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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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Washington Permanente Medical Group, P.C.; and Northwest Permanente, P.C. (collectively, "Defendants") will and hereby do move this Court to dismiss Relators Gloryanne Bryant and Victoria Hernandez's First Amended Complaint ("FAC"), Dkt. No. 117, under Federal Rule of Civil Procedure 12(b)(6).

Defendants bring this Motion on the grounds that Relators' False Claims Act ("FCA") claims fail because they fail to allege falsity and materiality. Their claims against all Defendants other than The Permanente Medical Group must additionally be dismissed because they are premised on implausible group allegations. Further, Relators cannot maintain a FCA conspiracy claim because they do not allege that there was any agreement between Defendants to submit fraudulent claims to the United States. And finally, Hernandez's employment claims fail because she does not adequately allege that The Permanente Medical Group was aware that she was engaged in any protected activity. The Court should dismiss the complaint in full.

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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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

TABLE OF AUTHORITIES
(continued)

Page

REGULATIONS

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This Court already has dismissed the majority of Relators Gloryanne Bryant and Victoria Hernandez's First Amended Complaint ("FAC")—disposing of all allegations of fraud on the Medicare Advantage risk-adjustment program, which was the primary focus of the complaint. All that remains are sparse and disjointed references to an alleged fraud on the Patient Protection and Affordable Care Act's ("ACA") risk-adjustment program and Hernandez's employment claims. The FAC fails to recognize the differences between the ACA and Medicare Advantage risk-adjustment programs, nor do any claims for relief even mention the ACA. Hernandez's retaliation claims also fall short of alleging that she engaged in any protected activity known to her employer The Permanente Medical Group ("TPMG"). The complaint suffers from multiple fatal defects; the Court should finish what it started and dismiss the entirety of the FAC.

Relators fail to allege a plausible fraud scheme on the ACA risk-adjustment program. Their complaint centers on an alleged scheme to submit false claims to the U.S. Centers for Medicare and Medicaid Services ("CMS") through the ***Medicare Advantage*** risk-adjustment program, in purported violation of the False Claims Act ("FCA"). But, as noted, the Court already has dismissed all Medicare-related claims under the FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5). *See* Dkt. No. 171 at 46. That has left Relators with nothing but a handful of conclusory allegations that Defendants[1] also defrauded the risk-adjustment program established under the ACA. As this Court already has acknowledged, "[t]he Affordable Care Act is an entirely different scheme [from Medicare Advantage], not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare." *Id.* at 44. Relators cannot use dismissed allegations about an alleged fraud under Medicare Advantage—a different program

[1] "Defendants" are Kaiser Foundation Health Plan; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group; Southern California Permanente Medical Group; Colorado Permanente Medical Group; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Washington Permanente Medical Group; and Northwest Permanente.

established under a different statute from the ACA risk-adjustment program—to satisfy their pleading obligations under Federal Rule of Civil Procedure 8, let alone the demanding particularity standard required in fraud cases under Rule 9(b).

In addition, Relators have not pleaded a fraud scheme because none of the alleged practices that they criticize violates any binding guidance or regulation. Relators instead contend that Defendants violated informal, subregulatory statements from private healthcare industry groups and those groups' responses to Relators' own email inquiries about coding certain medical conditions. Relators must do more than allege an internal dispute about coding guidance to establish an FCA violation. And they must do more than allege a violation of nonbinding guidance issued by third-party private organizations.

Relators likewise have failed to allege materiality. The FAC contains no allegations that the government would have refused to pay Defendants had it known about the allegedly false attestations on which Relators base their claims.

The Court should dismiss all Defendants other than TPMG for an independent reason—Relators do not allege any specific facts about any Defendants other than TPMG. Where, as here, each Defendant has a distinct function, collective allegations cannot satisfy Rule 9(b)'s particularity requirement. Relators cannot simply describe TPMG's conduct and cursorily assert that all other Defendants did the same.

Relators' FCA conspiracy claim fails for all the same reasons their other FCA claims fail. And it should be dismissed for the additional reason that Relators fail to allege that Defendants had any agreement to defraud the government: a central element of the claim.

Finally, the Court should dismiss Hernandez's employment claims against TPMG. Her Fair Labor Standards Act ("FLSA") claim must be dismissed because investigating coding problems is not a protected activity under the statute, whose scope is limited to unlawful wage-and-hour practices. She also has failed to allege any facts that show TPMG would have notice that she was engaging in a purportedly protected activity beyond her typical job duties. So her FCA and California Labor Code retaliation claims cannot stand.

For all these reasons, the Court should dismiss the FAC in full.

