UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, Plaintiff, v. ANTHEM, INC., Defendant.	Case No. 1:20-cv-02593-ALC-KHP **NOTICE OF DEFENDANT ANTHEM, INC.'S OBJECTION TO MAGISTRATE JUDGE'S ORDERS**

TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that Defendant Anthem, Inc. ("Anthem"), hereby respectfully moves this Court for an order sustaining its objection to Magistrate Judge Katharine H. Parker's July 2, 2026 Opinion and Order (Dkt. 542) and July 8, 2026 Order (Dkt. 546) denying Anthem's request for certain discovery regarding evidence that Plaintiff intends to offer in support of its allegations in this case.

Anthem's objection is based upon Federal Rule of Civil Procedure 72(a), Local Rule 72.1 of the Southern District of New York, the Court's Individual Practices, the Memorandum of Law in Support filed concurrently herewith, all papers and pleadings in this case, and any argument presented in connection with the hearing of the motion.

Dated: July 16, 2026

Respectfully submitted,

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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA,

Plaintiff,

v.

ANTHEM, INC.,

Defendant.

Case No. 1:20-cv-02593-ALC-KHP

MEMORANDUM OF LAW IN SUPPORT OF DEFENDANT ANTHEM, INC.'S OBJECTION TO MAGISTRATE JUDGE'S ORDERS

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Pursuant to Federal Rule of Civil Procedure 72, the Local Rules of the Southern District of New York, and the Court's Individual Practices, Defendant Anthem, Inc. ("Anthem") respectfully objects to Magistrate Judge Katharine H. Parker's July 2, 2026 Opinion and Order (Dkt. 542) (the "July 2 Order") and July 8, 2026 Order (Dkt. 546) (the "July 8 Order," and, with the July 2 Order, the "Orders"). The Orders deny Anthem's request for discovery regarding evidence that Plaintiff United States ("Plaintiff") recently disclosed to Anthem and which Plaintiff intends to offer in support of its claims for relief.[1] Anthem respectfully requests that the Court sustain Anthem's objection and compel Plaintiff to fully respond to the requested discovery.

INTRODUCTION

Anthem is one of the nation's largest health insurers, providing health insurance coverage to more than 40 million members through Anthem's many benefit programs. Anthem has long participated in the Medicare Advantage program ("MA program"), also known as Medicare Part C. In traditional or "fee-for-service" Medicare, the Centers for Medicare and Medicaid Services ("CMS"), which administers the Medicare program, directly pays healthcare providers for the services and treatment they render to beneficiaries. In the MA program, however, private insurers like Anthem, known as Medicare Advantage Organizations ("MAOs"), pay healthcare providers for the services and treatment provided to beneficiaries rather than CMS. The Medicare statute requires CMS to compensate MAOs for the financial risks they assume to provide Medicare benefits to those beneficiaries.

In 2020, Plaintiff sued Anthem under the False Claims Act, 31 U.S.C. §§ 3729 et seq. ("FCA"), and common law. Plaintiff alleges that, for "payment years" 2013 through 2016,

[1] Consistent with Local Rule 72.1(a), Anthem submits this objection within 14 days of the Orders. The page limits and formatting of this brief comply with the Court's Individual Practice 2(b).

Anthem violated the FCA by knowingly submitting certain false claims for payment to the MA program and knowingly and improperly refusing to correct allegedly false data that Anthem had previously submitted to the MA program regarding the health status of its MA members. Plaintiff contends that these FCA violations resulted from an industry-wide business practice that is commonly known as "retrospective chart review."

Anthem denies that retrospective chart reviews violated the FCA or any MA program requirement; in fact, it is undisputed that CMS authorized retrospective chart reviews and was aware of Anthem's specific chart review practices as early as 2010. Despite this knowledge, CMS took no adverse action against Anthem or any other MAO that conducted retrospective chart reviews. The agency continued to renew Anthem's MA contracts, never sanctioned Anthem and paid Anthem year after year. Notably, in 2014, CMS proposed a new regulation that would have required MAOs to design their retrospective chart reviews in the precise manner that Plaintiff alleges in this lawsuit was legally required. However, the agency ***withdrew*** that proposed rule after commenters raised objections about the scope and feasibility of the proposal, reinforcing that there was no MA program requirement to use retrospective chart reviews in the way Plaintiff now contends was required.

In February 2026, CMS issued a Notice of Intermediate Sanctions (the "Notice") to Anthem related to Anthem's business practices after the period at issue in this lawsuit. This Notice was issued six years ***after*** the Amended Complaint was filed in this case and was based entirely on Anthem's conduct after the relevant time period here. This Notice was unprecedented, resulted from an irregular administrative process, and pertained to conduct of which CMS had been aware for over seven years without taking any adverse action against Anthem. Nevertheless, shortly before the close of fact discovery in this case, Plaintiff notified Anthem that it intends to rely on

the Notice at trial to prove "materiality" under the FCA, which is an essential element of an FCA claim under which Plaintiff must show the alleged misrepresentations were material to the agency's decision to make payments to Anthem under its MA contracts. As a result, Anthem sought discovery regarding the origin and reasons for the Notice. Plaintiff refused to provide complete responses, and Anthem moved to compel. Following brief position statements by the parties (*see* Dkts. 523; 529; 535), Magistrate Judge Parker issued the Orders, denying Anthem's request for this discovery in its entirety.

In her July 2 Order, Magistrate Judge Parker emphasized that the Notice was not relevant to this case, stating that "the Notice concerns Anthem's conduct that is not at issue and therefore is at best tangential to the issues to be tried in this case." Anthem fully agrees that the Notice has no relevance here but Plaintiff intends to rely on the Notice at trial. Unless Anthem receives assurance that the Notice will not be admissible at trial, it must have the opportunity to obtain the discovery necessary to effectively contest Plaintiff's evidence and arguments about the Notice. The Orders also rest on the demonstrably false conclusion that Anthem's discovery requests will impose a substantial and undue burden on Plaintiff to respond. It is beyond genuine dispute that Plaintiff offered no record evidence to support this baseless finding.

