UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Neil Anand, et al.,	:	
	:	**CASE NO. 21-1635-CKK**
Plaintiff,		
Norman Clement,		
Intervenor	:	
v.	:	
	:	
U.S. Department of Health and	:	
Human Services et al.,	:	
Defendant.	:	
	:	

Motion for Intervention of Right Pursuant to Federal Rules of Civil Procedure Rule 24 (a) and Permissive Intervention Pursuant to Federal Rules of Civil Procedure Rule 24 (b)

Intervenor Norman Clement, moves Pro-Se, and requests MOTION TO INTERVENE BASED ON RIGHTS AND PERMISSION pursuant to F.R.C.P. Rule 24. The Intervenor seeks to provide a clear relation basis to the Plaintiffs. The issues are: 1) suitable for judicial resolution, 2) the withholding judicial review would cause undue hardship, and impair rights to the Intervenor, 3) Intervenor and the Plaintiffs Anand and Pompy have a common nucleus of operative facts resulting in Damage and Harm to Intervenor which can be resolved through Judicial Relief by the Court, 4) Intervenor requests that the Honorable Judge allow intervention by

right and permission for purposes of judicial economy, 5) Intervenor Clement needs the requested pertinent information to assist in his legal arguments against Defendant Drug Enforcement Agency in *Norman J. Clement vs. United States Drug Enforcement Administration*, CASE NO: 21-1262 UNITED STATES COURT OF APPEALS FOR DISTRICT OF COLUMBIA.

Under Rule 24(a), a party may seek to intervene "of right" on a timely motion if that party claims an interest in the pending litigation "and is so situated that disposing of the action may as a practical matter impair or impede the movant's ability to protect its interest, unless existing parties adequately represent that interest." Fed. R. Civ. P. 24(a)(2). Moreover, the party's interest must not be adequately represented by existing parties to the action. See *Defenders of Wildlife v. Perciasepe*, 14 F.3d 1317, 1322–23 (D.C. Cir. 2013). Intervenor Clement makes the instant claim that he must intervene in the current FOIA action to protect his interest in information critical to resolve Case No: 21-1262 United States Court of Appeals for District of Columbia in Intervenor's favor as well as the upcoming U.S. Supreme Court Case *Khan and Ruan Vs. United States* Case No. 20-1410 and Case No. 21-5261. The United States is currently opposing Plaintiffs Pompy and Anand ability to amend their complaint despite the worldwide release of pertinent new information from Defendant Health and Human Services and the Center for Disease

Control concerning errors within the 2016 CDC guidelines that were used in algorithms to induce the mass incarceration of physicians and pharmacists. Disposition by the District Court of the present FOIA action in favor of the United States would impede any ability for Intervenor Clement to protect his interest in the requested information.

Although previous Intervenors failed in their motions to this Court, in this brief Movant Clement intends to satisfy the requirements for permissive intervention to this Court under Rule 24(b), pursuant to which the Court "may permit anyone to intervene" who "(A) is given a conditional right to intervene by federal statute; or (B) has a claim or defense that shares with the main action a common question of law or fact." Fed. R. Civ. P. 24(b). See *EEOC v. Nat'l Children's Ctr., Inc*., 146 F.3d 1042, 1046 (D.C. Cir. 1998). Movant Clement plainly satisfies this standard citing federal statutes *supra* providing Clement a conditional right to intervene in the instant case. Movant Clement furthermore has a relevant "claim" related to the main action as relates to Clement's litigation against Defendant DEA. Clement requires the information in an expedited fashion for Case No: 21-1262 United States Court of Appeals for District of Columbia. When needed, a court "may use its equitable powers to require an agency to process documents according to a court-imposed timeline." *Clemente v. FBI*, 71 F. Supp. 3d 262, 269 (D.D.C. 2014). "[S]tale information is of little value." *Payne Enters., Inc. v. United States*, 837 F.2d

486, 494 (D.C. Cir. 1988). See *Bloomberg, L.P. v. FDA*, 500 F. Supp. 2d 371, 378 (S.D.N.Y. Aug. 15, 2007) "Congress has long recognized that 'information is often useful only if it is timely' and that, therefore 'excessive delay by the agency in its response is often tantamount to denial.'" *Open Soc'y Just. Initiative v. CIA*, 399 F. Supp. 3d 161, 165 (S.D.N.Y. 2019) (quoting H.R. REP. NO. 93-876, at 6271 (1974)).

On June 11, 2021, pro se Plaintiffs Neil Anand and Lesly Pompy (collectively, "Plaintiffs") filed the instant Freedom of Information Act ("FOIA"), 5 U.S.C. § 552, action against the U.S. Department of Health and Human Services ("HHS") and the U.S. Drug Enforcement Administration ("DEA"). The genesis of their case concerns a FOIA request submitted by Plaintiff on April 17, 2021, to HHS – Office of Inspector General ("HHS-OIG") seeking a number of records, including records on "data analytics algorithms used in the Pill Mill Doctor Project; all reports and work products generated by contractor Qlarant Corporation concerning the Pill Mill Doctor Project; statement of work and official contract of Qlarant Corporation; all reports from Blue Cross Blue Shield Corporation to OIG concerning improper prescribing of opiates by specific physicians and all reports of OIG concerning Neil Anand or Institute of Advanced Medicine and Surgery." See Compl. Ex. B.

Intervenor's Clement's mission includes promoting government transparency and accountability by gathering official information, analyzing it, and disseminating it

through reports, press releases, and/or other media, including social media platforms, all to educate the public.

Norman Clement is a journalist that owns and operates the internet journalist website youarewithinthenorms.com which receives several hundred visits daily. A top 15 list of my articles are below:

1. https://youarewithinthenorms.com/2021/12/08/crucified-on-the-blue-cross-the-story-of-dralves-gene-edwards-do-practicing-medicine-while-black-and-the-racial-profiling-of-physicians-of-color-in-america/
2. https://youarewithinthenorms.com/2021/10/31/the-queen-barratry-exposing-prosecutorial-mis-conduct-abdul-q-malik-md-vs-city-of-new-york/
3. https://youarewithinthenorms.com/2022/02/09/the-red-flags-of-doj-dea-great-enforcement-fraud-in-american-medical-science/
4. https://youarewithinthenorms.com/2021/12/01/hfpp-secret-algorithm-uniquely-targeted-older-white-physicians-based-on-assets-age-and-specialty/
5. https://youarewithinthenorms.com/2021/12/04/let-them-die-off-united-states-government-expert-andrew-kolodny-md-the-most-dangerous-physician-in-america-and-exposing-the-opioidgate-medical-scandal/

6. https://youarewithinthenorms.com/2021/12/25/the-london-brief-dea-represents-a-criminal-organization-blaming-physicians-and-pharmacist-exposes-their-big-lie/

7. https://youarewithinthenorms.com/2021/06/21/how-the-united-states-department-of-justice-and-the-drug-enforcement-opioid-prescribing-guidelines-has-endangered-the-lives-of-white-people-when-doctors-are-pressured-patients-suffer/

8. https://youarewithinthenorms.com/2021/01/01/the-full-testimony-of-richard-james-albert-dea-investigator-and-the-diversion-of-the-truth/

9. https://youarewithinthenorms.com/2020/12/23/united-states-department-of-justice-vs-walmart-pharmacy-part-1-understanding-the-history-of-deas-war-on-drugs-in-america-and-the-story-behind-the-economic-lynching-of-black-owned/

10. https://youarewithinthenorms.com/2022/02/02/the-destruction-of-the-black-practice-of-medicine-in-america-a-video-outline-with-carl-cp-populus-21st-century-focus-group/

11. https://youarewithinthenorms.com/2020/06/18/of-role-models-and-invisible-men-exposing-the-rise-and-mission-of-the-filtered-negroes/

12. https://youarewithinthenorms.com/2021/01/04/the-form-richard-james-albert-dea-investigator-and-the-diversion-of-the-truth/

13. https://youarewithinthenorms.com/2020/10/04/the-fraudulent-work-of-donald-sullivan-phd-the-ohio-state-university-college-pharmacy-professor-of-ethics/

14. https://youarewithinthenorms.com/2021/09/13/the-fraudulent-conviction-of-vilisini-ganesh-md-for-practicing-medicine-while-brown-and-married-to-black/

15. https://youarewithinthenorms.com/2021/10/02/this-is-a-public-service-announcement-brought-to-you-by-a-retired-detroit-police-sergeant-in-the-raw-story-of-i-once-was-a-hero-they-dont-feel-my-pain-part-5/

Intervenor Clement is requesting a waiver of all search and duplication fees, since the purpose of Intervenor's FOIA request is simply to advance the public interest. All the records that will eventually be produced by Plaintiffs FOIA requests will be made publicly available for free on the internet on Intervenor Clement's website youarewithinthenorms.com for citizens, journalists, and scholars to review and use.

Intervenor Clement is seeking vital information concerning USDOJ/DEA and Health and Human Services/OIG "Pill Mill Doctor Project" as well as associated documents needed to determine whether the DEA and HHS is willfully and knowingly "targeting" patients who are suffering from pain or addiction and the pharmacists who treat such diseases. Intervenor Clement is also seeking information whether the USDOJ/DEA and HHS/CMS/OIG is prosecuting individual practitioners as compared to large practices, small pharmacies as compared to large pharmacy chains, older pharmacists as compared to younger pharmacists and "colored" or dark-skinned pharmacists as compared to white pharmacists.

"[T]he basic purpose of FOIA is to ensure an informed citizenry, [which is] vital to the functioning of a democratic society." *NLRB v. Robbins Tire & Rubber Co*., 437 U.S. 214, 242 (1977). "FOIA was [therefore] enacted to 'pierce the veil of administrative secrecy and to open agency action to the light of public scrutiny.'" *Batton v. Evers*, 598 F.3d 169, 175 (5th Cir. 2010) (quoting *Dep't of the Air Force v. Rose*, 425 U.S. 352, 361 (1976)). *Founding Church of Scientology v. Bell*, 603 F.2d 945, 949 (D.C. Cir. 1979). *King v. U.S. Dep't of Justice*, 830 F.2d 210, 223–24 (D.C. Cir. 1987). *Mead Data Central, Inc. v. U.S. Dep't of the Air Force*, 566 F.2d 242, 251 (D.C. Cir. 1977). ("[FOIA] emphasizes a preference for the fullest

possible agency disclosure of such information consistent with a responsible balancing of competing concerns . . . .”). See *Halpern v. FBI*, 181 F.3d 279, 284–85 (2nd Cir. 1991)

Necessity for Pharmacists to Obtain the FOIA Information As Request by Plaintiffs

Intervenor Clement is of the class of healthcare providers seeking the information pursuant to the Freedom of Information Act. DOCTORS, PHYSICIANS, PHARMACISTS, DENTISTS, are not Drug Traffickers or Drug Dealers. The selective targeting and prosecution of certain members of the aforementioned classes will have far-reaching deleterious effects on the professions of Medicine, Nursing and other Mid-Level Practitioners and Pharmacists. Defendants DEA and HHS distort the STANDARD of CARE as it pertains to the practice of PHARMACY.

The practice of Pharmacy has many traditional and emerging roles and a one size fits all standard cannot apply. The proof of this is that certain facets are known as retail establishments, institutional establishments, healthcare organizations and others. Within these broad categories there are subdivisions. The Controlled Substances Act (CSA) and its implementing regulations established a closed system

of distribution to ensure appropriate medical care and to maintain the integrity of the system through an accountability process.

One of the most important principles underlying the CSA and its implementing regulations is that to be valid, every prescription for a controlled substance must be based on a determination by an individual practitioner, that the dispensing of the controlled substance is for a legitimate medical purpose in the usual course of professional practice. *United States v. Moore*, 423 U.S.C. 122 (1975) and 21 CFR 1306.04(a).

Federal regulations do not define the term legitimate medical purpose nor do they set forth the standards of medical practice. It is up to each DEA-registered practitioner authorized by DEA to do so, to treat patients according to his or her professional medical judgement in accordance with a standard of medical practice that is generally recognized and accepted in the United States.