II. BACKGROUND

A. The Medicare Advantage and ACA Risk-Adjustment Programs

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 ("HHS"), administers the Medicare program, including Medicare Part C, now known as Medicare Advantage. *See id.* at 873. Under the Medicare Advantage program, private health insurance plans, also known as Medicare Advantage Organizations ("MAOs"), "provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage." *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). 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.[2] *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), (a)(3). 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 must be submitted anew each year.

CMS's risk-adjustment payment model groups diagnosis codes into Hierarchical Condition Categories ("HCCs"). *See Becerra*, 16 F.4th at 874–75. 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. *Id.* During the period at issue, CMS determined the

[2] "Members" refers to the individual beneficiaries who are enrolled in the Medicare Advantage program or, where applicable, the ACA risk-adjustment program. Members become patients when they receive medical care as part of either program. Thus, for purposes of this Motion, the terms "members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

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.*

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*).[3]

Congress created a separate risk-adjustment program after it passed the ACA in 2010—one distinct from Medicare Advantage. Under the ACA, healthcare insurers can no longer deny coverage due to preexisting conditions. *See* 42 U.S.C. § 300gg-1; 45 C.F.R. § 147.108; *King v. Burwell*, 576 U.S. 473, 481 (2015). To encourage enrollment of both sicker and healthier members in health plans, Congress established the ACA's risk-adjustment program. 42 U.S.C. § 18063. The program redistributes funds from plans with healthier-than-average members to those with sicker-than-average members. *Id.*; *Vista Health Plan, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 31 F.4th 946, 948 (5th Cir. 2022). In other words, the program transfers money ***among insurers***. Congress did not authorize any government appropriations for the program. *See* 42 U.S.C. § 18063 (not authorizing appropriations for ACA's risk-adjustment program).

States operating a health-insurance exchange can choose to operate their own ACA risk-adjustment program or HHS can operate it for them. *See* 45 C.F.R. § 153.310. To operate the program, HHS uses a risk-adjustment methodology that consists of a risk-adjustment model and a risk-transfer formula. *See N.M. Health Connections v. U.S. Dep't of Health & Hum. Servs.*, 946 F.3d 1138, 1147 (10th Cir. 2019) (explaining that HHS "[a]veraged the individual risk scores to calculate a 'plan liability' risk score" and "[c]alculated how much plans would be charged or paid

[3] For additional information on how Medicare Advantage works, see Defendants' concurrently filed motion to dismiss the government's intervention complaint at 3–5.

by applying to each plan a payment transfer formula"). The ACA's risk-adjustment model considers both demographic factors, such as age and gender, and diagnoses to calculate the average cost to cover each insurer's member population. *Id.* Both the average risk score and certain plan-specific costs relative to market costs are then weighed to calculate transfer payments. *Id.* "The key feature of the HHS risk adjustment methodology is that the risk score alone does not determine whether a plan is assessed charges or receives payments. Transfers depend not only on a plan's average risk score, but also on its plan-specific cost factors relative to the average of these factors within a risk pool within a State." 78 Fed. Reg. 15,410, 15,417. Such cost factors include "local patterns of utilization and care delivery, local differences in the cost of doing business, and, within limits established by the Affordable Care Act, the age of the enrollee." *N.M. Health Connections*, 946 F.3d at 1164.

Accordingly, the ACA and Medicare Advantage risk-adjustment programs differ in important ways. The purpose of ACA risk adjustment is to transfer funds ***among health plans***, whereas Medicare Advantage risk adjustment calculates payments that MAOs receive ***from CMS*** for providing healthcare coverage to each member. Medicare Advantage risk-adjustment payments are made based on each individual member's risk-adjustment score, whereas ACA risk-adjustment calculations depend on the health plan's average risk score. And the ACA risk-adjustment program considers plan-specific costs relative to the market average when calculating transfers—which does not happen under Medicare Advantage.

B. Procedural History

Relators filed their original complaint on March 1, 2018. On June 6, 2021, this Court consolidated their suit with five related *qui tam* actions, including the first-filed *Osinek* action. Dkt. No. 61. The United States partially intervened in all six actions in July 2021. Dkt. No. 65. On November 15, 2021, Relators amended their complaint. Dkt. No. 117 ("FAC").

Defendants moved to partially dismiss *Bryant* and the four other later-filed *qui tam* actions under the FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5). Dkt. No. 141. As to *Bryant*, the Court granted the motion in part and dismissed all claims except: (1) claims of fraud related to the ACA's risk-adjustment program and (2) Hernandez's employment claims. Dkt. No. 171 at 46.

Although Relators alleged a fraud scheme under the Medicare Advantage risk-adjustment program, the Court concluded that the first-to-file bar required dismissal of that aspect of their complaint. *See id.* In allowing the ACA claims to survive the motion, the Court observed that "[t]he Affordable Care Act is an entirely different scheme, not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare." *Id.* at 44.

