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

DEFENDANTS' MOTION TO DISMISS
RELATOR'S THIRD AMENDED COMPLAINT

Defendants, Anthem, Inc. (Anthem) and American Imaging Management, Inc. (AIM), by and through Foley & Lardner, LLP, their attorneys, hereby move this Court to dismiss with prejudice all claims asserted against them by Relator Dr. Susan Nedza (Relator) in the Third Amended Complaint (Dkt. 220) (TAC).

Relator's fourth attempt to plead an FCA claim against Defendants fails to remedy the flaws already identified by this Court in its Order dismissing Relator's Second Amended Complaint. Dismissal is once again proper pursuant to Fed. R. Civ. P. 9(b) and 12(b)(6) because Relator's allegations do not meet the heightened pleading standard for fraud-based claims under Fed. R. Civ. P. 9(b) and otherwise fail to state a claim against Defendants upon which relief can be granted.

In particular, Relator again fails to plead materiality, making only impermissibly broad, generic allegations, and ignoring that CMS's decision to make payments under the Medicare Advantage (MA) capitated payment system is based on each beneficiary's geographic location, income status, gender, age, and health status, rather than any specific instance(s) of denying care.

In addition, Relator still does not identify a single false claim for payment aside from all of the MA plans' requests for capitated payments, which she does not allege make any reference to alleged denial rates or the use of utilization management (UM) processes. She has plead no nexus between any particular false claim and any particular fraud. Any theory of false claims for non-conforming services is similarly flawed, because the contracts between the Centers for Medicare and Medicaid Services (CMS) and AIM's MA plan clients are based on a fixed capitation rate per member per month which is not based on benefits recouped by beneficiaries, or UM-driven denials of claims.

Relator also still does not allege Defendants fraudulently induced CMS to contract with any of AIM's MA plan clients—at best, she presents only the fundamentally flawed theory that all claims submitted by the plans were necessarily false. Finally, Relator also fails again to plead any factual details indicating any beneficiaries received deficient Medicare coverage for which AIM's MA plan clients received payment.

Moreover, specific to Anthem, Relator's claims should be dismissed because Relator has failed to allege any basis for piercing the corporate veil or any direct participation by Anthem in the alleged conduct. In sum, the TAC should be dismissed as to both Defendants, with prejudice.

This Motion to Dismiss is supported by an accompanying memorandum of law.

Dated: July 23, 2019

Respectfully submitted,

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MEMORANDUM IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS RELATOR'S THIRD AMENDED COMPLAINT

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Relator's fourth attempt to plead an FCA claim against Defendants is as flawed as her first three. Once again, she has failed to remedy the many deficiencies this Court identified in its Memorandum and Order,[1] or to change any of her three inadequate theories. In dismissing the Second Amended Complaint (SAC), the Court ruled that Relator's theories of fraudulent inducement and false claims for non-conforming services were plainly incompatible with the Medicare Advantage (MA) capitated payment system. Order at 10-11. Undeterred by this Court's findings, Relator re-pleads the same flawed theories but just adds more words. Relator also has not changed the substance of her flawed implied false certification theory, which still fails to meet the demanding *Escobar* materiality standard previously identified and relied upon by this Court in dismissing her SAC. *Id.* at 11, 12-13.

In reality, Relator's Third Amended Complaint (TAC) merely reiterates her basic misunderstanding of the MA capitated payment system and the use of utilization management (UM). Though she now concedes the use of UM is not prohibited outright by Medicare, she continues to assert that virtually no request for medical services could be validly denied by an MA plan using UM without resulting in a false claim. And despite the Court's ruling identifying her lack of understanding of the MA capitated payment structure as a shortcoming, Relator still does not allege the Centers for Medicare and Medicaid Services (CMS) were fraudulently induced to contract with any of the MA plans that are AIM's clients. *Id.* at 10-11.

As this Court recognized in its Order, while Relator fails to recognize that the very purpose of UM is to ensure that taxpayers and the government are not paying for (and beneficiaries are not receiving) medically unnecessary care, she also ignores the differences between traditional fee-

[1] Memorandum Opinion and Order ("Order"), Dkt. 216 (Mar. 29, 2019).

for-service Medicare and MA capitated payments. "Relator does not identify, let alone allege, any false claim for payment beyond the [MA plans'] requests for capitated payments" from CMS—yet these requests make no alleged misstatements, and hence no false claims, regarding denial rates or AIM's allegedly rigged process. *Id.* at 11. Moreover, as the Court already has acknowledged, MA plans are not paid on a fee-for-service basis—leading Relator to attempt to shoehorn a fundamentally incompatible FCA theory for non-conforming services into the MA capitated payment context. *Id.* But CMS does not make capitated payments to MA plans based on the benefits received (or not received) by plan beneficiaries. Rather, capitated payments are based on the health and demographic information of each plan's beneficiary population. *Id.*

