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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 TAYLOR'S SECOND 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)

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

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

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| UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ,<br><br>Plaintiff,<br><br>v.<br><br>KAISER PERMANENTE, et al.,<br><br>Defendants. | Case No. 3:18-cv-01347-EMC<br><br>**NOTICE OF MOTION AND MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES**<br><br>Hearing Date: TBD (Dkt. No. 129)<br>Time: 1:30 PM<br>Judge: Hon. Edward M. Chen<br>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 TAYLOR'S SECOND 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 TAYLOR'S SECOND 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, Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Southern California Permanente Medical Group, and Colorado Permanente Medical Group (collectively, "Defendants") will and hereby do move this Court to dismiss Relator James Taylor's Second Amended Complaint ("SAC"), Dkt. No. 118, under Federal Rule of Civil Procedure 12(b)(6).

Defendants bring this Motion on the grounds that following this Court's first-to-file order, no claims remain against The Permanente Medical Group and Southern California Permanente Medical Group and so those Defendants must be dismissed. Additionally, the Court should dismiss claims against Kaiser Foundation Health Plan for the same reason and because they are based on impermissible group allegations. Taylor's allegations about a fraud involving healthcare providers external to the Kaiser Permanente-brand network and a Natural Language Processing program should be dismissed because they fail to plead falsity. The Court likewise should dismiss Taylor's claims that Defendants submitted false attestations to the U.S. Centers for Medicare and Medicaid Services ("CMS") because he has not alleged materiality with particularity. Taylor also has not alleged materiality to support his claims that Defendants submitted false diagnosis codes to CMS to the extent the codes were purportedly false due to so-called process-based coding violations. Finally, any claims against newly named Defendants Colorado Permanente Medical Group, The Permanente Medical Group, and Southern California Permanente Medical Group that predate November 15, 2011 run afoul of the FCA's statute of repose and must be dismissed as untimely.

In sum, the Court should dismiss Taylor's SAC except to the extent he alleges that Colorado Permanente Medical Group and Kaiser Foundation Health Plan of Colorado submitted

or caused to be submitted false diagnosis codes to CMS on or after November 15, 2011 that reflected medical conditions that did not exist as a clinical matter.

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

Dr. James Taylor brought this False Claims Act ("FCA") case in 2014 against several geographically discrete defendants operating under the Kaiser Permanente trade name, including medical groups in Georgia, the Northwest, and his own state, Colorado. After twice amending his complaint, he has dropped the Georgia and Northwest entities, and has focused on California and Colorado, just last year adding California and Colorado medical groups as Defendants.[1] He accuses Defendants of submitting false claims for payment to the U.S. Centers for Medicare and Medicaid Services ("CMS") in an effort to defraud the Medicare Advantage risk-adjustment program. But the Court's prior order on Defendants' motion to dismiss under the FCA's first-to-file bar and Taylor's own pleading failures limit his action in subject matter, geography, and temporal scope. The Court should dismiss all of Taylor's SAC with one narrow exception: allow him to proceed to discovery to the extent he alleges that Kaiser Foundation Health Plan of Colorado ("KFHP-Colorado) and Colorado Permanente Medical Group ("Colorado Permanente") (together, the "Colorado Defendants") submitted or caused to be submitted false diagnosis codes to CMS on or after November 15, 2011 that reflected medical conditions that did not exist as a clinical matter.

Taylor's operative Second Amended Complaint ("SAC") advances three theories of liability. He claims that Defendants falsified diagnosis codes and attestations submitted to CMS by incorrectly reporting medical conditions captured by:

- healthcare providers who worked at the medical groups (*i.e.*, internal providers);
- retrospective reviews of medical records from healthcare providers outside the Kaiser Permanente network who provided healthcare services to Defendant members[2] (*i.e.*,

[1] "Defendants" are Kaiser Foundation Health Plan, Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Southern California Permanente Medical Group, and Colorado Permanente Medical Group.

[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

external providers); and

- a Natural Language Processing ("NLP") program that used computer algorithms to search members' medical records for medical conditions.

Taylor's attempt to stitch together a cognizable theory of fraud against all Defendants under all three of these theories comes apart at the seams.

Out of the gate, the Court should narrow the complaint to an alleged Colorado-based fraud against only the Colorado Defendants. The Court's first-to-file order already narrows the SAC in part. It prevents Taylor from bringing an internal-provider fraud claim in California, given that the first-filed *Osinek* complaint encompasses Taylor's California internal-provider allegations. In addition, Taylor's external-provider and NLP allegations have nothing to do with Medicare Advantage members in California. Accordingly, no allegations remain as to The Permanente Medical Group ("TPMG") and Southern California Permanente Medical Group ("SCPMG")—together, the "California Defendants"—and they must be dismissed. Nor should the Court allow any allegations against Kaiser Foundation Health Plan ("KFHP") to stand. They fail for the same reasons as do the allegations against the California Defendants, and because Taylor does not allege sufficient facts against KFHP to state a plausible fraud claim under Federal Rules of Civil Procedure 8 or 9(b). Instead, he impermissibly groups KFHP with other Defendants, without explaining how KFHP purportedly engaged in fraud.

