UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

UNITED STATES, EX REL. DR. SUSAN NEDZA,	)	
	)	
Plaintiff-Relator,	)	NO. 15-CV-6937
v.	)	
	)	JUDGE JORGE L. ALONSO
AMERICAN IMAGING MANAGEMENT, INC., *et al.*,	)	
	)	
Defendants.	)	
	)	
	)	

RELATOR'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS THE THIRD AMENDED COMPLAINT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

I. INTRODUCTION

This is a case in which Relator, the former Medical Director of Defendant AIM, has made detailed allegations based on first-hand, high-level information, including repeated admissions by top corporate executives, that the Defendants AIM and Anthem systematically constructed and implemented a scheme to defraud the United States government's Medicare Advantage ("MA") Program. In this scheme, MA insurance plans ("MA Plans"), including Anthem subsidiaries, bid for and agreed to make individualized insurance coverage determinations and provide full Medicare benefits for seniors and other Medicare beneficiaries, and then systematically shirked their obligation by denying set percentages of benefits without medical review or justification and solely to increase profits.

Defendants seek to defeat this claim by making the extraordinary assertion that they are effectively immune from FCA liability because this fraud does not affect the *price* that the government pays. Defendants' Motion to Dismiss ("MTD"), ECF No. 225 at 2 (the alleged conduct "simply does not, and cannot, impact the amount of capitated payments CMS makes.") Somehow Defendants reason from the fact that the MA program makes payments on a set or "capitated" basis to the conclusion that they can escape FCA liability.

Defendants' argument is wishful thinking, and both flatly wrong and completely illogical. It would mean that Defendants could make coverage decisions with the flip of a coin or refuse to cover any benefits whatsoever, and so long as the rate charged to the government did not increase, no fraud is committed. Fortunately for the government and for the Medicare beneficiaries who were wrongly denied critical medical benefits, Defendants' interpretation is not the law. The FCA is written "'to reach all types of fraud, without qualification.'" *Cook Cnty. v. United States ex rel. Chandler,* 538 U.S. 119, 129 (2003). Nothing in the FCA requires that

the fraud necessarily impact the *price* the government pays. *United States v. Bornstein*, 423 U.S. 303, 307 (1976) (FCA liability for passing off goods "not of the required quality"). *See also* S. REP. 99-345 at 9 (1986) ("the most common" FCA claims include goods or services "provided in violation of contract terms, specification, statute, or regulation"). Though Defendants here shorted the government by at least $100 million in insurance coverage, the issue of financial loss is a "non-sequitur" in evaluating a motion to dismiss an FCA complaint. *United States ex rel. Main v. Oakland City Univ.*, 426 F.3d 914, 917 (7th Cir. 2005). *See also United States ex rel. Miller v. Weston Educ., Inc.*, No. 14-1760, 2016 WL 6091099, at *6 (8th Cir. Oct. 19, 2016) ("To the extent Heritage asserts that its statements, even if false, did not cause any actual harm, this is not an element of materiality"). Fraud is fraud whether Defendants overcharged or underperformed.

The fraud here is a premeditated, systemic failure to perform, enabled by lies. By law, when a treating physician recommends a procedure for a Medicare beneficiary, the MA insurer must decide whether to cover the procedure based on *an individualized evaluation of the specific Medicare beneficiary's medical situation and the application of Medicare coverage rules*. 42 U.S.C. §§ 1395w–22(a)(1)(A) and (g); 42 U.S.C. § 1395w–27(g)(1); 42 U.S.C. § 1395y(a)(1); 42 C.F.R. §§ 422.566(a), 422.112(a)(6)(ii), 422.101(a) and (b). In exchange for lucrative fees, AIM shortcut the coverage determination process and refused to look at individual medical information. It denied claims on illusory procedural technicalities, with no basis in medicine, to decrease expenses and increase profits. Third Amended Complaint ("TAC"), ECF No. 220, ¶ 61. It is specifically *because* the price does not change that the scheme enriched the Defendants' and their MA Plan clients; by unlawfully covering less medical care, the MA Plans kept more of the government payments. The fixed price is a key feature that enables this fraud.

In the face of Relator's allegations, Defendants' arguments about FCA pleading technicalities ring hollow. Relator presents extensive allegations about how this fraud scheme operated, including specific confessions from the C-suite of AIM and top executives at Anthem and statistics about the scale of the fraud. The concrete allegations are fully sufficient to give Defendants notice of the charges and demonstrate the basis for this case. This is anything but a fishing expedition, and the allegations more than meet the requirements of Rule 9(b).

Likewise, on a motion to dismiss, the allegations that AIM and Anthem willfully cheated on the most central statutory and regulatory requirements of the MA program pleads material fraud. This case is not about ancillary or secondary conditions, but about the very terms that define the product that the government was purchasing. CMS would not and could not permit MA Plans to operate with arbitrary, flip of the coin, coverage determinations for millions of Americans, let alone AIM's system that was actually rigged *against* the beneficiary.

It matters not whether fraud is perpetrated by overcharging or a failure to perform, as it is fraud by means of either method. And this is true whether defendants lie to get each payment or initially to get the entire contract, whether the scheme shaves a nickel or a quarter of every government dollar. Nothing exempts Defendants from FCA liability; they should not be permitted to hide behind assertions about the MA payment structure, misleading economic notions, corporate structures, or generic statements of law plucked from inapplicable contexts. The TAC pleads fraud by AIM and Anthem. The motion should be denied.

II. FACTS

A. The Medicare Advantage program

The Medicare Advantage program delivers Medicare health insurance coverage to millions of seniors and others eligible for Medicare through the private health insurance market.

Private insurers through "MA Plans" (essentially insurance policies) contract with the Centers for Medicare and Medicaid Services ("CMS") upon the express, legally mandated certification that they will provide *full Medicare insurance coverage* in exchange for a set price per beneficiary per month, called a "capitation payment." TAC ¶ 35. Specifically *because* the price does not change based on the amount of medical care MA Plans ultimately cover and pay for, the less medical care that MA Plans pay for, the more profitable are the fixed capitation payments. The MA Plans thus have an incentive to short the beneficiary by refusing to pay for medical care (thereby increasing the insurer's profits). TAC ¶¶ 35-37.