Relator's last throw is to allege a false certification theory, but she fails here again as well. As the Court recognized the last time, none of AIM's alleged improper conduct is *material*—because it simply does not, and cannot, impact the amount of capitated payments CMS makes to AIM's MA plan clients. As this Court noted, because "there are appropriate uses of utilization management tools in MA plans . . . the pleading of materiality [is] all the more important to distinguish FCA violations from innocent conduct." *Id.* at 14. Remarkably, though Relator has now removed from her lawsuit every Defendant who actually submitted a request for payment or made any certifications to the government (apparently acknowledging she cannot successfully state claims as to them), she nevertheless—and for the fourth time—seeks to plead a case for implied false certification as to Anthem and AIM—the only two Defendants whom Relator concedes did *not* submit requests for payment or certifications to the government.

Because Relator has failed to remedy the deficiencies identified by this Court's Order—despite being given an opportunity to amend—all of Relator's claims should again be dismissed, this time with prejudice. As to Anthem, Relator's claims should also be dismissed because Relator

has failed to allege any basis for piercing the corporate veil or any direct participation by Anthem in the alleged conduct.

FACTUAL BACKGROUND

As described in the Court's Order, Medicare Part C, or Medicare Advantage, pays private managed care insurance plans a capitated rate; that is, a fixed amount per member (*i.e.*, patient or beneficiary) per month, and those plans are then responsible for paying providers for services provided to beneficiaries. Order at 2-3; TAC ¶ 35. The capitation rate is based on a beneficiary's geographic location, income status, gender, age, and health status. *Id*. The rate is not based on denial rates or rationale, case aging, the faxed contents of medical records, coverage requests or other "ploys" alleged by Relator. Rather, capitation payments are established by an algorithm generated from the objective criteria enumerated above.

MA plans "assume full financial risk on a prospective basis" for the cost of providing health care for plan beneficiaries, and generally must cover beneficiaries for all the items and services that would be covered by traditional, fee-for-service Medicare. TAC at ¶ 36; 42 U.S.C. § 1395w-25(b). MA differs from fee-for-service Medicare in that the payments MA plans receive are unrelated to any particular benefits provided (or not provided) to beneficiaries. Instead, since 2006, MA plans submit to CMS annual "bids" based on estimated costs per enrolled beneficiary for covered services, and CMS only accepts bids meeting the necessary requirements. 42 C.F.R. §§ 422.254, 422.256.[2] The bids are compared to benchmark amounts that are set by formula and

[2] On a motion to dismiss, courts may consider "information that is properly subject to judicial notice." *Williamson v. Curran*, 714 F.3d 432, 436 (7th Cir. 2013). This includes "materials from proceedings in administrative agencies," *Truhlar v. John Grace Branch No. 825 of the Nat'l Ass'n of Letter Carriers*, No. 06C2232, 2007 U.S. Dist. LEXIS 23875, at *26 (N.D. Ill. Mar. 30, 2007), as well as statutes and regulations. *Demos v. City of Indianapolis*, 302 F.3d 698, 706 (7th Cir. 2002) ("[A] district court can always rely on public statutes.").

vary by geographic area. *Id.* at §§ 422.252, 422.264, 422.304. If a plan's bid is lower than the benchmark, then the MA plan and CMS each receive a portion of the difference between the bid and the benchmark, and the plan must use its share to provide supplemental benefits to its members. *Id.* at § 422.266. If a plan's bid is higher than the benchmark, plan members pay the difference to the MA plan as a monthly premium. *Id.* at § 422.262(a).

Medicare will only reimburse providers for medical services it deems "reasonable and necessary." 42 U.S.C. § 1395y(a)(1)(A). Utilization management is a process used by managed care plans, with CMS's knowledge, to determine whether a health care service is medically necessary. As this Court has recognized, "there are appropriate uses of utilization management tools in MA plans," making materiality pleading even more important. Order at 14. One aspect of UM is "pre-authorization"—the requirement that certain medical services be authorized before they are performed. *G v. Hawaii,* Civ. No. 09-00044 ACK-BMK, 2011 U.S. Dist. LEXIS 7940, at *49 (D. Haw. Jan 21, 2011). "The purpose of a prior authorization requirement is to manage and coordinate care and ensure consistent coverage determinations. . . . It also includes a cost effectiveness aspect." *Id.* CMS has confirmed that managed care plans may use UM processes, including pre-authorization review. CMS, Medicare Managed Care Manual, Pub. No. 100-16, Ch. 4 § 110.1.1.

MA plans must have effective procedures in place to make individualized medical necessity determinations, and "mechanisms to detect both underutilization and overutilization of services." TAC at ¶ 45; Order at 13-14 (quoting 42 C.F.R. § 422.152(b)(2)). AIM helps its MA plan clients make these individualized reimbursement determinations by providing UM services: evidence-based decisions generally made *before* any service is provided to a patient. This pre-authorization review ensures patients get necessary services for their conditions, as determined by

their physicians; but also that they do not get *unnecessary* services when their clinical circumstances do not warrant it. AIM provides these UM services not only for MA plans, but for dozens of commercial (non-Medicare) plans as well.[3] TAC at ¶ 7.