C. Relators' First Amended Complaint

Bryant is a medical coding professional who was employed in various "senior coding compliance positions," including with Kaiser Foundation Health Plan ("KFHP") from May 2009 until her retirement in October 2017. FAC ¶ 20. Hernandez is also a medical coding professional. *Id.* ¶ 21. She had worked for both KFHP and TPMG in coding and auditing positions, including as the Regional Director of Auditing & Coding Services for TPMG. *Id.* ¶¶ 9, 21. She resigned from TPMG in October 2015. *See id.* ¶ 21. Relators allege that Defendants committed fraud against the U.S. government in violation of the FCA, and Hernandez asserts that TPMG unlawfully retaliated against her for reporting coding issues at work.

1. Relators' Fraud Claims

Relators spend most of their complaint alleging a fraud on the Medicare Advantage risk-adjustment program. *See, e.g.*, *id.* at 2 (summarizing complaint as alleging a scheme to submit "false 'risk adjustment' information to [CMS] in order to improperly increase the amounts CMS pays" Defendants). Those allegations are now dismissed, but Relators also claim that Defendants engaged in a similar fraud on the ACA's risk-adjustment program through "techniques" that resulted in "over-documenting, over-coding and upcoding" of certain medical conditions. *Id.* ¶ 51. They allege that, in administering the ACA's risk-adjustment program, HHS "utilizes criteria and methods similar to those utilized under the Medicare Advantage program," and that HHS has adapted the HCCs used in the Medicare Advantage model for use in the ACA model. *Id.* ¶ 49. The complaint references the ACA in only 11 of 201 paragraphs (often in passing), and nowhere describes the program in any detail—even though ACA risk adjustment serves a different function and relies on a different payment methodology than Medicare Advantage risk adjustment. *See id.* ¶¶ 7–8, 10, 16, 49–51, 80, 86, 115, 128; *supra* at 3–5. Despite their scattered

references to the ACA, Relators' central claim is that Defendants submitted false risk-adjustment attestations "***to the Medicare Program***." *Id.* ¶ 52 (emphasis added).

Relators' fraud claims focus on coding practices for two specific medical conditions—aortic atherosclerosis ("AA") and ventilator dependence—as well as general business practices that they claim resulted in the submission of false claims to the government. But neither their AA nor vent-dependence allegations specifically mention ACA risk adjustment. As Relators themselves explain, the complaint purports to describe "specific schemes . . . engineered by [Defendants] . . . to circumvent proper documentation and coding practices and ***Medicare law***." *Id.* ¶ 151 (emphasis added).

Aortic Atherosclerosis. Relators claim that Defendants knowingly submitted false diagnosis codes for AA (commonly known as hardening of the arteries) to the government. They do not allege that any particular patient was diagnosed with AA who did not in fact have AA; rather, they assert that true and accurate AA diagnoses should not have been coded in some instances. They contend that AA "is often an incidental finding in radiology and imaging reports and neither treated nor managed after being identified." *Id.* ¶ 53. According to Relators, AA should "not be reported/coded ***to Medicare***" unless it is "related to signs, symptoms or conditions/diagnoses that necessitated the performance of the radiology and imaging test, treatment and management is actually directed toward the AA, or a follow-up office visit is ordered for treatment." *Id.* (emphasis added). They do not allege whether the same coding criteria apply to documenting AA under the ACA's risk-adjustment program.

Relators allege that clinical professionals at TPMG made the clinical determination that AA was "a chronic, systemic condition that should always be coded" when observed in members, again focusing on Medicare Advantage risk adjustment. *Id.* ¶¶ 57, 60, 64. They emphasize that this approach was endorsed by "Kaiser's ***Medicare*** Finance Group" and "regional leaders overseeing [] ***Medicare Advantage*** programs." *Id.* ¶¶ 56, 69 (emphases added). Relators—who are not medical doctors—were "uncomfortable" and "troubled" with this clinical advice because they "questioned whether [AA] was truly systemic." *Id.* ¶¶ 57, 58, 63. Their opinion was that "[u]nless AA is related to signs, symptoms or conditions/diagnoses that necessitated the

performance of the radiology and imaging test, treatment and management is actually directed toward the AA, or a follow-up office visit is ordered for treatment, it should not be reported/coded ***to Medicare***." *Id.* ¶ 53 (emphasis added).

In reaching this conclusion, Relators relied on only a single source: nonbinding guidance from the American Hospital Association ("AHA") Coding Clinic. That guidance does not mention AA. Nor does it mention ACA risk adjustment. The AHA Coding Clinic says only that it is "inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for the ***patient being seen in the emergency department***." *Id.* ¶ 54 (emphasis added). The statement does not mention any other scenario, such as outpatient visits.

