegations—which relate only to a limited set of alleged UM processes connected with a limited set of service types—do not come close to supporting her bald assertion that the extensive insurance coverage offered by the MA Plan Defendants was "deficient."

Instead, Relator claims that by using UM to deny medically inappropriate services, AIM and the MA Plan Defendants violated Medicare regulations.[8] But violation of regulations, even if it had occurred, is insufficient to render the MA Plan Defendants' coverage deficient; Relator has not pled and cannot plead that MA Plan Defendants did not provide extensive, substantial medical coverage to their beneficiaries. Further, Relator fails entirely to plead a violation of Medicare regulations related to the scope of coverage. The MA Plan Defendants are not required to provide any specific service to any beneficiary. Rather, they are required only to provide the same *benefits* available to patients enrolled in traditional Medicare—and Relator has not pled that they do not do so. Instead, Relator alleges only that the MA Plans used AIM's services to perform utilization management—a fully appropriate measure for MA plans to ensure that services are only provided when they are medically necessary. The SAC does not contain any allegation that MA Plan Defendants failed to offer insurance coverage for which they were paid, or that the insurance coverage they offered was fundamentally deficient; the post-hoc legal gymnastics in Relator's Response cannot convert the SAC into a complaint about non-conforming services.

[8] In a failed attempt to support her theory, Relator cites *Bornstein* and *Foglia*, which involved non-conforming goods, not services, and *Mack*, where the defendants billed for individual services that were never provided. *United States v. Bornstein*, 423 U.S. 303 (1976); *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153 (3d Cir. 2014); *United States v. Mack*, Civil No. H-98-1488, 2000 U.S. Dist. LEXIS 17367 (S.D. Tex. May 15, 2000). These cases are inapposite.

Next, Relator asserts she has alleged fraudulent inducement by the MA Plan Defendants to obtain MA contracts or extensions thereof. Resp. at 25. After adding almost a page of allegations and citations to regulatory requirements that are not mentioned in her SAC, Relator claims the MA Plan Defendants falsely represented they were in compliance with Federal statutes, regulations, and policies.[9] *Id.* at 30. Relator asserts these rules included the requirement that their enrollees would receive the same coverage as traditional Medicare, and that coverage determinations would be made on an individualized basis using Medicare coverage rules. *Id.* at 29-30. However, simply claiming that these requirements were "expressly 'material to the performance of'" the MA contracts does not mean the MA Plan Defendants actually made any express statement or certification that can predicate FCA liability. Nor are any such express statements or certifications identified by Relator in her SAC.

Relator cites *United States ex rel. Main v. Oakland City Univ.*, 426 F. 3d 914, 917 (7th Cir. 2005), where the defendant expressly assured the government on an application that it complied with a rule against contingent fees, but then later paid contingent fees. Similarly, in *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 542-44 (1943), the defendants certified their contract bids were "genuine and not sham or collusive" despite colluding with each other on bids. These statements in both *Main* and *Hess* both alleged violations of defendants' express certifications to the government. The same was true in *Upton*, where the relator included allegations of specific contractual provisions pursuant to which the defendant health care companies had explicitly agreed not to discriminate between enrollees on the basis of health

[9] Relator also asserts AIM agreed to comply with all "Medicare laws, regulations, and CMS instructions" and the MA Plan Defendants are liable for "any falsity caused by Defendant AIM's actions." Resp. at 31. While Medicare regulations do state that MA organizations are responsible for ensuring that delegated entities satisfy relevant requirements, 42 CFR 422.562(a)(3), attributing any FCA liability to the MA Plan Defendants based on AIM's conduct would also require a level of scienter on the part of the MA Plan Defendants, which Relator has not properly alleged. *See* 31 U.S.C. § 3729(a)(1)(A) and (B) (imposing liability for presenting false claims or statements "knowingly").

status, yet did so anyway. *United States ex rel. Barbara Upton v. Family Health Network, Inc.*, No. 09 C 6022, 2013 U.S. Dist. LEXIS 29620, at *14-15 (N.D. Ill. Mar. 4, 2013). Here, on the other hand, Relator alleges only the type of generic certification of compliance with Medicare rules and regulations that courts in this Circuit have repeatedly held cannot form the basis for FCA liability.[10] *United States ex rel. Lisitza v. Par Pharm. Cos.*, No. 06 C 0631, 2017 U.S. Dist. LEXIS 131246, at *43-44 (N.D. Ill. May 10, 2017); *United States v. Sanford-Brown, Ltd.*, 840 F.3d 445, 447-48 (7th Cir. 2016). Despite her new allegations, Relator has not set forth a theory for fraudulent inducement.