Defendant DEA has not promulgated any new regulations regarding the treatment of pain. Federal law and DEA regulations do not impose a specific quantitative minimum or maximum limit on the amount of medication that a practitioner may prescribe on a single prescription, or the duration of treatment intended for a particular patient. These critical limitations on a pharmacist's possible liability under § 1306.04 are no accident. They were added to the

regulation intentionally to avoid the unwarranted and counterproductive imposition of liability.

When first proposed in 1971, the regulation lacked the word "knowingly," which would have allowed penalties for any "person filling [an illegitimate] prescription." Purpose of Issue of Prescription, 36 Fed. Reg. 4847, 4948 (Mar. 13, 1971). Pharmacists protested such an expansive rule, however, and during the comment period specifically "objected to the responsibility placed upon a pharmacist under § [1306.04] to determine the legitimacy of a prescription." Comments and Objections to Part 306, 36 Fed. Reg. 7776, 7777 (Apr. 24, 1971). Defendant DEA agreed with these comments and changed the legal standard in the final regulations, noting the "language [was] revised to require knowledge."

A duty to treat patients afflicted with chronic pain and/or addiction, is established under Federal Law. Several medical, scientific, and ethical guidelines address the needs of palliative and chronic pain and addiction care. A duty to treat disabling chronic pain or substance use disorder is established under The American Disability Act §126, CFR 42 § 2.61-2.67, the Americans with Disabilities Act, 42 U.S.C. §12101, et seq., the Rehabilitation Act of 1973, 29 U.S.C. §701, et seq., the Affordable Care Act, 42 U.S.C. §18116, et seq, Nuremberg Code §4 and §44 Code of the Geneva Convention, Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) 'pain as the 5th Vital Sign', Emergency Medical Treatment and Labor Act (EMTALA) laws, Controlled Substance Act (CSA 802 (56)(c)), HHS Pain Management Best Practices. A duty to treat substance use disorder or addicted patients, by Data Waived Physicians, arises through the Drug Addiction Treatment Act of 2000 (Data 2000) under Substance Abuse and Mental Health Services Administration (SAMSHA).

The Plaintiffs have argued that Defendants are engaged in a national pattern of deliberate violation of search and seizure, payments, and violation of CFR 42 § 2.61-2.67, The American Disability Act §126, the DATA Waived Program of SAMSHA (Substance Abuse and Mental Health Services Administration). Despite the 2019 Center for Disease Control (CDC) admission that their opioid guidelines have been "misapplied" by many states, insurers and physicians as hard limits on opioid prescribing, the Department of Justice (DOJ) and Drug Enforcement Agency (DEA) have continued selectively targeting doctors for prosecution when they prescribe opioids at high doses. As a result, the number of physicians still willing to treat pain with opioid analgesics has dropped precipitously. And many thousands of patients have been involuntarily tapered or withdrawn from opioid therapy.

DOJ, state and local prosecutors have recently announced multi-billion dollar settlements with major pharmaceutical companies for false advertising and

promoting opioid pain relievers. However, a judge in Orange County, California threw out an opioid lawsuit against four Pharma companies. The Oklahoma Supreme Court also overturned a lower court verdict on appeal. In both cases, judges found no evidence to establish that the use or advertising of opioid painkillers is a "public nuisance." These cases offer precedents that might overturn other settlements or deny other government lawsuits against pharmaceutical companies.

Two physicians convicted of inappropriate prescribing have taken their appeals to the US Supreme Court. Their case will be heard in March. Prominent medical associations and law firms have submitted "Friend of the Court" (*amicus curae*) briefs, pointing out that there is presently no accepted "standard of practice" for prescription of opioids, against which to evaluate appropriateness. Thus, a presumption of physician good faith should prevail in the absence of conclusive evidence of intentional opioid misuse. If accepted, this premise will significantly narrow the grounds under which a physician can be prosecuted by DEA or DOJ for inappropriate opioid prescribing.

On July 16, 2021, the Board of Scientific Counselors of the CDC National Center for Injury Prevention and Control met in an online session to consider the report of their appointed Opioid Workgroup (OWG) evaluating progress in revising the 2016 CDC opioid guidelines. The OWG report provided a top-level "sneak peak" into the

content of the proposed revisions, without the supporting data or references used by five authors rewriting the guideline. For patients and advocates, this peek revealed a little shop of horrors. The OWG voiced fundamental concerns for unsupported or incorrect assertions concerning underlying science and medical practice.

Congress's long-standing and express prohibition on federal interference with state authority to regulate the medical professions is grounded in the uncontroversial notion that it is the states that are the laboratories of inventive "social and economic experiments" in our dual sovereignty system of government. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country").

Permitting state heterogeneity in medical practice bolsters medical innovation and benefits public health. *Gregory*, 501 U.S. at 458 (explaining that the very purpose of the clear statement rule is to preserve a "federalist structure of joint sovereigns . . . that will be more sensitive to the diverse needs of a heterogeneous society" and that "increases opportunity for citizen involvement in democratic processes; [and] allows for more innovation and experimentation in government").

Medical innovation is necessarily wrought from medical practitioners discretion to deploy their specialized training and expertise to pioneer new treatment approaches that may improve patients well-being. This is likely why there is not a single federal statute that indicates that Congress intended to permit a federal law enforcement agency to criminalize good faith yet mistaken attempts to revolutionize medical practice. *United States v. Lopez*, 514 U.S. 549, 583 (1995) (Kennedy, J., concurring) (cautioning against "foreclos[ing] the States from experimenting in an area to which States lay claim by right of history and expertise").

RED FLAGS OF DIVERSION

In recent enforcement actions it has filed across the country, accusing pharmacists and pharmacies of unlawfully dispensing medicines, the U.S. Department of Justice (DOJ) has aggressively attempted to sidestep § 1306.04's knowledge requirement. Citing pharmacists" 'corresponding responsibility," DOJ has argued that pharmacists are liable for filling prescriptions that allegedly present so- called "red flags"—factors that do not necessarily bear on a prescription's facial validity but that, in DOJ's opinion, suggest the prescriber may have written it for an illegitimate purpose.

Under DOJ's theory, the presence of one or more "red flags" not only proves that a prescription is illegitimate but that a pharmacist who fills it must be doing so "knowingly." (see Amicus Curiae Brief National Association Chain Drug Stores, US Supreme Court Case No. 20-1410, *Ruan vs. United States of America*)

The "red flags" advanced by DOJ include patients seeking to fill "[n]ew prescriptions for controlled substances a patient has never received before"; certain combinations of prescribed drugs; providing physician ordered refills when "one to three days of supply remained"; late filling of prescriptions; dispensing the same medications "for the same patients over long periods of time"; prescriptions for doses above "90 [morphine milligram equivalents]/day"; and prescriptions for more than one "immediate release opioid[ ] …sufficiently close in time that the supplies would have overlapped."

Even though in many circumstances these supposed "red flags" have legitimate explanations (medical or otherwise), DOJ has gone so far as to argue that the presence of one or more of these elements is "near conclusive evidence of a prescription's invalidity." According to DOJ, when faced with a prescription presenting one or more "red flags," a pharmacist must identify each issue, take steps to resolve it, and document in writing how it was resolved—no matter how many times the same patient has presented the prescription. Until and unless each "red flag" is resolved, DOJ says, a pharmacist must second guess the prescription's

appropriateness, override the prescriber's medical judgment, and refuse to fill it—or else face the threat of liability.

There are many problems with DOJ's "red flags" theory. It has no basis in the CSA or it's implementing regulations, or even in the DEA's Pharmacist's Manual. It imprudently dismisses the individualized, case- by-case approach that pharmacists take when filling prescriptions in favor of a categorical approach to culpability. And it traps pharmacists in an untenable position—either face liability under the CSA for filling a facially valid prescription that raises a "red flag," or face state-based professional liability, and even civil suits, for refusing to fill such a prescription.

But the critical point here is that § 1306.04 provides a protection for pharmacists that the Court should not inadvertently eliminate: a pharmacist may only be held liable if the pharmacist "knowingly fill[s]" a "purported" prescription. In other words, unless a pharmacist subjectively knows that a facially legitimate prescription has been prescribed for illegitimate reasons, the pharmacist should not face potential liability for dispensing medication based on that prescription.

A strict adherence to this knowledge element is critical to ensuring that pharmacists acting in good faith are not punished for filling facially valid prescriptions written by licensed and registered prescribers' punishment that, if rendered, would chill other pharmacists from performing their duties.

The U.S. Supreme Court Will Review Red Flags Identified In Dr. Xiulu Ruan Criminal Case

The Pill Mill Doctor Project is Health and Human Services' "Marque-Grande Project" to solve the U.S. "Overdose Epidemic". The Pill Mill Doctor Project, for Health and Human Services (HHS), is of the equivalent scale of the U.S. Manhattan Project which developed the first nuclear atomic bomb to end World War 2. Health and Human Services has spent millions of dollars on the Pill Mill Doctor Project over a period of many years. The project has even exceeded the length of time of the entire U.S. Manhattan Project and the development of the atomic bomb.

To date the Health and Human Services Pill Mill Doctor Project has been considered an abject failure with experts declaring that the Pill Mill Doctor Project is a total boondoggle; a titanic Tuskeegee Experiment wrought upon the whole U.S. populace that is arguably more embarrassing than the 20 year debacle of the "War in Afghanistan". CMS Medicare also recently announced a huge hike in Medicare premiums on its elderly and infirm Members to help cover the gigantic cost of the Pill Mill Doctor Project. The Pill Mill Doctor Project has led to documented widespread abandonment of U.S. patients by physicians, causing suicides among U.S. Veterans, as well as the sick and infirm, resulting in a rapid, multi-year

exponential rise in overdose deaths of U.S. Citizens. The Chinese Government has also publicly argued that the United States treats its own physicians worse than Chinese Uyghurs and that the legal persecution, incapacitation and removal of United States physicians and pharmacists that treat chronic pain and substance use disorders is the actual cause of escalating deaths from the U.S. opioid epidemic. Although, Health and Human Services Pill Mill Doctor Project may have contributed to the deaths of nearly 100,000 individuals in 2020 alone, it is estimated that HHS Pill Mill Doctor Project may ultimately contribute to the unintended deaths of millions of U.S. Citizens.

Health and Human Services, main partners in trying to "cure" or solve the opioid crisis in the United States is the Healthcare Fraud Preventive Partnership (HFPP), a public-private joint enterprise, whose "Partner Champions" are Independence Blue Cross, Blue Cross Blue Shield of Michigan and their parent franchisor, Blue Cross Blue Shield Association.

In order to combat the opioid epidemic, Health and Human Services needed a Manhattan Project equivalent of J. Robert Oppenheimer and the other U.S. geniuses who invented the atomic bomb to end World War 2, which HHS named with the moniker NBI Medic. Health and Human Services' main contractor to solve the "opioid epidemic" under the Pill Mill Doctor Project is Qlarant, also known as NBI Medic. Qlarant is a 503I company, in healthcare quality improvement, program

integrity, risk management, and innovative technology solutions. Qlarant has advertised that "it has over 45 years of success in improving quality and efficiency and rooting out fraud, waste, and abuse (FWA) in large health systems including Medicare and Medicaid." Qlarant focuses on a variety of healthcare topics including data analytics; risk scoring; and FWA detection and pursuit through their partnership with federal and state enforcement entities. Qlarant's partners include Health and Human Services (HHS)/ Office of Inspector General (OIG), the Federal Bureau of Investigation (FBI), and the Drug Enforcement Agency (DEA).

Qlarant combines subject matter expertise with data science and analytics to identify and resolve fraud. Qlarant was involved in the criminal trial of Dr. Xiulu Ruan (Criminal No: 15-0088-CG-B). Currently, Dr. Xiulu Ruan has recently been granted a writ of certiorari to the Supreme Court of the United States. The case is *Ruan v. United States*, No. 20-1410, in the U.S. Supreme Court. Xiulu Ruan, MD is a fellowship trained, multi-boarded pain management specialist, who has achieved a monumental 7 medical board/subspecialty board certifications in the United States.

Dr. Ruan was arguably a United States treasure, the "Michael Jordan of Doctors", setting the world record for the Most medical board certifications, according to the World Record Academy. Without dispute Dr. Xiulu Ruan was one of the most educated and greatest physicians in the United States and the entire planet Earth, equivalent to seven (7) fully specialized U.S. physicians combined.

