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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

NOTICE OF MOTION AND MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **NOTICE OF MOTION AND MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: TBD (Dkt. No. 129) Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **NOTICE OF MOTION AND MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: TBD (Dkt. No. 129) Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **NOTICE OF MOTION AND MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: TBD (Dkt. No. 129) Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

NOTICE OF MOTION AND MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

NOTICE OF MOTION AND MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

NOTICE OF MOTION AND MOTION

TO THE COURT, ALL PARTIES, AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE that, as convenient to the Court pursuant to the Court's scheduling order, Dkt. No. 129 at 2, in the courtroom of the Honorable Edward M. Chen (Courtroom 5) of the above-entitled Court, located at 450 Golden Gate Avenue, San Francisco, California 94102, Kaiser Foundation Health Plan, Inc. ("KFHP") and The Permanente Medical Group, Inc. ("TPMG") (collectively, "Defendants") will and hereby do move this Court to dismiss Relator Rhonda Osinek's First Amended Complaint ("FAC"), Dkt. No. 87, under Federal Rule of Civil Procedure 12(b)(6).

Defendants bring this Motion on the grounds that Osinek's False Claims Act ("FCA") claim fails because she fails to allege falsity, knowledge, and materiality. All three are required elements of any FCA claim, so the failure to allege even one of the three warrants dismissal. Additionally, any claims against newly named Defendants KFHP and TPMG that predate October 7, 2011 run afoul of the FCA's statute of repose and must be dismissed as untimely. Finally, Kaiser Permanente is not a legal entity and Osinek cannot maintain any claims against it; the Court should dismiss allegations against Kaiser Permanente not only under Rule 12(b)(6), but also Rules 12(b)(1), 12(b)(4), and 12(b)(5).

The Motion is based on this Notice of Motion, the accompanying Memorandum of Points and Authorities, any reply memorandum, and such other written and oral argument as may be presented to the Court.

Dated: June 21, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Relator Ronda Osinek first filed her *qui tam* complaint in 2013, giving her over eight years to refine her allegations and plead a False Claims Act ("FCA") violation. Her First Amended Complaint ("FAC") not only fails to state a claim but supports an obvious alternative explanation: that Defendants Kaiser Foundation Health Plan, Inc. ("KFHP") and The Permanente Medical Group, Inc. ("TPMG") (together, "Defendants")[1] acted rationally and competitively in diagnosing true and existing medical conditions of Medicare Advantage members.[2] The crux of Osinek's FAC is that Defendants used various business practices to ensure healthcare providers diagnosed and documented Medicare Advantage members' medical conditions so that Defendants could be appropriately compensated for those members' future healthcare expenditures—exactly what the U.S. Centers for Medicare and Medicaid Services ("CMS") expects and encourages health plans to do. Osinek alleges these practices were part of a "sophisticated scheme" that she calls "upcoding," *see* FAC (Dkt. No. 87) ¶ 2, but critically, Osinek ***does not allege that any healthcare providers documented false or nonexistent diagnoses*** because of these practices. Nor does she allege that Defendants submitted risk-adjustment data to CMS containing false or nonexistent diagnoses. Because her allegations are consistent with lawful, reasonable business strategy, Osinek fails to plead falsity—the "sine qua non" of an FCA violation—under either the plausibility standard of Federal Rule of Civil Procedure 8 or the heightened particularity requirements of Rule 9(b).

---

[1] The FAC also names "Kaiser Permanente" as a defendant, but "Kaiser Permanente" is not a legal entity. *See* Req. for Judicial Notice in Supp. of Mot. to Dismiss Pursuant to False Claims Act's First-to-File Bar (Dkt. 142) at 4–5, Ex. F. It is a trade name that refers to the nationwide collaboration among nonprofit health plans, nonprofit hospitals, and provider-directed medical groups to render healthcare services to their members, including millions of Medicare Advantage members. *See United States ex rel. Taylor v. Kaiser Permanente*, Case No. 3:21-cv-03894-EMC (N.D. Cal.), Dkt. No. 1 ¶¶ 16–17.

[2] "Members" refers to the individual Medicare beneficiaries who are enrolled in the Medicare Advantage program and receive their healthcare coverage through a private insurer known as a Medicare Advantage Organization. Members become patients when they receive medical care covered by the Medicare Advantage program. Thus, for purposes of this Motion, the terms "members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

The FAC likewise contains no factual allegations whatsoever about Defendants' knowledge that false claims were submitted to CMS or Defendants' reckless disregard or deliberate indifference to that risk—another essential element of an FCA claim. Osinek's conclusory recitations that Defendants "knowingly presented or caused to be presented" false claims and "knowingly made, used, or caused to be made or used, false records or statements," *see* FAC ¶¶ 46, 49, do not satisfy Rule 8. Osinek also fails to allege that Defendants submitted any false claims that were "material" to CMS's decision to reimburse Defendants. The materiality standard is demanding, yet Osinek alleges no more than the conclusory allegation that "Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims." *Id.* ¶ 49. This is not enough. Osinek's failure to allege falsity, scienter, and materiality requires dismissal of the FAC in its entirety.

The FAC contains other defects requiring dismissal. It purports to hold two newly named defendants, TPMG and KFHP, liable for alleged misconduct dating back to 2007, but the FCA's exception-free statute of repose prohibits any claims occurring ten years before Osinek filed the FAC. Accordingly, the Court should dismiss all claims against TPMG and KFHP before October 7, 2011. The Court also should dismiss non-entity defendant "Kaiser Permanente" with prejudice. "Kaiser Permanente" is not a legal entity and therefore is not subject to suit or service.

For these reasons, the Court should grant Defendants' Motion and dismiss the FAC.

II. BACKGROUND

A. The Medicare Advantage Program

Medicare is a federal health insurance program for older adults and individuals with disabilities. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 872 (D.C. Cir. 2021). CMS, an agency within the U.S. Department of Health and Human Services, administers the Medicare program. *Id.* Traditional Medicare consists of Medicare Part A, which covers inpatient hospital care, and Medicare Part B, which covers outpatient medical care. *Id.* CMS also administers Medicare Part C, now known as Medicare Advantage, through which Medicare Advantage beneficiaries elect to receive healthcare coverage from private insurers known as Medicare Advantage Organizations ("MAOs"). *Id.*

Under traditional Medicare, CMS compensates healthcare providers directly for all services rendered to Medicare beneficiaries. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under the Medicare Advantage program, however, private health insurance plans "provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage." *Becerra*, 16 F.4th at 872. CMS determines this flat monthly rate through an annual bidding process, and then CMS applies a risk-adjustment payment model, which adjusts the payment rate based on various demographic and health factors that can affect healthcare expenses, including age, gender, and medical diagnoses. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).