Discovery in this case has spanned more than three years, during which time Magistrate Judge Parker has issued well over a dozen separate rulings on discovery disputes. To date, Anthem has never objected to any of those rulings. But the Orders are so clearly erroneous and contrary to law, and on a subject of such critical importance to Anthem's ability to defend itself at trial, that Anthem is compelled to seek relief from this Court.

BACKGROUND

A. The MA Program and CMS's Risk Adjustment Payment System

Medicare is a federal health insurance program for older adults and individuals with

disabilities that is administered by CMS. Traditional Medicare has two parts: Part A covers inpatient hospital care, and Part B covers outpatient medical care. In the mid-1990s, Congress created Medicare Part C, which is now known as Medicare Advantage, to offer seniors an alternative to traditional Medicare. Under Part C, CMS contracts with private insurers—including Anthem—to provide traditional Medicare benefits to those seniors who choose to enroll in the MA plans sponsored by those insurers. *See* 42 U.S.C. § 1395w-27.

The payment systems for traditional Medicare and MA differ significantly. In traditional Medicare, CMS pays healthcare providers directly for the specific services that they have provided to beneficiaries. In the MA program, unlike traditional Medicare, CMS compensates MAOs prospectively for covering the cost of healthcare for MA beneficiaries based on the estimated cost of providing Medicare benefits during the next payment year. Each MAO receives payments that account for its MA members' risk of incurring higher healthcare costs based on their reported health conditions, 42 U.S.C. § 1395w-23, meaning that CMS pays an MAO more for members who are more likely to incur higher healthcare costs based on their health status. CMS calls this process—adjusting payments to reflect the anticipated cost of providing traditional Medicare benefits to each member—"risk adjustment."

CMS's risk-adjustment payment system relies in part on diagnosis codes, which are standardized alpha-numeric codes that correspond to a beneficiary's medical conditions and that a healthcare provider typically assigns in connection with a patient visit. After a visit, a healthcare provider records the beneficiary's diagnoses as diagnosis codes and submits them on a claim form to the beneficiary's MAO. *See* 42 C.F.R. § 422.310(d)(3). When the provider submits the claim form to the MAO, the provider represents and certifies that the diagnosis codes and other information in the claim is accurate and truthful.

The MAO then passes those diagnosis codes along to CMS, which uses those codes to calculate the monthly premium the MAO receives for that beneficiary. Under the Medicare statute, CMS must adjust the payments it makes to MAOs to reflect "risk factors [such] as . . . health status" in a way that "ensure[s] actuarial equivalence" with traditional Medicare. 42 U.S.C. § 1395w-23(a)(1)(C)(i). The Medicare statute's actuarial equivalence mandate requires CMS to "pay the same amount to Medicare Advantage insurers for their beneficiaries' care as CMS would spend on those same beneficiaries if they were instead enrolled in traditional Medicare." *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 883 (D.C. Cir. 2021).

B. This Case Concerns Retrospective Chart Reviews, an Industry Practice of which CMS Was Aware from the Early Years of the MA Program

CMS requires MAOs to report diagnosis codes anew each year for every MA beneficiary—even for chronic conditions that never resolve. 42 C.F.R. § 422.310. MA program requirements, and the nature of the risk-adjustment system itself, thus encourage MAOs to report all of their members' medical conditions each year, ensuring that they have the resources to care for those members. Medicare Program; Medicare+Choice Program, 65 FR 40,170-01. CMS regulations require MAOs to make good-faith efforts to report all diagnosis codes for each beneficiary and to certify, based on their best knowledge, information, and belief, that the submitted data is complete and accurate. *See, e.g.,* 42 C.F.R. § 422.504(*l*). CMS recognizes that MAOs cannot audit the tens of millions of diagnosis codes they receive from healthcare providers each year. 65 Fed. Reg. 40,170, 40,268. Thus, CMS does not expect MAOs to guarantee that every piece of diagnosis data is accurate; the agency requires only that they make "good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted." *Id.*

To satisfy this requirement, MAOs—including Anthem—often review beneficiaries' medical records for the purpose of reporting all diagnosis codes documented in the providers'

records; this process is called "retrospective chart review." Chart reviews are typically conducted by professionals trained in diagnosis coding—here, Anthem retained a vendor that utilized coders to conduct chart reviews. The vendors will typically contact the treating providers to collect selected medical records to review, often a year or more after the providers' visits with the MAOs' members. The coders will review the medical records and then submit an extract to the MAO that lists the diagnosis codes that the coders concluded were documented in the medical records in compliance with applicable coding guidelines. The MAO will then submit to CMS those diagnosis codes reported by the chart review coders that have not already been submitted to the agency.

Retrospective chart reviews are an industry-standard process that CMS monitored as early as 2008 and explicitly allows.[2] When providers report diagnosis codes to Anthem, they rely on their clinical judgment and their personal examination of their patients, and they certify that the information reported on the claim form is accurate. The chart review coders who examined medical records typically did not have that clinical background and they had no access to the treating physicians. Often, their review of the medical records included incomplete or illegible records covering only a portion of the patient's visits in which a given diagnosis code might appear. In addition, applicable diagnosis coding guidelines often contain vague and ambiguous language about which professional coders frequently disagree.