Taylor's external-provider and NLP allegations suffer from an additional pleading defect. Taylor premises the alleged fraud underlying these allegations on undefined "error rates" in diagnosis codes submitted to CMS, without any allegations of why these submissions were fraudulent. The errors could have been caused by anything from a computer malfunction to typographical issues to actual flaws in clinical determinations. But conclusory allegations about error rates only do not provide Defendants with notice of how or why the codes were "false" under the FCA.

Taylor likewise does not properly allege materiality for most of his claims. His FCA

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covered by the Medicare Advantage program. Thus, for purposes of this Motion, the terms "members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

claims are based on allegedly false attestations and diagnosis codes. But he never alleges that CMS would not have paid Defendants had CMS known that the attestations were false, as required under the FCA's demanding materiality standard. Similarly, to the extent he alleges that diagnosis codes were false because Defendants did not code diagnoses in compliance with coding guidelines (what Taylor calls "process-based" coding violations), Taylor's claims fail for the same reason: He never alleges that CMS would not have paid Defendants if it had known about the purported process-based violations underlying the diagnosis codes.[3]

Finally, the SAC runs afoul of the FCA's exception-free statute of repose. Taylor purports to hold three newly named defendants—Colorado Permanente, The Permanente Medical Group ("TPMG"), and Southern California Permanente Medical Group ("SCPMG")—liable for alleged misconduct dating back to 2004. But the FCA's statute of repose prohibits any claims against these entities occurring ten years before Taylor filed the SAC. Accordingly, the Court should dismiss all claims against Colorado Permanente and the California Defendants predating November 15, 2011.

Accounting for the various pleading defects, the Court should strictly limit Taylor's path forward and dismiss all of Taylor's SAC except to the extent he alleges that the Colorado Defendants submitted or caused to be submitted false diagnosis codes to CMS on or after November 15, 2011 that reflected medical conditions that did not exist as a clinical matter.

## 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

[3] This Motion does not challenge the materiality of diagnosis codes that reflect medical conditions that Taylor alleges did not exist as a clinical matter.

beneficiaries elect to receive healthcare coverage from private insurers known as Medicare Advantage Organizations ("MAOs"). *Id.* Finally, CMS runs Medicare Part D, which provides prescription-drug coverage that can be integrated into Part C coverage. SAC (Dkt. No. 118) ¶ 45.

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, by contrast, 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.[4]

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 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 [healthcare providers] taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record.'" *Integra Med*

[4] Medicare Part D uses a similar risk-adjustment model based on "Rx Hierarchical Condition Categories" ("RxHCCs"). Like HCCs, RxHCCs are "groups of clinically-related medical diagnoses that are ranked by disease severity and the cost associated with the pharmaceutical drugs used to treat them." SAC ¶ 54. Medicare Advantage plans "with Part D coverage are also given money to pay for the plan members' prescription drugs." *Id.* ¶ 48.

*Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 n.4 (9th Cir. 2021).

CMS regulations also require MAOs to submit an attestation to CMS representing that the risk-adjustment data they submitted, including diagnosis codes from healthcare providers who treated the MAOs' members, were accurate, complete, and truthful based on the MAOs' "best knowledge, information, and belief." 42 C.F.R. § 422.504(*l*). But CMS deliberately implemented a qualified attestation standard, recognizing that "encounter data [containing risk-adjustment data] come into [MAOs] in great volume from a number of sources, presenting significant verification challenges for the organizations." 65 Fed. Reg. 40,170, 40,268. Accordingly, MAOs need not ensure that every piece of data is indisputably accurate; rather, they must make "good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted." *Id.*

**B. Taylor's Allegations**

Taylor started working for Colorado Permanente in 1995 and held various clinical and diagnosis-coding roles within the organization. SAC ¶¶ 13–16. On October 22, 2014, he filed his original *qui tam* complaint under seal. He named Kaiser Permanente, KFHP, KFHP-Colorado, Kaiser Foundation Health Plan of Georgia ("KFHP-GA"), and Kaiser Foundation Health Plan of the Northwest ("KFHP-NW"). Compl. (*United States ex rel. Taylor v. Kaiser Permanente, et al.*, Case No. 21-cv-3894 ("*Taylor* Dkt.") (N.D. Cal.) Dkt. No. 1) ¶¶ 16–24. Taylor filed his first amended complaint on November 3, 2014, and named the same defendants. FAC (*Taylor* Dkt. No. 4) ¶¶ 16–24. Neither of these complaints named his former employer, Colorado Permanente.

After the United States partially intervened in this action, Taylor filed his operative SAC on November 15, 2021. SAC ¶¶ 17–27. The SAC dropped Kaiser Permanente, KFHP-GA, and KFHP-NW as defendants but for the first time named the California Defendants as well as Colorado Permanente—thus focusing the complaint on activities in Colorado and California. *See id.* The California Defendants provide medical care in Northern California (TPMG) and Southern California (SCPMG), while Colorado Permanente provides medical care in Colorado. *See id.* ¶¶ 24–27.