Finally, Relator claims that Defendants' "requests for MA payment" were false because they "included a false implied certification of compliance with material contractual, statutory, and regulatory terms, both by failing to disclose material violations of Medicare rules and by making misleading half-truth representations about the services provided[.]" Resp. at 26. As a threshold matter, Relator fails to plead any denial of a service, any rule violated by any such denial, or how any such violation led to "half-truth misrepresentations" about services provided or material violations of Medicare rules. 42 C.F.R. § 422.310 requires MA plans to "submit . . . the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner." If a service had not been provided to any particular beneficiary, whether based on AIM Guidelines or otherwise, Relator does not allege the MA Plan Defendants misrepresented to CMS that the service *was* provided. Rather, Relator claims only that Defendants violated MA's "same benefits and

[10] Relator also has alleged generally that Defendants have failed to comply with the "basic rule" and have failed to make individualized medical determinations. As discussed above, however, these bald assertions are not supported by any specifics at all, leaving Relator to rely on the unsustainable theory that use of UM is itself a fraudulent scheme.

individualized coverage determination rules" while certifying compliance with MA rules generally. Resp. at 30.

Again, however, generic certifications of compliance with Medicare rules and regulations cannot form the basis for FCA liability. In her attempt to argue the contrary, Relator cites a Fourth Circuit case and ignores the precedent of this Circuit. *Lisitza*, 2017 U.S. Dist. LEXIS 131246 at *43-44 (both before and after *Escobar*, it is not enough to prove a defendant "engaged in a practice that violated a federal regulation because violating a federal regulation is not synonymous with filing a false claim[.]" (citing *Universal Health Services, Inc., v. United States ex rel. Escobar*, 136 S.Ct. 1989 (2016)); *Sanford-Brown*, 840 F.3d at 447-48. Insisting that violation of any of the thousands of MA rules and regulations should lead to FCA liability is, quite simply, wrong under the precedent of both this Circuit and the Supreme Court.

V. RELATOR MISAPPLIES *ESCOBAR* AND HAS NOT PLED MATERIALITY.

Relator falsely equates this case with *Escobar*, apparently because both cases allegedly involve false certifications. Relator fails to appreciate the important distinction between the MA capitation payments at issue in this case and the Medicaid fee for service claims at issue in *Escobar*. In *Escobar*, the claims alleged sought fees for services performed by individuals who were prohibited by CMS regulations from performing those services. 136 S. Ct. at 1994. Here, the MA Plan Defendants submit bids approved by CMS, as well as risk adjustment data that provides "the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee[.]" 42 C.F.R. §§ 422.254, 422.310(b).

The MA Plan Defendants specifically have informed CMS exactly what services are provided to each beneficiary. They do not make any representations about specific metrics to use in pre-authorization, or UM processes with which they then do not comply. In *Escobar*, on the

other hand, the defendant billed Medicaid using codes for services that were required to be performed by licensed professionals, when in fact those services were performed by unlicensed individuals. The *Escobar* claims were "misleading half-truths" because the government had paid specifically for services performed by licensed professionals. 136 S. Ct. at 2000-2001. Here, Relator has not alleged that any data submitted to the government regarding services provided, bids, or denial rates, were at all inaccurate. Even if, as Relator alleges, AIM set its fax machines to stop printing after 10 pages, or told its staff to make only one attempt to contact medical providers, these are at worst regulatory or contract violations which are unrelated to and do not impact the information the government explicitly makes material to its decision to provide capitated payments to the MA Plan Defendants.[11] *See Gray*, 2018 U.S. Dist. LEXIS 98195, at *20 ("[T]he Court's analysis of each violation is not whether the violation is material to the government's decision not to pay claims under traditional Medicare [fee for service]. Rather, the Court views each violation through the lens of whether it is material to CMS's determination of the capitated payment amount.").