Healthcare providers typically record member diagnoses after member visits using "diagnosis codes" and send those codes to the members' Medicare Advantage plans. *Silingo*, 904 F.3d at 672; *see also* 42 U.S.C. § 1395w-23(a)(1)(C)(i). The plans then report the codes to CMS, which uses them to calculate payment rates for each Medicare Advantage member. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i). CMS compensates Medicare Advantage plans based on only those medical conditions diagnosed in the previous payment year, *Silingo*, 904 F.3d at 672, meaning diagnoses for chronic medical conditions that never resolve must be submitted anew each year.

CMS's risk-adjustment payment model groups diagnosis codes into Hierarchical Condition Categories ("HCCs"). *Id.* Each HCC is assigned a different "relative factor," which corresponds to that HCC's relative effect on the payment amount to the Medicare Advantage plan. *Becerra*, 16 F.4th at 874–75. During the period at issue, CMS determined the relative factors for each HCC through its statistical analysis of the average costs of treating members with those reported conditions in traditional Medicare. *Id.* Because the relative factors differ among HCCs, some HCCs have a larger effect on the payment amount to Medicare Advantage plans. *Id.* CMS uses the relative factors associated with each HCC applicable to a given Medicare Advantage member to calculate what it calls a "risk score," and this risk score is then used to compute the risk adjustment to the flat monthly payment for that member. *Id.*

The D.C. Circuit recently offered this example of how the HCC payment model works: "a 72-year-old woman living . . . with diabetes without complications (relative factor 0.118), and

multiple sclerosis (relative factor 0.556)" has a particular risk score keyed to her age, gender, other demographic factors, and medical diagnoses. *Id.* at 875. Both medical conditions raised her risk score by a "relative factor," but multiple sclerosis resulted in a higher increase in that score because CMS had previously determined that treating that condition costs the traditional Medicare program more than treating ordinary diabetes without complications. *See id.* In other words, under the HCC payment model, some medical conditions will result in higher risk scores and, in turn, higher CMS payments to Medicare Advantage plans because those conditions are associated with comparatively higher average medical costs than other conditions.

Given the structure of the HCC payment model, CMS has recognized that it is natural—indeed, expected—that MAOs and healthcare providers will attempt to code as many HCC-qualifying diagnoses as possible. CMS has explained that diagnosis coders in the Medicare Advantage context "should be aware of the background and prospective nature of the [risk-adjustment] payment process including its basis on chronic conditions, and dependence on validating chronic medical conditions for an annual payment on just the review of one record." Dkt. No. 150 at 10 (quoting *CMS 2014 RADV Reviewer Guidance* at 5 (May 8, 2014)). CMS has said that it is "***imperative therefore to code all chronic [medical] conditions*** documented by an acceptable provider type during a face to face encounter with the patient, whether or not there was specific treatment mentioned in the one record submitted." *Id.* at 10–11 (emphasis added). As a general matter, "CMS has acknowledged that there is nothing 'inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize [the] Medicare payment that is supported by documentation in the medical record.'" *Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 n.4 (9th Cir. 2021).

B. Osinek's Allegations

Osinek, a medical coder, worked for TPMG in the San Rafael facility as a Data Quality Trainer and Audit Manager from 2006 to 2014. *See* FAC ¶¶ 5, 25. She alleges that beginning "[i]n or about 2007," Defendants "defrauded the United States through a sophisticated scheme to upcode diagnoses to ensure Medicare [Advantage] payments for reimbursable, high-value conditions." *Id.* ¶¶ 2, 26. Like her original *qui tam* complaint, Osinek's FAC articulates a

number of documentation and coding business practices that she alleges resulted in "upcoding." Osinek describes "upcoding" as using diagnosis codes to make Defendants' Medicare Advantage members "appear less healthy than they actually are." *Id.* ¶ 27. This conclusory description is not supported by Osinek's allegations about Defendants' purportedly fraudulent business practices, as explained below.

The FAC describes various business practices that Defendants allegedly used to carry out this fraudulent "upcoding" scheme:

Data Mining. The FAC alleges that around 2007, Defendants initiated a "data mining" program. *Id.* ¶ 26. Through data mining, Defendants allegedly attempted to isolate "high value" HCCs and "began using a system to capture 'missed opportunities'" to help ensure that risk-adjusting diagnoses "[we]re brought to the attention" of Defendants' healthcare providers and documented in the medical record. *Id.* ¶¶ 26–27. According to Osinek, Defendants used a "variety of algorithms" to identify these "missed opportunities"—that is, medical conditions supported by members' medical records that a healthcare provider could have recorded at an encounter but did not. *Id.* According to Osinek, Defendants targeted specific "high value" medical conditions through data mining in order to "maximize [Defendants'] reimbursement from Medicare [Advantage] and increase [their] revenue." *Id.* ¶ 27. Wholly absent from Osinek's data mining allegations, however, is any allegation that data mining resulted in a single diagnosis that did not reflect a true and existing medical condition.

Refresh. Since CMS compensates Medicare Advantage plans based on medical conditions diagnosed in the previous payment year, plans must record and report members' chronic medical conditions anew each year. Osinek refers to Defendants' initiatives to annually identify and re-diagnose chronic medical conditions as "refresh." *Id.* ¶¶ 26, 35, 39. Similar to her allegations about data mining, Osinek alleges that Defendants "prompted" healthcare providers to add identified "refresh" conditions to members' medical records. *Id.* ¶¶ 32, 35. Osinek contends that Defendants were able to "increase [their] billings for high value" medical conditions through refresh practices. *Id.* ¶ 26. But Osinek does not allege that any "refreshed" diagnoses were made for medical conditions that Defendants' members did not actually have.

Addenda. Osinek also alleges that Defendants upcoded members' diagnoses by creating "addenda," which she describes as "supplemental documentation" to the medical record "to amend, correct, or enter documentation related to an encounter." *Id.* ¶¶ 22, 30. According to Osinek, healthcare providers generally enter documentation into the medical record at the time of the member encounter or shortly after. *Id.* ¶ 22. She concedes, however, that CMS recognizes that medical record documentation may need to be amended via addenda. *Id.* She nevertheless contends that Defendants directed their healthcare providers to "systematically addend [members'] records retroactively—often many months after [member] visits," including by addending medical records "with supporting statements or documentation that were not addressed at the time of an encounter." *Id.* ¶ 30. Tellingly, Osinek never alleges that any addenda contained diagnoses that did not reflect members' true and existing medical conditions.

Boilerplate Phrases. Osinek alleges that Defendants supplied "boilerplate phrases" to "justify" healthcare providers' additions to the medical record. *Id.* ¶¶ 30, 34. According to Osinek, Defendants encouraged the use of boilerplate phrases to "give CMS the impression that the [healthcare provider] thought about the addenda and want[ed] to comply with Medicare [Advantage] instructions for amendments and corrections." *Id.* Osinek does not allege, however, that any addenda purportedly "justified" by a "boilerplate phrase" contained inaccurate or unsupported diagnoses.