AIM's pre-authorization review process consists of four steps: (1) a treating doctor or other provider sends AIM a request for pre-authorization for insurance coverage; (2) AIM recommends whether the plan should approve or deny that pre-authorization request; (3) AIM communicates its recommendation to the insurance plan, medical provider, and/or the MA beneficiary; and (4) the insurance plan applies AIM's recommendation to approve or deny the request accordingly. *Id.* at ¶ 67. In particular, AIM reviews requests for certain advanced imaging services including Computerized Tomography, Echocardiography, Magnetic Resonance Angiograms, Magnetic Resonance Imaging, and Positron Emission Tomography scans, as well as sleep studies, among other procedures. *Id.* at ¶ 68. AIM can recommend denial of a pre-authorization request only after it has been reviewed by a licensed physician. *Id.* at ¶ 73.

ARGUMENT

In the dismissal Order, this Court correctly stated the standards for review of a motion to dismiss under Fed. R. Civ. P. 8, 9(b), and 12(b)(6). Order at 9-10.

Relator has not changed her alleged causes of action, which again plead claims under both the False Claim (31 U.S.C. § 3729(a)(1)(A)) and False Statement (§ 3729(a)(1)(B)) prongs of the FCA. To allege a claim under § 3729(a)(1)(A), Relator must plead as to each Defendant: (1) a

[3] Both Congress and CMS have directed that standard UM tools, including the pre-authorization review practiced by AIM, should be made applicable to certain providers of traditional fee-for-service Medicare (Parts A and B) by January 1, 2020. Protecting Access to Medicare Act of 2014, § 218; 42 C.F.R. § 414.94; Department of Human and Health Services, Centers for Medicare & Medicaid Services; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, 80 Fed. Reg. 70886, 71104 (Nov. 16, 2015).

false claim; (2) presented by Defendant to the United States for payment or approval; (3) with knowledge the claim was false. *United States ex rel. Fowler v. Caremark RX, L.L.C.*, 496 F.3d 730, 740-41 (7th Cir. 2007). To plead a violation of § 3729(a)(1)(B), the "False Statement" provision, Relator must allege: (1) each Defendant made a statement material to a false claim; (2) the statement was false; and (3) the Defendant knew the statement was false. *Thulin v. Shopko Stores Operating Co.*, 771 F.3d 994, 998 (7th Cir. 2014).

I. Relator Has Not Remedied The Significant Pleading Deficiencies Which Led To Dismissal Of Her Second Amended Complaint.

The Court's dismissal Order was correct in all respects, and the verbosity of Relator's TAC cannot mask that it still fails to remedy any of the pleading deficiencies this Court identified. First, Relator fails yet again to plead materiality, because she makes only broad, generic allegations, and CMS's decision to make payments under the MA capitated payment system is based on each beneficiary's geographic location, income status, gender, age, and health status—not instances of denying care to beneficiaries.

"Moreover, Relator [still] does not identify, let alone allege, any false claims for payment beyond [the MA plans'] requests for capitation payments[,]" and "it is not apparent from Relator's complaint that the requests for capitation payments made any explicit reference to particular denial rates or UM review processes." Order at 11. Relator also does not explain how she can allege false claims for non-conforming services when the contracts between CMS and AIM's MA plan clients were based on a fixed capitation rate per member per month, based on each beneficiary's demographic and health status information; that is, the capitation rate is not based on benefits recouped by beneficiaries, or UM-driven denials of claims. *Id.*

Second, Relator still does not allege Defendants fraudulently induced CMS to contract with any of the MA plans that are AIM's clients. *Id.* at 10-11. At best, she now alleges all claims submitted by AIM's MA plan clients were necessarily false, a theory that still fails under the FCA.

Finally, Relator still has not "plead any factual details to support the conclusion that any beneficiaries in fact received deficient Medicare coverage for which [any of AIM's MA insurance plan clients] received payment." Id. at 11. Her claims fail for all of these reasons.

A. Relator Has Not Remedied Her Failure to Sufficiently Allege Materiality.

As with her SAC, Relator's TAC boils down to her assertion that AIM caused MA plans to falsely certify compliance with Medicare rules. *See, e.g.*, TAC at ¶¶ 13, 48-49, 165. But as this Court held previously, under *Escobar*, a party seeking to plead an FCA claim based on implied certification must allege Defendants: "(1) submitted a claim for payment that (2) made specific representations about the services provided or failed to disclose violations of legal requirements that would make such representations misleading half-truths, and (3) those misrepresentations would be material to the Government's payment decision." Order at 12 (citing *United Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2001 (2016)). Even if Relator could satisfy the first two prongs—which she has not—she has failed again to plead the materiality of any alleged false statements to CMS's decision to pay AIM's MA plan clients. Order at 11-12.

