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., AND ANTHEM INC., Defendants.	Case No. 15-cv-6937 Judge Alonso Magistrate Judge Cox

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

Relator's Response never once acknowledges the Court's dismissal of her SAC, nor does it attempt to demonstrate how her TAC and SAC are materially different. To the contrary, Relator doubles down on the same flawed theories this Court already rejected when it first dismissed this case. Instead of acknowledging her theories are fundamentally incompatible with the Medicare Advantage capitated payment system, she instead asserts Defendants seek to inoculate *any* recipient of fixed-rate payments from fraud liability. That is a straw man, created to mask the ongoing flaws in her allegations. The putative scheme Relator alleges in her TAC simply fails to state an FCA claim.

Relator also has failed to allege the materiality required by the Supreme Court for FCA claims, both equating her case with *Escobar* and simultaneously avoiding its holding. *Universal Health Services, Inc. v. United States ex rel. Escobar*, 136 S.Ct. 1989 (2016). Relator's Response also does not (and cannot) remedy her admitted failure to plead any false *claim* submitted to the government, let alone with sufficient particularity. And none of the cases she cites in her Response support her position. Finally, Relator has not pled the direct participation required for Anthem to

be held liable for AIM's alleged fraud. Relator has had four chances to plead an FCA claim and still has not done so. All of her claims should be dismissed with prejudice.

I. RELATOR'S MISUNDERSTANDING OF MEDICARE ADVANTAGE AND UTILIZATION MANAGEMENT IS EVIDENT FROM HER RE-PLEADING OF THE SAME FLAWED THEORIES THIS COURT ALREADY DISMISSED.

Relator's Response continues to assert a theory the Court rejected in her SAC but which she re-alleges in her TAC: she claims Defendants caused AIM's MA plan clients to enter into contracts with CMS through which they falsely certified full compliance with all Medicare rules, including coverage rules identical to traditional fee-for-service Medicare. She alleges that despite these certifications, the MA plans allegedly provided their beneficiaries coverage that was more restrictive than fee-for-service Medicare, such that the government ultimately purchased more than it actually received. *See, e.g.*, Resp. pp. 1-2. This is precisely the theory this Court rejected in its Order dismissing the Relator's SAC. Order at pp. 6, 8, 16.

Relator repeatedly asserts in her Response that Defendants believe they are "effectively immune from FCA liability" merely because they operate in the MA capitated payment context and "because this fraud does not affect the *price* that the government pays." Resp. at 1, 8, 9. Defendants have never made that claim; moreover, Relator's focus on price is a red herring to distract from her failure to plead any false *claims*—such as any beneficiary who was denied care or received deficient care, any particular AIM guideline that violated a specific Medicare coverage rule, or any false statement embedded within the MA plan clients' certifications. This admitted failure to plead any claim dooms the TAC.

Defendants readily acknowledge the FCA can apply to Medicare Advantage plans. But even in this context, relators must provide actual details of material misstatements or particular claims in order to defeat a motion to dismiss. *See, e.g.*, *Graves v. Plaza Med. Ctrs., Corp.*, No. 10-

23382-CIV-MORE, 2015 WL 11199839 (S.D. Fla. Apr. 1, 2015) (Relator identified 28 specific claims, and provided allegations describing the increased risk factors of these 28 patients and the subsequent increased payments resulting from false diagnoses and false claims); *United States ex rel. Martin v. Life Care Ctrs. of Am., Inc.*, No. 1:08-cv-251, 2014 WL 11429265, at *11-12 (E.D. Tenn. Mar. 26, 2014) (Government's complaint provided "specific locations, managerial employees, and representative patients involved in the false or fraudulent claims" and "discusse[d] the billing scheme along with the minutiae of that scheme: the corporate directives, the relevant forms, and the process by which an allegedly false claim is created.").