To protect the government and Medicare beneficiaries from being cheated in such a manner, the core mandate of the MA program is that MA Plans (i) make individualized coverage decisions; (ii) based on medical necessity and (iii) cover *all* the same services that are covered by traditional Medicare (the "basic benefits"). TAC ¶¶ 41-47.[1] "MA plan coverage decisions thus must be based on 'coverage criteria no more restrictive than original Medicare's national and local coverage policies' and must consider 'the enrollee's medical history.'" TAC ¶ 44. These terms define what CMS purchases from the MA Plans: MA Plans get billions of dollars in government revenue to *conduct individualized coverage reviews* and provide *full Medicare insurance coverage*. It is not sufficient for an MA Plan to generally or sometimes cover a particular good or service, the MA Plan must actually cover each required good and service for every individual enrollee who should get them under Medicare rules. Not even Defendants dispute these core requirements. MTD at 3-4, 16.

Accordingly, to obtain annual contracts from CMS, the MA Plans certify that they provide "enrollees in each of its MA plans the basic benefits as required" by statute and

[1] *See* 42 U.S.C. §§ 1395w-22(a)(1)(A) and (g); 42 C.F.R. § 422.566(a); 42 C.F.R. § 422.112(a)(6)(ii); 42 C.F.R. §§ 422.101(a) and (b).

regulation. TAC ¶ 52. *See also* TAC ¶¶ 48-53 and Exhibits 1-2 (including language of the CMS contract documents and attestations from the MA Plan CEO). Compliance with these key "requirements and conditions" is expressly "material to the performance of the MA contract" between CMS and the MA Plans. 42 C.F.R. § 422.504(a); 42 U.S.C. § 1395w-27.

Likewise, "[b]ecause the [Medicare Advantage] program lends itself to fraud, Medicare Advantage organizations must certify the accuracy, completeness, and truthfulness of the data they provide to CMS … as a condition for receiving payment." *United States v. UnitedHealthcare Ins. Co.*, No. 15-CV-7137, 2018 WL 2933674, at *2–3 (N.D. Ill. June 12, 2018); 42 C.F.R. § 422.504(l). Each MA Plan certifies monthly the number of beneficiaries for whom the MA Plan covered *all of the services* listed in that MA Plan's annual bid package (as identified by the MA Plan identification number), and thus certifies that the MA Plan in fact did provide coverage for all required and promised services. TAC ¶¶ 54-56 and Exhibit 1. The MA Plan submits this certification with each monthly claim for a capitation payment from CMS. Without a truthful certification, the MA Plan does not get paid. TAC ¶¶ 56, 60.

B. The fraud.

In making coverage decisions for MA Plans, AIM's business model was to deliberately and systematically refuse to engage in a substantive medical review of requests for insurance coverage, ignore individual medical information, and deny requests for coverage for no medical reason at all, but only to hit denial quotas. TAC ¶¶ 61-66, 75. If a request for coverage is denied, the MA Plan does not pay for the medical service and the beneficiary does not receive the medical care (or pays for it out of pocket). TAC ¶¶ 7-8.[2] The deal here was simple: MA Plans, in effect, paid AIM $5 to deny $15 in care through an automated and flawed review

[2] The MA Plans require pre-authorization of coverage for medical services such as advanced diagnostic imaging (e.g. CT, MRI, or PET scans) before the medical service occurs. TAC ¶¶ 67-69.

system. *Id.* For dozens of MA Plans that cover over 1 million Medicare beneficiaries, this fraud denied essential Medicare benefits totaling over $100 million in medical care. TAC ¶¶ 5-6, 27. Defendants profited, the patients suffered, and government was defrauded by paying for fraudulent coverage decisions and defective insurance.

AIM frequently denied requests with no medical review, judgment, or excuse. The fraudulent gimmicks used by AIM to "fix" the review process and stack it against MA beneficiaries include, among others:

(a) Refusing to approve *all* requests for a certain service for a particular MA Pdzalan for *no reason* other than AIM was in danger of missing a contractual target for cost savings for that plan ("turning off the algorithms"), TAC ¶¶ 76-81;

(b) Denying coverage with no purported medical justification (without any notice) when a provider failed to call AIM within a business day ("case aging"), TAC ¶¶ 86-87;

(c) Preventing medical providers from submitting full medical information by secretly setting fax machines to stop printing after 10 pages, TAC ¶¶ 91-93;

(d) Designing and implementing flawed computerized algorithms that imposed rules with no medical basis to refuse to approve care, TAC ¶¶ 82-85; and,

(e) Concealing and covering up wrongful denials by falsely representing AIM's restrictive rules as official Medicare policy in written denial letters, TAC ¶¶ 105-106.

The rigged system was so arbitrary and unjustifiable that AIM's own physician reviewers complained about it harming patients. TAC ¶ 114. AIM's fraudulent scheme was the antithesis of individualized coverage decisions based on Medicare rules, and exactly the conduct the MA statutes and regulations prohibit.

This fraud was not a random or low-level occurrence, but rather was mandated and orchestrated from the top. AIM and Anthem executives openly discussed and even quantified the systemic fraud on the MA program. As Chief Medical Officer for AIM from July 2012 to January 2015, Dr. Nedza did not work at the lower levels of the company, making individual

coverage determinations. Rather, she worked with the executive leadership team where she personally saw and heard AIM and Anthem executives repeatedly admit to knowing about, directing, and condoning this fraud. TAC ¶ 19. These admissions, pled in detail, include:

a. In 2013, AIM Senior Medical Director Dr. Thomas Power studied a sample of 164 MA requests for pre-authorization that had been denied by AIM and determined that 160 (or 97.5%) of those requests should have been approved under mandatory Medicare rules. TAC ¶ 124.

b. In 2013, AIM prepared marketing materials to advertise to insurance companies that under Medicare coverage rules, 0.5% of requests for benefits coverage would be denied, but that AIMs review process prevented 5% to 9% of requests. In those materials, AIM further acknowledged that some of its denials "will likely be overturned by CMS." TAC ¶ 126.

c. On October 15, 2013, Dr. Julie Thiel, AIM Senior Vice President, proposed that AIM simply approve all MA requests until AIM could implement review procedures to stop '"incorrectly denying'" them. TAC ¶ 129. AIM leadership refused.

d. In 2014, Jennifer Dullum, AIM's Vice President of Compliance, warned that AIM's fraudulent review process risked landing its clients in jail. TAC ¶ 131.

e. At the end of 2014, Blue Cross Blue Shield of Michigan informed AIM that it was considering self-reporting to CMS the violations of Medicare coverage requirements being caused by AIM's review process. TAC ¶ 141.