As this Court previously recognized, the Supreme Court held in *Escobar* that the materiality standard is "rigorous" and "demanding," and "specifically rejected the theory that 'any statutory, regulatory, or contractual violation is material so long as the defendant knows that the Government would be entitled to refuse payment were it aware of the violation.'" *Id.* at 11-12 (quoting 136 S. Ct. at 2003-2004). Relator again makes only generic statements alleging materiality that do not satisfy this "demanding" standard. She claims "[i]f CMS had known that a MA plan's contract and bid falsely assured that it would provide at least the care provided by

original Medicare, when the insurer planned to provide lesser and defective insurance than CMS contracted for, CMS would not have contracted with the insurer for that MA plan . . . And if CMS had known that an insurer lied to CMS about MA plan coverage, and provided, in any given month, lesser and defective insurance than CMS contracted for, CMS would not have paid that insurer for the MA plan." TAC at ¶¶ 59-60. That Relator has now reworded her broad, generic allegations does not render them any less ineffective.[4]

As this Court has already held, "[g]iven the capitated payment scheme of the MA program, this Court must consider each alleged violation of Medicare Rules via the AIM UM review process through the lens of whether it is material to CMS's determination of the capitated payment amount." Order at 12 (internal quotation and citation omitted). Relator does not claim AIM's MA Plan clients failed to provide any coverage for the medical services at issue. Instead, she asserts AIM inappropriately denied specific instances of requests for services from beneficiaries. And aside from her failure to identify any particular beneficiary who allegedly received deficient coverage (or was denied a request for care), or any specific service allegedly not provided to beneficiaries, Relator also does not allege (and cannot allege) that any inappropriate denial of care would change the government's decision to pay an MA plan under the capitated payment system. MA plans receive prospectively set, capitated payments based on their beneficiaries' location, income status, gender, age, and health status—*not* based on whether any requested instance of care is denied. Indeed, "the government is 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

[4] Relator also includes various references to AIM and the plans' obligation to "comply with all applicable Medicare laws, regulations, and CMS instructions," *see, e.g.*, TAC at ¶¶ 52, 56-57, which this Court already rejected as insufficient to plead materiality. Order at 14.

would otherwise pay." *United States ex rel. Gray v. UnitedHealthcare Ins. Co.*, No. 15-cv-7137, 2018 U.S. Dist. LEXIS 98195, at *18 (N.D. Ill. June 12, 2018).

"[T]hat there are appropriate uses of utilization management tools in MA plans makes the pleading of materiality all the more important to distinguish FCA violations from innocent conduct." Order at 14. Relator's materiality allegations in the TAC still are conclusory and insufficient. *See United States ex rel. Petratos v. Genentech, Inc.*, 855 F.3d 481, 490 (3d Cir. 2017) (affirming dismissal of FCA complaint lacking detailed factual allegations that CMS would not have reimbursed claims if the reporting deficiencies had been cured); *United States ex rel. Maetski v. Raytheon Corp.*, No. 2:06-cv-03614-ODW(KSx), 2017 U.S. Dist. LEXIS 122685, at *20-21 (C.D. Cal. Aug. 3, 2017) (allegation the government would not have paid defendant's requests for payment if it knew the defendant had not complied with contractual specifications was "insufficient" because "it does not show *how* [the defendant's] misrepresentations were material"). Moreover, "Relator's [re-]pleading of senior AIM officials' comments and concerns that AIM UM guidelines were not compliant with Medicare Rules or that [] MA plans complained to AIM about noncompliance are similarly not compelling." Order at 15; *e.g.*, TAC at ¶¶ 131, 141, 145-47, 154. Under *Escobar*, materiality under the FCA examines "the effect on the likely or actual behavior of the recipient of the alleged misrepresentation." Order at 15 (quoting 136 S.Ct. at 2002) (internal citation omitted). "Whether AIM or MA plan officials thought, or even knew, that CMS could lawfully withhold payment to the [] MA plans is not equivalent to whether CMS in practice would withhold payment." *Id.* at 15-16. Accordingly, Relator fails yet again to plead the materiality of any alleged misrepresentation, and her claims should be dismissed on this basis.

B. Relator Still Does Not Identify Any False Claims Aside From MA Plans' Requests For Capitation Payments, Which Are Not Based On Benefits Recouped And Do Not Include Any Alleged Misstatements Regarding Denial Rates Or AIM's UM Review Process.