Plaintiff alleges, however, that during the relevant time period—covering "payment years" 2013 through 2016, which roughly corresponds to patient visits that occurred from 2012 through 2015—Anthem should have used its retrospective chart reviews to audit diagnosis codes that

[2] See CMS, Final Encounter Data Diagnosis Filtering Logic at 5 (Dec. 22, 2015) ("In addition to submitting records for encounters, plan sponsors are also allowed to submit encounter data records that reflect their reviews of medical records (called 'chart review' records)."), *available at* https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/FinalEncounterDataDiagnosisFilteringLogic.pdf

physicians submitted to Anthem in claim forms and that Anthem then passed along to CMS. Under Plaintiff's theory, Anthem should have categorically second-guessed ***every*** physician who was treating the MA beneficiaries and who actually saw the beneficiaries face-to-face. Plaintiff contends that Anthem should have assumed that the coders who failed to report a particular diagnosis during the chart review had concluded that the treating physicians, with whom the coders never communicated, falsely certified to Anthem that the diagnosis was present during the patient encounter. Plaintiff contends that Anthem's failure to overturn physician diagnosing decisions violates the FCA.

During discovery, Plaintiff identified to Anthem approximately 200,000 diagnosis codes for dates of service between 2012 and 2015 that it alleges are false under the FCA. Treating physicians submitted each of those diagnosis codes to Anthem on claim forms and certified to Anthem that the codes were accurate. Anthem then submitted those codes to the MA program. Plaintiff contends that Anthem should have deleted those 200,000 diagnosis codes from the CMS data systems because coders did not report those same codes during a retrospective chart review conducted a year or more after the physicians' visits with the MA beneficiaries.

Importantly, Plaintiff does not allege that any of the diagnosis codes reported by chart review coders from their review of physician medical records are false. In other words, Plaintiff's FCA allegations pertain only to codes that were *not reported* during the retrospective chart reviews; none of the new diagnosis codes reported from those chart reviews are at issue in this case. *See* Am. Compl. ¶¶ 153-154.

While that is Plaintiff's theory ***now***, CMS took a different view during the relevant time period. Despite knowing that MAOs usually did not utilize chart reviews to validate physician-submitted diagnosis codes, the agency took no adverse action against any MAOs based on their

chart review practices. CMS knew about Anthem's chart review practices specifically. In 2009, a routine CMS audit concluded, among other things, that the agency had underpaid Anthem: its auditors reviewed beneficiaries' medical records and found additional diagnoses documented in those records that Anthem had not submitted to the MA program. *See* Dkt. 408-2. Anthem responded to the audit with documentation explaining that the underpayment arose because the beneficiaries' providers had failed to report those codes to Anthem on their claim forms. Dkt. 408-3. To remediate this problem, Anthem expressly told CMS that it had implemented a retrospective medical-record review process to identify additional diagnosis codes for submission that providers had not previously reported to Anthem. *Id.* at 1. Despite Anthem's detailed disclosure of this business practice to CMS, the agency took no adverse action against Anthem. In fact, after Anthem's submission, CMS closed its audit, concluding that Anthem's response satisfied the agency's concerns. Dkt. 408-6. CMS also continued to contract with Anthem annually and to pay it without objection year after year.

C. CMS Abandoned a Proposed Regulation that Would Have Required MAOs to Conduct Chart Reviews in the Manner Plaintiff Alleges Was Required

CMS ***abandoned*** a proposed regulation that would have required MAOs to conduct chart reviews in the manner Plaintiff now contends was required. In January 2014, CMS proposed a rule that would have prohibited MAOs from using chart reviews to find unreported diagnosis codes unless the MAO also used that same review to confirm that codes it had already submitted to CMS were adequately documented in the records. *See* Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs, 79 Fed. Reg. 1918, 2053 (Jan. 10, 2014) ("Proposed Chart Review Rule").

CMS later ***withdrew that rule***, and declined to implement it after numerous commenters criticized the feasibility and breadth of the proposal. *See* 79 Fed. Reg. 29,844, 29,925–26 (May

23, 2014). In the many years since the agency withdrew the Proposed Chart Review Rule, CMS has never issued any MA program regulation or sub-regulatory guidance requiring MAOs to design their chart review programs in the manner Plaintiff alleges the law requires.

D. Following the Ninth Circuit's 2016 Decision in *United States ex rel. Swoben v. United Healthcare*, Anthem Implemented Changes to Its Chart Review Program and, Starting in 2018, Reported Diagnosis Codes to CMS that Were Potentially Unverified During Chart Reviews

In *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1167 (9th Cir. 2016), the Ninth Circuit questioned for the first time whether CMS regulations may require MAOs to design chart reviews to audit diagnosis codes that healthcare providers had already submitted to MAOs and that were passed along to CMS.[3] In response, Anthem launched a costly and time-intensive evaluation of how Anthem's data systems could be reconfigured to compare its vendor's chart review results to the provider-submitted claims data that contained the diagnosis codes providers had certified for visits with Anthem's MA members; this comparison was the essential first technical step that would be necessary for Anthem to isolate any provider-reported codes that the chart review coders did not also report during their later review of the providers' medical records. After approximately two years working on this process, Anthem constructed its data system to effect this change in its business processes.

On October 15, 2018, Anthem reported to CMS a detailed description of its new chart

[3] The Ninth Circuit's *Swoben* decision concerned whether a *qui tam* relator's effort to amend his complaint following dismissal was futile for failure to state a claim; the Ninth Circuit held that the relator was entitled to amend his complaint but did not have the benefit of any factual record. Anthem submits that *Swoben* was decided incorrectly, but in any event *Swoben* was subsequently dismissed by the district court on remand because the government could not adequately allege materiality under the FCA. *United States v. Scan Health Plan*, 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017). Other courts in the Ninth Circuit have declined to extend *Swoben* outside the pleading context. *See* Report and Recommendation Regarding Motion for Summary Judgment, *United States ex rel. Poehling v. UnitedHealth Group, Inc.,* 2:16-cv-08697 (C.D. Cal.) ECF No. 631, at 26-27.

review program, including this comparison process. Anthem later sent the agency a data file listing diagnosis codes that providers had reported on claim forms but that coders had not reported during chart reviews (the "Disclosed Diagnosis Codes"). Anthem did not represent to CMS that the Disclosed Diagnosis Codes were undocumented in the providers' medical records. Rather, it explained that the diagnoses were potentially unverified and asked to discuss with CMS how best to address the issue.