Pressure to Diagnose Risk-Adjusting Medical Conditions. The FAC describes a number of practices purportedly designed to "pressure" healthcare providers to diagnose risk-adjusting medical conditions. *Id.* ¶¶ 35, 37–40. For example, Osinek alleges that Defendants instituted an "escalation process for [healthcare providers] who do not agree with the data mining prompts," requiring them to meet "one-on-one" with Defendants' staff. *Id.* ¶ 35. She also alleges that Defendants issued "personal report cards" that assessed "how [a healthcare provider] respond[ed] to refreshing and data mining prompts." *Id.* ¶ 36. The FAC also describes "coding parties," events where healthcare providers allegedly were "gathered in a single room with computers and asked to review past progress notes for addenda." *Id.* ¶ 37. Each of these allegations, however, stops short of alleging that the practice resulted in any false or unsupported diagnoses.

Guidance and Policies. Finally, Osinek alleges that Defendants implemented guidance and policies aimed at targeting "high value" HCCs. *Id.* ¶¶ 29, 32. She claims that Defendants "tell[]" healthcare providers "to change diagnoses to upcode to higher value and more complicated" medical conditions, *id.* ¶ 32, or "to change coding practices to reflect new reimbursable" HCCs, *id.* ¶ 29. But Osinek does not allege that Defendants instructed healthcare providers to diagnose false or unsupported medical conditions.

C. Procedural History

Osinek filed her *qui tam* complaint, under seal, on August 22, 2013. Her complaint named "Kaiser Permanente" as the sole defendant. Compl. (Dkt. No. 1) ¶ 6. After Osinek filed her complaint, additional relators filed five more *qui tam* complaints against various Kaiser-affiliated entities.[3] On May 5, 2022 the Court granted in part Defendants' Motion to Dismiss Pursuant to the False Claims Act's First-to-File Bar, resulting in the complete dismissal of the *Arefi*, *Stein*, and *Bicocca qui tam* actions and the partial dismissal of the *Taylor* and *Bryant qui tam* actions. Dkt. No. 171; *see also* Dkt. No. 141.

After the United States intervened, Osinek filed the FAC on October 7, 2021. The FAC still named "Kaiser Permanente" as a defendant and also added TPMG and KFHP as defendants. FAC ¶¶ 6–8. Osinek brings two claims under the FCA—one for knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval under 31 U.S.C. § 3729(a)(1)(A), *see id.* ¶¶ 45–47, and one for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim under 31 U.S.C. § 3729(a)(1)(B), *see id.* ¶¶ 48–50.

III. LEGAL STANDARD

To survive dismissal under Rule 12(b)(6), Osinek's complaint must "state a claim to relief

[3] *See United States ex rel. Taylor v. Kaiser Permanente*, Case No. 3:21-cv-03894-EMC, Dkt. No. 1; *United States ex rel. Arefi, et al. v. Kaiser Foundation Health Plan, et al.*, Case No. 3:16-cv-01558-EMC, Dkt. No. 1; *United States ex rel. Stein, et al. v. Kaiser Foundation Health Plan, et al.*, Case No. 3:16-cv-05337-EMC, Dkt. No. 1; *United States ex rel. Bryant, et al. v. Kaiser Permanente, et al.*, Case No. 3:18-cv-01347-EMC, Dkt. No. 1; *United States ex rel. Bicocca v. Permanente Medical Group, Inc., et al.*, Case No. 3:21-cv-03124-EMC, Dkt. No. 1.

that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). This standard requires "more than a sheer possibility" that Defendants have acted unlawfully—Osinek must plead "factual content that allows the court to draw the reasonable inference that [Defendants] [are] liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). In evaluating plausibility, "courts must also consider an 'obvious alternative explanation' for [the] defendant's behavior." *Eclectic Props. E., LLC v. Marcus & Millichap Co.*, 751 F.3d 990, 996 (9th Cir. 2014) (quoting *Iqbal*, 556 U.S. at 682). Dismissal is proper where there is a "lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1990). While well pleaded facts can be accepted as true, the Court need not "assume the truth of legal conclusions merely because they are cast in the form of factual allegations." *Fayer v. Vaughn*, 649 F.3d 1061, 1064 (9th Cir. 2011).

Osinek's fraud allegations also must comply with the heightened pleading standard of Rule 9(b), which requires a party to "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). The allegations must be "specific enough to give [Defendants] notice of the particular misconduct which is alleged to constitute the fraud so that [Defendants] can defend [themselves] against the charge and not just deny that [they have] done anything wrong." *Bly-Magee v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001). To meet this standard, Osinek must state with particularity "the who, what, when, where, and how of the misconduct charged," as well as "set forth what is false or misleading about a statement, and why it is false." *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010). And while knowledge can be alleged generally in the pleadings, an FCA plaintiff must identify some "facts" that "support [the] conclusory allegation that defendants knowingly submitted false claims." *United States ex rel. Modglin v. DJO Glob. Inc.*, 48 F. Supp. 3d 1362, 1406 (C.D. Cal. 2014) (holding that the "allegation in the complaint that defendants 'knew that they were falsely and/or fraudulently claiming reimbursement' is too conclusory to plead a plausible claim for relief under Rule 8(a), *Iqbal*, and *Twombly*"), *aff'd sub nom. United States v. DJO Glob., Inc.*, 678 F. App'x 594 (9th Cir. 2017).

IV. ARGUMENT

The FAC must be dismissed because Osinek fails to state an FCA claim. To state an FCA claim, Osinek must allege several elements: (1) the existence of a false claim; (2) that any such claim caused and was "material" to the government's decision to pay; and (3) that any such claim was submitted "knowingly." 31 U.S.C. §§ 3729(a)(1)(A)–(B). She fails to allege all three elements, and the FAC suffers additional defects:

First, despite its attention to a number of business practices purportedly designed to "upcode" diagnoses, the FAC stops short of alleging that any of these practices actually led to the diagnosis of medical conditions that Defendants' members did not have. Nor does Osinek allege that any of these practices resulted in the submission of risk-adjustment data to CMS that contained falsified or nonexistent diagnoses. Having failed to plead the "what" of the alleged fraud, Osinek further fails to plead the "who," "when," "where," and "how" as required by Rule 9(b).

Second, Osinek fails to sufficiently plead knowledge. Absent plausible allegations of falsity, Osinek cannot demonstrate that Defendants knowingly submitted any false claims. And even setting aside this defect, the FAC is devoid of any facts that could be read to suggest knowledge, instead relying on conclusory statements that do not meet the plausibility standard.

Third, Osinek fails to allege materiality. The Supreme Court made clear in *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 194 (2016), that the "materiality standard is demanding." Materiality "cannot be found where noncompliance is minor or insubstantial," and the standard for pleading facts sufficient to support allegations of materiality "is a familiar and rigorous one." *Id.* at 194, 195 n.6. Yet despite having had the opportunity to amend her allegations after the Supreme Court's *Escobar* decision and in light of its teachings, Osinek is silent on what CMS would have done had it been aware of her allegations.