Relator still "does not identify, let alone allege, any false claims for payment beyond the [client MA plans'] requests for capitation payments." *Id.* at 11. To the extent Relator could assert a plan's "bid" to participate in the MA program is the claim, "claims" under the FCA are strictly limited to requests or demands for money from the government and do not include "mere false statements," even if those statements "ultimately lead to a request or demand for money or property." *United States ex rel. Atkinson v. Pennsylvania Shipbuilding Co.*, 255 F. Supp. 2d 351, 365 (E.D. Pa. 2002); *see also United States ex rel. Wride v. Stevens-Henager Coll., Inc.*, 359 F. Supp. 3d 1088, 1109-10 (D. Utah 2019) (relator's claim was dismissed with prejudice where it attempted to impose liability on false statements alone). Relator expressly asserts "[t]he capitation payments are the government payments that Defendants 'claim' from CMS each month." TAC at ¶ 55 (citation omitted). But capitated payments made under the MA rubric are not based on benefits recouped (or not recouped) by plan beneficiaries. Order at 11. MA plans do not receive any more or less money from CMS based on how many beneficiary coverage requests are granted or denied, or even whether the bases for acceptance or denial are proper. Instead, MA plans receive "a fixed fee per member per month, based on the beneficiary's geographic location, income status, gender, age, and health status." *Id.* Relator's argument that AIM's MA plan clients are somehow misleading CMS by failing to disclose AIM's "rigged pre-authorization review process" fails to consider the way the MA capitation payment rubric works.

MA plans, including AIM's clients, submit annual bids that reflect their expected costs for providing covered services. These bids reflect the plans' most recent claims experience and are subject to review and auditing by CMS before bid submissions are approved. 42 C.F.R. §§ 422.254, 422.256, 422.503(d). Thus, the bids incorporate the plans' experience with controlling costs for imaging services through the use of AIM's UM review. Any capitated payments made

by CMS to the MA plans were based on these bids reflecting the use of AIM's UM process, and not on any allegedly false statements or false claims.

As long as a plan's bid is below the CMS benchmark amount, which is set by formula and varies by geographic area, the plan is paid the amount of their bid, and both CMS and the plan receive a portion of the difference between the bid and the benchmark. 42 C.F.R. §§ 422.252, 422.264, 422.304. The MA plan is required to use its share to provide supplemental benefits to members. *Id.* at § 422.266. If a plan's bid is higher than the benchmark, CMS pays the benchmark amount to the plan, and plan members pay the difference to the plan as a monthly premium. *Id.* at § 422.262(a). In short, a plan receives the amount of its bid, unless it exceeds the benchmark—in which case it receives the benchmark amount. Accordingly, if a plan's bid were higher—to reflect historic higher costs for imaging services (or fewer denials of requests for pre-authorization)—then the government's payments to the plan would be higher as well. In contrast, under Relator's alleged scheme, in which *less* imaging is approved and paid for by the plan, the result is cost *savings* to the government. Further, even if the MA plans were to save money one year by using AIM's allegedly improper UM review process to deny care, their capitation payments would be reduced in the future, as their bids in subsequent years would reflect these lower payments.

As this Court already concluded, because the government payments here are made via capitation, Relator's allegations are fundamentally incompatible with the FCA. Order at 11. Not only is there no link between the only alleged "false claims" in the TAC (the capitated payment requests) and any payment from the government, but as this Court already has found, the requests for capitation payments make no "explicit reference to particular denial rates or UM review processes" employed by the MA plans. *Id*. Relator alleges (without any other factual support) that in each "monthly request for payment" an MA plan represents "that it provided all services

promised in its MA contract, and in compliance with all Medicare coverage rules." TAC at ¶¶ 55-56. And Relator continues to allege that AIM's UM review process is significantly flawed and that its denial rates are excessively high. *See, e.g., id.* at ¶¶ 67-75, 120. However, despite the Court's specific identification of this pleading deficiency, Relator again makes no allegation that AIM's MA plan clients make any representation (or reference whatsoever) as to any denial rates or the use of UM review processes in their requests for capitation payments.

C. Relator Still Does Not Plead Fraud And Cannot Merely Assert All Claims Were False.

"Nowhere in the SAC does Relator assert that CMS was fraudulently induced into contracting with [any of AIM's MA plan clients] for provision of Medicare Advantage plans." Order at 10-11. Relator now attempts to avoid this requirement altogether, alleging that *every* monthly request for capitated payments submitted by the MA plans was a false "claim" because CMS would not have contracted with the MA plans if it knew they planned to provide less coverage than required by Medicare, by using AIM. TAC at ¶¶ 59-60, 166. However, broadly pleading this type of general scheme, by which all claims are necessarily false, fails to satisfy the particularity requirements of Rule 9(b).[5] Indeed, to comply with Rule 9(b), each count of an FCA complaint must: "(1) identify specific false claims for payment or specific false statements made in order to obtain payment; (2) if a false statement is alleged, connect that statement to a specific claim for payment and state who made the statement to whom and when; and (3) briefly state why