Taylor's SAC brings three claims against Defendants under the FCA, alleging that

"[s]ince at least 2004 to present," they have "perpetrated a systematic fraud on the Medicare Advantage . . . program and Medicare Part D." *Id.* ¶ 2. First, Taylor asserts that Defendants knowingly presented, or caused to be presented, a false or fraudulent claim for payment or approval to the government under 31 U.S.C. § 3729(a)(1)(A) in the form of both false diagnosis-code data and false risk-adjustment attestations. *Id.* ¶¶ 236–39. Second, Taylor contends Defendants knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim to the government under 31 U.S.C. § 3729(a)(1)(B) in the form of false diagnosis-code data. *Id.* ¶¶ 241–43. And third, he alleges that Defendants violated the FCA's so-called Reverse False Claims provision, 31 U.S.C. § 3729(a)(1)(G), by improperly retaining overpayments from the government when Defendants knowingly did not correct erroneous diagnosis codes that had been submitted to CMS. *Id.* ¶¶ 2–3, 245–47.

Focusing primarily on alleged events in Colorado, Taylor describes various business practices that he claims illustrate this fraudulent scheme:

***Review of External Healthcare Provider Records.*** Taylor claims that the Colorado Defendants[5] rely on external healthcare providers—*i.e.*, providers who do not operate as part of the Kaiser Permanente brand—to provide care to the Colorado Defendants' members. *Id.* ¶¶ 103–04. Diagnosis codes collected from external providers are then submitted to CMS for reimbursement. *Id.* ¶ 103.

Taylor alleges that audits of the diagnosis-code data collected from these external healthcare providers identified "significant error rates" in the data submitted to CMS. *Id.* ¶ 105. He contends that "Kaiser"—which he defines as KFHP, KFHP-Colorado, and Colorado Permanente, *id.* ¶ 21—should have scrutinized the codes submitted by external healthcare

[5] Taylor calls the Colorado Defendants (KFHP-Colorado and Colorado Permanente) "Kaiser Colorado." *Id.* ¶ 25. As noted below, Taylor's external-provider (and other) allegations refer variously to "Kaiser Colorado" and "Kaiser." *See infra* at 13. Given his use of both terms, it is not clear to what extent KFHP—included in Taylor's definition of "Kaiser" but not "Kaiser Colorado"—is implicated in his external-provider allegations. *See infra* at 13–14. Taylor does not allege what role, if any, KFHP, which is alleged to be a non-profit health maintenance organization ("HMO") headquartered in Oakland, California, plays in scrutinizing codes submitted by external providers in Colorado as opposed to KFHP-Colorado.

providers more closely. *Id.* ¶ 118. Instead, Taylor claims that the Colorado Defendants implemented a retrospective chart-review program for external hospital claims in the Colorado region. *Id.* ¶¶ 119–20, 127. According to Taylor, through this chart-review program, coders would review members' medical records from external healthcare providers in hospital settings to look for additional diagnosis codes supported by the medical records. *Id.* ¶ 120. Taylor claims that "Kaiser" did not confirm "whether codes previously submitted by the external providers were accurate" and did not delete allegedly inaccurate diagnosis codes. *Id.* ¶¶ 121, 125.

Taylor alleges that this retrospective chart-review program caused "Kaiser" to improperly retain payments from diagnosis-code data previously submitted to CMS that were not supported by medical records. *Id.* ¶ 127. He claims that the program informed "Kaiser" that previously submitted diagnosis codes were false and rendered attestations to CMS false. *Id.* ¶ 132.

***Internal Healthcare Provider Diagnosing.*** Taylor also contends that audits of internal healthcare providers illustrated a problem with "false coding" at "Kaiser." *Id.* ¶ 137. Taylor points to alleged error rates from annual audits in the Colorado region and from other regions to illustrate these purported coding issues. *Id.* ¶¶ 141–42.

The alleged errors took two different forms. First, Taylor claims that some errors were due to so-called process-based coding violations—*i.e.*, coding medical conditions in alleged violation of coding guidelines. *See, e.g.*, *id.* ¶¶ 145, 184, 187–88, 190, 215–22. He claims, for example, that Defendants coded medical conditions where the condition was supported by only a radiologic or lab test, which he alleges coding guidelines did not allow. *Id.* ¶ 221.

Second, Taylor contends that Defendants coded diagnoses that were clinically inaccurate—*i.e.*, the member did not have or no longer had the condition reported. *See, e.g.*, *id.* ¶¶ 148–62, 163–71.

Taylor alleges that despite its knowledge of these coding errors, "Kaiser" failed to identify claims that were false and prevent their submission to CMS or delete them after submission. *Id.* ¶ 146. He claims that once "Kaiser" was aware of these error rates, its annual attestations to CMS also were rendered false. *Id.*

***Natural Language Processing Program.*** Finally, Taylor alleges that Defendants used an

NLP program to submit false claims related to Colorado members. According to Taylor, the NLP program uses an algorithm to search members' electronic medical records to find words that indicate that a member has a medical condition. *Id.* ¶¶ 224–34. He alleges that Defendants used the NLP program to find new diagnosis codes to submit to CMS. *Id.*

NLP results are broken into categories, one of which is "True Positive: diagnoses that have been confirmed by two Kaiser coders." *Id.* ¶ 229. According to Taylor, each Kaiser Permanente-affiliated region determines how to use this information. *Id.* ¶ 230. He claims that he reviewed 100 of the "True Positive" claims for the "Colorado region" and "found a 10% error rate." *Id.* ¶ 232. Nonetheless, according to Taylor, the "Colorado region passes the True Positive diagnoses to its claims submission system with no further review, even though Kaiser knows that many of these claims are likely false," leading to the submission of false claims to CMS. *Id.* ¶¶ 233–34.