Fourth, the FCA's statute of repose bars any claims against previously unnamed TPMG and KFHP occurring more than ten years before Osinek filed the FAC. To the extent Osinek seeks to hold Defendants liable for purported misconduct occurring before October 7, 2011, those claims must be dismissed.

Fifth, the FAC still names the nonexistent "Kaiser Permanente" as a defendant. Because "Kaiser Permanente" is not a legal entity, it cannot be sued and has not been served, and any claims against it must be dismissed.

A. Osinek Fails To Allege Falsity

The "sine qua non" of an FCA violation is a *false* claim for payment. *United States ex rel. Aflatooni v. Kitsap Physicians Serv.*, 314 F.3d 995, 1002 (9th Cir. 2002). "The FCA does not define false. Rather, courts decide whether a claim is false or fraudulent by determining whether a defendant's representations are accurate in light of applicable law." *United States v. Bourseau*, 531 F.3d 1159, 1164 (9th Cir. 2008). Because FCA claims are subject to Rule 9(b), the falsity allegations must give a defendant "notice of the particular misconduct which is alleged to constitute the fraud charged" and "supply reasonable indicia that false claims were actually submitted." *Ebeid*, 616 F.3d at 999.

"The FCA recognizes two types of actionable claims—factually false claims and legally false claims." *United States ex rel. Conner v. Salina Reg'l Health Ctr., Inc.*, 543 F.3d 1211, 1217 (10th Cir. 2008), *abrogated on other grounds by Escobar*, 579 U.S. 176. A factually false claim is one where "the claim for payment is itself literally false or fraudulent." *United States ex rel. Hendow v. Univ. of Phoenix*, 461 F.3d 1166, 1170 (9th Cir. 2006). Such may be the case where a defendant submits "an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided." *Mikes v. Straus*, 274 F.3d 687, 697 (2d Cir. 2001), *abrogated on other grounds by Escobar*, 579 U.S. 176. Conversely, a legally false claim occurs "when the claimant knowingly falsely certifies that it has complied with a statute or regulation the compliance with which is a condition for Government payment." *United States ex rel. Wilkins v. United Health Grp., Inc.*, 659 F.3d 295, 305 (3d Cir. 2011).

The FAC relies on a theory of factual falsity. As noted, both Osinek's original complaint and the FAC focus on various practices leading to "upcoding," which Osinek defines as "changes made over time in the diagnosis codes that make [Defendants' members] appear less healthy than they actually are," FAC ¶ 27—in other words, the submission of factually false diagnosis codes that document nonexistent conditions. But beyond the conclusory assertion that "upcoding" made

members "appear less healthy" than they are, ***she does not allege*** with particularity that any healthcare providers diagnosed medical conditions that did not exist, or that Defendants submitted diagnosis code data to CMS with false or nonexistent diagnoses. Instead, her allegations are consistent with a lawful, rational strategy to accurately code all medical conditions for Defendants' Medicare Advantage members. Osinek's allegations further fail to meet the particularity requirement of Rule 9(b).

1. The FAC Does Not Plausibly Plead Any False Claims

Osinek devotes the majority of the FAC to describing various business practices that reflect an appropriate and rational response to CMS's risk-adjustment model. Although she contends the alleged practices amounted to a "sophisticated scheme to upcode diagnoses to ensure Medicare [Advantaged] payments for reimbursable, high-value conditions," *id.* ¶ 2, none of the practices she describes plausibly suggests healthcare providers ever diagnosed inaccurate or nonexistent medical conditions, let alone that Defendants knowingly submitted diagnosis codes to CMS for medical conditions that Defendants' members did not in fact have. To the contrary, each of the business practices Osinek challenges in the FAC is consistent with lawful conduct designed to diagnose and document members' medical conditions to accurately and completely account for the financial risk that any given member might incur in future healthcare expenditures.

This "obvious alternative explanation" for Defendants' behavior dooms Osinek's theory of factual falsity. *See Integra*, 854 F. App'x at 844–45; *Cafasso, United States ex rel. v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1057 (9th Cir. 2011) ("In light of [relator's] failure to identify any particular false claims or their attendant circumstances, as well as the 'obvious alternative explanation' that no false claims occurred, we will not draw the unwarranted and implausible inference that discovery will reveal evidence of such false claims."). *Integra* is instructive. There, the relator brought an FCA action alleging that Providence and its affiliated hospitals submitted Medicare claims for certain diagnoses at a higher rate than comparable institutions, that the rate was not the result of chance or differences in patient outcomes, and that Providence used "tips" and "queries" to incentivize healthcare providers to incorporate language

in medical record documentation "conducive to coding higher-paying . . . diagnoses." 854 F. App'x at 844. But the Ninth Circuit could not "accept the conclusion that these allegations resulted from fraud or that doctors reported unsupported medical conditions." *Id.* The relator offered "only a *possible* explanation—that doctors lied about underlying medical conditions—to explain a statistical trend." *Id.* (emphasis in original). The relator failed to "rule out" the "plausible alternative (and legal) explanation" that Providence was "ahead of others in its industry" in Medicare coding and billing. *Id.* at 844. The Ninth Circuit noted that it "need not accept the conclusion that the defendant engaged in unlawful conduct when [the defendant's] actions are in line with lawful 'rational and competitive business strategy.'" *Id.* at 845 (quoting *Twombly*, 550 U.S. at 554). Accordingly, it reversed the district court's denial of Providence's motion to dismiss. *Id.*

Here, Osinek's explanation for Defendants' behavior is the same as the relator's in *Integra*—"that doctors lied about underlying medical conditions." *Id.* at 844; *see also* FAC ¶ 27. Even if that were "possible," it is not "plausible." 854 F. App'x at 844. And unlike the relator in *Integra*, Osinek does not even allege that Defendants submitted claims for particular diagnoses at a higher rate than other MAOs. Again, as noted above, CMS has recognized that there is nothing "'inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.'" *Id.* at 844 n.4. All of the business practices Osinek alleges are consistent with a lawful, rational strategy to code Medicare Advantage members' medical conditions and fail to plausibly plead falsity under Rule 8:

Data Mining and Refresh. Though the FAC does not precisely define what Osinek means by "data mining" or "refresh," the allegations are clear that neither practice resulted in the diagnosis of medical conditions that Defendants' members did not actually have. For example, Osinek alleges that through data mining and refresh, Defendants "used a variety of algorithms to identify" certain medical conditions and then "brought [those medical conditions] to the attention of [healthcare providers] to ensure that all possible Medicare [Advantage] billing opportunities [we]re captured." FAC ¶¶ 26, 27. But Osinek does ***not*** allege that Defendants or any healthcare

provider ever documented or diagnosed false or nonexistent medical conditions because of the data mining or refresh programs. As Osinek even points out, the "consequence" of these programs is that healthcare providers took "into consideration HCCs and the Medicare [Advantage] payment system when coding and recording [member] encounters." *Id.* ¶ 28. Taking the realities of the risk-adjustment model into consideration is ***not*** the same as diagnosing fake or nonexistent medical conditions; rather, it is exactly what CMS has said it expects healthcare providers to do. *See supra* at Part II.A.