Relator demonstrates she still does not understand the MA system and the CMS-sanctioned use of UM by managed care plans. She repeatedly claims, without support, that Defendants violated the FCA by causing AIM's MA plan clients to provide benefits that were not exactly the same as those available under traditional fee-for-service Medicare, such that mere denials of any service for a beneficiary would render a plan's certification of compliance with Medicare rules false. Resp. at 4, 16. However, the very *purpose* of UM is to ensure that beneficiaries are *not* receiving benefits where they are not medically necessary. *G. v. Hawaii*, Civ. No. 09-00044 ACK-BMK, 2011 U.S. Dist. LEXIS 7940, at *49 (D. Haw. Jan. 21, 2011). Inherent in the application of UM processes, such as pre-authorization review, is the reality that beneficiaries will (and should) be denied reimbursement for medically unnecessary care—even reimbursement that perhaps would have been paid for by traditional fee-for-service Medicare, which lacks a pre-authorization component. Denials for medically unnecessary care do not constitute violations of the FCA. 42 U.S.C. § 1395y(a)(1)(A) (Medicare will only reimburse providers for services it deems "reasonable and necessary."). Similarly, certifying that all claims complied with MA requirements—despite not complying with traditional fee-for-service requirements inapplicable

here—does not render the certifications false. Indeed, any MA plan that claims to have provided the *same* benefits required by traditional Medicare is more likely to be making false certifications, as the MA plan would then be failing to perform its managed care function—a function that CMS is paying for as part of its monthly capitation disbursement. The rubrics are not the same and do not have the same requirements.

Relator's theory of fraud through non-conforming services illustrates her fundamental misunderstanding of the MA system.[1] She argues the government purchased "individualized coverage determinations and full MA insurance" and received "defective and incomplete MA coverage[.]" Resp. at 12. But Relator's theory would require "full MA insurance" to always provide any beneficiary with all possible services available under traditional Medicare. If this were the case, UM would be completely unnecessary. And without any specific example of a beneficiary who did not receive any particular service, or for whom an individualized coverage decision was not made, there is no other way to interpret Relator's argument. *See* Order at 11 ("Relator does not 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."). Relator still has not (and cannot) allege that "requests for capitation payments made any explicit reference to particular denial rates or UM review processes." *Id.* Without any examples of her allegations actually resulting in any false statement or payment derived from a false statement,

[1] Relator critiques Defendants' skepticism that Relator has actually pleaded a claim "for non-conforming services when the contracts between CMS and AIM's MA plan clients were based on a fixed capitation rate[.]" Resp. at 11; Memorandum in Support of Defendants' Motion to Dismiss Relator's Third Amended Complaint ("Motion"), p. 6. But this Court has already expressed its own hesitation to characterize Relator's FCA claim as a "non-conforming services" case for the very same reason. Order at 11.

there is no FCA violation.[2] *United States ex rel. Dolan v. Long Grove Manor, Inc.*, No. 10 C 368, 2014 WL 3583980, at *3 (N.D. Ill. July 18, 2014) (A relator "must link specific allegations of deceit to specific claims for payment.") (citation omitted).

Relator's attempt to resuscitate her fraudulent inducement theory fares no better. Relator's argument now, as with her unsuccessful SAC, is that to "obtain an MA contract with CMS—and to participate in the MA program—each [MA plan] must certify to CMS as material terms of their agreement" that the proposed MA plan will comply with Medicare rules and regulations, including the "Basic Benefit Requirement." TAC ¶¶ 48-49, 164; *see also* SAC ¶ 32. Relator asserts that if CMS knew an 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." *Id.* at ¶ 59. For the reasons already set forth, Relator's assertion that an MA plan's promise to "provide at least the care provided by original Medicare" was false ignores the realities of managed care and UM, presuming instead that anything less than providing a beneficiary with all services available under fee-for-service Medicare (including non-medically necessary services) constitutes deficient coverage. And simply declaring that any certifications were "material terms" of the MA plans' contracts with CMS does not make them so.[3]

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[2] In a failed attempt to support her theory, Relator cites *Bornstein*, *Nargol*, and *Foglia*, which involved non-conforming goods, not services, and *Mack*, where the defendants billed for specific, individual services that were never provided. *United States v. Bornstein*, 423 U.S. 303 (1976); *United States ex rel. Nargol v. DePuy Orthopaedics, Inc.*, 865 F.3d 29 (1st Cir. 2017); *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153 (3d Cir. 2014); *United States v. Mack*, Civil No. H-98-1488, 2000 U.S. Dist. LEXIS 17367 (S.D. Tex. May 15, 2000). These cases are all inapposite.

[3] Nor does Relator provide any link between allegedly false statements and any false claims, instead asserting the "fraudulent inducement renders both the contract and *all* subsequent claims for payment false or fraudulent." Resp. at 13 (quotations omitted). Allegations that "all claims" must be false are insufficient. *See infra* § III.