Over the next seven years, Anthem continued to update CMS on its chart review program and to disclose additional diagnosis codes that may be undocumented in the providers' medical records. In these submissions to the agency, Anthem explained why chart review coders might not separately report codes that providers had previously certified, even where those diagnosis codes are in fact documented in the medical record—including the potential for additional medical record documentation from the provider, legibility issues with the medical record documentation in the chart review vendor's possession, variations in coding interpretations, along with various other factors. Anthem asked that CMS refrain from adjusting MA payments to Anthem in a manner that violated the Medicare statute's actuarial equivalence requirement, *see* 42 U.S.C. § 1395w-23(a)(1)(C)(i). Anthem also continued to invite a conversation with the agency regarding relevant MA program requirements.

CMS never agreed to meet with Anthem to discuss the applicable MA program requirements or the Disclosed Diagnosis Codes. Nor did CMS delete those codes from the agency's data systems, even though Anthem had given the agency all the data needed to do so. Over these seven years, CMS also never terminated Anthem's MA contracts, refused to pay Anthem, rejected Anthem's MA bids, or otherwise adjusted its payments to Anthem. Instead, CMS continued to contract with and pay Anthem year after year.

This lawsuit's allegations do not concern the Disclosed Diagnosis Codes or Anthem's new chart review program, which post-date the time period and business practices at issue in this case.

E. After Years of Inaction, CMS Issued Its Notice to Anthem, Sanctioning Anthem for Its 2018-2025 Disclosures

On February 27, 2026, CMS took the unprecedented step of issuing the Notice based on the Disclosed Diagnosis Codes.[4] The timing of CMS's decision is telling. As discussed above, CMS has been aware of Anthem's retrospective chart review program since at least 2010. In August 2025, Cheri Rice, the former Director of CMS's Medicare Plan Payment Group ("MPPG") and Deputy Director of CMS's Center for Medicare testified that the agency had never terminated or decided not to renew an Anthem MA contract, never rejected any of Anthem's annual bid submissions, never recouped any payment from Anthem, never issued a corrective action plan, or otherwise communicated to Anthem its disapproval of the chart review practices at issue in this litigation. *See* Dkt. 523-1 (8/27/25 Rice Tr.) 421:20-428:16.

This is a critical admission in this FCA litigation because, to prevail in this action, Plaintiff must prove that Anthem's conduct was ***material*** to the agency's decision to pay Anthem. *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 192 (2016). In a very similar case, *United States ex rel. Poehling v. UnitedHealth Group, Inc*., 2:16-cv-08697 (C.D. Cal.) ECF No. 212, the United States sued another MAO under the FCA for operating a very similar retrospective chart review program during a similar time period. The district court dismissed FCA claims analogous to those here because the government was unable to allege that the MAO's chart review practices were material to CMS's payment decision. In March 2025, the special master in *Poehling* subsequently issued a report and recommendation that summary

[4] Anthem disputes the imposition of sanctions as unlawful and a violation of agency regulations and is formally challenging the Notice through CMS's administrative appeals process.

judgment be granted in favor of the MAO on all remaining claims; in doing so, the special master noted that the fact that the "government knew of [the MAO's retrospective chart reviews] and nevertheless paid the claims for years without changing its position . . . would be hard to reconcile with the concept that the government believed [the MAO] to be making a material false claim for payment by failing to independently verify diagnostic codes identified by doctors." Report and Recommendation Regarding Motion for Summary Judgment, *Poehling*, 2:16-cv-08697, ECF No. 631 at 48.

On February 10, 2026, just a few months after Ms. Rice's deposition and the *Poehling* decision, Anthem deposed John Scott, the Director of CMS's Medicare Part C and D Oversight and Enforcement Group ("MOEG"). Like Ms. Rice, Mr. Scott testified that he had never received a referral to terminate an MAO's contract for failing to submit accurate risk adjustment data. Dkt. 523-2 (2/10/26 Scott Tr. 115:1-13). But, following a break in the deposition with Plaintiff's counsel, Mr. Scott asked to amend his prior testimony to disclose that his office had just recently received a referral from MPPG to sanction an unidentified MAO for failing to submit accurate data. *Id*. at 117:8-120:8; 120:18-121:2. When Anthem's counsel inquired further, Plaintiff's counsel stated that it would instruct Mr. Scott to not answer any substantive questions regarding this referral based on the deliberative process and attorney-client privileges. *Id*. at 119:12-20. The Notice was then issued, under Mr. Scott's signature, just seventeen days after the deposition.

Two weeks after the Notice was issued and shortly before the then deadline for fact discovery in this case, Plaintiff supplemented its Rule 26 disclosures—for the first time in three years—to list the Notice as a document it may rely upon to support its claims for relief. Because the Notice addresses diagnosis codes that are not at issue and is based on conduct after the relevant time period in this case, Anthem asked Plaintiff to explain its rationale for including the Notice in

its Rule 26 disclosures. Plaintiff responded that it intends to use the Notice as evidence to (i) support its materiality argument under the FCA and (ii) rebut Anthem's comments regarding CMS's inaction or action related to the same topics. *See* 3/17/26 Hr'g Tr. 40:14-21.

F. Anthem's Discovery Requests

Anthem contends that the Notice, which concerns an entirely different time frame and separate business practices, cannot be relevant to Plaintiff's claims for relief in this litigation. Nevertheless, because Plaintiff intends to offer evidence about the Notice at summary judgment and/or trial, Anthem sought the following discovery: (i) a document request seeking "[a]ll Documents Concerning the Notice"; (ii) an interrogatory requesting the identity of "all Persons who participated in the decision to issue the Notice"; and (iii) depositions of three CMS staff identified in the Notice, and/or named in Plaintiff's supplemental Rule 26 disclosures—John Scott, Kavin Stansbury, and Shruti Rajan. *See* Dkt. 529-1 (Notice).