Addenda. Like the data mining and refresh allegations, Osinek's addenda allegations do not suggest factual falsity. Osinek contends that Defendants' healthcare providers addended medical records with medical conditions that "were not addressed at the time of the [member] encounter," were based on a member's "previous test results," or were added "many months after [member] visits." FAC ¶¶ 30–31. She further alleges that Defendants encouraged addenda by "prompt[ing]" healthcare providers to "change diagnoses to upcode to higher value and more complicated forms of diseases," sometimes "without proper support (i.e., not a true causal connection)."[4] *Id.* ¶¶ 32–33. Those allegations do not plausibly point to false or nonexistent diagnoses. To the contrary, the only reasonable inference from Osinek's allegation that healthcare providers made medical record addenda based on "previous test results" or to include

[4] The only example of upcoding to "higher value" conditions that Osinek provides is that Defendants "prompted [healthcare providers] to addend diabetes diagnoses to include hyperlipidemia as a complication where tests or records reflected hyperlipidemia[,] regardless of whether the hyperlipidemia was actually *due to* diabetes." *Id.* ¶ 32 (emphasis in original). But nowhere does she allege that any healthcare provider ever recorded a hyperlipidemia complication diagnosis when the member did not have such a diagnosis. Further highlighting this deficiency is the image of an addended medical record included with the FAC's hyperlipidemia allegations. This medical record shows that the member *in fact had both* diabetes *and* mixed hyperlipidemia: "The previous note reflects that I evaluated the patient who has the diagnosis of dm2 with mixed hyperlipidemia as evidence[d] by tg 210 on 11-8-05, ldl 134 on 6-5-01." *Id.*

Similarly, Osinek provides two examples of addenda that she claims were made "without proper support," but she does not explain what she means by this charge. *See id.* ¶ 33. Nor does she allege that either patient did not in fact have the medical condition reflected in the addenda. Indeed, the second addendum, which changed a diagnosis of diabetic nephropathy to diabetic chronic kidney disease, explicitly contradicts any such charge, as the addenda notes that the change was made "because the latter is more appropriate for [the member's] condition." *Id.*

"higher value" diagnoses is that the members in fact had the medical conditions that were added to the medical record. *Id*. The same is true for purportedly "late" addenda made "months" after the member visit—Osinek does not allege that any such addenda were false or inaccurate, and a plausible alternative explanation is that the healthcare provider made a truthful and accurate addendum.

Boilerplate Phrases. Osinek's allegation that Defendants created "boilerplate phrases" or "cloned" language to help their healthcare providers "justify" addenda also does not suggest falsity because she does not allege that any such language included inaccurate or nonexistent diagnoses. *Id.* ¶¶ 30, 34. And Osinek's contention that healthcare providers are "expected to use these phrases rather than their own language and discretion based on what they recall from visits," *id.* ¶ 34, also stops short of alleging that any boilerplate language included diagnoses known or believed to be false, or that the use of boilerplate language somehow resulted in the documentation of inaccurate or nonexistent conditions. These allegations, instead, are consistent with a reasonable business practice of offering healthcare providers tools to efficiently and accurately update medical records.

Pressure to Diagnose Risk-Adjusting Medical Conditions. The practices allegedly showing that Defendants "pressured" healthcare providers to addend diagnoses, *id.* ¶¶ 35–41, likewise reflect reasonable business incentives. Osinek asserts, for example, that Defendants issued "report cards" to healthcare providers tracking their responses to data mining and refresh prompts, and that healthcare providers were subject to an "escalation process" to resolve disagreements about data mining prompts. *Id.* ¶¶ 35–36. Tellingly, Osinek does not allege any metric for these "report cards"—for example, whether healthcare providers were given credit for responding to a prompt regardless whether they diagnosed the condition or rejected the prompt—nor does she allege that healthcare providers who continued to disagree with a prompt after an "escalation" meeting faced any consequences. Osinek further alleges that Defendants rewarded healthcare providers with high refresh rates, held "coding parties" to facilitate addenda, pitted regions and affiliated medical facilities in competition against one another, and tied facilities' funding allocations to data mining and refresh rates. *Id.* ¶¶ 37–41. But again, these allegations

do not suggest that healthcare providers diagnosed or documented conditions that patients did not have, or that Defendants submitted risk-adjustment data to CMS with false diagnoses. Instead, they merely show that healthcare providers and facilities were evaluated on and incentivized by their responses to data mining and refresh prompts, and that certain healthcare providers addended records on specific dates.

Guidance and Policies. Finally, Osinek's allegation that Defendants "told" healthcare providers to focus on higher-value medical conditions does not demonstrate falsity. As one example, she alleges that Defendants "told [healthcare providers] to diagnose chronic kidney disease instead of the lower value nephritis or nephropathy," and she cites a chart that purports to show an increase in chronic kidney disease diagnoses accompanied by a simultaneous decrease in nephropathy diagnoses. *Id.* ¶ 28. But these allegations merely show a shift in diagnoses over a two-year period; they do not suggest that any chronic kidney disease diagnoses were clinically unsupported or were medical conditions that Defendants' members did not actually have. And the vague, conclusory assertion that Defendants "told" healthcare providers to diagnose chronic kidney disease, without any detail about the content of the actual instruction or guidance, does not show that Defendants encouraged healthcare providers to diagnose the condition absent clinical support. Similarly, Osinek's allegation that Defendants tell healthcare providers "to change coding practices to reflect new reimbursable" HCCs when "CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare [Advantage])" does not establish falsity. *Id.* ¶ 29. This allegation, again, stops short of suggesting that healthcare providers diagnosed invented or nonexistent conditions. Instead, the allegation shows only that Defendants communicated CMS reimbursement rules to healthcare providers to ensure that members' medical conditions were appropriately documented.

2. Osinek's Falsity Allegations Fail To Meet Rule 9(b)

Not one of Osinek's allegations about the purported "upcoding" scheme suggests that Defendants' healthcare providers diagnosed medical conditions members did not have, let alone that Defendants instituted these practices as part of a fraudulent scheme to submit risk-adjustment data to CMS containing false diagnoses. But even if Osinek had pleaded such facts, her

allegations still would fail to satisfy Rule 9(b).

Under Rule 9(b)'s exacting standard, Osinek must state with particularity the circumstances constituting the alleged fraud, including "the who, what, when, where, and how of the misconduct charged." *Ebeid*, 616 F.3d at 998. This includes alleging "what is false or misleading about a statement, and why it is false." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) ("*Swoben*"). As set forth above, the FAC does not plausibly plead the "what"—that is, the existence of any false claims—because Osinek's allegations are consistent with lawful, rational, and competitive business conduct. *See Integra*, 854 F. App'x at 845 (quoting *Twombly*, 550 U.S. at 554) (courts "need not accept the conclusion that the defendant engaged in unlawful conduct when its actions are in line with lawful 'rational and competitive business strategy'").