Relator cites *United States ex rel. Main v. Oakland City Univ.*, 426 F. 3d 914, 917 (7th Cir. 2005), where the defendant expressly assured the government on an application that it complied with a rule against contingent fees, but then later paid contingent fees. She also cites *United States ex rel. Marcus v. Hess*, 317 U.S. 537, 542-44 (1943), where the defendants certified their contract bids were "genuine and not sham or collusive" despite colluding with each other on bids. The statements in both *Main* and *Hess* alleged violations of *express* certifications to the government. The same was true in *Upton*, where the relator included allegations of specific contractual provisions pursuant to which the defendant health care companies had explicitly agreed not to discriminate between enrollees on the basis of health status, yet did so anyway. *United States ex rel. Barbara Upton v. Family Health Network, Inc.*, No. 09 C 6022, 2013 U.S. Dist. LEXIS 29620, at *14-15 (N.D. Ill. Mar. 4, 2013). Here, on the other hand, Relator alleges only the type of generic certification of compliance with Medicare rules and regulations that courts in this Circuit have repeatedly held cannot form the basis for FCA liability. *United States ex rel. Lisitza v. Par Pharm. Cos.*, 276 F. Supp. 3d 779, 796-97 (N.D. Ill. 2017); *United States v. Sanford-Brown, Ltd.*, 840 F.3d 445, 447-48 (7th Cir. 2016).

II. RELATOR'S IMPLIED FALSE CERTIFICATION THEORY DOES NOT SATISFY *ESCOBAR*'S MATERIALITY REQUIREMENTS.

Though Relator now calls it "fraudulent inducement through false certifications," Resp. at 13, Relator's theory—also alleged in her dismissed SAC—is that Defendants violated the FCA by causing MA plans to submit implied false certifications to the government. She asserts Defendants caused AIM's MA plan clients to submit "false certification[s] of compliance with material contractual, statutory, and regulatory MA terms" in each monthly payment request, and these "certifications both failed to disclose material violations of Medicare requirements and made misleading half-truth representations about the services provided[.]" *Id.*

As a threshold matter, Relator fails to plead any denial of any service, any rule violated by any such denial, or how any such denial led to "half-truth representations" about services provided. 42 C.F.R. § 422.310 requires MA plans to "submit . . . the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner." If a service had not been provided to any particular beneficiary, whether based on AIM Guidelines or otherwise, Relator does not allege Defendants caused the MA plans to misrepresent to CMS that the service *was* provided. Rather, Relator claims only that Defendants caused the plans to violate their "promise to . . . provide full Medicare coverage" while certifying compliance with MA rules generally. Resp. at 14. Once again, generic certifications of compliance with Medicare rules and regulations cannot form the basis for FCA liability. *Lisitza*, 2017 U.S. Dist. LEXIS 131246 at *43-44 (both before and after *Escobar*, it is not enough to allege a defendant "engaged in a practice that violated a federal regulation because violating a federal regulation is not synonymous with filing a false claim[.]" (citation omitted)).

To sustain her implied false certification theory, Relator falsely equates her case with *Escobar*, apparently because both cases allegedly involve false certifications. But this case is different from *Escobar* for many reasons. First, there is a significant difference between the MA capitated payments at issue here and the Medicaid fee for service claims in *Escobar*. In *Escobar*, the defendant falsely certified—and billed for—services performed by individuals who were prohibited by CMS regulations from performing those services. 136 S. Ct. at 1994. Here, AIM's MA plan clients submit claims based on bids approved in advance by CMS, supported by disclosed risk adjustment data that provide "the data necessary to characterize the context and purposes of each item and service provided to a Medicare enrollee[.]" 42 C.F.R. §§ 422.254, 422.310(b).