AIM's review process was so fraudulent–and so fraught with legal liability–that by 2012 *Anthem itself* barred its own MA Plans from using it. TAC ¶ 150. In other words, Anthem was so concerned with the potential legal liability that it refused to let its subsidiary insurance companies use AIM's illegal review service. Anthem, however, allowed AIM to continue the fraud for other insurers. TAC ¶¶ 151-55. And indeed, Anthem's partial resolve to obey the law did not last long, as after a few years it reversed course and again allowed its subsidiary insurance companies to use the fraudulently rigged AIM review process. *Id.* Anthem's decision, however, was so legally risky that AIM's CEO Brandon Cady wanted to make sure that Anthem executive '"Mary McCluskey's name is on an email approving the decision so when we get

caught [by CMS] it's on her.'" TAC ¶ 154. This scheme is fraud by any name, perpetrated with false statements and false claims to obtain MA contracts and government payments.

III. ARGUMENT

Contrary to the Defendants' arguments, the structure of the Medicare Advantage program does not immunize Defendants from liability for their fraud. The government contracted with each MA Plan for certain insurance services and a certain scope of insurance coverage, and the Defendants intentionally and systematically provided the government with less. Nothing in the FCA requires that a fraud necessarily impact the *price* the government paid.

The TAC states a claim for violations of the FCA and satisfies the applicable pleading requirements. Federal Rule of Civil Procedure Rule 9(b) requires just "some basis for [the] accusations of fraud," taking into consideration the relator's access to information, and that the case is not brought for "ulterior purposes." *Uni*Quality, Inc. v. Infotronx, Inc.*, 974 F.2d 918, 924 (7th Cir. 1992). Rule 9(b), like the FCA, is flexible to the circumstances of the case. The Seventh Circuit has warned both litigants and courts against taking "an overly rigid view" of Rule 9(b) because "the precise details that must be included in a complaint 'may vary on the facts of a given case.'" *United States ex rel. Presser v. Acacia Mental Health Clinic ("Presser"), LLC*, 836 F.3d 770, 776 (7th Cir. 2016) (citations omitted). The touchstone of Rule 9(b) is to ensure fair notice to defendants and to "screen against spurious fraud claims." *Id.* at 776. Rule 8 likewise only requires "[f]actual allegations …[that] raise a right to relief above the speculative level." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 545, 555 (2007). Dr. Nedza's complaint presents a compelling, detailed, and credible picture of significant fraud on a major government healthcare program that impacts millions. It more than satisfies Rules 8 and 9(b).

A. AIM and Anthem are not immune from the FCA just because the MA Program uses fixed (capitated) payments.

1. Neither fraud nor FCA claims necessarily turn on manipulation of the price.

Defendants AIM and Anthem seek immunity from FCA liability with the preposterous claim that the FCA does not apply to fraud unless it affects the *price* that the government pays—here the amount of the capitated MA payment. Defendants argue that "because the government payments here are made via capitation, Relator's allegations are fundamentally incompatible with the FCA." MTD at 11. Since MA payments do not vary by the services covered in any given month, Defendants argue that their conduct "simply does not, and cannot, impact the amount of capitated payments CMS makes to AIM's MA plan clients." MTD at 2.[3] This argument is nonsense. Defendants must provide the required individualized coverage decisions and Medicare benefits for a fixed price; that is their bargain with the government. Their scheme to avoid doing so is fraud and violates the FCA.

AIM and Anthem cannot craft FCA immunity out of the way the government structures MA payments. Whether the government pays by month, by person, by procedure, or otherwise, the FCA reaches "all types of fraud, without qualification.'" *Cook Cnty. v. United States ex rel. Chandler,* 538 U.S. at 129. The fact that Defendants failed to perform, rather than overcharged, is of no moment; the government is defrauded and harmed just the same. Paying a set price while intentionally providing less than what was bargained for results in a loss of money to the same extent as overpricing.[4]

[3] Defendants rely, in part, on a misleading presentation of *United States ex rel. Gray v. UnitedHealthcare Ins. Co.*, No. 15-CV-7137, 2018 WL 2933674, at *2–3 (N.D. Ill. June 12, 2018). MTD at 8-9. In *Gray*, the relator alleged that MA Plans paid for *too many* procedures, to which the court commented that the government is not harmed given the risk sharing features of the MA program. This case is the polar opposite—the MA Plans defraud the government by making arbitrary coverage decisions that cause MA Plans to pay for *too few* medical procedures.

[4] Further, financial loss or "damage to the government is not required" for an FCA claim. *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1173 (9th Cir. 2016). *See also United States v. Rogan*, 517

Defendants' arguments about capitated payment structure and government loss are a complete red herring. Under their theory, how the MA Plans make coverage decisions and the amount of coverage an MA Plan provides are irrelevant, because the government pays the same set capitated payment—"the payments MA plans receive are unrelated to any particular benefits provided (or not provided) to beneficiaries." MTD at 3. If the Defendants' argument were correct, AIM could make coverage decisions by flipping a coin, or looking at the first letter of a person's last name, or denying coverage for X-rays for women over 72 on Thursdays, and since the government capitation payment would be the same, there would still be no FCA claim. Defendants' argument is absurd.[5]

Yet the AIM system the Defendants seek to defend is just as arbitrary; it denied requests of beneficiaries when their doctor did not return AIM's phone call quickly enough, or when the request for coverage happened to come in during a month or year where AIM had not denied enough requests for their MA Plan to hit the quota, or when the doctor put the key medical information on page 11 of a faxed medical record. AIM's system is worse than arbitrary, it is rigged *against* the beneficiary only for greed. The FCA does not ignore such fraud.

2. The TAC pleads classic FCA claims.

The FCA has never been so narrowly interpreted as AIM and Anthem suggest. The fraud here is straightforward and clearly covered by the FCA. FCA liability attaches to "any person who— (A) knowingly presents, or *causes* to be presented, a false or fraudulent

---

F.3d 449, 453 (7th Cir. 2008) (upholding FCA damages where patients were obtained by kickbacks, even if the patient received all the medical care or the government "would have paid for" the medical care anyway). "[T]he statute provides for penalties even if (indeed, *especially* if) actual loss is hard to quantify." *United States ex rel. Main v. Oakland City Univ.*, 426 F.3d at 917 (reversing dismissal of an FCA claim where the government might have made financial aid payments in the same amount regardless of the fraud).