**C. First-to-File Order**

Defendants moved to dismiss Taylor's action in full under the FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5). Defendants argued that Ronda Osinek's complaint—the first of the *qui tam* actions in this consolidated matter—required dismissal of *Taylor* because both Osinek and Taylor allege that Defendants engaged in a scheme to "upcode" the diagnoses of Medicare Advantage members. Dkt. No. 141 at 19–21; *see also Taylor* Dkt. No. 1 ¶¶ 5, 61.

On May 5, 2022, the Court granted in part Defendants' first-to-file motion, resulting in the partial dismissal of Taylor's action. Dkt. No. 171 at 46. The first-to-file bar required the Court to compare the original *Osinek* and *Taylor* complaints—*i.e.*, the *Taylor* complaint that alleged a national scheme against entities in California, Colorado, Georgia, and the Northwest, before Taylor reduced his focus to California and Colorado in the SAC. *See id.* at 16. Evaluating *Taylor*'s original complaint, the Court dismissed *Taylor* "except to the extent that it pleads (1) a nationwide or corporate-wide fraud; (2) a fraud based on improper coding by external providers; and (3) a fraud based on True Positive results from the NLP program." *Id.* at 38, 46. Given Taylor's SAC, he no longer alleges a "nationwide or corporate-wide fraud," focusing instead on California and Colorado. In addition, the Court held that Taylor could not proceed with

California-based internal-provider upcoding claims, given that Osinek already alleged a California-centric scheme about upcoding high-value disease conditions. *See id.* at 35–36.

Accordingly, applying the first-to-file order to Taylor's SAC, he is left with allegations about a fraud based on (1) upcoding by internal providers in Colorado; (2) improper coding by external providers; and (3) True Positive results from the NLP program. As discussed below, the Court should dismiss most of these allegations as well.

## III. LEGAL STANDARD

To survive dismissal under Federal Rule of Civil Procedure 12(b)(6), Taylor's complaint must "state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). 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).

Taylor'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 they can defend 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) (quotations omitted).

## IV. ARGUMENT

Taylor fails to state a claim for all but the narrowest allegations. Under the FCA, Taylor must allege: (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). Taylor's SAC suffers multiple defects requiring dismissal of most of his complaint:

***First***, the Court should dismiss all the allegations against the California Defendants and KFHP. Given the first-to-file order and the SAC's allegations, Taylor pleads no cognizable claim

involving a fraud in California, requiring complete dismissal of the two California Defendants. And the few allegations about KFHP do not allege a plausible fraud claim that satisfies Rule 9(b)'s particularity requirements. In dismissing those three parties, the Court should limit the complaint to an alleged Colorado-based fraud scheme.

***Second***, Taylor fails to plead falsity to support his theory of fraud based on Defendants' external-provider chart-review practices and NLP program. He bases his theory of falsity on nothing more than vague "errors" that he fails to describe with any particularity.

***Third***, Taylor fails to plead materiality for his attestation-based claims and his diagnosis code-based claims to the extent he alleges diagnosis codes were false because of non-compliance with coding guidelines (*i.e.*, false because of so-called process-based issues). He does not allege, as required under the demanding materiality standard, that CMS would have refused to make risk-adjustment payments based on the purported falsity.

***Fourth***, the Court must dismiss claims against the newly named Defendants—Colorado Permanente and the California Defendants—that predate the SAC by ten years under the FCA's ten-year statute of repose.

In sum, the Court should dismiss Taylor's SAC except to the extent he alleges that the Colorado Defendants submitted or caused to be submitted false diagnosis codes to CMS on or after November 15, 2011 that reflected medical conditions that did not exist as a clinical matter.

### A. The Court Should Dismiss the California Defendants and KFHP

The Court should dismiss the two California Defendants and KFHP, limiting Taylor's complaint to an alleged fraud centered on the Colorado Defendants.

***The California Defendants.*** Given the Court's first-to-file order and Taylor's SAC, no allegations remain about an alleged fraud involving healthcare services rendered in California, requiring complete dismissal of the California Defendants (TPMG and SCPMG). The SAC implicates the California Defendants in its allegations about how internal healthcare providers improperly diagnosed high-value medical conditions. *See* SAC ¶¶ 82, 210, 213. But the Court's first-to-file order makes clear that *Osinek* encompasses Taylor's allegations about uncovering high-value conditions through audits of internal providers to the extent those allegations applied

to California. Dkt. No. 171 at 35–36. Taylor thus has no viable fraud claims about any Defendant's conduct in California on those grounds.

Taylor's two other theories of liability that survived the first-to-file motion—about external providers and the NLP program, *id.* at 46—do not implicate any Defendant's operations in California and cannot save the California Defendants from dismissal. Taylor's external-provider claims are limited to Colorado by the face of the SAC. Indeed, the section of the SAC on external providers is titled "Kaiser Conducted Impermissible One-Way Look Chart Reviews of ***Colorado*** External Providers." SAC at 26 (emphasis added). None of the allegations in that section relates to any allegedly improper conduct by healthcare providers in California. Taylor also conceded in his opposition to Defendants' first-to-file motion that the alleged external-provider fraud "would not even have been possible in California." Dkt. No. 156 at 15.

Taylor's NLP allegations also do not concern healthcare services provided in California. While Taylor alleges that "all face-to-face visits" are "run through" the NLP software, *see* SAC ¶¶ 229–33, he does not allege any improper NLP practices in California.