The MA plans have informed CMS exactly what services are provided to each beneficiary (when medically necessary). Unlike the defendant in *Escobar,* the MA Plans do not make any representations about specific metrics to use in pre-authorization, or UM processes with which they then do not comply. *Cf.* 136 S. Ct. at 2000-2001. Here, Relator has not alleged that any data submitted to the government regarding services provided, bids, or denial rates, were inaccurate. Even if, as Relator alleges, AIM set its fax machines to stop printing after 10 pages, or told its staff to make only one attempt to contact medical providers, these are at worst regulatory or contract violations[4] which are unrelated to and do not impact the information the government explicitly makes material to its decision to provide capitated payments to the MA Plan Defendants. *See* Order at 13 ("Given 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.") (citing *United States ex rel. Gray v. UnitedHealthcare Ins. Co.*, No. 15-cv-7137, 2018 WL 2933674, at *7) (N.D. Ill. June 12, 2018) (quotations omitted). Moreover, the FCA is not intended to reach "all types of fraud, without qualification." Resp. at 9 (citing *Cook Cnty v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003)).[5] "[T]he False Claims Act does not adopt such an extraordinarily expansive view of liability." *Escobar*, 136 S. Ct. at 2004.

This Court, following the Supreme Court in *Escobar*, already explicitly rejected Relator's theory of "sweeping contractually-imposed materiality irrespective of whether payment is actually contingent on compliance." Order at 14 (citing 136 S. Ct. at 2004). Though Relator cites cases

[4] None of the alleged practices even constitutes a rule violation. Motion at 14-16.

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

from other circuits where "actual harm" was not a requirement for materiality, Resp. at 15, these cases do not change the Supreme Court's holding that alleged misrepresentations must be "material to the Government's payment decision."[6] Order at 12 (citing *Escobar*, 136 S. Ct. at 2002). Defendants do not claim that a recipient of fixed-rate payments (like MA capitated payments) is automatically inoculated from FCA liability. Rather, Defendants simply state—consistent with *Escobar*—that an FCA claim fails where, as here, none of the alleged false certifications are "material to CMS's determination of the capitated payment amount," which is based instead on MA plan beneficiaries' location, income status, gender, age, and health status.[7] Order at 11.

Relator also attempts to re-cast alleged statements by senior AIM officials into proof of materiality, despite the Court's previous rejection of this approach. Resp. at 18; Order at 15-16. She repeatedly refers to such alleged statements as "admissions" and "confessions," but without

[6] Courts in this Circuit and others have routinely dismissed complaints where Relators fail to sufficiently allege materiality. *See, e.g.*, *Sanford-Brown*, 840 F.3d at 447 (dismissing complaint when relator failed to show how government's decision to pay would have been different if it had known of allegedly fraudulent conduct); *United States v. Pfizer Inc.*, No. 16-cv-7142, 2019 U.S. Dist. LEXIS 41344 (N.D. Ill. Mar. 14, 2019) (same); *United States ex rel. Buth v. Walmart, Inc.*, No. 18-CV-840, 2019 U.S. Dist. LEXIS 136642 (E.D. Wis. Aug. 13, 2019) (same); *United States ex rel. Kietzman v. Bethany Circle of King's Daughters of Madison, Ind., Inc.*, 305 F. Supp. 3d 964, 977 (S.D. Ind. 2018) (same); *United States ex rel. Folliard v. Comstor Corp.*, 308 F. Supp. 3d 56, 87 (D. D.C. 2018) ("Without more than citations to the regulatory framework, the relator has failed to show that any alleged false claim was material to the government's decision to pay."); *United States ex rel. Martinez v. Orange Cty. Glob. Med. Ctr., Inc.*, No. 8:15-cv-01521-JLS-DFM, 2017 U.S. Dist. LEXIS 221085, at *6-7 (C.D. Cal. Sep. 14, 2017) (dismissing claims where relator failed to plausibly plead government's disbursements were affected by false billing).

[7] Relator's reliance on *Wall* and *IBEW* and FCA claims under the Davis-Bacon Act do not counsel a different result. *United States ex rel. Wall v. Circle C Const., L.L.C.*, 697 F.3d 345 (6th Cir. 2012); *United States ex rel. Int'l Bhd. of Elec. Workers, Local Union No. 98 v. Fairfield Co.*, No. Civ. A. 09-4230, 2013 WL 3327505, at *5 (E.D. Pa. July 2, 2013). *Wall* relied on a pre-*Escobar* materiality standard, and both cases involved violations of express contractual requirements that the defendants pay prevailing wages to their employees pursuant to the Act. These cases do not stand for the proposition that generic certifications of compliance with Medicare rules or the types of alleged examples of non-compliance (with unspecified Medicare rules) Relator lists in her TAC would suffice to predicate FCA liability. *Hutcheson* is also inapposite, as it evaluated whether alleged kickbacks were capable of influencing the government's decision to make payments set by diagnosis-related groups. *United States ex rel. Hutcheson v. Blackstone Med., Inc.*, 647 F.3d 377, 394-95 (1st Cir. 2011).