Under Rule 9(b), the FAC also does not identify ***who*** at Defendants designed any of the various "upcoding" practices or supposedly orchestrated the scheme; it does not state ***when*** the scheme began (aside from the vague allegation that "[i]n or about 2007, there was a shift in the interactions with doctors and the management," *see* FAC ¶ 26); it does not allege ***which specific medical groups*** purportedly engaged in the fraudulent practices; and it does not explain ***how*** Defendants purportedly submitted risk-adjustment data to CMS containing false diagnoses. These deficiencies warrant dismissal under Rule 9(b), in addition to Rule 8.

Finally, Osinek fails to allege with particularity who at Defendants was involved in the submission of allegedly false claims. Rule 9(b) does not permit a relator to "lump multiple defendants together," but rather requires relators to "differentiate their allegations when suing more than one defendant and inform each defendant separately of the allegations surrounding his alleged participation in the fraud." *Swoben*, 848 F.3d at 1184 (quoting *United States ex rel. Lee v. Corinthian Colls.*, 655 F.3d 984, 997–98 (9th Cir. 2011)). In contravention of Rule 9(b), the FAC lumps all the named defendants together, generally referring to them as "Kaiser." But they are different entities whose roles in the alleged misconduct logically could not be the same. KFHP is the entity that contracts with CMS and submits risk-adjustment data to CMS. *See* Dkt. No. 110 ¶¶ 20, 21, 70. TPMG, on the other hand, does not contract with CMS and instead contracts with

KFHP to provide medical services to members enrolled in healthcare plans, including KFHP's Medicare Advantage plans. *See id.* ¶ 23. Osinek's failure to differentiate her allegations against these defendants does not satisfy Rule 9(b) because it fails to give either entity fair notice of the nature of the misconduct charged against it. *Swoben*, 848 F.3d at 1184.

B. Osinek Fails To Plausibly Plead Knowledge

Osinek's claims should be dismissed in their entirety for the additional reason that she fails to plausibly allege that Defendants acted with knowledge. The FCA "is not 'an all-purpose antifraud statute,' or a vehicle for punishing garden-variety breaches of contract or regulatory violations." *Escobar*, 579 U.S. at 194 (quoting *Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662, 672 (2008)). Liability attaches only to the knowing presentation of false claims or the knowing making or using of a statement material to a false claim. *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996); *see also* 31 U.S.C. § 3729(a)(1)(A), (a)(1)(B), (b)(1). The knowledge requirement is "critical" to any FCA case: Congress has made "firm its intention that the [FCA] not punish honest mistakes or incorrect claims submitted through mere negligence." *United States ex rel. Hochman v. Nackman*, 145 F.3d 1069, 1073 (9th Cir. 1998) (quoting S. Rep. No. 99–345, at 7 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5272).

In the Ninth Circuit, "the requisite scienter is the knowing presentation of what is known to be false"; that standard "does not mean scientifically untrue; it means a lie." *Id.*; *see also Hopper*, 91 F.3d at 1267 (the FCA requires "an intentional, palpable lie"). "Innocent mistakes," "negligent misrepresentations," and "differences in interpretation" are simply not actionable. *Hopper*, 91 F.3d at 1267; *see also Corinthian Colls.*, 655 F.3d at 996. And while Rule 9(b) permits a relator to allege knowledge generally, it does not give license "to evade the less rigid—though still operative—strictures of Rule 8," which require pleading facts that give rise to a plausible claim for relief. *Iqbal*, 556 U.S. at 686–87; *Cafasso*, 637 F.3d at 1055 ("[W]e hold that claims of fraud or mistake—including FCA claims—must, in addition to pleading with particularity, also plead plausible allegations."). Accordingly, an FCA relator must identify facts supporting the allegation that the defendants knowingly submitted false claims. *Modglin*, 48 F.

Supp. 3d at 1406 (finding allegation that defendants "knew that they were falsely and/or fraudulently claiming reimbursement" too conclusory to plead a plausible claim for relief). This standard is not met when there is an "obvious alternative explanation" to the defendant's knowing submission of false claims. *Gonzalez v. Planned Parenthood of L.A.*, 759 F.3d 1112, 1116 (9th Cir. 2014).

The FAC fails to allege any facts suggesting Defendants' knowledge of false claims. Like her original *qui tam* complaint, Osinek's FAC focuses exclusively on various practices that allegedly resulted in "upcoding," *compare* Compl. ¶¶ 25–41, *with* FAC ¶¶ 27–43, but none of the allegations indicate that Defendants ***knew*** any false claims were submitted based on these practices or that Defendants acted with reckless disregard or deliberate indifference to that risk. Indeed, the FAC's ***only*** knowledge allegations are the perfunctory and conclusory statements in Counts 1 and 2 that "Defendants knowingly presented or caused to be presented to the United States Government false or fraudulent claims for the payment or approval of medical services in violation of 31 U.S.C. § 3729(a)(1)(A)," and that "Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States Government in violation of 31 U.S.C. § 3729(a)(1)(B)." FAC ¶¶ 46, 49. This is plainly insufficient.[5]

Osinek does allege a "shift" in Defendants' coding and documentation practices "away from [their] focus on data quality and auditing physician coding" to refresh and data mining

[5] Nor has Osinek alleged facts that could be read as the "building block[s]" for plausibly pleading knowledge. *Cf. Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1211–12 (9th Cir. 2019). In *Godecke*, a relator sufficiently pleaded scienter based on allegations that (i) the defendant had set up tracking systems to mask its scheme, (ii) the relator's colleague had personally reviewed submitted claims that lacked appropriate documentation, (iii) the defendant's management instructed personnel to not appeal denials of certain claims for fear Medicare would notice the lack of appropriate documentation, and (iv) the defendant quickly terminated the relator, her supervisor, and the company's senior vice president after all three raised concerns about false claims being submitted. *Id.* By contrast, Osinek does not allege that Defendants established policies designed to deliberately avoid identifying inaccurate or improperly documented medical conditions, or that Defendants gave instructions to diagnose false or nonexistent medical conditions. Nor does Osinek allege that she—or anyone else—raised compliance concerns that Defendants' management ignored.

practices, FAC ¶ 26, but this also does not plausibly show that Defendants had knowledge (actual or otherwise) of the submission of any false claims. Instead, it shows only that Defendants began focusing on documenting all conditions their members had—a focus the risk-adjustment model is designed to encourage and reward. *See supra* at Part II.A. Absent factual allegations plausibly suggesting that inaccuracies in Defendants' risk-adjustment data submissions to CMS were "anything more than innocent mistakes," the FAC fails to plead scienter. *United States ex rel. Parker v. Sea-Mar Cmty. Health Ctr.*, 2020 WL 2041744, at *6 (W.D. Wash. Apr. 28, 2020); *see also United States ex rel. Cook v. Providence Health & Servs.*, 2014 WL 4094116, at *6–7 (W.D. Wash. Aug. 18, 2014) (finding relator failed to plausibly plead scienter where she did not allege defendant Providence had knowledge of subsidiary's collection activities or that Providence deliberately ignored or recklessly disregarded information about subsidiary's unlawful collection activities).