***KFHP.*** Taylor also fails to allege a cognizable FCA claim against KFHP, which he implicates in an alleged fraud across both California and Colorado. First, to the extent Taylor alleges a California-based fraud against KFHP, the Court should dismiss KFHP for the same reason the Court should dismiss the California Defendants: Taylor's SAC does not allege a cognizable fraud scheme in California, given the effect of the first-to-file order and the SAC's allegations.

In any case, the Court should dismiss all claims against KFHP because Taylor does not allege sufficient facts to put KFHP on notice of the claims against it. As noted, under Rule 9(b), Taylor's allegations must be "specific enough to give [each defendant] notice of the particular misconduct which is alleged to constitute the fraud so that [the defendant] can defend itself against the charge." *Bly-Magee*, 236 F.3d at 1019. In other words, Taylor must allege with particularity "the who, what, when, where, and how of the misconduct charged" for each defendant. *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010). A plaintiff cannot satisfy Rule 9(b) by "merely lump[ing] multiple defendants together." *Swartz v. KPMG*

*LLP*, 476 F.3d 756, 764 (9th Cir. 2007). While courts may allow collective allegations to satisfy pleading requirements where each defendant has allegedly "engaged in precisely the same conduct," *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016) ("*Swoben*"), collective allegations are not permitted where each defendant has a distinct role and function, *see Hausauer v. City of Mesa*, 2020 WL 2735970, at *3 (D. Ariz. May 26, 2020) (dismissing claims where plaintiff "repeatedly lumps [defendants] together as a collective whole" although defendants "presumably did not each engage in the exact same conduct").

Taylor's sparse allegations about KFHP fail to meet Rule 9(b)'s requirements. Taylor does no more than identify KFHP as a non-profit HMO headquartered in Oakland, California that has "subsidiaries." *Id.* ¶¶ 17, 22.[6] Based on such limited allegations, KFHP has no notice of the fraud allegations against it and therefore cannot adequately defend itself.

It is true that Taylor uses certain collective terms that encompass KFHP and other Defendants, but he does so in confusing and inconsistent ways that give no clarity to his allegations against KFHP. Taylor defines both "Kaiser" and "Defendants" as KFHP, KFHP-Colorado, and Colorado Permanente. *Id.* ¶ 21. He separately defines "Kaiser Colorado" as KFHP-Colorado and Colorado Permanente; the term does not include KFHP. *Id.* ¶ 25. He alleges that Colorado Permanente contracts with KFHP-Colorado "to provide medical care to its members," without any similar allegation about Colorado Permanente's relationship to KFHP. *Id.* ¶ 23. And he has acknowledged that KFHP contracts with CMS to operate a Medicare Advantage plan in ***California***, while KFHP-Colorado contracts with CMS to operate a Medicare Advantage plan in ***Colorado***. Dkt. No. 156 at 20 n.20.

Yet when alleging a fraud scheme in Colorado, Taylor appears to conflate "Kaiser" and "Kaiser Colorado," referring to them seemingly interchangeably. For instance, in describing the alleged external-provider fraud, Taylor claims in one paragraph that "***Kaiser Colorado*** has conducted a retrospective chart review project on external hospital claims." *Id.* ¶ 120 (emphasis added). Two paragraphs later, he states that "***Kaiser*** collected all medical charts generated by [a

[6] Besides this introductory description, he specifically references KFHP only twice in his 247-paragraph complaint, and only to describe a couple of employees' titles. *Id.* ¶¶ 75, 86.

Colorado external provider] for ***Kaiser's*** [members] and proceeded to send each chart through an additional level of review." *Id.* ¶ 122 (emphasis added). The former allegation implies that only the two Colorado Defendants were involved in retrospective chart review, while the latter allegation implies that KFHP also may have been involved. KFHP does not know which allegation to follow.

Given the descriptions of the Defendants and imprecision in group terms, it is not plausible that KFHP—a California-based HMO that contracts with CMS to run a Medicare Advantage plan in California—would have engaged in "precisely the same conduct" as two Colorado entities that contract with each other to provide healthcare to members in Colorado. *Swoben*, 848 F.3d at 1184. The flaw in Taylor's pleading is not that "collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct." *Id.* Rather, the flaw is the failure "to allege particular details of the scheme as applied to" KFHP, *see id.*, where the FAC does not plausibly allege that KFHP could have engaged in "precisely the same conduct" as the Colorado Defendants. KFHP has no notice of the specific fraud claims against it, and the Court should dismiss KFHP from this action entirely.

**B. Taylor Fails To Plead Falsity for His External-Provider and NLP Allegations**

Taylor also fails to plead falsity with the requisite particularity for his external-provider and NLP allegations. Taylor fails to "allege particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Ebeid*, 616 F.3d at 998–99 (quotations and citations omitted). Both fraud theories depend on the existence of "errors" in diagnosis coding, but Taylor does not define with any particularity what these errors are—*i.e.*, why any claims are "false" under the FCA.