[5] Related, Defendants' mistaken factual claim that the AIM fraud *saves* the government money, MTD at 10-12, is, at best, a disputed factual issue involving the denial of coverage, MA insurance bids and pricing, experience rating, benchmark setting, CMS audits and adjustments, and a host of factual issues beyond the pleadings, none of which are appropriate to consider on a motion to dismiss.

claim for payment or approval, (B) knowingly makes, uses, or *causes* to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1) (2010).[6] Here, for a set price (the capitated payment amount), MA Plans agree to make individualized coverage determinations and provide insurance coverage *equal or greater* than that of original Medicare. Defendants then caused the MA Plans to provide *defective and lesser* insurance than required by the MA program through rigged decisions that denied coverage for no medical reason, but only to extract improper profits. The MA Plan performance was deficient, defective, and cheated the government; the scheme was facilitated and covered up with lies (false statements). This is fraud. Nothing more is required for an FCA claim.

The fraud here also matches at least three variants of fraud recognized by courts in FCA cases: non-conforming services, fraudulent inducement to contract, and false certifications.

a. The TAC pleads fraud through non-conforming services.

Defendants claim to be perplexed about Relator's claim "for non-conforming services when the contracts between CMS and AIM's MA plan clients were based on a fixed capitation rate." MTD at 6. But fraud through defective goods or services is about the product delivered, not the price. Shirking is classic fraud. The government is defrauded when it purchases one thing and a contractor provides something else or something defective. *See United States v. Bornstein*, 423 U.S. 303 (1976). If the government contracts for 500 chemotherapy treatments at $119 per treatment, including the dose of drugs ordered by each patient's physician, but the contractor gives 500 chemotherapy treatments with 83% of each dose, the government has been defrauded. A contractor who submits 87 octane gasoline on a contract that required 91 octane gasoline

[6] Defendants emphasize that they are not the entities that "actually submitted a request for payment or made any certifications to the government." MTD at 2. This is no defense as the FCA reaches defendants—like AIM and Anthem—who *cause* a third party—here the MA Plans—to submit false claims and statements. 31 U.S.C. § 3729.

defrauds the government, even if the monthly invoice says nothing about the octane of the fuel and correctly lists the gallons provided. *United States v. Science Applications Int'l Corp.*, 626 F.3d 1257, 1269 (D.C. Cir. 2010) (illustrating a hypothetical false claim and holding "claims for nonconforming counseling and technical assistance were false").

The government here purchased individualized coverage determinations and full MA insurance and it received much less. Defendants caused the client MA Plans to pass off defective and incomplete MA coverage as complete and compliant in the same way as the defendant who "palmed off [as compliant] … [medical] devices that materially deviated from the approved specifications," causing others to submit false claims for reimbursement to the government,[7] or the doctor in Texas who defrauded Medicaid by billing for complete Early Periodic Screening, Diagnosis, and Treatment screenings of children when only performing incomplete screenings,[8] or the company that charged the government for full vials of prescription, when a patient only used partial vials.[9] It makes no difference that CMS pays MA Plans in advance, rather than as reimbursement, or that the capitated rate is set. The capitation rate is set based on a level of service that the insurance plans falsely promised to provide.

b. The TAC pleads the fraudulent inducement to contract.

Defendants also defrauded the government by causing the MA Plans to submit fraudulent statements to induce CMS to enter MA contracts or extensions. Defendants ignore the allegations of the TAC to argue that "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." MTD at 1. But the TAC in fact includes that specific allegation. TAC ¶¶ 48-

[7] *United States ex rel. Nargol v. DePuy Orthopaedics, Inc.*, 865 F.3d 29, 40 (1st Cir. 2017).

[8] *United States v. Mack*, No. CIV.H-98-1488, 2000 WL 33993336, at *2 (S.D. Tex. May 16, 2000).

[9] *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 158 (3d Cir. 2014).

59, 164-65. The MA Plans made repeated false statements about providing all Medicare coverage and making individualized coverage decisions to obtain and keep MA contracts. TAC ¶¶ 48-53. Without these false statements, the MA Plans would not have CMS contracts. This "fraudulent inducement" renders both the contract and *all* subsequent claims for payment "false" or "fraudulent." *See United States ex rel. Marcus v. Hess*, 317 U.S. 537, 542-44 (1943); *United States ex rel. Main v. Oakland City Univ.*, 426 F.3d at 916; *United States ex rel. Upton v. Family Health Network, Inc.*, No. 09 C 6022, 2013 WL 791441 at *4 (N.D. Ill. Mar. 4, 2013) (St. Eve, J.) (FCA claim based on periodic false statements related to capitated payments under Medicaid managed care contracts that were used "to keep the funding spigot open.").[10]

c. The TAC pleads the fraudulent inducement through false certifications.

Further, Defendants defrauded the government by causing the MA Plans to submit false statements to claim monthly capitation payments. Each monthly payment request by the MA Plans included a false certification of compliance with material contractual, statutory, and regulatory MA terms. The certifications both failed to disclose material violations of Medicare requirements and made misleading half-truth representations about the services provided, just as in *Universal Health Servs., Inc. v. United States ex rel. Escobar ("Escobar")*, 136 S. Ct. 1989 (2016). TAC ¶¶ 13, 54-60.

To collect monthly capitation payments, each MA Plan submitted a monthly request for payment for a certain number of enrollees *and* for the certain services (i.e. insurance coverage) identified by specific MA Plan identification number. The MA Plan identification number refers to the Plan's annual MA bid submission, which in turn specified (i) the benefits the Plan would

[10] Defendants' argument that contract and bid statements were merely "false statements" and not "claims" under the FCA, MTD at 10, ignores this binding precedent that fraudulent inducement to contract is fraud under the FCA. The subsequent claims for payment under the contract are the FCA "claims."

provide, (ii) the monthly cost of providing all Medicare benefits to a Plan enrollee, and (iii) based on those services, the capitated rate CMS would pay the MA Plan. *See* 42 C.F.R. §§ 422.252, 422.254(b)(1)(i). The MA Plans thus monthly submitted claims to be paid the capitation rate for the services specified in their particular MA bid submission, at a rate which was premised on and expressly included the promise to follow Medicare coverage rules and provide full Medicare coverage. TAC ¶¶ 53-54 (citing the underlying documents). In other words, each month each MA Plan submitted a request to be paid based on a false certification that they had provided services in compliance with their approved bid submission. The MA Plans never informed the government that this certification was false, and that instead they were using AIM's services to provide defective and lesser coverage. And just as the defendant's silence in *Escobar* led the government to assume that the counseling not only had been provided (and the session occurred), but that the therapist who completed it was licensed, the MA Plans failure to disclose the "violation of a material statutory, regulatory, or contractual requirement"—here the scope of insurance coverage and method of making coverage decisions—constitutes a misrepresentation that renders the claim false or fraudulent under the FCA. *Escobar*, 136 S. Ct. 1989 (2016).