Plaintiff refused to provide meaningful discovery responses in connection with these three requests; it refused to produce any documents save a handful of documents already in Anthem's possession; and it only identified the CMS Administrator—Dr. Mehmet Oz—in response to Anthem's interrogatory. *See* Dkt. 529. Plaintiff subsequently refused to make any of the three CMS staff available for depositions, including Mr. Scott, who signed the Notice.

G. The July 2 Order and July 8 Order

On June 9, 2026, Anthem moved to compel. *See* Dkt. 523. Anthem argued before Magistrate Judge Parker that the Notice was pretextual and issued by CMS to bolster Plaintiff's required showing of materiality. Anthem contended that the Notice addresses conduct and diagnosis codes entirely separate from those at issue in this litigation and that CMS's decision to issue it followed an irregular administrative process. Anthem also argued that Plaintiff cannot rely on the Notice as affirmative evidence while refusing Anthem the means to test its relevance and

origin. On June 22, 2026, Plaintiff filed its response, reaffirming its intention to rely on the Notice as evidence. Plaintiff argued that the Notice shows (i) "that CMS ***does*** care about a[n MAO's] failure to comply with its regulatory and contractual obligations by refusing to delete unsupported diagnosis codes;" and (ii) "CMS's reaction to an instance where CMS had actual knowledge of specific noncompliance." Dkt. 529. But Plaintiff argued that Anthem is not entitled to any additional discovery about the Notice because responding would be unduly burdensome. *Id*.

Plaintiff submitted no evidence to support its burden claim. It conducted no preliminary searches, evaluated no custodians, identified no difficulties in obtaining the requested records, and explained no special burden associated with making witnesses available for deposition. Plaintiff also proffered no facts refuting Anthem's *prima facie* showing that the Notice was motivated by a desire to bolster Plaintiff's FCA allegations.

On this record, Magistrate Judge Parker issued her July 2 Order denying Anthem's request for additional discovery. *See* Dkt. 542. Magistrate Judge Parker concluded that "[a]s a threshold matter, the Notice concerns Anthem's conduct that is not at issue and therefore is at best tangential to the issues to be tried in this case," and that Anthem already had the information it needs to argue the Notice was not relevant. *Id.* at 4. Stating that "[t]his case is over six years old and fact discovery needs to come to an end," Magistrate Judge Parker then held that Anthem's requests "would require the Government and CMS to conduct a broad search and undertake a substantial privilege review" and would thus impose a "significant" burden on Plaintiff. *Id.* at 4-5. Magistrate Judge Parker did not cite any record evidence identifying Plaintiff's alleged burden—nor could she, as Plaintiff did not submit any record facts substantiating its burden.

On July 7, 2026, the parties held a case management conference, where Magistrate Judge Parker further clarified the scope of her July 2 Order. *See* 7/7/26 Hr'g Tr. 104:14-17 ("[T]his

[sanctions issue] is really just, sort of, a fine point. It's not core to the [issues]"). Magistrate Judge Parker also confirmed that the July 2 Order extended to Anthem's separate request to depose three CMS staff about the Notice. *Id*. at 95:18-23. While Plaintiff once again affirmed that it intended to use the Notice in support of its materiality arguments (*see id.* at 97:19-98:11), Magistrate Judge Parker did not engage further with the materiality standard and instead stated that the only possible relevance she saw for the Notice concerned whether the analysis Plaintiff alleges Anthem should have implemented was actually feasible to accomplish—a topic not discussed in the parties' position statements. *Id.* at 95:11-14. Magistrate Judge Parker subsequently issued the July 8 Order, which separately confirmed that Anthem's request for depositions was denied for the same reasons stated in the July 2 Order. *See* Dkt. 546.

STANDARD OF REVIEW

"It is well-settled that a magistrate judge's resolution of a nondispositive matter should be afforded substantial deference and may be overturned only if found to have been an abuse of discretion." *Jablonski v. Special Couns., Inc.*, 2023 WL 2644212, at *1 (S.D.N.Y. Mar. 27, 2023) (Carter, J.) (internal quotations and citations omitted). But, under Rule 72(a), the Court must "modify or set aside any part of [a Magistrate Judge's] order that is clearly erroneous or contrary to law." *Id.* "The magistrate judge's findings may be considered clearly erroneous when on the entire evidence, the district court is left with the definite and firm conviction that a mistake has been committed." *Id.* And "[a] ruling is contrary to law when it fails to apply or misapplies relevant statutes, case law or rules of procedure." *Id.*

The Court is limited in this objection to considering information available to the Magistrate Judge. *See Rivera v. Hudson Valley Hosp. Grp., Inc.*, 2019 WL 3955539, at *9 (S.D.N.Y. Aug. 22, 2019) (collecting cases); *Bernstein v. Cengage Learning, Inc.*, 2023 WL 6211771, at *3

(S.D.N.Y. Sept. 25, 2023) (Carter, J.). If Plaintiff should seek to remedy this omission by belatedly submitting new supporting evidence, the Court should disregard it.

ARGUMENT

A. The Orders Unfairly Handicap Anthem's Ability to Contest Plaintiff's Intended Use of the Notice at Trial

Plaintiff has repeatedly stated its intention to use the Notice as evidence of materiality to support its FCA allegations; under Plaintiff's theory, the Notice purportedly shows "CMS's reaction to an instance where CMS had actual knowledge of specific noncompliance" and thus proves "that CMS ***does*** care about a Medicare Advantage Organization's failure to comply with its regulatory and contractual obligations by refusing to delete unsupported diagnosis codes." *See* Dkt. 529 at 2 (emphasis in original); 3/17/26 Hr'g Tr. 40:14-21; 7/7/26 Hr'g Tr. 97:19-98:11; 101:4-10; 102:6-14. Plaintiff cannot fairly be permitted to put the Notice at issue if Anthem is barred from taking discovery necessary to effectively contest that evidence at summary judgment and/or trial. Basic principles of due process and our adversarial system require nothing less.