**1. External-Provider Allegations**

As explained above, one of Taylor's key theories of liability is that audits identified "error rates" in claims submitted to CMS based on "diagnoses provided by [Colorado] external providers." SAC ¶ 105. Taylor lists, for example, the "error rates" from 2007 to 2013 audits of external-provider data and alleges that such "error rates" were higher than the rates for internal providers in the Colorado region. *Id.* ¶¶ 105–10. Taylor claims that, with knowledge of these

"errors," the Colorado region launched a "one-way look chart review program." *Id.* ¶ 119. Through this program, the Colorado region allegedly conducted retrospective reviews of medical records from a hospital chain called Exempla, and based on this review, submitted diagnosis codes to CMS that had not been submitted previously. *Id.* ¶¶ 120–21. Taylor claims that the Colorado region did not attempt to delete any previously submitted diagnosis codes that the "review demonstrated were erroneous." *Id.* ¶ 130.

While Taylor repeatedly refers to coding "errors" identified in external-provider audits, he does not explain how or why the codes were erroneous. *See id.* ¶¶ 106–10. Saying that something was erroneous, without any context for the purported error, is tantamount to saying something was "false"—a conclusory assertion of the falsity element that cannot satisfy Rule 9(b)'s particularity requirement. *Vess v. Ciba-Geigy Corp.*, 317 F.3d 1097, 1108 (9th Cir. 2003) (finding that plaintiff's "conclusory allegations" against a specific defendant "simply [were] not" enough to give the defendant notice of the alleged misconduct and fell "far short of satisfying Rule 9(b)"). The audit may have identified an "error" due to anything from a computer glitch to a typographical issue to actual flaws in clinical determinations. The allegations leave Defendants with no notice of what they must defend against.

Taylor does provide one hypothetical example of how the external-provider chart review allegedly worked, but that does not clarify the alleged falsity. He asserts that the Colorado Defendants might identify a "diagnosis of diabetes for which its own coder found no support," but then fail to remove that diagnosis code from the data submitted to CMS. SAC ¶ 126. Yet Taylor himself calls this example a "hypothetical," *id.*—in other words, fictional—and he otherwise does not allege what types of "errors" the external-provider audits or chart-review program identified. Indeed, the error rates could relate to a system malfunction, diagnosis codes that do not adhere to internal guidelines, diagnosis codes that are not clinically supported, or myriad other issues. Without a description of the alleged external-provider "errors," Defendants are left without notice of how the diagnosis codes were allegedly false.

Taylor might seek to argue that *Swoben* allowed allegations about a one-way chart-review scheme to survive a motion to dismiss in another Medicare Advantage risk-adjustment FCA case,

and that this Court should do the same. *See Swoben*, 848 F.3d at 1175. But *Swoben* is distinguishable. There was no dispute in that case that the defendants' alleged chart-review practices caused the defendants to ignore actual, not hypothetical, false claims. *Id.* That is not the case here, where the falsity of the relevant diagnosis codes has not been pleaded with particularity.

**2. Natural Language Processing Allegations**

Taylor's NLP allegations similarly focus on undefined "error rates," and thus also fail to plead falsity. Taylor alleges that "Kaiser" developed an NLP audit program that reviewed all face-to-face visits with Medicare Advantage members. SAC ¶¶ 224, 229. He claims that "NLP analysis can be an effective tool to find diagnoses that were properly documented in the physician treatment notes but not submitted in the claims data." *Id.* ¶ 224. According to Taylor, the NLP program would identify diagnoses that have been confirmed by two coders (*i.e.*, True Positives), and the Colorado region would submit codes for those diagnoses to CMS without further review. *Id.* ¶¶ 229–30, 233. He alleges that he found a 10% "error rate" in his review of 100 of the True Positive claims for the Colorado region. *Id.* ¶ 232.

As with the external-provider "error rates" discussed above, Taylor rests his NLP allegations on the supposed "error rate" found in audits of True Positives. Beyond conclusory assertions of "errors," he does not explain how these error rates translate to false claims under the FCA. At most, he notes that NLP "***appears***" to pick up "diagnoses that appear in problem lists," which he claims is improper. *Id.* (emphasis added). But this is not even an allegation that the errors actually involved improper coding from problem lists, especially given his allegation that True Positive claims are confirmed by two coders and are not automatically passed through to CMS based solely on being present on problem lists. What is more, Taylor does not allege that the 100 claims he reviewed were representative of all True Positive claims; he does not allege how he even selected the 100 claims or that he, as someone "heavily involved" in "physician coding practices" at Colorado Permanente, caused any further analysis of the True Positive claims. *See id.* ¶ 13. What Taylor alleges, in sum, is that across his many years at Colorado Permanente, he identified a total of ten True Positive claims that based on his personal review

were coded in error. He does not allege what steps he took to review those ten claims or whether he had any communication with the reviewing coders to determine what caused them to validate the code.

### C. Taylor Fails To Plead Materiality

Taylor likewise fails to plead materiality for most of his claims. The FCA defines materiality as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 181 (2016) (quoting 31 U.S.C. § 3729(b)(4)). Because the FCA "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 SAC does not meet this standard for Taylor's attestation-based claims or his diagnosis code-based claims to the extent those claims rely on purported violations of coding guidance (rather than the submission of diagnosis codes for medical conditions that did not exist).