B. Materiality: This systemic fraud guts the core of Medicare Advantage

Defendants wrongly assert that their fraudulent conduct cannot be *material* because it does not affect the amount of the capitated payments CMS makes to MA Plans. MTD at 2. This sweeping statement makes no sense, and has no foundation in the law. *Supra* Section I.A.1. The Supreme Court has expressly rejected the proposition that the materiality inquiry can '"rest on a single fact or occurrence as always determinative.'" *Escobar*, 136 S. Ct. at 2001; *United States ex rel. Lisitza v. Par Pharm. Cos., Inc.*, 276 F. Supp. 3d 779, 802 (N.D. Ill. 2017) (Supreme

Court prescribed holistic approach to materiality). And courts have repeatedly rejected Defendants' specific argument that fraud is material only if it alters the payment amount. *See, e.g.*, *United States ex rel. Miller v. Weston Educ., Inc.*, No. 14-1760, 2016 WL 6091099, at *6 (8th Cir. Oct. 19, 2016) ("To the extent Heritage asserts that its statements, even if false, did not cause any actual harm, this is not an element of materiality"); *United States ex rel. Simpson v. Bayer Corp.*, 376 F. Supp. 3d 392, 410 (D.N.J. 2019) (rejecting argument that Government '"would not care'" about fraud because it had "'no effect on the Government fisc'"); *United States ex rel. Duffy v. Lawrence Mem'l Hosp.*, No. 14-2256-SAC-TJJ, 2018 WL 4748345, at *8 n.8 (D. Kan. Oct. 2, 2018) ("[W]hether the U.S. Treasury is ultimately impacted is not relevant to the question of whether an alleged misrepresentation affected or would likely affect a reimbursement decision."); *United States ex rel. Dan Abrams Co. v. Medtronic, Inc.*, No. LA CV15-1212 JAK (ASx), 2017 WL 4023092, at *9 (C.D. Cal. Sept. 11, 2017) (fact that "the amount paid by the government for a spinal surgery is not affected by whether one or more of the [noncompliant devices] ... are used" does not render fraud immaterial).

Defendants' argument would inoculate the recipient of fixed-rate payments (the MA Plans) from fraud liability and render meaningless the government's entitlement to the benefit it bargained. Taken to its logical conclusion, Defendants' argument means that so long as the government did not pay more, it would be immaterial that it received little or nothing in exchange. The materiality inquiry looks to the effect of the fraud on the "likely or actual behavior of the" the government. *Escobar*, 136 S. Ct. at 2002. The government "considers factors other than the bald dollar amount of a [payment] request when deciding whether to pay a claim, including the claimant's compliance with applicable statutory requirements." *United States ex rel. Simpson v. Bayer Corp.*, 376 F. Supp. 3d at 410. Even if "a noncompliant claim

would not cost the Government *more* than a compliant claim [it] does not mean the Government is 'indifferent' to underlying compliance violations." *Id.* at 410–11.

For example, the Davis-Bacon Act, which requires contractors to pay prevailing wages to employees working on government projects, was enacted to promote the government's interest in "protect[ing] local wage standards by preventing contractors from basing their bids on wages lower than those in the prevailing area." *United States ex rel. Wall v. Circle C Const., L.L.C.*, 697 F.3d 345, 355 (6th Cir. 2012). Because the government has prioritized local wage protection over its own savings, it regularly pursues FCA claims against contractors who falsely certify compliance with the Davis-Bacon Act, even when the fraud allows those contractors to underbid their competitors and save the government money. *See, e.g.*, *United States ex rel. Int'l Bhd. of Elec. Workers, Local Union No. 98 v. Farfield Co.*, No. CIV.A. 09-4230, 2013 WL 3327505, at *5 (E.D. Pa. July 2, 2013). Defendants' argument that the government must necessarily excuse core statutory and legal violations "impermissibly cabins what the government may consider material." *United States ex rel. Hutcheson v. Blackstone Med., Inc.*, 647 F.3d 377, 394–95 (1st Cir. 2011) (refusing to say as matter of law that misrepresentations were incapable of influencing Medicare's decision to pay even though hospitals payments were set regardless of services).

Here, Relator alleged more than sufficient facts to plead the materiality of the Defendants' fraudulent conduct. The fundamental requirements of the MA program are that insurers must make individualized coverage determinations using Medicare's own coverage rules and pay for all medical care covered by original Medicare. TAC ¶ 37. "Persons who choose to enroll in MA Plans . . . must be provided with the same benefits that are available to those enrolled in traditional Medicare." *Meek-Horton v. Trover Solutions, Inc.,* 915 F. Supp. 2d 486, 488 (S.D.N.Y. 2013). The government has publicly announced its commitment to the integrity of

the MA program by promising MA Plan enrollees: "'1. You're still in the Medicare Program; 2. You still have Medicare rights and protections; 3. You still get complete Part A and Part B coverage through the plan.'" TAC ¶ 38.

Defendants here repeatedly and intentionally violated those promises and their own obligations. They caused MA Plans to falsely certify compliance with MA rules, to implement a rigged process for making coverage decisions, and to intentionally deny covered services to Medicare beneficiaries, causing them medical and financial harm. TAC ¶¶ 36-47, 156-58, 162-167. Defendants' suggestion "that Congress would have the FCA turn a blind eye to such behavior is simply inconceivable." *United States v. Merck-Medco Managed Care, L.L.C.*, 336 F. Supp. 2d 430, 442 (E.D. Pa. 2004) (rejecting argument that relator must show economic harm to federal fisc because that "would mean that any government program that involved a fixed … contribution from the Government would be completely immune from claims of abuse").

Defendants counter that the certifications and statements in this case are too broad to support an FCA claim. MTD at 8, n.4. Defendants are wrong. The fraud and false statements here are not mere technicalities on the fringe of a government program. They go to the very definition of MA insurance and the heart of the MA program and contracts. *See Escobar*, 136 S. Ct. at 2003 n.5 (misrepresentation going to "'very essence of the bargain'" is material). The MA statute "***requires a Medicare Advantage Organization to provide the same benefits to enrollees***" as traditional Medicare. *Humana Med. Plan, Inc. v. Western Heritage Ins. Co.*, 832 F.3d 1229, 1242 (11th Cir. 2016) (emphasis added). The MA Plans false statements with each MA contract and payment—caused by AIM and Anthem—support an FCA claim. *United States ex rel. Cieszyski v. LifeWatch Servs., Inc.*, No. 13-CV-4052, 2015 WL 6153937, at *8 (N.D. Ill. Oct. 19, 2015) ("[t]he Seventh Circuit has held that a promise . . . to abide *by all Medicare and*

Medicaid laws and regulations—is specific enough to support an express false certification theory of liability") (emphasis added).