In 2012, Relators wrote a memo distributed to coding leaders in Northern California advising that "AA should not be coded except under certain limited conditions." *Id.* ¶ 62; *id.*, Ex. 2. Leadership at TPMG, including physicians, disagreed with the memo's conclusion about AA's clinical impact. *Id.* ¶ 67. TPMG had determined that "once AA is present it never goes away and is then a lifelong risk factor" and concluded that AA "does impact care and decision making." *Id.*

Between 2013 and 2015, Bryant participated in presentations to "various Kaiser regional leadership audiences" about TPMG's approach to coding AA. *Id.* ¶ 69. Yet she remained "concerned" about the clinical guidance she was endorsing. *Id.* ¶ 70. Eventually she asked the AHA Coding Clinic whether AA was a "chronic systemic condition." *Id.* ¶ 71. In response, the AHA Coding Clinic did not take a position; it simply observed that "it is appropriate to assign a code" for a chronic systemic condition that affects a patient for "the rest of his/her life." *Id.*, Ex. 13 at REL0000189. The AHA Coding Clinic did not state that it would be inappropriate to code AA even if AA were not a chronic systemic condition. *See id.*

Relators allege that in 2015, KFHP's National Compliance Office concluded that AA was not a chronic systemic condition and should not be coded unless documentation showed how AA impacted the provider-member encounter. *Id.* ¶ 75. Relators claim that despite this guidance, Defendants did not validate the accuracy of AA documentation for prior years, and never reimbursed amounts "falsely obtained" from "over-diagnosing and over-coding AA." *Id.* ¶ 79.

They allege that from 2010 to 2015, the number of AA codes that Defendants submitted "to Medicare and other payers" increased dramatically. *Id.* ¶ 76. They do not identify the "other payers." *See id.* And while they quantify the number of AA claims submitted to Medicare and the corresponding dollar amount, they fail to allege that even a single AA claim was submitted to the ACA program. *Id.* ¶¶ 76, 78.

Ventilator Dependence. Relators describe a similar coding dispute about vent dependence. According to Relators, healthcare providers can code vent dependence "when a patient requires long-term, continued ventilator support to breathe beyond the acute care phase." *Id.* ¶ 80 (emphases in original). They claim that TPMG prohibited healthcare providers from diagnosing vent dependence before a member had been on a ventilator for 12 hours. *Id.* ¶ 83. TPMG later revised that policy to prohibit diagnosing vent dependence before 30 days of ventilator use. *Id.* They claim that Southern California Permanente Medical Group ("SCPMG") had a similar policy preventing diagnosing vent dependence before 21 days of ventilator use. *See id.* Relators disagreed with these time-based rules on coding vent dependence because they believed that the condition "should be infrequently assigned and coded." *Id.* ¶ 86. Relators nowhere allege that they ever communicated a proper standard for coding vent dependence. Instead, they merely allege that they had "deep concern and investigated Kaiser's coding practices for vent dependence status . . . including for ***patients in the Medicare Advantage program***." *Id.* ¶ 96 (emphasis added).

Based on their research of coding practices and a private email to an individual at the American Health Information Management Association ("AHIMA"), a private professional organization, Relators concluded that "the vent dependence status code would not be appropriate for newborn initial clinic visits, follow-up clinic visits, or hospital short-term acute visits." *Id.* ¶¶ 88–90. They claim that TPMG leadership disagreed with Relators and continued to follow its policies. *Id.* ¶ 90. They also claim that coding data shows that "vent dependence coding volume skyrocketed" at Defendant regions across the nation. *See id.* ¶ 101.

Business Practices. Relators also describe multiple business practices at TPMG that they claim resulted in fraud on "the government and its Medicare and Medicaid programs." *Id.* ¶ 104.

First, they describe "policies and procedures" that allegedly violated "coding and diagnostic principles" and led to "improper documentation, coding and overbilling." *Id.* ¶¶ 105–06. For example, coding professionals can "query" healthcare providers for "clarification and additional documentation prior to code assignment." *Id.* ¶ 109. Relators allege that Defendants used templates for these queries that violated guidelines found in "practice briefs" developed by AHIMA because they improperly led providers to document specific diagnoses. *See id.* ¶¶ 109–13, 115. Relators also opposed a policy requiring all inquiries sent to the AHA Coding Clinic to be directed through the Coding Governance Group ("CGG"), a group of healthcare providers from the various Permanente Medical Groups. *Id.* ¶¶ 119–20. Bryant believed that she should have had "independence" and the ability to send inquiries directly to the AHA Coding Clinic without further review. *Id.* ¶ 121.