Relator evidently believes that if AIM did not perfectly comply with all (unidentified) Medicare regulations, then the MA Plan Defendants' beneficiaries' coverage must have been compromised. Even if this were true, it is not the type of violation meant to be addressed by the FCA. The FCA is not intended to reach "all types of fraud, without qualification." Resp. at 19 n.13, 25 (citing *Cook Cnty. v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003)).[12]

[11] Relator claims she has alleged that "Defendants themselves believe their violations were material." Not only is there no authority for Relator's assertion that Defendants' purported subjective beliefs actually evidence materiality, but she never alleged Defendants believed their violations were material to CMS's determination of their capitated payment amount, the only relevant inquiry here, as opposed to any other non-payment related government investigation or action. *See, e.g.*, SAC ¶¶ 110 (AIM knew of "compliance risk"); 141 (AIM executive feared getting "caught [by CMS]").

[12] This statement in *Chandler* was made in the context of whether a municipality could properly be a defendant in an FCA action. Relator's reliance on it is misplaced.

Instead, the Supreme Court has more recently held that merely alleging a violation of a statute or regulation is insufficient to bring an FCA claim, as "the False Claims Act does not adopt such an extraordinarily expansive view of liability." *Escobar*, 136 S. Ct. at 2004.

While Relator relies heavily on *Escobar*'s statement that materiality does not rest on a single fact or occurrence, she concedes, as she must, *Escobar*'s holding that "if the [g]overnment 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[.]" 136 S.Ct. at 2004. Despite this concession, Relator does not attempt to explain how the government's continued payments to the MA Plan Defendants, despite learning of AIM's alleged improprieties via audits Relator herself alleges, is not "strong evidence" that any alleged violations were immaterial. *See, e.g.,* SAC ¶¶ 73 (CMS audits of Defendant Regence Blue Shield of Idaho and PacificSource in 2014 found "that AIM's specific practice allegedly violated Medicare Rules"), 107 (by at least 2008, CMS had cited Anthem in an audit related to cases adjudicated by AIM), 136 (CMS audit finding prior to 2008 criticized an Anthem plan (through AIM) for ignoring Medicare Rules in the AIM review process). Instead, it is apparent from Relator's own allegations that CMS was aware of AIM's practices and never gave any indication it would no longer make capitated payments to the MA Plans, rendering any claim of fraud immaterial. *See United States ex rel. Cressman v. Solid Waste Servs.*, Civil Action No. 13-5693, 2018 U.S. Dist. LEXIS 59183, at *19 (E.D. Pa. Apr. 6, 2018) (where federal agencies continued to pay invoices for services performed by defendant following relator's lawsuit and a subsequent investigation by the Department of Justice, who declined to intervene, federal agencies did not deem the alleged violation material to payment of invoices for services).

Rather, all the MA Plan Defendants continued participating in the MA program and using AIM for their UM review. Any alleged misrepresentation was immaterial, and Relator's claims fail.

VI. RELATOR'S CLAIMS REQUIRE DISMISSAL PURSUANT TO THE PUBLIC DISCLOSURE BAR.

Relator's former position as "a high-level AIM executive" does not save her claims from the public disclosure bar. Nor are Movants required to attach any documents to support this defense, when *Relator's own allegations* demonstrate that her claims were publicly disclosed.[13] Taking a noticeable step back from the liberal embellishment she applies to her allegations in the rest of her Response, Relator tries in the public disclosure section of her Response to downplay her allegations of audits to avoid dismissal. Not only does Relator allege that government audits: (1) found two Defendants failed, on at least one occasion, to make sufficient contacts with medical providers; and, (2) questioned coverage decisions on a couple of occasions, these are not the only audits or findings that appear in the SAC. Resp. at 49. Relator herself also makes separate allegations about other audits revealing improprieties with AIM's UM review process and its alleged non-compliance with Medicare rules. SAC ¶¶ 107, 119, 136, 137, 145. Tellingly, Relator now glosses over these allegations, in a transparent, yet futile attempt to save her claims from the public disclosure bar.