#### 1. Attestation-Based Claims

Taylor has not sufficiently pleaded materiality in support of his attestation-based fraud allegations, which form part of his first claim for relief. SAC ¶ 237 (alleging Defendants presented or caused to be presented false claims for payment "in the form . . . of false risk adjustment attestations certifying the completeness, accuracy, and truthfulness of Defendants' risk adjustment data"). In false certification cases, the falsity of the certification "must be material to the Government's payment decision." *Escobar*, 579 U.S. at 181. A relator cannot merely allege that the certification or attestation is a condition of payment or that the government "would have the option to decline to pay" if the defendant failed to comply with the certification requirement. *Id.* at 194. Instead, "materiality looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation." *Id.* at 193.

Courts have applied *Escobar*'s materiality standard to dismiss a plaintiff's attestation-based claims in similar FCA cases against MAOs. In *United States v. Scan Health Plan* ("*Swoben II*"), the government's complaint did not "allege that CMS would have refused to make

risk adjustment payments to the [defendants] if it had known about [their] alleged involvement with the . . . chart review process." *Swoben II*, 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017) (internal citations omitted). The court held that the government did not plead materiality for these claims, and was required to plead "that [CMS] would not have paid these claims had it known of these violations." *Id.* Although the court granted the government leave to amend its complaint to make the necessary materiality allegation, the government voluntarily dismissed all of its claims against the defendants. *See* Notice of Dismissal Without Prejudice Pursuant to Fed. R. Civ. Proc. 41(a) or (c), *Swoben II*, 2:09-cv-5013-JFW-JEM, Dkt. No. 341 (C.D. Cal. Oct. 12, 2017).

Similarly, in *Poehling*, the court dismissed the government's attestation-based claims for failure to plead materiality. *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487, at *9 (C.D. Cal. Feb. 12, 2018). The government "failed to allege that CMS would have refused to make risk adjustment payments if it had known the Attestations were false." *Id.* at *10 ("To the extent the FCA claims are based on violations related to the Attestations, the Government must plead that the Attestations are "material to [the Government's] course of action," specifically, to the "Government's payment decision." (quoting *Escobar*, 579 U.S. at 191, 192)). In dismissing the attestation-based claims, the court emphasized that "[i]t is not enough to allege that Defendants were obligated by various regulations and contracts to comply with the Attestation requirements" or that CMS would "have had the option to decline to pay" if it were aware of a failure to comply with such requirements. *Id.* at *9.

Here, like the plaintiffs in *Swoben II* and *Poehling*, Taylor fails to plead that the purported falsity of the attestations was material to CMS's payment decision. While Taylor alleges that an MAO's attestation submission is a condition of payment and that Defendants' attestations were "rendered false" once they allegedly became aware of the submission of false diagnosis codes, *see, e.g.*, SAC ¶¶ 74, 146, 201, 209, Taylor stops short of pleading that CMS would have refused payment if it had known about the allegedly false attestations.

Finally, even if Taylor had made the threadbare recital that the government would not have paid Defendants had it known of these violations, he still would have failed to adequately plead materiality. Taylor's SAC does not contain other indications that these alleged violations

would have been material to CMS's decision to pay, such as an allegation that CMS has ever denied payment to an MAO based on the practices Taylor alleges. *See United States v. Vora*, 2022 WL 89177, at *4–5 (W.D. Ky. Jan. 1, 2022) (dismissing FCA complaint that included conclusory materiality allegations and failed to allege, among other things, that the government had refused to pay claims subject to similar alleged violations); *see also Knudsen v. Sprint Commc'ns Co.*, 2016 WL 4548924, at *12 (N.D. Cal. Sept. 1, 2016) (dismissing complaint where relator's "conclusory statement" about compliance with a specific contract provision being material was "insufficient"); *United States ex rel. Dresser v. Qualium Corp.*, 2016 WL 3880763, at *6 (N.D. Cal. July 18, 2016) (similar). Accordingly, the Court should dismiss Taylor's first claim for relief to the extent it pleads an attestation-based fraud.

**2. Diagnosis Code-Based Claims**

Taylor also fails to plead materiality for his diagnosis code-based claims to the extent that they rely on purported violations of coding guidance to establish the falsity of the codes. Taylor alleges that Defendants submitted diagnosis codes that were "false" because they were recorded in violation of coding guidelines. *See supra* at 8.[7] To plead materiality, Taylor must show that the alleged falsity would have been material to CMS's payment decision. *Escobar*, 579 U.S. at 181, 194.

Taylor does not plead facts to show that alleged process-based coding violations would have affected CMS's decision to pay Defendants had CMS known about the violations. Instead, Taylor's materiality allegations are conclusory and found only in his claims for relief. He alleges: "If CMS had known that Defendants had presented or caused to be presented false claims based on these improper codes, CMS would have refused to make risk-adjustment payments based on the improper coding ***and/or taken other appropriate actions*** to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining

[7] As noted, Taylor also contends that Defendants submitted diagnosis codes to CMS that reflected medical conditions that did not exist. For the purposes of this Motion, Defendants do not challenge materiality for claims based on the alleged submission of such diagnosis codes to CMS.

repayments in enforcement actions." SAC ¶¶ 238, 242, 246 (emphasis added).