Second, Relators criticize TPMG for an alleged "emphasis on financial outcomes." *See id.* at 38. They fault TPMG's clinical documentation practices for focusing too narrowly on risk-adjusting payers and capturing medical conditions that would increase revenue. *See id.* ¶ 128. They similarly criticize the Regional Reporting Group ("RRG"), which comprised leaders from both KFHP and the Permanente Medical Groups, for sharing "best practices" about coding and documentation that focused on increasing capture of high-value medical conditions. *Id.* ¶ 135–36. And they fault TPMG for providing employee and leadership bonuses related to "revenue capture." *Id.* ¶ 139.

Third, Relators highlight TPMG's allegedly "improper" use of technology, including data mining, algorithms that carried over "add" and "block" files from previous years, and Computer Assisted Coding. *Id.* ¶¶ 141–50. Data mining uses algorithms to scan medical records and identify diagnoses that the healthcare provider may have missed. *Id.* ¶ 141. When potential diagnoses are identified, coders will query the original healthcare provider about adding the diagnoses. *Id.* ¶ 142. Relators do not explain what "add" and "block" files are; they merely allege that TPMG ***may*** have used them in a way that "improperly carried over HCCs from previous years to the current year." *Id.* ¶ 144. According to Relators, Computer Assisted Coding was "a valuable tool and asset to increase coding productivity, coding accuracy, and [diagnosis

code] capture." *Id.* ¶ 146. Relators allege they audited the program and discovered errors, which TPMG purportedly covered up. *Id.* ¶ 148.

Relying on these allegations, Relators bring FCA claims based on the submission of "Risk Adjustment Attestations." They assert that Defendants knowingly presented or caused to be presented or knowingly made, used, or caused to be made or sused "a false Risk Adjustment Attestation" to "receive and retain risk adjustment payments ***from the Medicare Program***" in violation of 31 U.S.C. § 3729(a)(1)(A)–(B). *Id.* ¶¶ 157, 162 (emphasis added). They contend that Defendants conspired with each other "by getting risk adjustment payments ***from the Medicare Program*** based on a false or fraudulent claim for risk adjustment payments and/or a false or fraudulent Risk Adjustment Attestation" in violation of 31 U.S.C. § 3729(a)(1)(C). *Id.* ¶ 168 (emphasis added). Finally, they bring a claim under 31 U.S.C. § 3729(a)(1)(G), alleging that "Defendants knowingly made, used, or cause to be made or used a false Risk Adjustment Attestation material to an obligation to repay risk adjustment payments to which they were not entitled ***from the Medicare Program***." *Id.* ¶ 172 (emphasis added). Their claims for relief repeat and re-allege all other allegations, but do not specifically reference the ACA. *See id.* ¶¶ 156–76.

2. Hernandez's Retaliation Claims

Hernandez also alleges that she voluntarily resigned from her job at TPMG in October 2015. *Id.* ¶ 182. She claims that when she worked for TPMG, she received a "poor review" in which she was "criticized for purported lack of communication" and "reprimanded for communicating her concerns about TPMG's coding and auditing functions." *Id.* ¶¶ 179–81. She alleges that the review was due to her "observing and reporting internally several of the coding errors and systemic fraud" alleged in the FAC. *Id.* ¶ 180. Hernandez admits that "TPMG leadership" asked her to "stop looking for another job," but she alleges that she felt "set up to be terminated" and voluntarily resigned. *Id.* ¶ 181.

Based on these allegations, Hernandez brings four employment claims against TPMG. She claims that TPMG violated the FCA's retaliation provision, California Labor Code sections 98.5 and 1102.5, and the FLSA. *See id.* ¶¶ 177, 187–91, 192–96, 197–201.

III. LEGAL STANDARD

To survive dismissal under Federal Rule of Civil Procedure 12(b)(6), Relators' 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).

Relators' fraud allegations must also satisfy the heightened pleading requirements of Rule 9(b), which requires a party to "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). Relators' allegations must be "specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged 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

The Court previously whittled down Relators' FCA fraud claims to only alleged ACA-related fraud, for which Relators have not made out a plausible claim for relief. To succeed on their FCA claims, Relators 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), (G).

Relators have failed to allege falsity or materiality. As to falsity, Relators cannot use their allegations about risk adjustment under Medicare Advantage to establish falsity because Relators' Medicare Advantage claims have been dismissed. The ACA is a different program, with a different payment method and purpose from Medicare Advantage. In any event, Relators' allegations describe nothing more than their own disagreement with TPMG's determinations about when to code AA and vent dependence, supported by nothing but nonbinding statements from nongovernmental organizations that cannot form the basis for an FCA action. Nor do Relators sufficiently allege that any claim for payment was material to HHS. Indeed, they make

no reference to the materiality of any alleged claims to HHS—focusing instead on the materiality of attestations to CMS through the Medicare Advantage program.