That the CMS audits did not reveal every detail Relator has supplied also does not overcome the public disclosure bar. *United States ex rel. Ziebell v. Fox Valley Workforce Dev. Bd. Inc.*, 806 F.3d 946, 952 (7th Cir. 2015) (allegations in a complaint are publicly disclosed when "the critical elements exposing the transaction as fraudulent are placed in the public domain.") (citation omitted). This case is not like *Leveski v. ITT Educ. Servs.*, 719 F.3d 818, 830

[13] *United States ex rel. Gagne v. City of Worcester*, Civil Action No. 06-40241-FDS, 2008 U.S. Dist. LEXIS 56143 (D. Mass. June 20, 2008), does not counsel otherwise, as in that case, the relators had not themselves made allegations evidencing the relevant information was within the public domain.

(7th Cir. 2013), where the relator alleged a "much more sophisticated—and more difficult to detect—violation" of federal requirements and included allegations "wholly absent" from the previously disclosed case. Here, Relator herself has alleged a CMS audit disclosed "an Anthem plan (through AIM) [] ignor[ed] Medicare Rules in the AIM review process." SAC ¶ 136.

Like the relator in *United States ex rel. Hastings v. Wells Fargo Bank, NA, Inc.*, 656 F. App'x 328, 331-32 (9th Cir. 2016), Relator also does not "add value" to what the government already knew from its own audits, and she is not an original source; instead, her allegations "provide only background information and details relating to the alleged fraud[.]" Accordingly, Relator's claims should be dismissed.

VII. CONCLUSION

For the foregoing reasons, Movants respectfully request that this Court grant their Motion to Dismiss Relator's Second Amended Complaint with prejudice.

Dated: July 6, 2018

Respectfully submitted,

/s/ *Lisa M. Noller*

Lisa Noller
Patrick McMahon
Foley & Lardner LLP
321 North Clark Street, Suite 2800
Chicago, IL 60654
Telephone: 312.832.4500
Facsimile: 312.832.4700
lnoller@foley.com
pmcmahon@foley.com

Michael J. Tuteur (admitted *pro hac vice*)
Jessica E. Joseph (admitted *pro hac vice*)
Foley & Lardner LLP
111 Huntington Avenue
Boston, MA 02199
Telephone: 617.342.4000
Facsimile: 617.342.4001
mtuteur@foley.com

jjoseph@foley.com

Attorneys for AIM Defendants, Anthem Health Plans of Kentucky, Inc., Anthem Health Plans of New Hampshire, Inc., Anthem Health Plans, Inc., Anthem Insurance Companies, Inc., Blue Cross of California, Blue Cross and Blue Shield of Georgia, Inc., Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Community Insurance Co., Compcare Health Service Insurance Corp., Empire Healthchoice HMO, Inc., Empire HealthChoice Assurance, Inc., HMO Colorado, Inc., HMO Missouri, Inc., Blue Cross of Idaho Care Plus, Inc. and PacificSource Community Health Plans.

and

/s/ *David Goldhaber*
David Goldhaber
Michael J. O'Malley
Wilson Elser Moskowitz Edelman & Dicker LLP
55 West Monroe Street, Suite 3800
Chicago, IL 60603
Telephone: 312.704.0550
Facsimile: 312.704.1522
david.goldhaber@wilsonelser.com
michael.o'malley@wilsonelser.com

Attorneys for Moda Health Plan, Inc.

CERTIFICATE OF SERVICE

I hereby certify that, on July 6, 2018, a copy of the foregoing document was electronically filed through the ECF system and will be sent electronically to all persons identified on the Notice of Electronic Filing.

/s/ *Lisa M. Noller*
Lisa M. Noller
lnoller@foley.com