[5] Nor is pleading a scheme by which false claims *could* have been submitted enough, without pleading the actual submission of a false claim. *U.S. ex rel. Dolan v. Long Grove Manor, Inc.*, No. 10 C 368, 2014 U.S. Dist. LEXIS 98429, at *11 (N.D. Ill. July 18, 2014) ("relator cannot merely describe a private scheme in detail but then . . . allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government.") (internal quotations omitted). Relator does not do so.

those claims or statements were false." *United States ex rel. Garst v. Lockheed-Martin Corp.*, 328 F.3d 374, 376 (7th Cir. 2003); *United States v. A Plus Physicians Billing Serv.*, No. 13 C 7733, 2015 U.S. Dist. LEXIS 167334, at *9-10 (N.D. Ill. Dec. 15, 2015) (Alonso, J.); *see also Dolan*, 2014 U.S. Dist. LEXIS 98429 at *11 (allegations must "link specific allegations of deceit to specific claims for payment.").

In *United States ex rel. Zverev v. United States Vein Clinics of Chi., LLC*, 244 F. Supp. 3d 737 (N.D. Ill. 2017), the relator provided "no information . . . about bills submitted for procedures performed by any of the doctors who are alleged to have admitted . . . that they performed and billed for medically unnecessary surgeries." *Id.* at 747–48. Consequently, the court held "the complaint's allegations do not provide a basis to rule out a single bill . . . from the scope of this alleged scheme; to defend against this claim on the basis of the allegations presented, the defendants would be required to review the details of every procedure performed." *Id.* at 748. The court dismissed the relator's claim, stating "this claim is the antithesis of a claim pled with particularity and, accordingly, it fails." *Id.*; *see also Garst*, 328 F.3d at 378 ("A contention that the 'total claims' are false . . . fails the requirement of specificity."). Relator here tries to employ the same type of generic, sweeping pleading by asserting all of the capitated payment requests made by AIM's MA plan clients were necessarily false claims.[6] Relator fails yet again to provide a single "concrete example" required to sustain her claims—she does not allege details of any specific AIM guidelines that were allegedly improper and does not name even a single beneficiary

[6] At the same time, somehow, Relator herself provides examples that she says show the alleged fraud was unsuccessful—undermining her assertion that "all claims" were necessarily false. *See* TAC at ¶¶ 80-82 (alleging AIM's "thermostat," a more complex algorithm "that would allow for a more sophisticated implementation of denials" was never implemented to Relator's knowledge, and that AIM's algorithms were "inadequate to properly implement even the AIM Guidelines").

who allegedly did not receive care to which they were entitled. She needs more. *United States ex rel. Keen v. Teva Pharms. USA Inc.*, No. 15 C 2309, 2017 U.S. Dist. LEXIS 518 at *9-10 (N.D. Ill. Jan 4, 2017) (Relator must allege that a false claim for payment was actually submitted to the government and provide "concrete examples").

Even if Relator's allegations were true, and AIM did use a "rigged review process" and ploys such as limiting calls to physicians for additional information, cutting off the number of pages providers could fax, or training employees to improperly deny requests for coverage, *see, e.g.*, TAC at ¶¶ 10, 67, none of the conduct alleged explicitly violates any applicable Medicare regulations, and Relator links none of those practices to any particular claim.

For example, Relator claims that to meet contractual targets for cost savings to its client MA plans, AIM would sometimes "turn off" its computer algorithm, and deny every request for pre-authorization. *Id.* at ¶¶ 10, 71, 78. She also asserts AIM would secretly prevent medical providers from submitting a beneficiary's full medical record by setting fax machines to shut off after receiving 10 pages. *Id.* at ¶ 71. However, even if this were true (it is not), there are no Medicare rules or regulations that prohibit the alleged practices; rather, 42 CFR § 422.562(a)(3) provides only that MA plans are responsible for monitoring their delegated entities to ensure they satisfy relevant requirements. The same is true with respect to Relator's allegation that AIM would train and incentivize its employees to deny requests—Medicare rules and regulations do not prohibit this practice. TAC at ¶¶ 107-16.

Relator also claims that AIM's alleged "case aging" policy would violate the Medicare regulations and guidance requiring MA plans to make individualized determinations based on medical necessity and take reasonable and diligent efforts to obtain necessary information from providers. *Id.* at ¶¶ 10, 86-87. Here, too, Medicare does not set forth any explicit rules regarding

the time period for a response by a physician such that AIM's alleged "case aging" policy renders its client plans noncompliant. Any alleged practice of keeping reviewers from making more than one contact to medical providers for additional information related to pre-authorization requests (which Relator calls the "one contact limit" rule) also does not violate any Medicare regulation. *Id.* at ¶¶ 10, 88. Indeed, Medicare guidance states that "[i]n instances when outreach is necessary to make a coverage or appeal decision, a minimum of one attempt to obtain additional information, is sufficient[.]"[7] Centers for Medicare and Medicaid Services, Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (Feb. 2019), available at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Parts-C-and-D-Enrollee-Grievances-Organization-Coverage-Determinations-and-Appeals-Guidance.pdf, § 10.6.