having alleged a single false claim, Relator's statements are mere hyperbole. *E.g.*, Resp. at 3, 7, 20, 22. Moreover, even if all of Relator's allegations were true—that is, if AIM's officials did admit to causing MA plan clients to provide different benefits than would have been approved through fee-for-service Medicare (without UM)—none of this would mean Defendants violated the FCA. Relator does not allege these officials stated they had caused an MA plan to submit a specific false statement for certification, or that any given beneficiary was denied benefits they should have received. Similarly, allegations that Anthem chose to stop using AIM's review process for Anthem MA plans, or that AIM or Anthem executives opined AIM's review process "violated Medicare requirements," fail to demonstrate, much less with any particularity, that AIM's UM process caused any false claim, or would have been material to CMS's determination of the capitated payment amount for the MA plans.[8] Resp. at 18; TAC ¶¶ 146, 150; Order at 11.

III. RELATOR FAILS TO SATISFY RULE 9(b).

Conceding she cannot identify any specific false claims, or even a single example of an improper AIM guideline or a beneficiary wrongly denied benefits, Relator instead asserts that *all* claims submitted were false, and that she has pled a scheme by which "fraudulent claims [were] made every month." Resp. at 13, 19. Relator's own characterization of her TAC as pleading "a specific scheme" and "detailed practices" does not solve her failure to satisfy Rule 9(b). Resp. at 20; *United States ex rel. Keen v. Teva Pharm. USA Inc.*, No. 15 C 2309, 2017 WL 36447, at *4 (N.D. Ill. Jan 3, 2017) (Rule 9(b) requires "at least concrete examples of false statements and false claims") (citation and quotations omitted); *United States ex rel. Suarez v. Abbvie Inc. & Abbott*

[8] Relator misstates the Court's opinion in *United States v. Snap Diagnostics, LLC*, No. 1:14-cv-3988, 2018 WL 2689270, at *4 (N.D. Ill. June 5, 2018). There, the Court held routine payment of duplicate claims by the Government was not strong evidence of a lack of materiality because, by resubmitting the duplicate claims, the defendant falsely represented that each of those specific claims was in fact medically necessary.

Laboratories, No. 15 C 8928, 2019 WL 4749967, at *12 (N.D. Ill. Sept. 30, 2019) ("pleadings lacking such detail [about specific documents, bills, or invoices] have satisfied Rule 9(b) only where the alleged facts *necessarily* led one to the conclusion that the defendant had presented claims to the Government." (quotations and citations omitted). As explained *supra*, this Court cannot necessarily find fraud from Relator's allegations.

Relator cites *United States ex rel. Derrick v. Roche Diagnostics Corp.*, 318 F. Supp. 3d 1106, 1112-13 (N.D. Ill. 2018) to suggest that because AIM's MA plan clients received monthly capitated payments from CMS, "the monthly claims for payment . . . necessarily lead to the conclusion that [the MA plans] presented claims to CMS that were tainted by the alleged fraud." Resp. at 19-20. But the *Derrick* relator satisfied 9(b) by alleging a specific and detailed kickback scheme resulting in a *per se* FCA violation, because one defendant paid another defendant a bribe to purchase items for which it sought federal monies. 318 F. Supp. 3d at 1112-1113. Here, Relator has not alleged that certified compliance with a bid's contents *necessarily* cased a false claim to be submitted; indeed, she does not even allege that every (or any) beneficiary was denied medically necessary care. "Explaining how any person or entity could hypothetically submit false claims does not suggest that Defendants necessarily did so as a result of the alleged [] scheme[.]" *Suarez*, 2019 WL 4749967 at *12-13 (dismissing FCA claims where "allegations just as easily allowed for an inference" that doctors prescribed a drug to patients because they thought it was medically necessary, rather than in exchange for kickbacks). Merely because AIM's MA plan clients are paid under the capitated payment model does not necessarily mean they made false certifications to support payment claims. Nor do any of Defendants' alleged regulatory violations necessarily create such an inference. And because Relator has not identified any particular beneficiary that was improperly denied care or even any service AIM improperly denied, but rather, only a scheme

by which false claims *could* have been submitted, Relator's allegations are insufficient.[9] *Id.*; *Dolan*, 2014 WL 3583980 at *3.