Qlarant and insurer Blue Cross Blue Shield through their mass surveillance program was able to identify and classify through its algorithms that the most educated physician in the entire World, Dr. Xiulu Ruan was operating as a criminal drug dealer. The television show American Greed said that Dr. Xiulu Ruan was not operating a "pill mill" but a "money mill".

NBI MEDIC Qlarant referred Ruan to the USDOJ for criminal indictment, whereupon during Ruan's trial with Qlarant's help the USDOJ was able to speed, coordinate, and strengthen Dr. Ruan's conviction through the manipulation of data. Dr. Xiulu Ruan according to a published Qlarant Case Study was identified in a proactive data model for excessive distribution of opioids. Prescribing data and medical claims were used to identify Ruan as a "pill mill" doctor i.e. those who prescribe opioids and other controlled substances to patients lacking in medical necessity. According to Qlarant the flagging of Dr. Ruan included a high incidence of patients traveling excessive distances to see him, as well as a high percentage of patient overdoses. "The investigation opened by law enforcement included detailed clinical analysis performed by the Qlarant clinicians, which established that Dr. Ruan represented an existential threat to the health and safety of his patients: Ruan routinely provided morphine equivalents dosages of over 1,000 mg per day; Ruan failed to comply with dosing standards, increasing the risk of overdose; he used opioids restricted to cancer patients for patients who did not have cancer."

The Qlarant data team also provided evidence that Dr. Ruan was in fact the highest prescriber in his state of an opioid restricted for use in cancer patients, and that he had been paid by the drug's manufacturer. According to a published Qlarant Case Study, Dr. Ruan then opened his own pharmacy, which almost exclusively dispensed the drug, Subsys®, and which received significant rebates from the drug manufacturer. Qlarant and its experts identified Dr. Ruan's actions to be illegal in nature which is why he was referred for criminal indictment. In the testimony of Qlarant employee, Kevin McCash, excerpt from day 13 of Ruan's trial before the Honorable Judge Callie Granade, McCash testified that "Data analytics is a general term that means the manipulation and analysis of data in order to uncover facts and statistics to make conclusions."

McCash explained to the Court, "The doctor analysis project is a data analysis algorithm that runs against prescription information given to us by the Centers for Medicare and Medicaid Services, and it is intended to identify prescribers who are prescribing schedule II, III, and IV controlled substances to Medicare beneficiaries and identifying those that are at high risk for fraud, waste, and abuse in doing so." McCash explained to the Court stating that "Some of our models are predictive in nature, and the first models we made were predictive. So they were predicted risk scores. In this case it's an anomaly detection project, which means it's an abnormality detection project and it's not a predicted score, it's similarly a risk

score…..A Score ranges from zero to 1,000… individuals scoring 1,000 are most at risk for fraud, waste, and abuse." McCash explained when asked, "how many doctors, roughly, are analyzed through this Medicare project each month?" that it "varied from month to month, but it's usually between 60,000 and 70,000 prescribers were considered as high risk if the number of [Medicare] beneficiaries prescribed controlled II substances… are above the 75th percentile, you're high risk or as long as you were also above the 95th percentile in the nation for all of the 17 risk factors combined."

When asked how many providers Qlarant's process yielded, McCash testified that " It's usually between 1,000 and 800. The 75th percentile applies to the entire -- the entire population of prescribers that are included in the project that can receive scores, those meeting the minimum thresholds." Qlarant's program places the top 25% of 70,000 prescribing physicians or 17,500 physicians in the high risk category. Then the top 5% of those 17,500 physicians the Qlarant computer targets 875 physicians for referral for criminal indictment. McCash states that a Qlarant computer score "of 951 to 1,000 is determined by the 95th percentile. The 75th percentile is used to determine whether or not they are high risk."

Saint Louis University Journal of Health Law and Policy states that "while many physicians are registered to prescribe scheduled drugs, pain treatment advocates argue that many of them do not prescribe scheduled drugs, or do not prescribe them

on a long-term basis, and the burden of prescribing opiates for chronic pain patients falls primarily on approximately 4,000-6,000 physicians who specialize in pain management." The American Medical Association has identified 5,875 pain management practitioners in the country. Qlarant, HFPP and the USDOJ have already criminally indicted over 1,700 of these physicians.

Qlarant's artificial intelligence places 17,500 physicians in the high risk category which is roughly three times the number of physicians that actually treat pain in the United States, thereby intentionally and erroneously classifying all U.S. physicians who treat pain as high risk physicians. Even though Qlarant's artificial intelligence program places all pain management U.S. physicians in a high risk category, McCash testified in Federal Court that Qlarant's artificial intelligence then further subclassifies these "high risk" pain management physicians to roughly target 1,000 physicians per year (which is roughly 20% of all pain management practitioners in the United States) with referral for criminal indictments.

During Dr. Ruan's trial, Qlarant employee Kevin McCash testified that Dr. Couch, and Dr. Ruan scored 1000, the highest score, on a pill mill analysis. McCash in his testimony declared that a Medicare project algorithm analyzes 17 factors related to a doctor's practice and scores doctors on a spectrum from zero to 1,000. The higher the score the more abnormal as compared to other doctors. Qlarant also explains in its case study that following his arrest, Ruan decided to go

to trial rather than accept a plea deal. Qlarant explains that there were multiple pre-trial meetings with the data team to assist with the multiple and complex issues of healthcare fraud and diversion. Analysts and clinicians from the data team testified in the trial, which lead to a conviction on all counts. Dr. Ruan was sentenced to over 20 years on violations of the Controlled Substance Act, the Anti- Kickback Statute, and Healthcare Fraud.

Qlarant through its case study advertises and publicizes to the entire World that it is able to refer cases to the USDOJ for criminal indictment and then assists USDOJ Prosecutors in the trial to ensure the conviction of the person whom they originally referred to the USDOJ. Qlarant advertises that it can identify waste, fraud, abuse, improper prescribing etc. for referral to law enforcement and then ensure high conviction rates on those referrals. Qlarant ensures that the USDOJ is able to obtain a conviction with recovery of waste fraud and abuse through civil asset forfeiture or restitution. Based on McCash's testimony in the Ruan criminal trial, Qlarant is utilizing a modification of US Department of Health and Human Services Office of Inspector General HHS-OIG Toolkits. OEI-02-17-00560; OEI-02-17-00561.

Qlarant in company documents states that examples of analytical results that can be used as key indicators are: Patients who are prescribed more than 100 morphine milligram equivalents per day; Patients who have obtained prescriptions from six or more sources during a given prior period; Patients who are currently prescribed

more than 40 morphine milligram equivalents of methadone daily; Patients who have been prescribed opioids for more than 90 consecutive days.

Qlarant states in its corporate documents "that the key to identifying issues with opioids is understanding the vulnerabilities that have created pathways to abuse and overutilization …that data analysis, when interpreted correctly, can reveal those risk factors, but that it necessitates using sophisticated targeted algorithms and an automated tool to mine data sources for connections, patterns, outliers, and trends that contribute to the likelihood of increased use and misuse of opioids. Qlarant analyzes: Insurer claims, Prescription Drug Monitoring Data, Hospital data, Law enforcement intake records, Incarceration data, and State Managed Care data."

Qlarant (formerly Health Integrity) advertises that it has been the only contractor providing surveillance and detection of prescription drug abuse to the Centers for Medicare & Medicaid Services (CMS) nationally since 2009. That its contract with HHS (via statement of work) primarily involves data analysis and investigation into wasteful and fraudulent drug payments, including the misuse and unsafe use of controlled substances, focusing on opioids in particular. Qlarant publicizes that with the subject-matter knowledge of expert pharmacists, data analysts, and investigators, Qlarant staff develops key risk indicators and algorithms to be applied to data files, looking for patterns and questionable behavior and interactions. Qlarant uses data files which can be prescription-drug claim, monitoring data, law-

enforcement intake records, medical record databases, and other data sets that may be either publicly known or only available to state agencies or law enforcement responsible for public health and safety.

Qlarant boasts its uniqueness as compared with other data analysis vendors in that "Qlarant's algorithms are developed in collaboration with law enforcement to take advantage of their decades of experience and that Qlarant's robust data analysis plans and statistical modeling work goes through rigorous supervisory approval to ensure only outcomes that are statistically significant are pursued." Qlarant in its public marketing documents reveals that it uses client data sources coupled with third-party data sources to ensure a complete data inventory. That with respect to Medicare, Medicaid and state work "Qlarant uses claims, encounters, pharmacy invoices, beneficiary and provider enrollment files, state licensing-board information, property records of targeted health care physicians, Google maps, ownership/asset and financial filings of targeted health care physicians, court records, and other custom data."

Qlarant advertises to the world that it is an industry leader in conducting predictive modeling and analytics and is the CMS contractor responsible for the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) program and that the purpose of NBI MEDIC is to detect and prevent FWA in the

Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level, which provides Qlarant with substantial experience on a national level at reviewing key metrics to identify outliers for prosecution and enforcement initiatives.

Qlarant has advertised expertise in conducting investigations and supporting testimony before the courts with law enforcement entities. Furthermore, Qlarant states in its white paper, "as new payment methodologies are implemented (including the new value-based models), there will be emerging schemes to investigate. Qlarant is committed to remaining knowledgeable about regulations and the best practices for fighting the opioid epidemic."

Through these types of analyses described in corporate marketing materials, Qlarant "has investigated hundreds of providers for their overprescribing of opioids and has referred those investigations to law enforcement for criminal investigation." Qlarant also explains in its pamphlet in its ability to help the USAO in a section titled, Coordinating for Conviction. Qlarant explains in this section that it is involved in developing the criminal case itself, which includes organizing and preparing data to support search warrants, arrests, and convictions. Qlarant also advertises in this section that is an effective and efficient data partner for law enforcement.

After referral for criminal investigation in its case study section on Coordinating for Conviction, Qlarant explains its expertise in aiding the U.S. Prosecutor in convicting the provider that they have referred to the U.S. Prosecutor. In the Qlarant marketing materials to U.S. Prosecutors titled Strength of Your Convictions, Qlarant explains to the U.S. Prosecutor quoting that "If data are the building blocks of evidence, then your resources for data acquisition and analysis are likely to play a decisive role in your success at trial. When it's time to select a data team partner, it's time to talk to Qlarant."

Qlarant also offer U.S. Prosecutors customized program options, that in addition to the preceding core services, Qlarant can create a program around specific needs in each respective region. According to Qlarant these options give the U.S. Prosecutor great latitude to build upon specific issues known in their area based upon experiences and knowledge of the potential bad actors. Qlarant will help a US Prosecutor build an indictment against a healthcare provider that the US Prosecutor would like to target and then give custom options to the US Prosecutor to ensure conviction. In this manner Qlarant can help ensure a conviction when the US Prosecutor has identified a "bad actor" health care provider.

Qlarant employee McCash testified in Federal Court that "Data analytics is a general term that means the manipulation and analysis of data in order to uncover

facts and statistics to make conclusions." Qlarant and its employees including, Kevin McCash, can manipulate the evidentiary data of a US Prosecutor identified "bad actor" with customized program options through Qlarant's Coordinating for Convictions process.

Qlarant's manipulation of evidentiary data by its algorithms for U.S. Prosecutors, allow U.S. Prosecutors to persecute previously identified "bad actors" with a successful conviction. Once a U.S. Prosecutor identifies a bad actor and provides information to Qlarant, Qlarant will be able to manipulate the evidentiary data to create proof of evidence of the crime in order to help the US Prosecutor persecute the bad actor and achieve a conviction. Qlarant advertises that it leverages the extensive knowledge of its qualified medical experts to determine if providers have over-prescribed controlled substances and that federal and state agencies continue to rely on Qlarant to provide expert testimony in court cases because of its excellent track record of assisting law enforcement to achieve convictions in high-profile litigations.