Thus, while Anthem agrees with Magistrate Judge Parker that "the Notice concerns Anthem's conduct that is not at issue and therefore is at best tangential to the issues to be tried in this case," (*see* July 2 Order at 4), this Court has not ruled that the Notice is inadmissible at trial. Without the assurance that the Notice will be deemed inadmissible, Anthem must have the opportunity to defend itself through documents and deposition testimony that rebut and contextualize the Notice. The Orders improperly denied Anthem that opportunity.

1. The Orders Ignore Controlling Case Law on Materiality

Controlling precedent makes clear that denying Anthem this discovery was an abuse of discretion. To prevail on its FCA claims, Plaintiff must prove that Anthem's alleged non-compliance with MA program requirements was "material" to CMS's decision to pay Anthem; in

short, Plaintiff must prove that if CMS had known about Anthem's retrospective chart reviews, it would have impacted the agency's decision to pay Anthem.

The Supreme Court has held that the FCA's materiality standard is "demanding." *Escobar*, 579 U.S. at 194. When a government agency continues to pay a defendant while aware of the conduct at issue, that is strong evidence that the conduct is not material. *Id.* at 195; *United States ex rel. Berg v. Honeywell Int'l, Inc.*, 740 F. App'x 535, 538 (9th Cir. 2018) (summary judgment warranted where government continued to pay claims "despite being aware of Relators' fraud allegations since 2002"); *United States ex rel. McBride v. Halliburton Co*., 848 F.3d 1027, 1034 (D.C. Cir. 2017) (continued government payment "even after the Government learned of the allegations" was "very strong evidence" of immateriality (internal citations omitted)); *United States ex rel. Janssen v. Lawrence Mem'l Hosp*., 949 F.3d 533, 542 (10th Cir. 2020) (holding that "the Government's actual behavior in this case suggests Janssen's allegations are immaterial" where CMS was aware of the issues and has "done nothing in response and continue[d] to pay" defendant's Medicare claims); *United States ex rel. Harman v. Trinity Indus.*, 872 F.3d 645, 663 (5th Cir. 2017) ("[C]ontinued payment by the federal government after it learns of the alleged fraud substantially increases the burden . . . in establishing materiality."). Moreover, "a misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment, nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant's noncompliance." *Escobar*, 579 U.S. at 194; *see United States ex rel. Foreman v. AECOM*, 19 F.4th 85, 109 (2d Cir. 2021). This is because materiality "'looks to the effect on the likely or actual behavior of the recipient of the alleged

misrepresentation,' rather than superficial designations." *United States v. Strock*, 982 F.3d 51, 59 (2d Cir. 2020) (quoting *Escobar*, 579 U.S. at 193).

Because materiality looks to the agency's behavior, the Second Circuit has held that post hoc enforcement actions and other efforts to "manufacture materiality" carry limited probative weight. In *Strock*, the Second Circuit held that "*Escobar* indirectly indicates that allegations of post hoc prosecutions or other enforcement actions do not carry the same probative weight as allegations of nonpayment" and that "*Escobar* eschews a materiality analysis that prioritizes the government's claims about how it would treat a requirement over how the government actually treats a requirement upon discovering a violation." *Id.* at 63, 60. *Strock* observed that allegations about what the government "would have done" are "inherently self-serving" and that post hoc enforcement actions are improper efforts to manufacture materiality and are therefore unpersuasive evidence of materiality. *Id*. at 63-64 ("[T]he government may not manufacture materiality by alleging it had an option not to pay after the fact. Allowing the government to rely on post hoc enforcement efforts to satisfy the materiality requirement would allow the government to engage in just such materiality manufacturing . . . ."); *see also Foreman*, 19 F.4th at 112-13. Courts in this Circuit applying *Strock* have held that post hoc enforcement efforts initiated ***after*** the government learned of the allegations but where it continued to pay the defendant "actually hurt[]" the plaintiffs' case and "cut[] heavily against a finding of materiality." *United States ex rel. Lee v. N. Metro. Found. for Healthcare, Inc.*, 2021 WL 3774185, at *11-12 (E.D.N.Y. Aug. 25, 2021), *aff'd*, 2022 WL 17366627 (2d Cir. Dec. 2, 2022). *Escobar*, *Strock*, and their progeny make clear that whether the Notice was pretextual is directly relevant to its evidentiary weight on materiality. Anthem is entitled to discovery on exactly that question: which agencies and personnel were involved in the decision to issue the Notice, what prompted discussions about its issuance after

seven years of inaction and continued payment to Anthem year after year, and when those discussions commenced. Because the Orders—which nowhere address or even mention *Strock* or any of the cases dealing with manufactured materiality—deny Anthem discovery to which it is entitled under controlling precedent, they are contrary to law.

2. The Record Demonstrates that the Notice was Likely Issued to Support Plaintiff's Allegations of Materiality under the FCA

As Anthem demonstrated to Magistrate Judge Parker, the record contains *prima facie* evidence that the Notice was issued to supply evidence of materiality in this case—a contention that Plaintiff has never directly denied. *See* Dkts. 535 at 1; 529. Notably, it did not offer Magistrate Judge Parker any declaration from CMS officials refuting Anthem's contention that the Notice resulted from an irregular administrative process and for the primary purpose of supporting Plaintiff's materiality allegations in this case.

With only a few months left in fact discovery, Plaintiff was left with a fatal failure of proof on materiality. Despite being aware of Anthem's legacy chart review program in 2010 (*see* Dkt. 407-4) and learning of Plaintiff's allegations in this case as early as 2020, the record is clear that CMS took absolutely ***no*** adverse action against Anthem. *See* Dkt. 523-1. And, although Anthem disclosed its post-2018 chart review practices to CMS in numerous letters between October 2018 and October 2025, CMS took no adverse action for seven years, instead continuing to renew Anthem's MA contracts year after year and paying Anthem without disruption.