C. Osinek Fails To Allege Materiality

The FAC does not meet the FCA's high standard for materiality. The FCA defines materiality as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Escobar*, 579 U.S. at 182 (2016) (quoting 31 U.S.C. § 3729(b)(4)). Because "[t]he False Claims Act is not an all-purpose antifraud statute," the "materiality standard is demanding," *id.* at 194, and the FCA includes "a heightened standard for pleading materiality," *United States v. Comstor Corp.*, 308 F. Supp. 3d 56, 85 (D.D.C. 2018). The FAC falls short. Osinek does not even allege that CMS would not have paid Defendants had it been aware of the allegations in her complaint. The most she alleges is that "Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims." FAC ¶ 49. Given this conclusory assertion, the FAC should be dismissed for failure to adequately allege materiality.[6]

[6] *See, e.g.*, *Knudsen v. Sprint Commc'ns Co.*, 2016 WL 4548924, at *12 (N.D. Cal. Sept. 1, 2016) (dismissing complaint where relator's "conclusory statement" that the compliance with a specific contract provision was material was "not sufficient to meet the rigorous standard for pleading materiality"); *United States ex rel. Dresser v. Qualium Corp.*, 2016 WL 3880763, at *6 (N.D. Cal. July 18, 2016) (similar).

D. The FCA's Statute of Repose Prohibits Osinek from Pursuing Any Claims Against TPMG and KFHP Occurring Before October 7, 2011

The FCA's strict statute of repose bars Osinek from pursuing claims against TPMG and KFHP occurring more than ten years before her FAC—*i.e.*, pre-October 7, 2011. Neither TPMG nor KFHP was named in Osinek's original 2013 complaint. Though the FAC does not identify when Defendants purportedly first submitted false claims to CMS, Osinek appears to seek to hold each entity named in the FAC liable for misconduct dating back more than 15 years. *See* FAC ¶ 26 (alleging that Defendants' upcoding scheme began "[i]n or about 2007"). The FCA's statute of repose places an outer limit on a defendant's liability and is designed to protect against the assertion of stale, outdated claims like Osinek's new claims against TPMG and KFHP. The statute of repose accordingly bars any claims occurring more than ten years before the filing of the FAC on October 7, 2021.

Under the FCA's statute of repose, an FCA action may "in no event" be brought "more than ten years after the date on which the violation is committed." 31 U.S.C. § 3731(b); *see also United States ex rel. Hyatt v. Northrop Corp.*, 91 F.3d 1211, 1218 (9th Cir. 1996) (explaining that the "in no event" clause of § 3731(b) is a statute of repose). Unlike statutes of limitations, which focus on a plaintiff's diligence in bringing suit and "promote justice by preventing surprises through [the] revival of claims that have been allowed to slumber until evidence has been lost, memories have faded, and witnesses have disappeared," statutes of repose "reflect legislative decisions that as a matter of policy there should be a specific time beyond which a defendant should no longer be subjected to protracted liability." *CTS Corp. v. Waldburger*, 573 U.S. 1, 8–9 (2014) (quotation marks and citations omitted). A statute of repose therefore is equivalent to a "cutoff" and creates an "absolute bar" on a defendant's liability. *Id.* at 8. This is true even if a plaintiff "does not suffer or discover its injury until after the repose period has closed[;] any claim is untimely, even if brought immediately upon injury." *In re Countrywide Fin. Corp. Mortg.-Backed Sec. Litig.*, 900 F. Supp. 2d 1055, 1062 (C.D. Cal. 2012); *see also Underwood Cotton Co. v. Hyundai Merch. Marine (Am.), Inc.*, 288 F.3d 405, 408 (9th Cir. 2002) (noting that a statute of repose "can bar a suit even before the cause of action could have accrued, or, for that matter,

retroactively after the cause of action has accrued").

Osinek might seek to argue that the FAC "relates back" to her original complaint under Rule 15(c) such that pre-October 7, 2011 claims against TPMG and KFHP are timely. Rule 15(c) generally allows an amended pleading to relate back to an original complaint when the amended claims arise from the same "conduct, transaction, or occurrence" set out in the original pleading and the party to be brought in by amendment had notice of the original complaint and knew or should have known the action would have been brought against it absent mistake. Fed. R. Civ. P. 15(c)(1)(B), (C). But the FCA's statute of repose is exception-free. *See* 31 U.S.C. § 3731(b) ("in no event" may an FCA claim be brought "more than 10 years after the date on which the violation is committed"). And where a statute of repose permits no exception, parties cannot invoke Rule 15(c) to circumvent the repose period.

Courts interpreting the Securities Act's three-year statute of repose, which uses the same "in no event" language as the FCA's statute of repose, have held that parties "cannot avoid the statute of repose on a 'relation back' theory" under Rule 15(c) because the statute "by its terms allows no exceptions." *In re IndyMac Mortg.-Backed Sec. Litig.*, 793 F. Supp. 2d 637, 643 (S.D.N.Y. 2011), *aff'd in part sub nom. Police & Fire Ret. Sys. of City of Detroit v. IndyMac MBS, Inc.*, 721 F.3d 95 (2d Cir. 2013); *see also Silvercreek Mgmt., Inc. v. Citigroup, Inc.*, 248 F. Supp. 3d 428, 451 (S.D.N.Y. 2017) ("the statute of repose cannot be circumvented by the relation-back doctrine"); *In re Lehman Bros. Sec. & ERISA Litig.*, 800 F. Supp. 2d 477, 483 (S.D.N.Y. 2011) ("the Rule 15(c) relation back doctrine does not apply to statutes of repose"). Similarly, courts have found that the Truth in Lending Act's statute of repose "cannot be extended" under Rule 15(c). *Baldain v. Am. Home Mortg. Servicing, Inc.*, 2010 WL 2606666, at *6 n.6 (E.D. Cal. June 28, 2010); *see also Miguel v. Country Funding Corp.*, 309 F.3d 1161, 1165 (9th Cir.), *as amended on denial of reh'g* (Dec. 23, 2002); *In re Cmty. Bank of N. Va.*, 467 F. Supp. 2d 466, 481–82 (W.D. Pa. 2006), *as amended* (Oct. 20, 2010).