Qlarant advertises that it achieves its high conviction rates by first mining for trends & targets. It explains in a white paper, that first on the list of challenges and opportunities involved in combating the opioid epidemic on the data front is identifying aberrant prescribing or dispensing behavior, as it allows law

enforcement to more effectively leverage their resources to address the worst offenders. Quoting Qlarant, "Through these types of analyses, specialized data teams partnering with law enforcement have investigated thousands of providers for their over-prescribing of opioids, and have both referred investigations to law enforcement and aided criminal prosecution teams through conviction. Such teams have testified in trials across the country, at both the state and federal level." Qlarants' Data Team Best Practices includes collaboration with law enforcement to benefit from their experience and ensure the data team consists of individuals with a proven track record of supporting cases through conviction.

HHS, DEA or Qlarant has not published a detailed analysis of the available published mathematical and statistical methods used by Qlarant to ensure that there are no large internal errors, significant bias, incorrect conclusions in either their criminal forensic tools or data analytics algorithms. Qlarant has not published who has analyzed the raw data for independent verification of Qlarant's mathematical axioms and algorithms used to generate the resulting zero to 1,000 output in Qlarant's HHS Pill Mill Doctor Project criminal forensic tool. Qlarant has not published information on the peer reviewers who have reviewed the raw data and verified the accuracy and reliability of the 0 to 1000 pill mill analysis score to date nor any analysis by United States Food and Drug Administration concerning the use of the score in patient treatment or as a criminal forensic tool to be used by the

USDOJ. Qlarant has failed to answer general questions on the population and samples as well as other questions concerning the descriptive, and inferential statistics utilized. Qlarant has not published its criminal forensic tools regarding regression, correlation analysis, and predictive analytics.

The Defendant's Criminal Forensic Tools Have Not Been Validated

In the document ("study") titled, "The Use of a Prescription Drug Monitoring Program to Develop Algorithms to Identify Providers with Unusual Prescribing Practices for Controlled Substances" was published by author(s): Christopher Ringwalt, Sharon Schiro, Meghan Shanahan, Scott Proescholdbell, Harold Meder, Anna Austin, Nidhi Sachdeva. (Federal funds provided by the U.S. Department of Justice and prepared the following final report Document No.: 249481, Date Received: November 2015, Award Number: 2012-R2-CX-0002).

The USDOJ funded study states that reviews of algorithms designed to identify inappropriate prescribing have reported that false positives generally constitute between 70% and 90% of cases later subjected to expert judgement. The study stated that "suggestions are appearing in the literature that states develop processes to systematically review PDMPs to identify providers with inappropriate prescribing behaviors and then refer them to appropriate licensing or law

enforcement authorities…however there is no standardized set of strategies available to search for providers with unusual prescribing patterns." The study states that "there is little empirical data available concerning risk factors that are associated with unusual or uncustomary provider prescribing patterns related to controlled substances…the literature does suggest several characteristics of individuals filling prescriptions at high risk for opioid misuse, abuse and diversion. These include securing prescriptions from multiple providers and filling multiple prescriptions, filling them at multiple pharmacies, refilling prescriptions early, and filling prescriptions for multiple controlled substances and high doses of opioids."

The study states, "we sought to identify providers writing high numbers of prescriptions for high doses of opioids greater than 100 MMEs daily, a definition which is emerging as the industry standard. We also developed a metric to identify providers who consistently prescribe high levels of opioids that fall below this threshold, to identify those who may seek to avoid detection as a "pill mill". The study also provided "in descending order for each metric, the top 1% of providers in the tail of its distribution, including their rank (i.e., 1-100), metric score and DEA number. By this mechanism, the SBI or State Medical Board will be able to show all providers on whom they may choose to open an investigation the shape of the entire distribution and their precise place along the curve."

The study describes analysis of "numbers of prescriptions for: (1) benzodiazepines in conjunction with high levels (>100 MMEs) of opioids, (2) opioids regardless of dose, (3) high level opioids, and (4) benzodiazepines…we constrained the providers in the tail of the distribution of each metric to those who were also among the top 1% of all prescribers of controlled substances."

The study undermined the validity of their criminal forensic tools by stating that, "some of our metrics may appear arbitrary, and there are certainly others that should be considered by future investigators. In developing the study's metrics, however, we paid particular attention to recommendations by key stakeholders in the State as to which metrics they thought would prove most fruitful…That said, our study is the first to report the results of a series of algorithms designed to mine a PDMP to indicate providers manifesting unusual or uncustomary prescribing practices. It is also the first to report the results of an exploratory effort to validate these algorithms."

The prescient study concluded that, "the development of accurate and efficient algorithms that yield lists of prescribers manifesting unusual prescribing patterns that maximize true positives and minimize false positives presents multiple challenges. But the results, if obtainable, should be well worth the effort, particularly if they are utilized in conjunction with other strategies, such as clear

guidelines governing prescribing practices related to controlled substances, and automated warning letters or email messages to providers whose prescribing patterns have been identified as unusual and potentially uncustomary. As has been compellingly stated, ‘One renegade physician can illegally prescribe enough narcotic drugs to cripple an entire country will addiction’”.

The Center For Disease Control Has Recently Admitted That The Algorithms Are Junk Science

For years, groups like the American Medical Association (AMA) have urged the CDC to reconsider the 2016 guideline. "The CDC's new draft guideline -- if followed by policymakers, health insurance companies, and pharmacy chains -- provides a path to remove arbitrary prescribing thresholds, restore balance, and support comprehensive, compassionate care," said Bobby Mukkamala, MD, chair of the AMA board of trustees, in a statement. "The previous guidance has harmed patients with chronic pain, cancer, sickle cell disease, and those in hospice," he noted. "The restrictive policies also failed patients who are stable on long-term opioid therapy, and it has denied care to post-surgical patients and those with an opioid use disorder."

The old guideline did nothing to stem the drug overdose epidemic, Mukkamala added. "In fact, the epidemic has become more lethal despite the CDC restrictive

guideline due to illicitly manufactured fentanyl, fentanyl analogs, heroin, methamphetamine, and cocaine," he said. (https://www.medpagetoday.com/painmanagement/opioids/97133?xid=nl_mpt_DHE_2022-02-11&eun=g1767887d0r&utm_source=Sailthru&utm_medium=email&utm_campaign=Daily%20Headlines%20Top%20Cat%20HeC%20%202022-02-11&utm_term=NL_Daily_DHE_dual-gmail-definition)

New draft guidelines for primary care and other clinicians proposed by the CDC no longer promote hard thresholds on opioid prescribing. The draft guidance for acute, subacute, and chronic pain is part of a proposed update to the controversial 2016 CDC opioid guideline for chronic pain. The 2016 guideline was interpreted as setting medication dose and duration limits and was misapplied by some organizations, leading CDC researchers to attempt to clarify the document in 2019. The new guideline isn't designed to replace clinical judgment, but is a tool to help providers and patients make safe, effective pain care decisions and provides "voluntary recommendations on the use of opioids to treat pain," the CDC noted. Overall, however, the proposed guidelines represent a substantial improvement on the advice the CDC gave in 2016. "The framing is better," says Kate Nicholson, president of the National Pain Advocacy Center. She notes "much more emphasis on the importance of treating pain, individualization, patient-centered care,

disparities in care, and [the point] that the guideline should not be used as the basis for policy or a substitute for clinical judgment." She adds that "the two provisions that wreaked the most havoc—the day and dosage thresholds—have been removed from the actual recommendations."

It is not intended to be applied as an inflexible standard, CDC added. It's also not intended to lead to rapid opioid tapering or discontinuation, and does not apply to sickle cell disease-related pain, cancer pain, and palliative or end-of-life care. "I was very pleased to see clear language that the proposed guideline is not a replacement for clinical judgment or individualized, person-centered care," noted pain specialist Beth Darnall, PhD, of Stanford University School of Medicine. "This is crucial, as misapplications of the 2016 guideline centered around a reductive focus on dose-based limits and tapering that was associated with patient harms," Darnall told *MedPage Today.*

The CDC acknowledges the concern that advice tied to specific doses might lead to suboptimal care and misguided policies, as happened with its earlier emphasis on the 90 MME/day threshold. Its solution is to omit any reference to the 50 MME/day threshold from its highlighted recommendation, relegating that discussion to the "implementation considerations." Lynn Webster, a former president of the American Academy of Pain Medicine, notes that the CDC does not acknowledge the weak

scientific basis for MME thresholds, which do not take into account wide variation in how patients metabolize and respond to pain medication.

Webster is less impressed by the CDC's changes. "The good thing," he says, is that "the explicit dose limits were removed and the days of opioid supply for acute pain are not specific." But "although they say that the guideline should not be an inflexible standard of care imposed on specific populations," he notes, "they do not expressly state that law enforcement and policy makers should not use them to set a standard of care or to prosecute providers."

The CDC's bias against opioids does not seem to be justified by the addiction risk it emphasizes. In 2015, according to the National Survey on Drug Use and Health, nearly 100 million Americans used prescription opioids, including nonmedical users as well as bona fide patients. Judging from their responses to survey questions, about 2 million of them, slightly more than 2 percent, qualified for a diagnosis of "substance use disorder"—a catchall category that subsumes what used to be known as "substance abuse" and the more severe "substance dependence"—at some point during the previous year. By comparison, data from the same survey indicate that 9 percent of past-year drinkers had an alcohol use disorder in 2015.

Nor are fatal overdoses as common as the CDC implies. A 2015 study of opioid-related deaths in North Carolina, reported in *Pain Medicine*, found 478 fatalities among 2.2 million residents who were prescribed opioids in 2010, an annual rate of 0.022 percent. Webster notes that the CDC dubiously blames opioid prescribing for increases in drug-related deaths between 1999 and 2010 without acknowledging that the upward trend in fatalities accelerated after the government succeeded in reducing the use of opioid pain medication. As opioid prescriptions fell, opioid-related deaths, primarily involving heroin and illicit fentanyl, rose to record levels.

Webster questions why the CDC felt a need to advise doctors about pain treatment in the first place. That function "should be left to professional organizations," he says. "Several experts in the field predicted the outcome of the 2016 CDC guidelines before they were issued.…The debacle with the 2016 CDC guidelines [illustrates] the reason the CDC should not be imposing their views on how pain medicine should be practiced."

The problems revealed by the CDC to its 2016 guidelines Opioid Guidelines have since been compounded in at least two ways. First, research has shown that the underlying rationale of the CDC guideline and the proposed revisions is grounded upon a concept that is best characterized as “junk science.” Much of the damage done by the 2016 CDC guideline was caused by daily dose recommendations based

on morphine milligram equivalents (MME). However, MME is not a single metric or even the correct one to base decisions on. In fact, there are four different models for MME which generate significantly different estimates for the "equivalence" between various opioid medications. Likewise, a June 2021 FDA Workshop on MME research revealed significant weaknesses in the methods and protocols from which these models were developed. Finally, a recently published review of the clinical literature for opioids and chronic pain reveals a 15-to-1 range in minimum effective dose for opioids used in long term therapy for moderate to severe pain. Much of this range appears to be caused by genetic differences in key liver enzymes which metabolize opioids. The literature also reveals very low risks of addiction among pain patients actively managed on opioids. Many papers mistake "pseudo-addiction" for drug tolerance or addiction.

A clinical practice guideline is a clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together. It is intended to be flexible to enable person-centered decision-making, taking into account an individual's expected health outcomes and well-being. A clinical practice guideline is not a replacement for clinical judgment or individualized, person-centered care. A clinical guideline is not intended to be applied as inflexible standards of care across patients, and/or patient populations by healthcare professionals, health systems, pharmacies, third-

party payers, or governmental jurisdictions or to lead to the rapid tapering or discontinuation of opioids for patients. Therefore, pharmacists should avoid abrupt discontinuation of opioids, especially for patients receiving high dosages of opioids and should avoid dismissing patients from care.

"The use of the Milligram Morphine Equivalents is scientifically flawed because it fails to take into account even the most basic tenets of pharmacology, rendering it scientifically meaningless. Contrary to conventional wisdom, conversion values are not based on pharmacologic properties. Instead, they arose 60 years ago from small single-dose clinical studies in postoperative or cancer populations with pain score outcomes; toxicologic effects (eg, respiratory depression) were not evaluated." See Nabarun Dasgupta, et. al., The Clinical Journal of Pain: August 2021 - Volume 37 - Issue 8 - p 565-574 doi: 10.1097/AJP.0000000000000948 where all aggregate data and code used for statistical analyses are publicly available at www.opioiddata.org and institutionally archived at the Carolina Digital Repository (https://doi.org/10.17615/zst5-nc25).