In addition, Relators' FCA claims against every Defendant except for TPMG independently fail because Relators rely on implausible collective allegations that group together 14 other Defendants—each of which Relators acknowledge has a distinct function—into their allegations about TPMG's conduct.

Finally, Hernandez's retaliation claims all fail because she either does not allege that she engaged in a protected activity under the relevant statute or because she does not allege that TPMG was aware that she was engaged in a protected activity.

A. The Court Should Dismiss Relators' Remaining FCA Fraud Claims

1. Relators Fail To Identify Any False Claims Submitted to HHS Under the ACA's Risk-Adjustment Program

Relators fail to allege falsity in support of any of their FCA fraud claims. FCA claims must meet Rule 9(b)'s heightened pleading standard. The allegations must address "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) (quotations and citations omitted); *see also United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) ("*Swoben*").

Here, Relators fail to meet Rule 9(b)'s heightened pleading standard for any purported fraud under the ACA. Relators do not identify a single allegedly fraudulent code or attestation that was submitted to HHS under the ACA's risk-adjustment program. They cannot meet the rigors of Rule 9(b) with passing references to the ACA in fewer than a dozen paragraphs, failing to describe how the ACA risk-adjustment program actually works, and repeating that their allegations concern not the ACA, but the "Medicare Program."

The Court should reject Relators' attempt to piggyback on their Medicare Advantage allegations by asserting that "Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program." FAC ¶ 10. As this Court recognized,

"[t]he Affordable Care Act is an entirely different scheme, not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare." Dkt. No. 171 at 44. Medicare Advantage risk adjustment calculates a per-member payment from the government to an insurer based on the individual member's risk score to compensate the insurer for covering the anticipated cost of that member's healthcare in the following year. *See Becerra*, 16 F.4th at 873–4. The ACA program, by contrast, relies on each insurer's average risk score and other market-based cost factors to calculate payment transfers among insurers to spread risk. *See N.M. Health Connections*, 946 F.3d at 1148. "The ACA claims thus state causes of action entirely different and distinct from the Medicare Advantage claims." Dkt. No. 171 at 44. Relators cannot establish the particular who, what, where, when, and why that Rule 9(b) requires by describing conduct relevant to the Medicare Advantage program and then cursorily alleging that the fraud on the ACA program was the same. Their tacked-on ACA allegations do not even satisfy Rule 8's lower plausibility standard, and should be dismissed. *See Twombly*, 550 U.S. at 555.

Even if the Court were to conclude that all of Relators' Medicare Advantage-specific allegations apply equally to the alleged fraud on the "entirely different" ACA program, their FAC still does not allege a plausible fraud scheme with Rule 9(b)'s requisite particularity. Relators assert that Defendants falsified AA and vent-dependence diagnosis codes specifically, and engaged in a variety of business practices that led to false diagnosis codes generally. But none of their allegations plausibly suggests that Defendants submitted false claims to the government.

Aortic Atherosclerosis. Relators have not plausibly alleged that Defendants submitted any false claims related to coding AA under the ACA program. They fail to allege that a single AA diagnosis code was submitted to the ACA program—let alone establish that a diagnosis was false. Relators' theory of AA fraud is not that Defendants diagnosed AA in members who did not have the condition. It is that TPMG's internal coding policies were inaccurate because they were based on the clinical determination that AA is a systemic condition. FAC ¶¶ 57, 61. But Relators have failed to cite any binding requirement that prohibits treating AA, an irreversible hardening of the arteries, as systemic.

Relators allege only that TPMG violated AHA Coding Clinic ***guidance***, none of which

binds Defendants. Only "noncompliance with material statutory, regulatory, or contractual ***requirements***" can be the basis for an FCA claim. *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 190 (2016) (emphasis added). The alleged violation of subregulatory documents, such as advice from the AHA Coding Clinic or AHIMA, cannot support an FCA action. Subregulatory documents "do not have the force and effect of law." *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 97 (2015) (marks omitted). They can "***never*** form[] the basis for an enforcement action" because they do "not impose any legally binding requirements on private parties." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2420 (2019) (marks omitted) (emphasis added). Enforcement actions "must" be based on "a legislative rule" that is the product of "notice and comment." *Id*. That a defendant in an FCA action "may have failed to technically comply" with a guidance document that was "not promulgated pursuant to any rulemaking power of [an] agency . . . does not establish an FCA violation." *United States ex rel. Yannacopoulos v. Gen. Dynamics*, 2007 WL 495257, at *3 (N.D. Ill. Feb. 13, 2007).