Finally, Relator also asserts that AIM quoted language from AIM Guidelines in patient denial letters, rather than providing the actual reasons for denial of care. TAC at ¶¶ 10, 106. Medicare guidance states that denial letters should "provide a specific and detailed explanation of why the medical services/items were denied, including a description of the applicable coverage rule *or applicable plan policy*…upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable." Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, § 40.12.1

[7] Ignoring this, Relator instead cites older CMS guidance providing recommendations and "best practices" identified by CMS "[i]n the course of conducting audits and best practices reviews" for the proposition that AIM is *required* to make "'at a minimum 2 attempts to contact a provider's office during the provider's business hours on 2 different days and at different times of the day' for appropriate outreach." CMS, Best Practices and Common Findings Memo #2 from 2012 Program Audits (July 30, 2013); TAC at ¶ 88. A memorandum that expressly provides only "best practices" and recommendations is not a binding requirement such that failure to comply constitutes a violation of the FCA. *See* United States Department of Justice Memorandum for All Components: Limiting Use of Agency Guidance Documents in Affirmative Civil Enforcement Cases, Jan. 25, 2018.

(emphasis added). Again, even if AIM did engage in this practice, no Medicare rule was violated. Relator points generally to Medicare regulations and guidance instructing insurers to make individual medical necessity determinations, and use reasonable and diligent efforts to obtain necessary medical information to make coverage decisions, but none of these sources actually prohibit the conduct Relator alleges. *See, e.g.*, 42 C.F.R. § 422.112(a)(6)(ii); *id* at § 10.6.

Having failed to allege a prohibited practice, or any connection of any alleged practice to the bids the MA plans submit to obtain capitated payments from CMS, Relator also still has failed to allege any false statement embedded within the certifications the plans submit to CMS regarding compliance with Medicare rules. She has not plead a scheme showing all claims submitted to CMS by the MA plans were necessarily false, and also fails to satisfy Rule 9(b).

D. Relator Still Does Not Plead That Any Beneficiaries Received Deficient Medicare Coverage For Which Any Of AIM's MA Plan Clients Received Payment.

This Court dismissed Relator's SAC in part because she failed to "plead any factual details to support the conclusion that any beneficiaries in fact received deficient Medicare coverage for which [AIM's MA plan clients] received payment." Order at 11. The TAC is no better. Now, however, Relator asserts she is unable to provide any specific claims information because she "left without taking patient files[.]" TAC at ¶ 121. Relator's excuse for her inability to plead the most essential element of her claims is unavailing. *See, e.g.*, *Keen*, 2017 U.S. Dist. LEXIS 518 at *8 (pleading the actual submission of a false claim for payment to the government is "the sine qua non of a False Claims Act violation.") (citations omitted); *Dolan*, 2014 U.S. Dist. LEXIS 98429 at *11 (allegations must "link specific allegations of deceit to specific claims for payment.").

While cases like *Lusby* have applied a more relaxed standard for relators without access to certain information, the relators in those cases still were able to provide some specifics, while Relator here provides none. *See United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849,

854 (7th Cir. 2009) (relator named specific allegedly non-conforming parts shipped on specific dates and related "details of payment"); *cf. United States ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770, 779 (7th Cir. 2016) (Relator pled specific circumstances regarding defendants' misuse of a particular billing code (which relator specifically identified) and representations to the government "that a certain treatment was given by certain medical staff when in fact it was not.").

In *Presser*, for example, the court specifically noted the relator's position as a nurse practitioner, "a position that does not appear to include regular access to medical bills," in holding it "did not see how she would have been able to plead more facts pertaining to the billing process." 836 F.3d at 778. Here, however, Relator expressly claims she "was responsible for development of clinical guidelines and regulatory compliance for Medicare programs, including compliance with Medicare policies and regulations" and "witnessed firsthand the design of rules, policies and practices calculated to deny care with no medical basis and in violation of the core Medicare requirements." TAC at ¶ 19. If Relator indeed "witnessed firsthand" the design of the allegedly noncompliant AIM Guidelines, "it should not be difficult to identify" actual examples of improper Guidelines. *United States ex rel. Soulias v. Northwestern Univ.*, No. 10 C 7233, 2013 U.S. Dist. LEXIS 90340, at *10 (N.D. Ill. June 27, 2013) (where relator alleged "she was personally aware of instances in which the [defendant] hospital received double payment for the same medical treatment . . . it should not be difficult to identify actual instances of double billing." . . . "That does not mean [relator] is required to remember and identify specific patient names . . . [but relator] is still required to provide some actual examples of the double billing she alleges, with enough specificity to satisfy Rule 9(b).").