Morphine-standardized doses are used in clinical practice and research to account for molecular potency. Ninety milligrams of morphine equivalents (MME) per day are considered a "high dose" risk threshold in guidelines, laws, and by payers. Although ubiquitously cited, the "CDC definition" of daily MME lacks a clearly defined denominator. The Defendants algorithms therefore lack an objective

way to assess denominator-dependency on “high dose” classification across competing definitions and fail to identify definitional variants.

The Defendants computer algorithms manners and methods of toxicologic framing where the artificial intelligence identifies the highest single-day MME exposure, irrespective of days supply or opioid tolerance is unpublished. Prescriptions dispensed *pro re nata* are assumed to be consumed immediately, regardless of how long the prescription is written for. Yet, paradoxically, the “maximum” does not conceptually include consumption for intentional self-harm. MME alert thresholds are incorporated in “doctor shopping algorithms” and automated proactive reporting, but are routinely devoid of diagnosis or ICD code. Thus, the law enforcement metric of use daily MME to target prescribers or pharmacists is clearly erroneous as it is not correlated to disease.

Penalizing clinicians solely on the basis of 90 MME limits is problematic because the mean is not always the message and policymakers reading PDMP reports based solely on MME averages are in danger of making decisions based on metrics that are artifactually inflated. Medians and ranges may convey a more accurate picture in these scenarios.

Dispensing data do not necessarily reflect actual consumption. About 60% of patients prescribed opioids retain unused medication. As a pharmacist and a journalist, Intervenor Clement is trying to obtain the databases to study the standard

assumptions and limitations inherent to database studies of medication use. The Defendants' databases obtained pursuant to FOIA will allow study for specification and completeness, generic equivalence, and analysis of the presence or absence of counterfeits. Intervenor Clement seeks Defendants computer algorithms, formulae, conversion tables, computer code, sensitivity analyses by definition choice, and methods of treating MME exposure as a transformed continuous mathematical variable. Identification of a clustering effect would also identify prescribing motivations at certain MME thresholds which might be used as a cap to appear in compliance with external government mandates. Clinical reasons could be identified for patients who cluster at 90 MME per day outside of policy, health system, and payer requirements; likewise patients could be identified that might have otherwise received higher doses but are subsumed under this threshold due to U.S. Executive Agency mandates.

There is also evidence that CDC violated its own internal standards for objectivity when it selected the writers of the opioid guideline and recent revisions. Dr. Roger Chou, one of the co-authors of the original and revised guideline, has an established history of collaboration with key figures in anti-opioid organizations. Moreover, as pointed out by the OWG, a disproportionate number of publications where Chou was a principal author were used as source research for the guidelines as published. Chou not only led research on opioid outcomes and

contributed to writing the guidelines, but also sits on the Board of Scientific Counselors that appointed the OWG. He was thus in a position to lobby actively for his own work as a national standard of care. This is a fundamental professional conflict of interest. As we near the release of a revised draft CDC guideline, one central trend seems clear. If the writers of this guideline insist on doubling down on the errors of their original effort in 2016 – as they apparently did in July 2021 – then it will be time to remove CDC from its oversight of the practice of pain medicine, perhaps in favor of FDA or the National Academies of Medicine.

Historically, the transition of the MME concept from pain relief to toxicology within the Defendants algorithms seemed to have ignored the clinical medical concept of differential tolerance. With opioid dose escalation, analgesic and unintended effects emerge asynchronously. While 90 MME may have cautionary mnemonic benefits in the midst of broad societal concern, a renewed emphasis on opioid tolerance and definitional harmonization for daily MME and long-term therapy seems overdue.

Defendants DEA and HHS Seek Unlawful Return On Investment (ROI)

The US Supreme Court concluded that the state actors/ agencies were liable to antitrust claims stating that "Limits on state-action immunity are most essential

when the State, seeks to delegate its regulatory power to active market participants, for established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor. In consequence active market participants cannot be allowed to regulate their own markets free from antitrust accountability." *See Midcal. Supra At 106, 100 S.Ct. 937.* Prohibitions against anticompetitive self-regulation by active market participants are an axiom of federal antitrust policy. *See Allied Tube and Conduit Corp V. Indian Head Inc.*

Qlarant has also touted the ability in its marketing materials to "review past prosecutions and the exposed vulnerabilities and recommend potential business process modifications to enhance and negate those vulnerabilities in future prosecutions." Qlarant states that "building this type of process improvement can develop solid resolutions and close those gaps for a sound prosecution with visual demonstrative evidence that appeals to jurors and prosecutors who do not fully understand the complexity of healthcare fraud." Qlarant through its advertising materials has stated that the process of criminal indicting and convicting a health care physician by the USDOJ is merely a "business process" and therefore Qlarant has identified the various factors that cause "business losses" in terms of health care

criminal convictions and thus is able to help US Prosecutors avoid "USDOJ business losses" by ensuring a successful conviction.

Defendants' DEA and HHS measure of success of their project mission is based off Return of Investment (ROI) business model. In *Tumey v. Ohio*, 273U.S 510 (1927), the US Supreme Court struck down a scheme that financially rewarded for successfully prosecuting cases related to Prohibition of alcohol. Despite complete field preemption under Controlled Substance Act (CSA 802 (56)(c)), the Defendants are public agencies, or agents of the government, who have the intent to benefit from prosecution of U.S. Citizens by the Controlled Substance Act. Pursuant to *Tumey*, Defendants and the HFPP "cartel" private insurance partners, are not entitled to pecuniary gains from prosecutions of healthcare providers under the Controlled Substance Act. The Excessive Fines Clause now covers healthcare providers in both the federal and state courts. The U.S. Supreme Court's landmark 9-0 decision in *Timbs v. Indiana* protects pharmacists who have been facing the civil or criminal forfeiture of assets that took them a lifetime to earn.

The Return of Investment strategies by Defendants or other private health insurers of the HFPP is unlawful. Forfeiture under §§881(a)(4) and (a)(7) is a monetary punishment and, as such, is subject to the limitations of the Excessive Fines Clause. The determinative question is not, as the Government would have it,

whether forfeiture under §§ 881(a)(4) and (a)(7) is civil or criminal. "The Eighth Amendment's text is not expressly limited to criminal cases, and its history does not require such a limitation. Rather, the crucial question is whether the forfeiture is monetary punishment, with which the Excessive Fines Clause is particularly concerned. Because sanctions frequently serve more than one purpose, the fact that a forfeiture serves remedial goals will not exclude it from the Clause's purview, so long as it can only be explained as serving in part to punish." See *United States v. Halper*, 490 U. S. 435, 448.

"Consideration must be given to whether, at the time the Eighth Amendment was ratified, forfeiture was understood at least in part as punishment and whether forfeiture under §§ 881(a)(4) and (a)(7) should be so understood today." See *Austin v. United States*, 509 U.S. 602 (1993). A review of English and American law before, at the time of, and following the ratification of the Eighth Amendment demonstrates that forfeiture generally, and statutory in rem forfeiture in particular, historically have been understood, at least in part, as punishment. See *Peisch v. Ware*, 4 Cranch 347, 364.

"Forfeitures under §§ 881 (a)(4) and (a)(7) are properly considered punishment today, since nothing in these provisions contradicts the historical understanding, since both sections clearly focus on the owner's culpability by expressly providing "innocent owner" defenses and by tying forfeiture directly to the commission of

drug offenses, and since the legislative history confirms that Congress understood the provisions as serving to deter and to punish. Thus, even assuming that the sections serve some remedial purpose, it cannot be concluded that forfeiture under the sections serves only that purpose." See *Austin v. United States*, 509 U.S. 602 (1993)

In *Timbs*, the state sought civil forfeiture of property valued at more than four times the maximum monetary fine that could even be assessed for a criminal drug conviction. The Indiana Supreme Court held that the Excessive Fines Clause applied only to federal action and was inapplicable to the individual States. The U.S. Supreme Court vacated that decision and unequivocally held that the protections of the Eighth Amendment's Excessive Fines Clause also apply to the states under the Fourteenth Amendment.

The U.S. Supreme Court has also ruled in *Austin v. United States* that civil in rem forfeitures in the federal context fall within the protection of the Eighth Amendment's Excessive Fines Clause when they are at least partially punitive. The Defendants and HFPP private insurers strategies of seeking criminal and civil forfeitures of an excessive amount of a pharmacists assets amounts to nothing more than an unconstitutionally excessive punitive fine as determined by the authority of the U.S. Supreme Court.

The Eighth Amendment's Excessive Fines Clause is an incorporated protection applicable to the States under the Fourteenth Amendment's Due Process Clause. The Fourteenth Amendment's Due Process Clause incorporates and renders applicable to the States Bill of Rights protections "fundamental to our scheme of ordered liberty," or "deeply rooted in this Nation's history and tradition." *McDonald v. Chicago*, 561 U. S. 742,

"The prohibition embodied in the Excessive Fines Clause carries forward protections found in sources from Magna Carta to the English Bill of Rights to state constitutions from the colonial era to the present day. Protection against excessive fines has been a constant shield throughout Anglo-American history for good reason: Such fines undermine other liberties. They can be used, e.g., to retaliate against or chill the speech of political enemies. They can also be employed, not in service of penal purposes, but as a source of revenue. The historical and logical case for concluding that the Fourteenth Amendment incorporates the Excessive Fines Clause is indeed overwhelming." See *Timbs v. Indiana.*

Under *Tumey*, the profiting from conviction arising from conviction, in the presence of a biased judiciary, under alcohol prohibition was prohibited. Furthermore, the impartiality regulation, 28 C.F.R. § 45.2 prohibits a USDOJ employee, without written authorization, from participating in a criminal investigation or prosecution if he has a personal or political relationship with any

person or organization substantially involved in the conduct that is the subject of the investigation or prosecution, or any person or organization which he knows has a specific and substantial interest that would be directly affected by the outcome of the investigation or prosecution. Defendants with its partners BCBSA and HFPP stand to gain from substantial restitution from Intervenor Clement.

Defendant DEA's Actions Are Causing Increased Rates of Overdose Death

It is difficult to draw conclusions about prohibition's impact on crime at the national level, as there were no uniform national statistics gathered about crime prior to 1930. It has been argued that organized crime received a major boost from Prohibition. The same is true about the War on Drugs. The efforts of the DEA, shutting down legitimate operating pharmacies are providing drug cartels a major boost. The arrogance of their wrongs are perpetrated, with each pharmacy that is closed, the sales of illegal pain medication is increasing in the community. Just imagine if the DEA went after Walmart, the largest company in the United States, and disrupted the prescription sales of Controlled Substance Schedule 2 pharmaceuticals. This would certainty disrupt the legal sales and promote illegal sales. Corruption causses blindness to the facts of the laws. This blindness has caused the DEA to become numb and not objective at viewing right from wrong.

When the government allies itself with criminals, when the ends of fighting the war on drugs justifies the means of the fight, is it then any wonder that the people no longer respect the government, the law, or the United States? *Olmstead v. United States*, 277 U.S. 438, 484, 48 S.Ct. 564, 574-75, 73 L.Ed. 944 (1928) (Brandeis, J., dissenting)

The U.S. Department of Justice's DEA office have claimed that pharmacies have ignored their legal duty to prevent the diversion of narcotic painkillers for illicit uses. The Agents of the DEA have deceived the courts to secured search administration warrants and search warrants. Within the State of Florida, the agents claim they raid Pharmacies to slow down the Opioid crises within Florida. This claim is so far deceptive that it fails to document the facts that illegal fentanyl sales have increased due to Defendant DEA's actions.

Also, in Florida DEA agents have unlawfully been employed by Drug Cartels. This combination of efforts has caused the DEA to be the gate keeper and sub-recipients of illegal drugs sales into the United States. Their efforts to undermine and discourage legal sales through FDA approved medications has promoted the sales of illegal drug sales. They have caused this by means of judicially obtained "searches and seizures" based on reasonable suspicion to remove all Controlled Substance Scheduled Class 2 medications and equipment.