Then, after seven years of inaction and just months before the close of fact discovery, CMS took the unprecedented step of issuing the Notice—an action the agency had ***never*** previously taken against any MAO based on the alleged failure to correct diagnosis code data in the agency's data systems. *See* Pl.'s R&Os to Anthem's RFA Nos. 121, 122, 131, 132, and 228. Two weeks later, Plaintiff supplemented its Rule 26 disclosures for the first time in nearly three years to add

the Notice as evidence it intends to rely on to prove materiality. The years of inaction combined with the testimony of senior CMS officials support the reasonable inference that the Notice resulted from an irregular administrative process and was likely an effort to create evidence of materiality where such evidence did not otherwise exist.

3. Magistrate Judge Parker Erred in Finding that Anthem Already Has the Discovery It Needs to Rebut Plaintiff's Use of the Notice

Anthem cannot defend against the Notice using the discovery it currently possesses. The handful of documents Plaintiff produced were either publicly available or already in Anthem's possession: the Notice itself, publicly available agency pronouncements, correspondence between Anthem and CMS regarding Anthem's post-2018 chart review practices, and correspondence initiated ***after*** the Notice was issued. Plaintiff's productions cannot be fairly characterized as discovery at all, as Plaintiff produced no information Anthem did not already possess.

Anthem cannot effectively defend itself solely by referencing the content of the Notice, as Plaintiff has suggested, because Anthem contends that internal communications and documents will demonstrate that the Notice was issued for reasons different from those stated in the Notice. At trial, Plaintiff will inevitably call a witness to introduce the Notice and tell the jury that it proves CMS "***does*** care" about undocumented diagnosis codes. Dkt. 529 at 2. Plaintiff will use the Notice not just to show CMS's public actions, but to characterize the agency's state of mind regarding what actually influences the agency's payment decisions.

Anthem cannot effectively refute that testimony or challenge its credibility without discovery regarding the state of mind of CMS's decision-makers and the agency's motive for issuing the Notice. Without access to the internal agency records that might call the truth of CMS's representations into doubt, the Orders effectively require Anthem to accept CMS's professed reasons for issuing the Notice. Without that discovery, Anthem will be handicapped in its efforts

to impeach Plaintiff's evidence or advance its defense that the Notice was a litigation tactic that was designed to fill an evidentiary gap.

The Orders are clearly erroneous for another more fundamental reason. Under the Orders, Anthem is prohibited from deposing Plaintiff's intended trial witnesses ***about their expected testimony regarding the Notice***. *See* Dkt. 471-3 (Pl. Supplemental Rule 26 Disclosures). Plaintiff cannot offer testimony to the jury about CMS's reasons for issuing the Notice and simultaneously deprive Anthem of the internal agency records that would allow Anthem to impeach that testimony by showing that CMS's proffered reasons are pretextual. As a matter of basic fairness, if Anthem is denied this discovery, Plaintiff should forfeit the right to characterize CMS's motives or reasons for issuing the Notice at summary judgment or trial.

4. The Second Circuit Has Repeatedly Held that It Is an Abuse of Discretion to Not Permit Targeted Responsive Discovery

This is not a speculative request for documents that may not exist. Anthem seeks targeted discovery into a specific CMS decision that Plaintiff has repeatedly affirmed it intends to use in support of its FCA allegations. Allowing Plaintiff to rely on the Notice while denying Anthem discovery to rebut it would be clear error and contrary to law.

For example, the Second Circuit has repeatedly held that, under Rule 56(d), it is an abuse of discretion for a court to grant summary judgment where a nonmoving party identified non-speculative discovery essential to the nonmoving party's defenses, and that "[t]he nonmoving party must have had the opportunity to discover information that is essential to his opposition to the motion for summary judgment." *Hellstrom v. U.S. Dep't of Veterans Affs.*, 201 F.3d 94, 97 (2d Cir. 2000) (internal citations omitted). This is particularly the case where the nonmoving party is denied an opportunity to conduct responsive discovery to challenge specific identified documents. For example, in *Miller v. Wolpoff & Abramson, L.L.P.*, a case concerning whether a debt-collection

letter on attorney letterhead violated the Fair Debt Collection Practices Act, the Second Circuit concluded that a district court had abused its discretion in granting summary judgment without allowing the nonmoving party to collect discovery into the involvement of attorneys in generating the letter in question. 321 F.3d 292, 303-07 (2d Cir. 2003). The Second Circuit has ruled similarly in other cases where a party was prevented from obtaining discovery to rebut specific documents used by a moving party in support of their claims for relief. *See Elliott v. Cartagena*, 84 F.4th 481, 493-94 (2d Cir. 2023) (holding that grant of summary judgment was abuse of discretion where nonmoving party was denied the opportunity to seek discovery concerning at-issue contract).

B. Plaintiff Failed to Make Specific, On-The-Record Showings of Undue Burden

The Orders are also clear error and contrary to law because they rest on factual findings about burden that find no support in the record. "If a party resists production on the basis of claimed undue burden, it must establish the factual basis for the assertion through competent evidence." *Eletson Holdings Inc. v. Levona Holdings Ltd.*, 2025 WL 1335511, at *2 (S.D.N.Y. May 7, 2025) (citing *Fletcher v. Atex, Inc*., 156 F.R.D. 45, 54 (S.D.N.Y. 1994)). "[B]oilerplate objections lacking any specific explanations as to the grounds [invoked] and without supporting affidavits or evidence . . . cannot serve as a basis for [a party] to resist discovery." *United States v. Veeraswamy*, 347 F.R.D. 591, 601 (E.D.N.Y. 2024).