Instead, in her fourth attempt to sue Defendants, Relator still does not identify a single specific AIM guideline which allegedly violated applicable Medicare rules. She provides three vague examples of how AIM Guidelines for imaging benefits allegedly "materially deviated from Medicare coverage rules" but again does not allege any information as to which AIM guideline counseled the denial of benefits; or even, on the other hand, any specific "Medicare Rule" requiring coverage for any of these benefits, from which the Guidelines "materially deviated." TAC at ¶ 100.

Relator has provided no detail to sustain her claims under Rule 9(b), even under the more relaxed standard espoused by cases like *Presser* or *Lusby*, and despite that Relator herself alleges she had access to the very information which she continues to be unable to provide. She clearly can never meet Rule 9(b), and her claims should be dismissed with prejudice.

II. Relator Does Not Plead Veil-Piercing Or Direct Participation Necessary To State A Claim Against Anthem.

The vast majority of Relator's TAC describes alleged conduct by AIM, Anthem's subsidiary. *Id.* at ¶ 25. "Parent corporations are not liable for the wrongs of their subsidiaries unless they cause the wrongful conduct (and are so directly liable) or the conditions of investors' liability ('piercing the corporate veil') have been satisfied." *United States ex rel. Stop Ill. Mktg. Fraud, LLC v. Addus Homecare Corp.*, 13-cv-9059, 2017 U.S. Dist. LEXIS 15226, at * 19 (N.D. Ill. Feb. 3, 2017) (quoting *Bright v. Hill's Pet Nutrition, Inc.*, 510 F.3d 766, 771 (7th Cir. 2007)) (citation omitted). Relator does not plead there was a unity of interest between AIM and Anthem, or a degree of ownership and control exercised by Anthem over every aspect of AIM's operations such that the corporate veil could be pierced to state a claim against Anthem; nor does she plead that "adherence to the fiction of separate corporate existence would sanction a fraud or promote injustice." *Judson Atkinson Candies, Inc. v. Latini Hohberger Dhimantec*, 529 F.3d 371, 378-79

(7th Cir. 2008) (citations omitted). "The [TAC] must, therefore, contain some allegation that would make [Anthem] liable for [AIM]'s alleged fraud. *Stop Ill. Mktg Fraud*, 2017 U.S. Dist. LEXIS at *19.

Though Relator makes the conclusory assertions that "AIM and Anthem designed, marketed and implemented a fraudulent scheme" and "Anthem, the parent company of AIM, was intimately involved in the design and direct approval of AIM's rigged review process[,]" she does not sufficiently allege any direct participation on the part of Anthem in any of these activities. TAC at ¶ 4, 11. Relator's basic theme is that Anthem "allegedly controlled [AIM], which did not itself submit false claims but is alleged to have caused [MA plans] to submit them." *United States ex rel. Lisitza v. Par Pharm. Cos.*, No. 06-C-06131, 2013 U.S. Dist. LEXIS 31224, at *14 (N.D. Ill. Mar. 7, 2013). However, "[i]t has been established that merely being a parent corporation of a subsidiary that commits an FCA violation, without some degree of participation by the parent in the claims process, is not enough to support a claim against the parent for the subsidiary's FCA violation." *Id.* at *17-18 (quoting *United States ex rel. Hockett v. Columbia/HCA Healthcare Corp.*, 498 F. Supp. 2d 25, 60 (D. D.C. 2007)). "In addition to allegations of knowledge, [Relator] must supply facts to plausibly assert that [Anthem] *caused* other parties' false statements or the submission of false claims. This requires some affirmative participation or action by [Anthem] that furthers the unlawful objective." *Id.* at *16 (emphasis in original) (citing *United States ex rel. Sikkenga v. Regence Bluecross Blueshield of Utah*, 472 F.3d 702, 714-15 (10th Cir. 2006)).

Relator does not allege anyone at Anthem created or implemented AIM's allegedly fraudulent UM scheme. Rather, she merely asserts Anthem was "aware that the rigged AIM review process violated Medicare requirements" and there was an internal back-and-forth at Anthem about whether to use the "rigged AIM review process for the numerous large MA plans

operated by [Anthem's] insurer subsidiaries." TAC at ¶¶ 146, 148. Indeed, Relator alleges that "[s]ome Anthem executives, such as Vice President Dr. Alan Rosenberg tried to have Anthem take control of approving and revising the AIM Guidelines . . . [b]ut AIM and its executives pushed back[,]" resulting in AIM maintaining its control over the Guidelines—not Anthem. *Id.* at ¶ 147.

Relator's TAC does not plead any circumstances supporting piercing the corporate veil, and "does not allege facts that *the scheme itself* was controlled or directed" by Anthem, so her claims against Anthem should be dismissed. *Lisitza*, 2013 U.S. Dist. LEXIS at *19 (emphasis in original).

CONCLUSION

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

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Respectfully submitted,

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