AHA is a healthcare industry trade group—not a government agency—so the guidance it writes is not subject to formal rulemaking and does "not have the force and effect of law." *Perez*, 575 U.S. at 97. Even if TPMG "failed to technically comply with" statements from AHA's Coding Clinic, that failure "does not establish an FCA violation." *Yannacopoulos*, 2007 WL 495257, at *3. Nowhere do Relators even attempt to assert that AHA Coding Clinic guidance binds Defendants when coding diagnoses for ACA risk adjustment. Because Relators have failed to identify any binding guidance or regulation that prohibited Defendants from coding AA for submission to the ACA risk-adjustment program, Relators have not alleged that Defendants submitted any false attestations to the government.

In any event, Relators fail to even establish that Defendants' AA coding practices ran afoul of the AHA Coding Clinic guidance, which says only that "[i]t is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a ***patient being seen in the emergency department***." FAC ¶ 54 (emphasis added). By its text, this guidance is limited to emergency-department visits. It does not purport to set guidelines for coding medical conditions

diagnosed outside of the emergency setting, so this guidance cannot apply to Relators' claims about coding AA in "clinic," "outpatient surgery," and "inpatient" encounters. *Id.* ¶ 56. This guidance also says nothing about the proper clinical treatment of AA. Relators even acknowledge that when they followed up with the AHA Coding Clinic to shore up their own view of AA, the AHA Coding Clinic confirmed that the impact of AA is a clinical determination to be made by the healthcare provider. *Id.* ¶ 71.

Relators also cannot save their AA allegations by pointing to Defendants' increased rates of AA diagnoses from 2010 to 2016. *Id.* ¶ 78. The Ninth Circuit has rejected efforts to allege falsity based on statistical analysis where there is a "plausible alternative (and legal) explanation" for the defendants' conduct. *Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 (9th Cir. 2021) (allegations that hospital submitted certain diagnoses at a higher rate than comparable institutions failed to state a fraud claim in FCA action). Where, as here, fraud is "only a *possible* explanation" of statistics that are consistent with a plausible and legal explanation—that TPMG began to prioritize coding a serious cardiac condition that could be dangerous or deadly to members—Relators "do[] not state a plausible claim for relief, and [their] complaint must be dismissed." *Id.* at 844–45 (emphasis in original).

Ventilator Dependence. As with AA, the thrust of Relators' vent-dependence allegations is their own disagreement—based on their own interpretation of nonbinding coding guidance—with Defendants' internal policies about when to code vent dependence. FAC ¶¶ 80, 83–84. They do not allege that Defendants diagnosed vent dependence for members who were not on a ventilator. Instead, Relators argue that TPMG and SCPMG impermissibly relied on time-based standards to code vent dependence, while proposing no alternative standard. *Id.* ¶ 83.

But like with the AA allegations, Relators do not plausibly suggest that Defendants violated any legally binding requirements when submitting vent-dependence diagnoses to the government. They cite only nonpublic statements by the AHA Coding Clinic and by one AHIMA employee, both of which were issued in response to inquiries initiated by Relators themselves. *Id.* ¶¶ 81, 88. As with the guidance cited in support of the AA allegations, these nonpublic opinions issued by nongovernmental organizations cannot form the basis for an FCA

action. *See Kisor*, 139 S. Ct. at 2420; *Yannacopoulos*, 2007 WL 495257, at *3. And as with the AA claims, Relators' allegation about an increase in vent-dependence diagnoses, FAC ¶ 101, does not save them from a failure to allege falsity. *Integra*, 854 F. App'x at 844.

Business Practices. Relators' criticisms of various TPMG business practices also do not plausibly allege that TPMG caused any false claims to be submitted to the government.

First, Relators allege that these practices resulted in fraud on only "[the] Medicare and Medicaid programs." FAC ¶ 104. They do not allege that the business practices resulted in any fraud on the ACA risk-adjustment program, so these allegations cannot possibly support Relators' remaining FCA claims.

Further, Relators fail to identify anything improper about any of the business practices discussed in their complaint. Relators assert that certain TPMG policies "contravene coding and diagnostic principles," specifically the CGG's oversight of AHA Coding Clinic inquiries and the use of query templates. *See id.* ¶¶ 105, 120. But Relators once again fail to identify a single binding statute or regulation that prohibits the policies described. Relators' main complaint with CGG oversight is that it limited Bryant's "independence" to send AHA Coding Clinic inquiries whenever she wanted. *Id.* ¶ 121. That does not plausibly suggest a false claim. And though Relators contend that the use of query templates violates AHIMA practice briefs, as explained above, *see supra* at 10, AHIMA guidance is not binding on Defendants. In addition, the Ninth Circuit has held that allegations like Relators' about the use of "leading queries" and similar efforts designed to encourage healthcare providers to completely and accurately diagnose all medical conditions are not sufficient to state a claim for fraud. *Integra*, 854 F. App'x at 844–45.