Plaintiff failed to discharge this fundamental obligation. While Plaintiff argued before Magistrate Judge Parker that Anthem's requested discovery would impose a burden, it did not present a single piece of evidence in support of that contention. It did not present evidence that it conducted any preliminary searches, evaluated any custodians, or identified any difficulties in obtaining the requested records. It offered no explanation of the burden associated with making witnesses available for deposition—including witnesses whose testimony Plaintiff has disclosed it may rely on at trial. Plaintiff submitted no declaration from any CMS personnel and cited no

record fact from which any conclusion about burden could be plausibly drawn. There are no facts on record about any burden ***at all***, let alone facts establishing that the burden would be "undue."

Nor is there any reason to believe the burden would be significant. Anthem seeks discovery regarding a single agency decision, the Notice, where CMS acted within the last six months, not a decade or more ago. The number of associated documents is likely to be minimal. And it is simply not credible for Plaintiff to assert an undue burden in response to Anthem's interrogatory asking to identify the personnel who were involved in the decision to issue the Notice. This response should simply involve asking the relevant agencies for names. And Plaintiff cannot credibly argue undue burden in making three witnesses available for depositions when Plaintiff stated in its Rule 26 disclosures that it may rely on some of those witnesses at trial.

Plaintiff has further complained that responding to Anthem's document request would require it to generate a privilege log and review privileged material. Dkt. 529 at 4. But there is no record evidence that any responsive documents satisfy the high standard for asserting privilege, or evidence characterizing the volume of documents that are potentially privileged. In any event, it is ***Plaintiff*** that has put the Notice at issue in this litigation, not Anthem; Plaintiff cannot use the Notice as a sword and simultaneously assert privilege to shield against the preparation of a privilege log.

Despite the absence of any record evidence, Magistrate Judge Parker held that Anthem's request "would require [Plaintiff] and CMS to conduct a broad search and undertake a substantial privilege review," imposing a "significant" burden on Plaintiff. July 2 Order at 5. That factual finding cannot be squared with the record evidence that Plaintiff submitted to Magistrate Judge Parker. That finding is therefore contrary to the settled law of this District, which requires that burden be shown through facts, not attorney argument, and constitutes an abuse of discretion.

C. While Anthem Agrees with Magistrate Judge Parker that "Discovery Must Come to an End," Anthem Had No Reasonable Opportunity to Collect This Discovery

In the July 2 Order, Magistrate Judge Parker expressed frustration that "[t]his case is over six years old and fact discovery needs to come to an end." Dkt. 542. Anthem shares Magistrate Judge Parker's frustration with the pace of discovery and her desire to bring discovery to a close. To date, Plaintiff has proposed four extensions of the fact discovery schedule, and Anthem has consented to those extensions. The discovery process has imposed a massive financial and administrative burden on Anthem and its personnel. However, no amount of diligence on Anthem's part could have allowed it to collect discovery into this issue, because CMS did not issue the Notice, and Plaintiff did not add the Notice to its Rule 26 disclosures, until this spring. When Plaintiff supplemented its Rule 26 disclosures, fact discovery was then slated to end approximately three months later. Approximately three weeks after Plaintiff supplemented its Rule 26 disclosures, Anthem responded by disclosing its document requests to Plaintiff and serving the interrogatory seeking information about the Notice. Anthem also notified Plaintiff of its intention to seek deposition testimony about the Notice after it obtained Plaintiff's responses to the document requests and interrogatory. Cutting off Anthem's ability to collect responsive discovery into this issue simply because of Plaintiff's strategic timing would unfairly prejudice Anthem, particularly where the *prima facie* evidence suggests that CMS issued the Notice with this litigation in mind.

Further, Magistrate Judge Parker concluded in the July 2 Order that Anthem would be able to obtain discovery into the Notice via the CMS administrative proceedings. July 2 Order at 6, n.2. Neither party represented to the Court that Anthem could obtain this discovery in the administrative proceeding. In fact, Plaintiff argued the opposite. Plaintiff told Magistrate Judge Parker that Anthem was seeking to obtain discovery in this case for use in the administrative

proceeding and that Anthem was doing so because it would not be entitled to receive that discovery under applicable CMS regulations. Dkt. 529 at 4. It is entirely unclear whether Anthem would be authorized to obtain any discovery in the administrative proceeding challenging the Notice, much less the specific discovery at issue in this objection.[5] And even if Anthem could eventually obtain the discovery, it is virtually certain that Anthem could not do so before the close of fact discovery in this case on August 31, 2026. This incorrect finding constitutes a separate and independent reason why the Orders are contrary to law.

CONCLUSION

For the reasons described herein, Anthem respectfully requests that the Court sustain its objection to Magistrate Judge Parker's Orders and compel Plaintiff to fully respond to Anthem's requested discovery.

[5] *See generally* Centers for Medicare and Medicaid Services, Office of Hearings, Hearing Officer Appeal Procedures (April 25, 2025), publicly available at: https://www.cms.gov/files/document/office-hearings-hearing-officer-appeal-procedures.pdf. Subsequent to Magistrate Judge Parker's Orders, CMS has indefinitely stayed that administrative process over Anthem's objection.

Dated: July 16, 2026

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to the Local Rules of the United States District Courts for the Southern and Eastern Districts of New York, including Local Rules 6.3, 7.1(c), 72.1, and the Individual Practices of the Court, including Individual Practice 2(b), I hereby certify that Defendant Anthem, Inc.'s Memorandum of Law in Support of Defendant Anthem, Inc.'s Objection To Magistrate Judge's Orders complies with length and formatting requirements described in the above-referenced Rules and Practices, and that additional pages provided under Individual Practice 2(b) above Local Rule 6.3's default limit contain no more than 350 words, counted using the Microsoft Word program used to prepare it.

Dated: July 16, 2026

/s/ K. Lee Blalack, II

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