None of Relator's other attempts to evade Rule 9(b) fares any better. Relator cites various purported "admissions" and "confessions" from AIM executives, but never provides any support for the assertion that AIM's supposedly fraudulent process caused any false claims.[10] Relator also relies on *Presser* and *Derrick* for the proposition that her alleged lack of access to specific reviews of requests for approval of coverage excuses her failure to provide specific examples of false claims. Resp. at 21 (citing *United States ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770 (7th Cir. 2016); *Derrick*, 318 F. Supp. 3d at 1112-13)). Her argument fails, however, given Relator's representations about her own level of involvement in developing clinical guidelines at AIM and witnessing "firsthand" the design of the allegedly improper rules and policies. Motion at 17 (citing TAC ¶ 19). Taking Relator's own allegations as true, she cannot credibly assert she did not have access to information about AIM's clinical guidelines, their

[9] Plaintiff fails successfully to distinguish *Zverev*, *Keen*, and *Dolan*, each of which supports the Defendants' position that generally pleaded schemes lacking claims detail cannot survive a motion to dismiss. These cases do not stand only for the proposition that "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." Resp. at 20 (citing *United States ex rel. Zverev v. United States Vein Clinics of Chi., LLC*, 244 F. Supp. 3d 737 (N.D. Ill. 2017); *Keen*, 2017 WL 36447 at *4; *Dolan*, 2014 WL 3583980)).

[10] These alleged "admissions" of fraud also do not satisfy Rule 9(b), and are different from the statements in cases Relator cites. In *United States ex rel. Howard v. KBR, Inc.*, 139 F. Supp. 3d 917 (C.D. Ill. 2015), the relators provided much more detail as to the alleged fraud—including specific examples of how relevant regulations were allegedly violated—than Relator does here. Moreover, the *Howard* relators' claims were allowed to proceed due to the issue of reasonableness of costs under the Federal Acquisition Regulations being a "highly contestable and fact-specific inquiry" inappropriate for a 12(b)(6) motion to dismiss, none of which is at issue here. *Id.* at 943 (citations omitted)). In *United States v. R&F Properties of Lake Cty, Inc.*, 433 F.3d 1349, 1360 (11th Cir. 2005), the relator nurse practitioner alleged specifically that she was told a lie that all nurse practitioner and physician assistant services were billed incident to the service of a physician, even when rendered independently. Relator here alleges only generically that AIM officials commented that the review process was unlawful or violated Medicare coverage rules—not that any particular beneficiary was denied care or any AIM guideline was improper. *See, e.g.*, TAC ¶ 131.

alignment with Medicare guidelines, or their application; the information she does plead is insufficient.[11] *See Keen*, 2017 WL 36447 at *4 (relator had not pled FCA claims with particularity where she did not "so much as 'set forth the circumstances of any particular false statement or cite a single example of a false claim or a provider that made a false claim[.]'") (citations omitted); *United States ex rel. Prose v. Molina Healthcare of Illinois, Inc.*, No. 17 C 6638, 2019 WL 3555336, at *3 (N.D. Ill. Jul. 31, 2019) (FCA claims dismissed where relator failed to "point to a specific record or submission made to the government with particularity, much less that the challenged submission contained a materially false statement.").

United States ex rel. Swoben v. United Healthcare Ins. Co., 848 F.3d 1161 (9th Cir. 2016), a case outside this Circuit, also does not support Relator's position. The *Swoben* relator outlined a much more detailed scheme, and though he did not plead specific diagnosis codes that were allegedly intentionally underreported, there was no need for specific codes to be identified for the larger scheme to be made clear as to the defendants. Here, Relator did not plead how Defendants did anything other than provide UM services, nor any Medicare coverage rules that were allegedly violated when benefits allegedly were denied. *Swoben* is also inapposite because in that case, the MA plans were conducting retrospective reviews to identify and submit only those diagnosis codes that led to *increases* (but not decreases) in their risk adjustment payments—thus avoiding the repayment of monies from CMS to which they were not entitled. As such, in *Swoben*, the MA plans were receiving additional funds they would not have otherwise received. No similar conduct is alleged (or has taken place) here.[12]

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[11] Moreover, in *Presser*, the only allegations surviving dismissal were those where the relator pled specific circumstances regarding the defendants' misuse of a particular billing code (which the relator specifically identified) and representations to the government "that a certain treatment was given by certain medical staff when in fact it was not." 836 F.3d at 778-79.