Indeed, Anthem and AIM executives themselves believed that CMS would consider their violations material, even to the extent that they temporarily chose to pull the Anthem MA Plans out of AIM's fraudulent review process, and forego millions of dollars in profit, out of fear of prosecution. TAC ¶¶ 150, 154. Although not CMS employees, these executives were industry experts with decades of experience interacting with CMS and its practices and policies, as well as the necessary regulatory expertise to devise a scheme to systematically defraud CMS. Their conviction that CMS would exact severe consequences for their fraud, as reflected in their words and actions, was well-informed. While not "equivalent to whether CMS in practice would withhold payment," MTD at 9, it weighs in favor of materiality.[11] *See Escobar*, 136 S. Ct. at 2002-03 (materiality inquiry considers whether defendant knew or had reason to know government would attach importance to specific matter); *United States v. Luce*, 873 F.3d 999, 1007–08 (7th Cir. 2017) (finding omissions by defendant with extensive government experience material because, in part, "subjective knowledge of the importance attached to the representation by the recipient may serve as the foundation of materiality").

At this stage, Relator has pled more than sufficient facts to permit the reasonable inference that the false statements were "capable of influencing" the government's decision to pay the MA Plans. 31 U.S.C. § 3729(b)(4); *Escobar*, 136 S. Ct. at 2002-03.

[11] Any further suggestion that CMS's continued payment to MA Plans using AIM's review process reflects CMS's view on materiality is "a logical falsity," "misstates the Supreme Court's position in *Escobar*," and "is an argument unfit for the motion to dismiss stage." *United States v. Snap Diagnostics, LLC*, No. 1:14-CV-3988, 2018 WL 2689270, at *4 (N.D. Ill. June 5, 2018).

C. Relator provides sufficient detail to satisfy Rule 9(b).

Relator pleads the design and operation of this fraud in detail, along with specific and explicit confessions from AIM and Anthem executives. Relator's allegations—consistent with her access to information— give fair notice to the Defendants and demonstrate that this is no "spurious fraud claim." *Presser*, 836 F.3d at 776; *Pirelli Armstrong Tire Corp. Retiree Med. Benefits Tr. v. Walgreen Co.*, 631 F.3d 436, 441–42 (7th Cir. 2011) (Rule 9(b) is not inflexible). Rule 9(b) requires "only a 'general outline' of the alleged scheme sufficient to put defendants on notice about their roles in the fraudulent or false activity." *United States ex rel. Salmeron v. Enter. Recovery Sys., Inc.*, 464 F. Supp. 2d 766, 768 (N.D. Ill. 2006). A relator need allege "with particularity" only "a set of circumstances that, if true, makes a whole set of claims at least prima facie false." *United States ex rel. Bookwalter v. UPMC*, No. 18-1693, 2019 WL 4437732, at *35-36 (3d Cir. Sept. 17, 2019) ("Rule 9(b) does not require the relators to plead … the date, time, place, or content of every single allegedly false Medicare claim.").

Relator does not attack the legitimate use of utilization management or pre-authorization or "assert that virtually no request for medical services could be validly denied by an MA plan using UM without resulting in a false claim." MTD at 1. These are simply straw man arguments. Relator complains about the *fraudulent* design and use of AIM's review process. The TAC describes step-by-step and gimmick-by-gimmick the fraudulent system that makes automated economic decisions—not individual medical decisions. In the face of compelling factual allegations from an impressive relator, Defendants' claims of insufficient pleading fall flat.

First, Defendants continue to press the absurd argument that perhaps there were no claims made to the government. MTD at 12, n.5 ("Nor is pleading a scheme by which false claims *could* have been submitted enough."). In fact, there were fraudulent claims made every month. In the

MA program, the "monthly claims for payment … necessarily lead to the conclusion that [defendant] presented claims to CMS that were tainted by the alleged fraud." *United States ex rel. Derrick v. Roche Diagnostics Corp.*, 318 F. Supp. 3d 1106, 1112–13 (N.D. Ill. 2018) (rejecting the argument that relator must specify which MA capitated payments were impacted by the fraud). Cases about when a relator needs to specify or detail claims that went to the government—to confirm that the fraud impacted the government rather than private insurers—are simply inapposite here. *E.g. United States ex rel. Zverev v. United States Vein Clinics of Chi., LLC*, 244 F. Supp. 3d 737 (N.D. Ill. 2017); *United States ex rel. Keen v. Teva Pharm. USA Inc.*, No. 15 C 2309, 2017 WL 36447, at *4 (N.D. Ill. Jan. 4, 2017); *United States ex rel. Dolan v. Long Grove Manor, Inc*., No. 10 C 368, 2014 WL 3583980 (N.D. Ill. July 18, 2014). Nor is this an incoherent complaint "so sprawling as to be essentially incomprehensible," where the allegations must be rescued by examples to provide fair notice. *United States ex rel. Garst v. Lockheed-Martin Corp.*, 328 F.3d 374, 376 (7th Cir. 2003). Relator here states a fraud in plain English. The TAC does not need an additional allegation that, for example, MA Plan BCBS of Idaho claimed MA payments in April of 2017 to be credible or give Defendants fair notice of the accusations.

Nor, second, does Rule 9(b) require further details by way of other examples. As a former executive working at the highest levels of AIM, Relator pleads a specific scheme, detailed practices, and stark confessions, all of which establish a basis for the allegation of fraud. Here, AIM made coverage decisions for MA Plans with a crude and worse-than-arbitrary process designed to save money. The AIM process declined to approve coverage only to hit denial rate quotas and cost savings targets—with no pretense of medical justification. TAC ¶¶ 78-80 (turning off the algorithms). The AIM process denied coverage where a physician did not call

AIM back within 24 hours, a basis for denial that AIM kept secret from the physicians and beneficiaries. TAC ¶¶ 86-87 (case aging). The AIM process denied coverage where the relevant medical information was on page 11 or 17 of a faxed medical record, another requirement kept secret from the medical providers and their patients. TAC ¶ 91. Although Relator cannot provide the names and dates of the sample of 164 Medicare beneficiaries whose requests were reviewed by AIM after denying them services during 2013, TAC ¶ 124, she pleads with far more probative value that AIM's own Senior Medical Director Dr. Thomas Power concluded that 97.5% of those denials violated Medicare coverage rules. *Id.*