The multidimensional levels of corrupted behavior have allowed the DEA to view themselves as enforcers of justice. Within their own eyes they see no wrong. As this agency continues on their trajectory, they could resort to violent acts to protect the agency or themselves from detection. This agency has subordinated the laws in exchange to justify their actions. Right or wrong they stand behind what they do and believe. This deliberate drive to be, has shifted a once knowledgeable and professional agency, to accept deviant, dishonest, improper, unethical or criminal behavior.

The men and women of this once well-known and respected agency would understand the impact of deception. Today the DEA does not and cannot accept errors of their ways. Scot Rivkees MD the Florida State Surgeon General, "The panel determined that probable cause of a violation does not exist." Please note that section 456.073(9)(c), Florida Statutes, states," ln any disciplinary case for which probable cause is not found." Yet, instead of correcting actions, the DEA hunkers down. They have become more hardened and have tipped towards to factors of a Group Think. Such aggressive act clearly displays that this government agency has lost their way.

"YOU ARE WITHIN THE NORMS" Identifies Prosecutorial Misconduct

Intervenor Clement as a journalist working through "You Are Within the Norms" website has been involved with the executive team of 4 physician non-profit organizations and 1 law organization that was analyzing the evidence in the botched criminal prosecution of Dr. Vilasani Ganesh and Dr. Gregory Belcher. See *United States v. Ganesh.*

Dr. Ganesh alleged she had significant legal abnormalities involved in her case including alleged fabricated evidence. She presented her story and evidence to large numbers of physicians over the internet and around the world. Dr, Ganesh had the 4 physician non-profit organizations and the Law Project organization evaluate evidence in her criminal case and a digital forensic expert was hired to independently evaluate the evidence.

The independent digital forensic expert determined that forensic evidence from examining the digital discovery indicated that evidence presented in the criminal trial of Dr. Ganesh and Dr. Belcher was modified post-trial. This forensic evidence was presented to hundreds of doctors around the World including Youtube. Dr. Ganesh then visited the U.S. Supreme Court, The U.S. White House, and U.S. Congress Offices to peacefully protest what she declared was an unjust conviction prior to her incarceration. I spoke with Dr. Ganesh personally. "I was prosecuted like a slave," Ganesh told NRI Pulse. "My family, children, and I have been put

through severe psychological and emotional trauma. It feels like they have a knife to my throat and a gun to my head all the time. I've been waking up with nightmares for the past five years."

The one-time family medicine and urgent care physician said "her life changed upside down" when she decided to fight insurance companies for non-payment of over $500,000 in patient care service claims dating back to 2012 for medical care provided to her patients. Ganesh states, "I reached out to the California Medical Association, and they gave me referrals to attorneys to reach out to. The attorneys suggested that I file a lawsuit against the insurance companies." Ganesh filed a lawsuit against Blue Cross Blue Shield who then retaliated against Ganesh to USDOJ with fraud complaints instead of paying Ganesh on the claims they owed her. The Northern California Department of Justice initiated a health care fraud case against her and secured an indictment soon after. Ganesh and her legal counsel Lisa Rasmussen, who is executive director of ACLU, (American Civil Liberties Union) Nevada spoke to NRI Pulse recently over Zoom. Both insist that the charges were false and the jury was tricked into believing false, fabricated evidence.

"They did not find anything against us, so they fabricated evidence. They took thousands of patients' records, claims from another doctor's office and blamed it on us," Ganesh said. "We did not realize this during the trial because they had redacted

the tax ID and provider names. After the trial, one of the. attorneys discovered thousands of claims in the form of spreadsheets from another doctor's office. They committed fraud over the jury." As part of evidence, checks purportedly written way back in 1988 were presented. "They sentenced me based on checks issued way back when I was a teenager in India. I wasn't even in the US in 1988," Ganesh said.

Healthcare advocate and founder of Doctors of Courage, Linda Cheek MD, who "believes the Department of Justice has cookie-cutter methods that they use now against doctors, more and more of which are actually criminal in action, breaking the law in order to convict an innocent doctor…Even when as in Dr. Ganesh's case, egregious false evidence is used to convict her, and when exposed, the court does nothing to correct the law-breaking or hold those who did it responsible. This gives the entire DOJ license to break the law to convict innocent people," she told NRI Pulse via email.

Doctors of Courage and 4 other medical organizations were involved in analyzing the criminal case identified numerous anomalies in the trial of *United States v. Ganesh and Belcher*. "Techniques that the DOJ uses regularly, and are even being trained to use, are to modify records that are brought into trial. Changing names and dates on medical records, redacting exculpatory evidence on the chart, and altering audio recordings of visits are just some of the egregious actions. They

also then force patients of the doctor to be witnesses and commit perjury or face charges of possession with intent to distribute and go to prison themselves if they don't."

A digital forensic analysis of the digital files metadata of evidence submitted in the criminal trial record shows that the spreadsheet evidence was intentionally and deliberately tampered with. The tampered forensic evidence was shared and analyzed with hundreds of concerned physicians around the country who considered the criminal case to be tainted.

Intervenor Clement and Plaintiffs Anand and Pompy among others were on the executive team of physicians and/or physician attorneys who were coordinating with the 4 physician national organizations in attempting to find the underlying cause of so much identified prosecutorial misconduct in criminal cases involving the Blue Cross Blue Shield companies.

Blue Cross Blue Shield Association is franchisor who directs, and controls thirty six (36) Blue Cross Blue Shield franchisees. The franchisees include Blue Cross Blue Shield of Michigan Mutual Insurance Company and Independence Blue Cross. The franchisees and franchisor often act over broadly, under the direction and control of the state or federal governments. For proprietary pecuniary and market share gains, BCBSA and the Defendants intertwined in traditional law enforcement

function by providing “state” agents for the federal agencies, Health And Human Services (HHS) and Drug Enforcement Agency (DEA), under a public and private partnership, namely, HFPP.

As private companies, the Blue Cross franchisees are acting as state actors without the substantive and procedural constitutional safeguard by establishing arbitrary and capricious: 1) evaluation and management (E&M) codes, 2) data mining without means of correcting errors, 3) establishing the elements of a “Pill Mill” despite complete field preemption under the Controlled Substance Act (CSA 802 (56)(c)).

BCBSA and its franchisees, has a history of a violation of Sections 1, 2 and 3 of the Sherman Antitrust Act because it decreased competition between and among the plaintiffs and the defendants in health insurance markets by: “(1) allocating geographic territories; (2) limiting the Member Plans from competing against each other, even when they are not using a Blue name, by mandating a minimum percentage of business that each Member Plan must do under that name, both inside and outside each Member Plan’s territory; (3) restricting the right of any Member Plan to be sold to a company that is not a member of BCBSA; and (4) agreeing to other ancillary restraints on competition.”

Subsequent Ganesh's and Belcher's criminal trial it was discovered that the government failed to disclose exculpatory materials pursuant to *Brady v. Maryland* by failing to disclose to the defendants in the case that Gary Jizmejian, a former fraud investigator for Anthem's Special Investigations Unit, was investigated from at least two years prior to the trial in this case and he was indicted in the Central District of California on or about May 20, 2018 for his role in a 20 million fraud scheme against Anthem. Several "source spreadsheets" in this case came from Anthem's Special Investigation Unit". Gary Jizmejian, a former fraud investigator for Anthem's Special Investigations Unit, in court documents describes tests and procedures fraudulently billed to Blue Cross Blue Shield which ranged from office visits to "nerve conduction tests" and something labeled "fluorescent antibody; titer." The indictment alleges that, in return for cash payments, Jizmejian assisted Khadem and others by providing them with confidential Anthem information that helped them submit fraudulent bills to Anthem. In September 2012, Jizmejian allegedly gave Khadem insurance billing codes – CPT Codes – that Jizmejian reportedly knew could be used to submit fraudulent claims to Anthem without Anthem detecting the fraudulent claims. Jizmejian allegedly gave Khadem the billing code for an allergy-related lab test and instructed her to submit to Anthem large numbers of bills with this CPT code. Khadem and other members of the conspiracy allegedly used this billing code to submit approximately $1 million in

fraudulent claims to Anthem, according to the indictment. The indictment further alleges that Jizmejian worked to prevent the insurance companies from detecting the fraud at the clinics, which included helping Khadem avoid responding to inquiries from fraud investigators, diverting the attention of other Anthem SIU investigators away from the clinics and closing Anthem investigations into fraud that was being committed at the clinics. In September 2015, based on confidential information obtained from State Actor Anthem, Jizmejian allegedly tipped Khadem off about a federal criminal investigation into the clinics, according to the indictment.

Blue Cross Blue Shield's ability to create custom evidence for a U.S. Prosecutor after the U.S. Prosecutor has identified a bad actor may incentivize Blue Cross Blue Shield to produce false or misleading evidence. A bedrock principle of our democracy is that the State may not use false evidence to obtain a criminal conviction. See *Hayes v Brown, Napue v. Illinois*. It is well settled that the presentation of false evidence violates due process. *Napue v. Illinois*, 360 U.S. 264, 269 (1959)("[A] state may not use false evidence, including false testimony, to obtain a tainted conviction. . ."); *United States v. LaPage*, 231 F.3d 488 (9th Cir. 2000)("The due process clause entitles defendants in criminal cases to fundamentally fair procedures. It is fundamentally unfair for a prosecutor to

knowingly present perjury to the jury.”). The fundamental unfairness of a conviction obtained through the use of false evidence has long been recognized by the Supreme Court. *Mooney v. Holohan,* 294 U.S. 103 (1935); *Pyle v. Kansas*, 317 U.S. 213 (1942); *Napue*, supra.

Exculpatory evidence, even if it is only impeachment evidence must be disclosed whether it goes to the issue of guilt or punishment. A conviction achieved through the use of false or misleading evidence violates due process because if the evidence is false, the false evidence would be material to probable cause as well as a grand jury indictment and could convert “U.S. Prosecutors” pursuing “cookie cutter prosecutions” into “U.S. Persecutors” undermining confidence of U.S. Courts of Law. *United States v. Zuno- Arce*.

Where the DEA and the HHS OIG/CMS possesses information about the Blue Cross Blue Shield companies and is able to but chooses not to disclose potentially exculpatory evidence to prosecuted physicians or pharmacists in response to a “Brady request” constitutes a Brady violation. (*Brady v. Maryland*, 373 U.S. 83 (more) 83 S. Ct. 1194; 10 L. Ed. 2d 215; 1963 U.S. LEXIS 1615)

The Defendants Target Healthcare Providers Based On Skin Color and Nation or Origin

The Defendants' software criminal forensic tools uses plausibility evidentiary standard that misrepresents the statutory, beyond a reasonable doubt, criminal evidence standard. A public/private partnership named HFPP (Healthcare Fraud Prevention Partnership), selects pharmacists based on race, age, financial assets, real estate, and nation of origin as a suspect class, preventing those pharmacists from practicing medicine in a race –neutral manner by coordinating selective enforcement of the Controlled Substance Act.

Under the "State Involvement Doctrine" such behavior is improper because the software scheme that violates the Equal Protection Clause of the U.S. constitution. The software data analytic services or data is sold to HFPP, for cash or in kind data information. HFPP uses the data analytics used to manufactured probable cause to induce, and coordinate criminal proceedings via an improper standard of evidence. Such behavior occurred in violation of 5 C.F.R. § 2635.501 - 503 (Subpart E - Impartiality in Performing Official Duties)

The Defendants' created a suspect class comprising of pharmacists who treat patients suffering from the diseases of chronic pain, and/or substance use disorders. Pursuant to *Robinson v. California*, Supreme Court of the United States, 1962 370 U.S. 660, 82 S. Ct. 1417; it was improper to qualify a person as a criminal, simply because of the medical status of the person. Statistical analysis of the selection

process by analyzing indicted pharmacists reveals a classification selection process that has produced a disproportionate number of pharmacists of African American origin (i.e. pharmacists of minority racial origin) or pharmacists of old age for criminal investigation and prosecution. Health and Human Services (HHS), Drug Enforcement Agency (DEA), and the HFPP public private joint enterprise's, algorithms almost exclusively targets older pharmacists, wealthy pharmacists, dark skinned colored pharmacists, or small pharmacies (as compared to large national pharmacy chains).