Taylor's allegation fails to meet *Escobar*'s materiality standard because it lists only a series of potential actions that CMS ***might have taken*** had it known about false diagnosis codes. Taylor does not make a definitive assertion—much less one supported by factual allegations—that CMS would have refused payment for each code submitted that suffered from a process-based coding violation. *See Escobar*, 579 U.S. at 194 ("[I]t [is not] sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant's noncompliance."). Taylor's non-exclusive list of possible options cannot save him, because it leaves open the possibility that all CMS "would have" done is authorized an enforcement action. If that were sufficient, the materiality standard would be a nullity whenever the government filed FCA claims or intervened in a relator's suit. *United States ex rel. Mei Ling v. City of Los Angeles*, 2018 WL 3814498, at *20 (C.D. Cal. July 25, 2018) ("[I]f the Government's decision to intervene in an action were given substantial weight, then materiality would be a fait accompli in any case where intervention has occurred, thus working an end-run around *Escobar*."). The optional nature of Taylor's materiality allegation renders the allegation insufficient.

### D. The FCA's Statute of Repose Prohibits Taylor's Claims Accruing Before November 2011 Against Colorado Permanente and the California Defendants

Finally, the FCA's strict statute of repose bars Taylor from pursuing claims against the three newly named medical groups—Colorado Permanente and the two California Defendants—occurring more than ten years before the SAC, *i.e.*, pre-November 15, 2011. Not one of these Defendants was named in Taylor's 2014 complaints. Yet Taylor seeks to hold each entity named in the SAC liable for misconduct dating back to 2004—more than 17 years ago. *See* SAC ¶ 82. 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 Taylor's new claims against these three newly added medical groups. The statute of repose accordingly bars any claims against these entities occurring more than ten years before the filing of the SAC.

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 may 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) (quotations 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").

Taylor might seek to argue that the SAC "relates back" to his original complaint under Rule 15(c) such that pre-November 15, 2011 claims against Colorado Permanente and the California Defendants 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 the 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" (quotations 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 Taylor might seek to relate the SAC's allegations back to his own prior complaint, or that he does not seek to add new relators or new theories of liability stemming from the same conduct as his 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 [Taylor's]," and accordingly prohibits any and all claims against Colorado Permanente and the California Defendants 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. Taylor had ample opportunity to name any of the three new Defendants well before 2021. Indeed, Taylor's original complaint alleges he was an employee of Colorado Permanente and joined the "Colorado branch" in 1995. *Taylor* Dkt. No. 1 ¶ 12. His original complaint also includes allegations referencing the California regions. *See id.* ¶¶ 80, 94. There is no reason that Taylor could not have named Colorado Permanente or the California Defendants in an earlier amendment, such as his November 2014 FAC. Allowing Taylor to recover against these Defendants for claims that were time-barred before he 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).

## V. CONCLUSION

As a Colorado physician who practiced in Colorado at Colorado Permanente for nearly two decades, Taylor has brought an FCA claim rooted in Colorado. KFHP and the two California Defendants should be dismissed because Taylor pleads no cognizable claim involving a fraud in California. Taylor's external-provider and NLP allegations also fail to plead falsity and must be dismissed. The Court likewise should dismiss Taylor's attestation-based claims and diagnosis code-based claims to the extent they allege process-based coding violations because Taylor has not alleged materiality with particularity. Finally, all of Taylor's claims against the newly added

Defendants—Colorado Permanente and the California Defendants—predating November 15, 2011, must be dismissed under the FCA's ten-year, exception-free statute of repose. In sum, the Court should dismiss Taylor's SAC except to the extent he alleges that the Colorado Defendants submitted or caused to be submitted false diagnosis codes to CMS on or after November 15, 2011 that reflected medical conditions that did not exist as a clinical matter.

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 TAYLOR'S SECOND AMENDED COMPLAINT**

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

(CAPTION CONTINUED)

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| UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC.,<br><br>Plaintiff,<br><br>v.<br><br>KAISER FOUNDATION HEALTH PLAN, INC., et al.,<br><br>Defendants. | Case No. 3:16-cv-01558-EMC<br><br>**[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT**<br><br>Hearing Date: TBD (Dkt. No. 129)<br>Time: 1:30 PM<br>Judge: Hon. Edward M. Chen<br>Courtroom: 5, 17th Floor |

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|---|---|
| UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE,<br><br>Plaintiff,<br><br>v.<br><br>KAISER FOUNDATION HEALTH PLAN, INC., et al.,<br><br>Defendants. | Case No. 3:16-cv-05337-EMC<br><br>**[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT**<br><br>Hearing Date: TBD (Dkt. No. 129)<br>Time: 1:30 PM<br>Judge: Hon. Edward M. Chen<br>Courtroom: 5, 17th Floor |

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| UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ,<br><br>Plaintiff,<br><br>v.<br><br>KAISER PERMANENTE, et al.,<br><br>Defendants. | Case No. 3:18-cv-01347-EMC<br><br>**[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT**<br><br>Hearing Date: TBD (Dkt. No. 129)<br>Time: 1:30 PM<br>Judge: Hon. Edward M. Chen<br>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 TAYLOR'S SECOND 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 TAYLOR'S SECOND 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 Taylor's Second Amended Complaint is GRANTED. The Court dismisses the Second Amended Complaint except to the extent that Taylor's claims are premised on allegations that Defendants Colorado Permanente Medical Group and Kaiser Foundation Health Plan of Colorado submitted or caused to be submitted false diagnosis codes to the U.S. Centers for Medicare and Medicaid Services on or after November 15, 2011 that reflected medical conditions that did not exist as a clinical matter.

**IT IS SO ORDERED.**

DATED:

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HONORABLE EDWARD M. CHEN
UNITED STATES DISTRICT JUDGE