Relator did not review individual requests for coverage and did not take beneficiary files with her to plead the examples Defendants demand. MTD at 15-17. As in *Presser*, Relator did not have "regular access to medical bills," or the equivalent here, specific reviews of requests for approval of coverage for medical procedures. *Presser*, 836 F.3d at 778. Defendants cannot escape being answerable for their fraud by way of Rule 9(b) arguments merely because the Relator's knowledge of the fraudulent scheme came from her position as a high level executive rather than a request reviewer, and she did not take files with her when she left her job. *See United States ex rel. Derrick v. Roche Diagnostics Corp.*, 318 F. Supp. 3d 1106, 1112–13 (N.D. Ill. 2018) (declining to dismiss an FCA claim in the MA program where the "relator would not be expected to have access to information about [defendant]'s claims submission"); *United States ex rel. Sloan v. Waukegan Steel, LLC*, No. 15 C 458, 2018 WL 1087642, at *4 (N.D. Ill. Feb. 28, 2018) (Alonso, J.) (FCA complaint sufficient where "Relator has not left the Court to speculate about the presence of a claim or the occurrence of a government payment."); *United States ex rel. Litwiller v. Omnicare, Inc.*, No. 11-CV-8980, 2014 WL 1458443, at *10 (N.D. Ill. Apr. 14, 2014) (finding Rule 9(b) met where relator pled the structure of government payment generally).

Moreover, the fraud here is essentially the sale to the government of intentionally defective, substandard insurance coverage decisions and coverage. The false claims are the monthly submissions for payment for the defective coverage, claimed with false certifications, and based on fraudulently obtained contracts. *See United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1183 (9th Cir. 2016) (holding that allegations of false certifications, not examples of patients with falsified diagnoses codes, pled an FCA claim in the MA program). The fact that Relator does not at the pleading stage and without the benefit of discovery identify by patient name and date requests for coverage that were wrongly denied does not change the fact that she has clearly alleged in detail the use every month of a fraudulent scheme used to make coverage decisions.

Instead, Relator had access to and pleads striking admissions by Anthem and AIM executives, up to the CEO, which provide an even stronger basis to allege fraud than examples of the implementation of the fraudulent review process or a sample of patients whose medical benefits were wrongly denied. *See United States ex rel. Howard v. KBR, Inc.*, 139 F. Supp. 3d 917, 943-44 (C.D. Ill. 2015) (holding an FCA complaint sufficiently pled with admissions by executives that they violated reasonable cost contracting rules, even without identifying any particular example of an unreasonable cost); *United States v. R&F Properties of Lake Cty., Inc.*, 433 F.3d 1349, 1359–60 (11th Cir. 2005) (holding an FCA claim pled with the details of a billing scheme admitted by a manager for the defendant even without a single example). Relator here reveals that at least by 2012 Anthem itself concluded that its subsidiary, AIM, was breaking the law and refused to participate, at least for a time, all the while profiting from the fraud through AIM's work for other (non-Anthem) MA Plans. Relator reveals that in 2013 AIM reviewed its claims and concluded that 97.5% of the denials violated Medicare coverage rules. Relator reveals

that in 2014 AIM's own client MA Plan concluded it should turn itself in and self-report to CMS all of the fraud AIM had caused. TAC ¶¶ 150, 124, 141. Relator names the specific executives who ran and confessed to this scheme. TAC ¶¶ 124-154. AIM itself counted wrongful denials. TAC ¶¶ 123-125. There is no doubt that MA Plans deceived and lied to CMS every month about how coverage decisions were made—and that seniors and other MA beneficiaries were harmed—AIM's entire purpose was to deny coverage. Defendants do not need additional allegations to assess the fraud; AIM's own computer systems contain every rigged review and denial. TAC ¶¶ 61, 121. An additional allegation in the complaint that Sally Jones should have been approved for a CT of the head on April 14, 2016 is neither possible for Relator at this point nor required by Rule 9(b) in this context.[12] This is no fishing expedition.

Third, Defendants try to nitpick the specific AIM tactics and practices against specific CMS regulations. MTD at 14-15. But Defendants do not fundamentally dispute and cannot hide from the elephant in the room. Under the MA statute and contracts, MA Plans (and by extension AIM) must make (1) *individualized coverage decisions* (2) *based on medical necessity* and (3) *using the Medicare coverage rules*. TAC ¶¶ 41-47. AIM blatantly violated each one of these simple rules every time it used its rigged review system that denied coverage decisions for economic reasons, not medical reasons. *See United States v. Snap Diagnostics, LLC*, No. 1:14-CV-3988, 2018 WL 2689270, at *2-3 (N.D. Ill. June 5, 2018) (refusing to dismiss an FCA complaint for Medicare medical necessity decisions that were "not based on a clinical determination of the specific patient's needs"). AIM caused the MA Plans to violate the basic

[12] *See United States ex rel. Nargol v. DePuy Orthopaedics, Inc.*, 865 F.3d 29, 39 (1st Cir. 2017) (holding relator need not plead examples); *United States ex rel. Heath v. AT & T, Inc.*, 791 F.3d 112, 125-26 (D.C. Cir. 2015) (rejecting the arguments that Rule 9(b) requires specific examples because "precise details of individual claims are not, as a categorical rule, an indispensable requirement of a viable False Claims Act complaint"); *Hill v. Morehouse Med. Assocs., Inc.*, No. 02-14429, 2003 WL 22019936 (11th Cir. Aug. 15, 2003) (holding an FCA claim pled with the details of a billing scheme, even where "she could not identify patient names nor the exact dates that the fraudulent claims were submitted").

MA requirement with a review process that denied coverage to hit a quota, or for a slow phone call, or by hiding evidence, or to delay multiple scans into different visits.

Defendants claim that "Medicare does not set forth any explicit rules regarding" various business practices and that Relator "failed to allege a prohibited practice." MTD at 14, 16.[13] But CMS does not need to spell out a narrow rule prohibiting every possible path to fraud. It does not need to write a specific regulation to say "don't make coverage decisions by flipping a coin," or just to hit a quota, or do not turn off your fax machine. The absence of additional specific regulations does not free Defendants to brazenly violate the basic rules that coverage decisions must be individualized and made on medical merit pursuant to Medicare coverage rules.