A potential reason is that the U.S. Executive Branch agencies, Defendants HHS and DEA, consider colored or older pharmacists to be disposable is that there is less worry that there will be a public outcry by the general population for the targeting of dark skinned minority pharmacists or elderly pharmacists. A potential reason is that the U.S. Executive Branch agencies, Defendants HHS and DEA target wealthy pharmacists is to maximize return on investment (ROI). A potential reason that Defendants HHS and DEA target individual pharmacists or small medical entities is that these smaller entities lack the financial resources for proper legal defense, allowing the USDOJ to achieve "easy" convictions regardless of the innocence or guilt of its victims. The targeting of individual, small, and upstart health entities by the Defendants allows the larger member entities (i.e. private members of HFPP and

the joint enterprise) to eliminate competition, restrain trade, flourish and monopolize the U.S. pharmacy market.

The DEA and HHS selection process discriminates based on age, race and nation of origin as HFPP, Qlarant, BCBSA joint enterprise algorithms categorize age, race and nation of origin as the "suspect class" which violates the 14th Amendment Equal Protection Clause of the US Constitution. The selection process generates probable cause, to induce criminal proceedings, against the "suspect class," via the wrong standard of evidence. The software uses plausibility evidentiary standard that misrepresents the statutory, beyond a reasonable doubt, criminal evidence standard.

The pattern amounts to a custom or practice amounting to a policy of deliberate indifference to constitutional rights of pharmacists who were classified as members of the suspect class. The pattern amounts to cause violations of international law and human rights for sick, infirm, and disabled human patients. The members of the suspect class experience a common nucleus of operative facts, namely, an improper style of an investigation that violated the Equal Protection Due Process of the 14th U.S Constitutional Amendment, and the 5th U.S. Constitutional Amendment Due Process. These constitutional injuries among others are the actual and proximate cause of commercial or tort injury to suffering patients and their physicians.

My website, YOU ARE WITHIN THE NORMS has documented seven physicians that have represented to a Court of the United States Third Circuit that physicians (especially of colored skin) are being targeted in a pattern of racial discrimination by Blue Cross Blue Shield insurance companies for the purposes of civil asset forfeiture and incapacitation. Doctors communicated with or reported on include: 1) Dr. Neil Anand, 2) Dr. Lesly Pompy, 3) Dr. Walter Wrenn, 4) Dr. Richard Kaul (who has argued to the U.S. Supreme Court and several Federal U.S. District Courts that insurance companies racially targeted him to deprive him of liberty and happiness) 5) Dr. Clarence Verdell, 6) Dr. Evangelos Megariotis, and 7) Dr. Andrew Berkowitz. The common pattern of behavior by the Blue Cross Blue Shield companies exceeds the plausibility standards for the obtaining of legal redress and judicial relief from a U.S. Federal District Court against the Defendants.

BCBSA franchisees have publicly documented its successful retaliation against other physicians whom were colored, non-white and dark skinned. Physicians targeted for criminal indictments by BCBSA franchisees include Dr. Jorge A. Martinez (Hispanic), Dr. Clarence Verdell (Black), Dr. Walter Wrenn (Black), Dr. Neil Anand (Indian); Dr. Lesly Pompy (Black), Dr. Ganiu Edu (Black), Dr. David Lewis (Black), Dr. Rajendra Bothra (Indian), Dr. Richard Kaul (Indian), Dr. Arun Gupta (Indian), Dr. Dralves Edwards (Black), Dr. Sreekrishna Cheruvu (Indian), Dr.

Xiulu Ruan (Chinese), Dr. Kamal Tiwari (Indian), Dr. Vilasini Ganesh (Indian), Dr. Gregory Belcher (Black) and Dr. Sanjay Kumar (Indian).

Upon information or belief BCBSA and their franchises targeted the now deceased, Rev. Ronald V. Myers, Sr., M.D the founder of one of eleven of the United States National Holidays, Juneteenth. Upon information or belief BCBSA and their franchises were opposed to another Doctor who was also a Reverend obtaining another national holiday for celebrating African-American culture. BCBSA targeted Reverend Dr. Ronald Myers because they opposed the Juneteenth National Holiday as there was already a national holiday for Reverend Dr. Martin Luther King. The general consensus of the common public is that Reverend Dr. Ronald Myers was martyred for his beliefs and ideologies regarding the Juneteenth Holiday. See https://youarewithinthenorms.com/2021/10/12/exposing-healthcare-apartheid-in-the-united-states-of-america-targeting-convictions-imprisonments-of-doctors-of-color-and-its-disparity-covid-mortality-rates/

In 1988, Dr. Myers and his wife opened a family health center in Tchula, Mississippi, located in an area with scarce medical resources and a high infant mortality rate. In 1990, he was ordained by Pilgrim Rest Missionary Baptist Church in Milwaukee, and commissioned by the Wisconsin Baptist Pastors Conference as a medical missionary to the Mississippi Delta. Myers was also elected as Chairman of

the National Juneteenth Holiday Campaign, National Juneteenth Christian Leadership Council, National Juneteenth Observance Foundation, and the National Association of Juneteenth Jazz Presenters.

On April 15, 2016, Rev. Ronald Vincent Myers, Sr., MD was indicted in association with 3 other providers in action on in Oklahoma City, OK. He was charged with one count of racketeering and two counts of unlawfully distributing controlled substances on accusations he prescribed painkillers and antidepressants to multiple people who had no medical reason for receiving the drugs. See "Murder, racketeering indictments come down from 'pill mill' operation in Sequoyah County." https://tulsaworld.com/news/local/crime-and-courts/murder-racketeering-indictments-come-down-from-pill-mill-operation-in-sequoyah-county/article_901bad7a-ef73-50ed-afd6-ff77a84cfabc.html#:~:text=OKLAHOMA%20CITY%20%E2%80%94%20A%20multicounty%20grand,79%2C%20of%20Wichita%3B%20Dr

There are currently eleven national public holidays in the United States designated in Title V of the United States Code (5 U.S.C. § 6103). These federal holidays apply to all federal government entities. State and city holidays may be observed concurrently with federal holidays. Federal Holidays are among the United States of America's most treasured ultra-precious AMERICAN cultural

commodities. Federal law also provides for the declaration of other public holidays by the President of the United States. Generally, the president will provide a reasoning behind the elevation of the day, and call on the people of the United States to observe the day "with appropriate ceremonies and activities." Examples of presidentially declared holidays were the days of the funerals for former Presidents Ronald Reagan, George H. W. Bush, and Gerald Ford; federal government offices were closed and employees given a paid holiday. The eleven national holidays are: National New Year's Day, Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Juneteenth National Independence Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day.

The Freedom of Information Act requests will allow the common public to evaluate the Red Flags used by federal agencies including the Defendants that identified Dr. Xiulu Ruan, America's most educated physician, and Reverend Dr. Ronald Myers, physician founder of a U.S. National Holiday, as criminal drug traffickers.

HHS, DEA and Their Contractors Violate International Law

The Defendants and their contractors' computer algorithms fail to consider all the variety of medical scientific theories and guidelines. The computer algorithms fail

to consider that only from an uninhibited exchange of ideas and information can authentic scientific advancement occur. HHS, DEA, HFPP, and Qlarant artificial intelligence computer programs are admitted to be pilot programs and are thus "medical or scientific experiments not necessitated by the medical treatment of a protected person" and are thus prohibited by International Law.

According to Article 147 of Geneva convention, HHS, CMS Medicare, DEA, HFPP, and Qlarant are conducting biological experiments on protected persons (patients suffering from chronic diseases or addiction) which is a grave breach of the Convention. HFPP and Qlarant's data analytic programs and the utilization of HHS and DEA "healthcare provider conviction engines" in addition to controlled substance algorithms against sick patients suffering from disease are crimes against humanity violating: Nuremberg Code #1: Voluntary Consent; Nuremberg Code #2: Yield Fruitful Results Unprocurable By Other Means; Nuremberg Code #3: Base Experiments on Natural History of Disease; Nuremberg Code #4: Avoid All Unnecessary Suffering and Injury; Nuremberg Code #5: No Experiment to be Conducted if There's Reason to Think Injury Will Occur; Nuremberg Code #6: Risk Should Never Exceed the Benefit; Nuremberg Code #7: Preparation Made Against Remote Possibility of Injury, Disability or Death; Nuremberg Code #8: Experiment Must Be Conducted by Scientifically Qualified Persons; Nuremberg Code #9: The

Freedom to Bring the Experiment to an End At Any Time; Nuremberg Code #10: Bring the Experiment to an End At Any Time if There's Probable Cause of it Resulting in Injury or Death.

According to the International Commission of Jurists, for a country's avenues of redress to be effective, they "must be prompt, accessible, available before an independent body, and lead to reparation and, where applicable, to cessation of the wrongdoing". Qlarant and the HFPP private insurers acted under the color of law, under the direction, control, and supervision of law enforcement as a government contractor, agent and/or State Actor. Neither Qlarant nor the HFPP private insurers have qualified or absolute immunity.

Defendants DEA and HHS in partnership with HFPP and Qlarant is specifically targeting pharmacists who treat patients with pain or substance use disorders in direct violation of Centers for Disease Control and Prevention (CDC) guidelines, Health and Human Services Pain Management Best Practices Inter-Agency Task Force Report, National Committee for Quality Assurance (NCQA), Healthcare Effectiveness Data and Information Set (HEDIS), among others.

DEA, and HHS through the USDOJ prosecutes pharmacists that pursue these alternative treatments as computer algorithms classify these treatments as not medically necessary. HHS and DEA actively advocates with the State and Law

Enforcement to close the opioid and non-opioid channels of medical treatments for chronic pain. Defendants HHS and DEA advocate on behalf of the HFPP without demonstrating what alternative channels are best for the health, safety, and the general welfare of the population.

Despite Defendants HHS and DEA actions to greatly reduce the manufacturing and distribution of opioid and other controlled substance medications, there is a multi-year exponential rise in the deaths of U.S. Citizens. By removing necessary medications as already determined by the U.S. federal government to have benefits that exceed the risks, the Defendants HHS and DEA have violated international law under the Geneva Convention, and are preventing the utilization of medications by U.S. pharmacists to treat chronic pain and addiction diseases.

The private HFPP members have no absolute or qualified immunity. HFPP acted under the color of law, under the direction, control, and supervision of law enforcement as a government contractor and agent to reduce the supply of opioid medications and deny treatment of patients with controlled substances. HFPP has no immunity. Upon information and belief these algorithms were ratified by high level HFPP private insurer managerial employees and the Board of Directors and such conduct was unreasonable. Title 18, U.S.C., Section 241, provides criminal and civil sanctions for the violation of the Geneva Convention. A private entity

who voluntarily chooses to violate the Geneva Convention lacks any possible qualified or absolute immunity.

Title 18, U.S.C., Section 242 also prohibits the deprivation of Rights Under the Color of Law. HFPP members acted in whole or in part, under the direction, control, supervision of law enforcement via USDOJ. HFPP via its employees, and board of directors were private entities, working under the color of law, to violate the Geneva Convention.

Intervenor has standing as a medical professional and human being damaged by these violations of the Geneva Convention by Defendant DEA. In 1948, the Convention on the Prevention and Punishment of the Crime of Genocide defined genocide as "acts committed with the intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such." It also specified that these acts include not just killing but also attempted group destruction through "bodily or mental harm," impeding reproduction, harsh living conditions and child removal.

The U.N. remediation guidelines for mass human rights violations like genocide have some clear goals. These include safeguarding basic human rights of the offended group, investigating abuses and providing redress. Intervenor Clement's primary focus is on validating the thousands of Americans subjected to serial violations of their federal rights under color of law. In describing violations of their

rights via the Motion to Intervene, Clement attests to a persistent, national pattern of persecution which for innumerable Americans is torture proscribed by the International Covenant on Civil and Political Rights; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and The Universal Declaration of Human Rights.

Articles of the Covenant or Convention alleged to have been violated by Defendants DEA and HHS- International Covenant on Civil and Political Rights:

> Article 2, ¶3(a) and (b): 3. Each State Party to the present Covenant undertakes: (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity; (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
>
> Article 7: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

Article 14, ¶1.: 1. All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.