This is so because statutes of repose vest defendants with a substantive right to be free from liability after a legislatively determined period of time. *Police & Fire Ret. Sys.*, 721 F.3d at 106 ("in contrast to statutes of limitations, statutes of repose create a substantive right in those

protected" (quotation marks omitted)); *Miguel*, 309 F.3d at 1165. Under the Rules Enabling Act, the Federal Rules of Civil Procedure may not abridge or modify a substantive right. 28 U.S.C. § 2072(b); *see also* Fed. R. Civ. P. 82 (prohibiting any construction of the Rules that would extend the jurisdiction of the federal district courts). Allowing a party to use Rule 15(c) to avoid the consequences of a statute of repose would impermissibly enlarge the court's jurisdiction and violate the Rules Enabling Act. *Miguel*, 309 F.3d at 1165; *In re Cmty. Bank*, 467 F. Supp. 2d at 482; *see also In re IndyMac*, 793 F. Supp. 2d at 643 ("Rule 15 may not be construed to permit relation back because such a construction would conflict with the Rules Enabling Act."); *In re Lehman Bros.*, 800 F. Supp. 2d at 483 (same).

It makes no difference that Osinek might seek to relate the FAC's allegations back to her own prior complaint, or that she does not seek to add new relators or new theories of liability stemming from the same conduct as her original complaint. The statute of repose is an "absolute bar" on a defendant's temporal liability. *CTS*, 573 U.S. at 8. Its focus is "on [Defendants'] interests rather than [Osinek's]," and accordingly prohibits any and all claims against TPMG and KFHP after the repose period expires, "irrespective of the time of accrual of the cause of action." *Balam-Chuc v. Mukasey*, 547 F.3d 1044, 1049 (9th Cir. 2008); *Underwood Cotton*, 288 F.3d at 408; *In re Countrywide Fin. Corp.*, 900 F. Supp. 2d at 1062; *see also Silvercreek Mgmt.*, 248 F. Supp. 3d at 451 (rejecting argument that relating back to own prior complaint poses no issue because statutes of repose protect defendants from stale claims regardless of "whether the suit is brought by a new party or by a party with a lawsuit already pending").

The basic purpose of the statute of repose would be turned upside down if relation back under Rule 15(c) were allowed here. Osinek had ample opportunity to name either new defendant well before 2021. Indeed, Osinek's original complaint alleged that she worked at TPMG as early as 2006. Compl. (Dkt. No. 1) ¶ 5. There is no reason to conclude Osinek could not have named TPMG when she first filed suit. Further, nothing prevented Osinek from naming KFHP earlier by amending while her complaint was under seal; multiple relators in this action amended their pleadings before unsealing. Allowing Osinek to recover against TPMG and KFHP for claims that were time-barred before she first brought them "is not the correction of an

inconsequential pleading error, it is the abrogation of a statutorily created substantive right." *FDIC for Colonial Bank v. First Horizon Asset Sec. Inc.*, 291 F. Supp. 3d 364, 374 (S.D.N.Y. 2018). Accordingly, all claims against TPMG and KFHP occurring before October 7, 2011 must be dismissed.

E. "Kaiser Permanente" Is Not a Legal Entity and Must Be Dismissed

"Kaiser Permanente" must be dismissed because it is not a legal entity and therefore cannot be sued. "Under California law, a civil action can be maintained only against a legal person, i.e., a natural person or an artificial or quasi-artificial person; a nonentity is incapable of suing or being sued." *Florists' Mut. Ins. Co. v. Floricultura Pac., Inc.*, 2020 WL 6440039, at *8 (N.D. Cal. Apr. 3, 2020). In ruling on Defendants' motion to dismiss under the FCA's first-to-file bar, the Court acknowledged that "there does not appear to be any legal entity with the name 'Kaiser Permanente.'" Dkt. No. 171 at 29. Because "Kaiser Permanente" is a trade name, not a legal entity, *see* Dkt. 142-1, Ex. F, the Court lacks subject matter jurisdiction over it, and Osinek's claims against it must be dismissed under Rule 12(b)(1). *Florists' Mut.*, 2020 WL 6440039, at *8–9 (dismissing "Sentry Insurance Group" because it "is not itself a company or legal entity" but instead "is used to refer to a group of insurance companies that have separate legal existences"); *Mocha Mill, Inc. v. Port of Mokha, Inc.*, 2019 WL 1048252, at *3–4 (N.D. Cal. Mar. 5, 2019) (dismissing claims against non-entity defendant "Mokha Foundation" for lack of jurisdiction).

Dismissal is also warranted under Rule 12(b)(6). *See Morris v. Fid. Invs., FMR LLC*, 2018 WL 2463228, at *3 (N.D. Cal. June 1, 2018) (dismissing "Fidelity Investments" under Rule 12(b)(6) because "'Fidelity Investments' is a licensed trade name and not a legal entity"); *Cota v. Liberty Mut. Ins.*, 2018 WL 1453209, at *2 (E.D. Cal. Mar. 23, 2018) (finding "Liberty Mutual Insurance" a service mark of Liberty Mutual Insurance Company, dismissing under Rule 12(b)(6) because "service marks are not legal entities and do not have capacity to sue or be sued"). And because "Kaiser Permanente" is not a legal entity, it has not been served with the FAC, *see* Dkt. Nos. 123, 124, so Rules 12(b)(4) and 12(b)(5) further require dismissal. *Velasco Briseno v. Mktg. & Mgmt. Sols., LLC*, 2019 WL 2646661, at *6 (D. Kan. June 27, 2019).

Since Osinek already has amended her original complaint to add TPMG and KFHP as defendants, there is no need to grant leave to amend to name any additional defendants. *Cf. Cota*, 2018 WL 1453209, at *3 (allowing amendment so plaintiff could name proper party).

V. CONCLUSION

The FAC should be dismissed in its entirety. Despite having had over eight years to craft and refine her pleadings, Osinek fails to allege falsity, knowledge, or materiality—three key elements of her FCA claims. Additionally, all of Osinek's claims against TPMG and KFHP predating October 7, 2011 must be dismissed pursuant to the FCA's ten-year, exception-free statute of repose. Finally, Osinek cannot state a claim against "Kaiser Permanente" because "Kaiser Permanente" is not a legal entity and is not subject to suit or service. The Court should grant this Motion, dismiss the FAC in its entirety, and dismiss "Kaiser Permanente" with prejudice.

Dated: June 21, 2022

Respectfully submitted,

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC.,

Plaintiff,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al.,

Defendants.

Case No. 3:16-cv-01558-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE,

Plaintiff,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al.,

Defendants.

Case No. 3:16-cv-05337-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:18-cv-01347-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR OSINEK'S FIRST AMENDED COMPLAINT

Hearing Date: TBD (Dkt. No. 129)
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

[PROPOSED] ORDER

With good cause shown, Defendants' Motion to Dismiss Relator Osinek's First Amended Complaint is GRANTED. The Court dismisses the First Amended Complaint in its entirety.

IT IS SO ORDERED.

DATED:

_____
HONORABLE EDWARD M. CHEN
UNITED STATES DISTRICT JUDGE