Rule 9(b) does not require Relator to plead additional details of false claims to demonstrate that this case is not a fishing expedition. She "has done better than point to a single fraudulent bill—she has explained how several specific billing practices led to . . . thousands of fraudulent bills." *United States ex rel. Trombetta v. EMSCO Billing Servs., Inc.*, Nos. 96 C 226, 99 C 151, 2002 WL 34543515, at *4 (N.D. Ill. Dec. 5, 2002). *See also United States ex rel. Kennedy v. Aventis Pharm., Inc.*, 512 F. Supp. 2d 1158, 1167 (N.D. Ill. 2007) (refusing to dismiss a complaint that stated specific "facts regarding defendants' alleged off-label marketing," even without facts about specific claims). AIM and Anthem may–or may not–later dispute the *accuracy* of the allegations, but such disputes are questions of fact that have no bearing on a motion to dismiss. Even under Rule 9(b), the Court must take "the plaintiff's allegations as true and draw all reasonable inference in the plaintiff's favor." *United States v. Sanford-Brown, Ltd.*, 788 F.3d 696, 704 (7th Cir. 2015).

[13] Defendants further argue that CMS now accepts a one-call practice, MTD at 15, and through their silence do not dispute that, as even AIM concluded, CMS previously required multiple calls. TAC ¶ 89. Similarly, Defendants defend the practice of quoting AIM Guidelines in denial letters, but ignore the allegation that AIM lied and falsely presented AIM Guidelines language *as CMS coverage requirements*. TAC ¶ 106.

D. Anthem is directly liable for this fraud.

Defendants wrongly suggest that Relator can state a claim against Anthem only by alleging that it "created or implemented" or "controlled or directed" AIM's fraudulent scheme. MTD 19, 20. The bar is not so high. Relator need only allege facts showing that Anthem actively participated in AIM's scheme and caused other parties' false statements or the submission of false claims. *See United States ex rel. Lisitza v. Par Pharm. Cos., Inc.*, No. 06 C 06131, 2013 WL 870623, at *4 (N.D. Ill. Mar. 7, 2013); *United States ex rel. Tyson v. Amerigroup Illinois, Inc.*, 488 F. Supp. 2d 719, 735 (N.D. Ill. 2007).

Anthem actively participated in AIM's scheme by directing its subsidiary MA Plans to use AIM's fraudulent review process, first from around 2008 to 2011 and again in 2014. TAC ¶¶ 149, 153. Anthem executives openly discussed this fraud and fully understood that they were causing their Anthem MA Plans to submit false claims to Medicare, but the lure of additional profit overrode their concerns. TAC ¶¶ 145-48. Anthem's subsidiary MA Plans benefited from the fraudulent coverage decisions and denials, which dramatically reduced expenses without diminishing Medicare capitation payments. A portion of those extra Medicare dollars then went to AIM, another Anthem subsidiary, in the form of fees. TAC ¶¶ 160-61. All of this new income ultimately flowed to the parent corporation, Anthem.

Anthem further participated in the scheme when its CEO, Angela Braly, rejected a push from senior executives to assume control of the AIM Guidelines and bring them into compliance. TAC ¶ 147. Braly, who had the authority to stop the fraud, instead knowingly sided with AIM and permitted the company to continue offering its unlawful review process. *Id.* By affirmatively deciding to allow AIM to continue the fraud and then "enjoy[ing] the resulting corporate profits," Anthem "proximately caused the fraud, and can be liable under the False

Claims Act." *United States ex rel. Schagrin v. LDR Indus., LLC*, No. 14 C 9125, 2018 WL 6064699, at *6 (N.D. Ill. Nov. 20, 2018); *see also United States v. President & Fellows of Harvard Coll.*, 323 F. Supp. 2d 151, 187 (D. Mass. 2004). Anthem similarly caused the submission of false claims when it knowingly allowed AIM, its fully-controlled subsidiary, to continue providing the fraudulent coverage review process to non-Anthem-owned MA Plans from 2011 to 2014, despite being so concerned about its unlawful nature that it forced its own Plans to seek an alternative. TAC ¶¶ 150-51.

IV. CONCLUSION

AIM and Anthem for years cheated the government and public by designing and implementing a fraudulent scheme to cause the delivery of flawed and deficient Medicare insurance coverage, and covered up the scheme with annual and monthly lies that kept billions of dollars flowings to the MA Plans. Defendants wrongly attempt to hide behind Rule 9(b) standards by quoting broad statements about pleading and presenting misleading characterizations of MA payment mechanisms and MA regulations. But their fraud may not be so easily dismissed. The Seventh Circuit recognizes that Rule 9(b) must be tailored to each specific case. The allegations in this case, for this fraud, from this Relator, state a plausible claim for fraud with more than sufficient particularity. Defendants' motion should be denied.

Dated: September 20, 2019

Respectfully Submitted:

Counsel for Relator

/s/ Matthew J. Piers
Matthew J. Piers, mpiers@hsplegal.com
Charles D. Wysong, cwysong@hsplegal.com
HUGHES SOCOL PIERS RESNICK & DYM, LTD.
70 W. Madison Street, Suite 4000
Chicago, IL 60602
312.580.0100

Steven Cohen, scohen@cohenlawgroup.com
COHEN LAW GROUP
70 West Madison Street, Suite 4000
Chicago IL 60602
312.327.8800

Erika Kelton, ekelton@phillipsandcohen.com
Peter Budetti, pbudetti@phillipsandcohen.com
Samuel Brown, sbrown@phillipsandcohen.com
PHILLIPS & COHEN LLP
2000 Massachusetts Ave. NW
Washington, DC 20036
202.833.4567

CERTIFICATE OF SERVICE

The undersigned, an attorney, certifies that he caused a copy of this **RELATOR'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTIONS TO DISMISS THE THIRD AMENDED COMPLAINT** to be served through CM/ECF system to counsel of record on September 20, 2019.

Respectfully submitted,

/s/ Matthew J. Piers
One of the Attorneys for
Relator-Plaintiff Dr. Susan Nedza

Matthew J. Piers, mpiers@hsplegal.com
Charles D. Wysong, cwysong@hsplegal.com
HUGHES SOCOL PIERS RESNICK & DYM, LTD.
70 W. Madison Street, Suite 4000
Chicago, IL 60602
312.580.0100

Steven Cohen, scohen@cohenlawgroup.com
COHEN LAW GROUP
70 West Madison Street, Suite 4000
Chicago IL 60602
312.327.8800

Erika Kelton, ekelton@phillipsandcohen.com
Peter Budetti, pbudetti@phillipsandcohen.com
Samuel Brown, sbrown@phillipsandcohen.com
PHILLIPS & COHEN LLP
2000 Massachusetts Ave. NW
Washington, DC 20036
202.833.4567