Article 17: 1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation. 2. Everyone has the right to the protection of the law against such interference or attacks.

Article 19: 1. Everyone shall have the right to hold opinions without interference. 2. Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice. 3. The exercise of the rights provided for in paragraph 2 of this article carries with it special duties and responsibilities. It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary: (a) For respect of the rights or reputations of others; (b) For the protection of national security or of public order (order public), or of public health or morals.

Article 26: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Articles of the Covenant or Convention alleged to have been violated by Defendants DEA and HHS- The Universal Declaration of Human Rights:

Article 5: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 7: All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8: Everyone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law.

Article 10: Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations and of any criminal charge against him.

Article 12: No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honor and reputation. Everyone has the right to the protection of the law against such interference or attacks.

Article 19: Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.

Article 29, ¶ (2): (2) In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

Clement argues that the apparent goals of persecution by the Defendants (which for some clearly amounts to mental torture) overlaying persistent, extreme U.S.

legal system abuse are as follows: 1. Disparage and discredit targets through legal process; 2. Intimidate and perhaps terminate witnesses and/or targets; 3. Neutralize and eventually preempt the target's access to courts; 4. Impoverish the targets; and, 5. Incarcerate the targets.

Clement argues that the Defendants violate Article 14, paragraph 1. of the ICCPR: All persons shall be equal before the courts and tribunals. In the determination of any criminal charge against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law. ICCPR, Art. 14, ¶1. Article 17 of the ICCPR provides: 1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honor and reputation. 2. Everyone has the right to the protection of the law against such interference or attacks. ICCPR, Art. 17 "Everyone shall have the right to hold opinions without interference." ICCPR, Art. 19, ¶1. This right is subject to restrictions, "but these shall only be such as are provided by law and are necessary: (a) For respect of the rights or reputations of others; (b) For the protection of national security or of public order (order public), or of public health or morals." ICCPR, Art. 19, ¶3 (a)-(b). "All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this

respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." ICCPR, Art. 26

Articles of the Covenant or Convention alleged to have been violated by Defendants DEA and HHS- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: Article 16, ¶1.: 1. Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article I, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

DEA and HHS data analytics and controlled substances conviction algorithms, induce the deliberate denial of diagnosis and treatment of patients who suffer from chronic pain or substance use disorders. The algorithms target old physicians or colored, non-white physicians. These USDOJ criminal forensic tools to create a "physician conviction engine" to cause the mass abandonment of sick patients are

violations of Human Rights Under Article 32 of the 1949 Geneva Convention IV. See *United States v. Karl Brandt*

The algorithms violate international law including, U.N. General Assembly Resolution 60/147 (Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations). Pursuant to Article 15 of the Rome Statute of the International Criminal Court, Intervenor Clement has discovered publicly available evidence probative of "Crimes against humanity" within the meaning of Article 7 in terms of "facilitating the commission of such a crime" and/or "contributing to the commission or attempted commission of such a crime by a group of persons acting with a common purpose" respectively within the meaning of Article 25, subparagraphs 3.(c) and (d). of said statute by Defendants DEA and HHS.

Clement is seeking additional evidence pursuant to FOIA to help sick patients receive medical treatment in compliance with Article 2, paragraph 3(a) and (b) of the International Covenant on Civil and Political Rights (ICCPR) which mandates effective domestic remedies for ICCPR violations under color of law and seek judicial relief of organized persecution and psychological torture attendant to organized legal system abuse by alleged violators through the literal weaponization of America's legal system against pharmacists. "Crimes against humanity" which

itself is a crime within jurisdiction of the International World Court, apparently "(f)or the purpose of facilitating the commission of such" crimes and/or "contributing to the commission or attempted commission of such (crimes) by a group of persons acting with a common purpose", both offenses within the respective meaning of Article 25, subparagraphs 3.(c) and (d). of the Rome Statute.

Public documents reveal that HHS, DEA, Qlarant, HFPP, Blue Cross Blue Shield may have committed "Crimes against humanity" within the meaning of Article 7 in terms of "facilitating the commission of patient abandonment" and/or "contributing to the commission or attempted commission of such a crime by a group of persons acting with a common purpose" respectively within the meaning of Article 25, subparagraphs 3.(c) and (d).

Clement is part of the group of U.S. pharmacists who treat patients suffering from chronic diseases whom are at imminent risk of losing life, liberty, and/or property as a direct and proximate result of mutual international treaty and U.S. federal law violations which may stem from one or more acts of treason as defined by the U.S. Constitution and expounded upon by the U.S. Supreme Court. Alternatively, there may be further violations that stem from one or more torts cognizable under the U.S. Federal Tort Claims Act. Persecution of pharmacists

through untested predictive criminal forensic tools is causing increased overdose deaths of U.S. citizens which are crimes against humanity.

Defective or untested criminal forensic tools may be intentionally corrupting the process by which one or more agents of U.S. government imply that our national government or one of its states has verified the veracity of evidence produced by these defective or untested HFPP or Qlarant criminal forensic tools. See, *U.S. v. Rudberg*, 122 F.3d 1199 The reckless actions of HHS, DEA, Qlarant, HFPP insurers and BCBSA are inducing via peaceful protest, national pain rallies where sick patients, the "People" being duly empowered to resist "any Form of Government . . . destructive" in the indicated manner of their lives, liberty, and/or property.

Sickly, U.S. citizen patients via peaceful protest are hereby wielding the right for themselves and as envoys for "the People to alter . . ." U.S. government such that they "seem most likely to effect Safety and Happiness" and that of our fellow countrymen and countrywomen as well as America's children. Clement seeks information pursuant to FOIA concerning the identification of past, present and future, pharmacists that are at imminent risk of losing life, liberty, and/or property as a direct and proximate result of America's confirmed violation of its ICCPR – specifically the treaty's Article 2, paragraph 3(a) and (b) which mandate effective

domestic remedies for ICCPR violations under color of law – and what may be the country's de facto policy of extending impunity to HFPP, Blue Cross Blue Shield or Qlarant for their role in persistent, organized U.S. legal system abuse.

America's International Covenant on Civil and Political Rights (ICCPR) requires good faith execution of all corresponding administrative, investigative, adjudicatory, and legislative processes anticipated by U.N. General Assembly Resolution 60/147 (Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations) on behalf of any and all American pharmacists or patients alleging to have endured organized U.S. legal system abuse facilitated by unchecked judicial misconduct as of 1990 A.D. or later, plus U.S. ratification of the First Optional Protocol to its ICCPR. Sick patients who can not achieve legal redress may be able to approach the U.N. Human Rights Council (UNHRCouncil) as a "class of Americans . . . who as of 1990 A.D. or later, exhausted all ostensible avenues of relief before the three (3) branches of U.S. federal government and appropriate state governments in seeking a fair and impartial redress of actual or reasonably perceived U.S. legal system abuse facilitated by unchecked regulatory capture by HFPP private insurers, and whose legal claims were respectively

thwarted primarily due to America's de facto policy of judicial impunity with regard to such allegations."

Clement requested additional information pursuant to FOIA is to identify possible regulatory capture or the conversion of United States adjudicatory as well as quasi-adjudicatory agencies and courtrooms to 'conclusively determine whether they themselves are corrupted; reduced to a charade at will; regularly re-purposed to serve a distinct, illicit end that it seems no lone voice or fleeting coalition can thwart through any lawful private citizen and/or government oversight no matter the dissenter's previous impact on public affairs' all of which may constitute ICCPR violations by the USA, specifically in violation of the International Law and the Treaty's Article 2, paragraph 3(a) and (b) which mandate effective domestic remedies for ICCPR violations under color of law.

Summary

Intervenor Clement believes that one or more of the parties to this HFPP agreement, committed acts that are themselves torts against pharmacists nationwide in pursuance of the agreement amongst the partnership. The HFPP Insurers are

private companies that are pervasively entwined with Qlarant, and General Dynamics Information Technology. Intervenor Clement needs the requested pertinent information to assist in his legal arguments against Defendant Drug Enforcement Agency in *Norman J. Clement vs. United States Drug Enforcement Administration*, CASE NO: 21-1262 UNITED STATES COURT OF APPEALS FOR DISTRICT OF COLUMBIA. Intervenor Clement desires information on the formal and informal business arrangements of the private companies with the government agencies DEA and HHS to protect his interests. Intervenor needs information regarding the utilization of algorithms as a criminal forensic tool by Health and Human Services and Drug Enforcement Agency as pertaining to the Pill Mill Doctor Project to protect his interest in his appeal in the USCA District of Columbia. Intervenor Clement requires all information pertaining to developed algorithms as a criminal forensic tool by USDOJ, Drug Enforcement Agency, Health and Human Services including all studies pertaining to the authentication and validation of the efficacy of these unique criminal forensic tools.

Criminal forensic tools that intentionally produces false results produces false legal proceedings via the legal doctrine of FALSUS IN UNO, FALSUS IN OMNIBUS, which are a threat to fair and impartial criminal tribunals. Intervenor is an interested health care pharmacist and therefore has standing to intervene by right and permission in Plaintiff's FOIA lawsuit.

Chronic pain patients nationwide have been protesting wholesale abandonment causing them to widely complain especially on social media of a persistent, national pattern of persecution and psychological torture imposed through U.S. legal system abuse, where pharmacists and their patients are: disparaged and discredited through legal process; intimidated for their passive grassroots activism through violence and/or threats of violence; denied the equal protection of law and corresponding access to courts; causing pharmacist impoverishment through questionable job losses, unwarranted black listings, and/or the questionable imposition/denial of fines, sanctions, and/or damages awards; via incarcerated under questionable circumstances. Nationwide previously incarcerated pharmacists uniformly express: procedural legal irregularities (particularly hearing request denials, untimely notice, and/or evidence tampering/destruction); one or more questionable departures from well-established legal precedent; undisclosed grounds for adverse credibility determinations; personal character disparagement; and total or substantial denial of relief through judicial activism, *i.e.*, an arguable usurpation of legislative powers; judicial proscriptions that are the functional, civil equivalent of *ex post facto* law; and/or total or substantial denial of relief pursuant to some form of Judicial Engineering.

Intervenor Clement as a pharmacist has the right or obligation to: (a) Take appropriate legislative and administrative and other appropriate measures to prevent

(these gross human rights) violations (b) Investigate (the alleged) violations effectively, promptly, thoroughly and impartially and, where appropriate, take action against those allegedly responsible in accordance with domestic and international law; (c) Provide those who claim to be victims of (these violations) with equal and effective access to justice irrespective of who may ultimately be the bearer of responsibility for the violation; and (d) assist with providing effective remedies to victims, including reparation.

Recurrences of discriminatory violations should be prevented, and responsible parties should be brought to justice. Intervenor Clement intervention in the FOIA litigation will help intervenor obtain his goals. Judicial relief should not be contingent on the wealth, celebrity, and/or political clout of targeted offenders or their victims. The Intervenor, Norman Clement respectfully requests the Court to GRANT Intervenor's request pursuant to Intervention by Right and Permission.

Respectfully Submitted,
/s/ *Norman Clement*
Norman Clement Date 2/15/2022
prontopharmacy@aol.com

Certificate of Service

Norman Clement hereby certify that on the date set forth below a copy of the foregoing was filed with clerk of courts. Notice of this filing will be sent to all parties by email or by regular mail.

Douglas C. Dreier, Esquire

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/s/ *Norman Clement*

Norman Clement

prontopharmacy@aol.com

2/15/2022

Date

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Neil Anand, et al.,	:	
	:	**CASE NO. 21-1635-CKK**
Plaintiff,		
Norman Clement,		
Intervenor	:	
v.	:	
	:	
U.S. Department of Health and	:	
Human Services et al.,	:	
Defendant.	:	
	:	

ORDER

AND NOW, this day of ___ , _____2022, upon consideration of the Motion

To Intervene as Plaintiff ("Motion"), filed by Intervenor, Norman Clement, it is hereby **ORDERED** that the Motion is **GRANTED**.

BY THE COURT:

_____

The Hon. Colleen Kollar-Kotelly