[12] In addition, *Swoben* also undercuts Relator's exaggerated argument that Defendants assert FCA claims would be impossible in the MA context. This is clearly not the case.

Finally, Relator continues to allege that mere business practices constitute fraud. Resp. at 23-24. She again resorts to hyperbole, claiming Defendants argue they could decide patients' coverage simply by flipping a coin. *Id*. at 24. Relator's argument ignores that any alleged practice, even if it violated a Medicare rule (and thus might subject Defendants to consequences such as civil monetary penalties or enrollment sanctions) does not automatically constitute fraud. *See Escobar*, 136 S. Ct. at 2003 ("The False Claims Act is not an all-purpose antifraud statute . . . or a vehicle for punishing garden-variety breaches of contract or regulatory violations." (quotations and citation omitted). This is especially true here, where none of the alleged practices are prohibited by the applicable Medicare rules, Motion at 14-16, and Relator has not linked any alleged practices to any particular claim. *See United States ex rel. Berkowitz v. Automation Aids, Inc.*, 896 F.3d 834, 842 (7th Cir. 2018) ("This court has recognized that a violation of a regulation is not synonymous with filing a false claim.") (citation omitted); *United States ex rel. Lisitza v. Par Pharm. Cos.*, 276 F. Supp. 3d 779, 797 (N.D. Ill. 2017) (citations omitted).

IV. RELATOR DOES NOT PLEAD DIRECT PARTICIPATION BY ANTHEM.

In her Response, Relator simply tries to reframe Anthem's alleged knowledge of any fraudulent scheme into the direct participation required for her to successfully state a claim against it. But *in addition* to allegations of knowledge, Relator was required to "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." *United States ex rel. Lisitza v. Par Pharm. Cos.*, No. 06-C-06131, 2013 U.S. Dist. LEXIS 31224, at *16 (N.D. Ill. Mar. 7, 2013) (emphasis in original) (citation omitted)). Instead, Relator merely states "Anthem . . . allowed AIM, its fully-controlled subsidiary, to continue providing the fraudulent coverage review process[.]" Resp. at 26 (citing TAC ¶¶ 150-51). That Anthem is AIM's

parent company does not automatically mean it actively participated in the actions of its subsidiary; indeed, such an argument would render a distinction between corporate entities meaningless.

Relator claims Anthem knew about the alleged fraud and affirmatively allowed AIM to continue it, but was "so concerned about its unlawful nature that it forced its own plans to seek an alternative." Resp. at 25-26. Yet Relator alleges that when some Anthem executives tried to have Anthem take control of the AIM Guidelines, AIM pushed back and maintained control. TAC at ¶ 147. Relator cannot have it both ways: either Anthem actively encouraged AIM's allegedly fraudulent activities (which Relator cannot allege) or it lacked the ability to stop them (which is what Relator actually alleges). But the latter cannot support imposing FCA liability on Anthem.

Relator also claims Anthem's subsidiary MA plans benefited financially from reducing expenses via fraudulent coverage decisions and denials, and that these savings flowed up to Anthem. This assertion again demonstrates Relator's failure to understand the MA capitated payment system, because MA plans cannot simply pocket amassed savings from providing beneficiaries less care. Rather, even if an MA plan were to save money one year by using AIM's allegedly improper UM review process to deny care, its capitation payments would automatically be reduced in the future, as its subsequent bids would necessarily reflect the lower costs of care.

In short, Relator has not adequately pled that Anthem controlled or directed any alleged fraudulent scheme (or that it was able to do so). Instead, she has pled only that Anthem was aware of AIM's alleged scheme, allowed it to happen, and eventually removed its own MA plans from the AIM review process. Such allegations are insufficient. *Lisitza*, 2013 U.S. Dist. LEXIS at *19.

V. CONCLUSION

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

Dated: October 21, 2019

Respectfully submitted,

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