Relators similarly do not identify any false claims that resulted from an alleged "emphasis on financial outcomes." FAC ¶¶ 126–40. While Relators imply that TPMG's focus on revenue resulted in fraud, "there is nothing 'inappropriate, unethical or otherwise wrong with [healthcare providers] taking full advantage of coding opportunities to maximize [] payment that is supported by documentation in the medical record.'" *Integra*, 854 F. App'x at 844 n.4 (citations omitted).

Finally, Relators do not identify a single false claim that resulted from TPMG's use of data mining, "add" and "block" files, and Computer Assisted Coding. *See supra* at 10. They fail

to cite any binding rule that prohibits the use of such technology. At most, Relators allege that Hernandez determined that TPMG's Computer Assisted Coding program had "an overall poor accuracy rate" during its "pilot phase." FAC ¶ 147. But they do not allege what the accuracy problems were, whether those same problems remained after the "pilot phase" ended, or that any codes identified by the coding program were actually submitted to HHS. *See 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)").

2. Relators Fail To Allege That Attestations Were Material to HHS

Relators also fail to satisfy the FCA's heightened materiality standard. They premise their FCA causes of action on the submission of purportedly false risk-adjustment attestations to the government and the retention of overpayments based on the same. FAC ¶¶ 157–58, 162–63, 168, 172. But Relators have not alleged that the attestations Defendants allegedly submitted were material to the government.

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 192–93. 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). As the Supreme Court has explained, the demanding materiality standard is necessary because 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 (citations omitted). To adequately plead materiality, it is "not enough to allege that Defendants were obligated by various regulations and contracts to comply with the Attestation requirements" or that HHS would "have had the option to decline to pay" if it were aware of a failure to comply with such requirements. *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487, at *9 (C.D. Cal. Feb. 12, 2018) (quotations and citations omitted); *United States v. Scan Health Plan* ("*Swoben II*"), 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017) (dismissing government's complaint where it failed to allege "that [CMS] would not have paid these claims had it known of the[]

violations" that allegedly rendered the attestations false). Instead, Relators must allege facts showing that if the government had known of the coding and business practices described in the complaint, it would not have paid Defendants. *See id.*

Here, Relators do not allege even a threadbare recital of materiality for any purported false claims ***to HHS***. They instead devote four paragraphs to allegations about the materiality ***of diagnosis data to CMS under Medicare's risk-adjustment program***. FAC ¶¶ 152–55. Nowhere do they address the materiality of false ***attestations*** to either the ACA or Medicare Advantage program. Nowhere do they address the materiality of any statement made to ***HHS under the ACA***. Not a single paragraph in the FAC's materiality section meets the demanding threshold required to establish that HHS would not have paid Defendants had it known of the alleged falsity. It is not even clear from the complaint what HHS—which itself pays no money into the ACA risk-adjustment program—would have done had it been aware of a false attestation. Relators do not allege that HHS previously declined to pay health plans that engaged in similar alleged practices under the ACA risk-adjustment program. *Escobar*, 579 U.S. at 195 (observing that "evidence that . . . the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular" requirement could support a finding of materiality); *see also 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). Relators do not describe any communications from HHS to Defendants about attestations at all. Without clear allegations about how HHS makes (or redistributes) payments to health plans under the ACA's risk-adjustment program, it is not possible to understand how attestations would be material to that decision.

Finally, the Court should reject Relators' contention that the government's partial intervention by itself supports materiality. FAC ¶ 155. That cannot be the case. The government has intervened in cases and filed complaints that are then dismissed for the government's own failure to allege materiality. *See, e.g.*, *Poehling*, 2018 WL 1363487, at *9; *Swoben II*, 2017 WL 4564722, at *6. "[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*." *United States ex rel. Mei Ling v. City of Los Angeles*, 2018 WL 3814498, at *20 (C.D. Cal. July 25, 2018). And here, the government did not intervene in any ACA claims, so Relators' logic makes no sense anyway.

3. Relators Fail To Allege Claims Against Non-TPMG Defendants

The FAC's reliance on group pleading offers the Court an independent basis for dismissing the complaint as to all Defendants except TPMG. Relators impermissibly lump the other Defendants into allegations about TPMG's conduct.

Rule 9(b) "does not allow a complaint to merely lump multiple defendants together." *Swartz v. KPMG LLP*, 476 F.3d 756, 764 (9th Cir. 2007). Plaintiffs must "differentiate their allegations when suing more than one defendant and inform each defendant separately of the allegations surrounding [its] alleged participation in the fraud." *Swoben*, 848 F.3d at 1184. While courts do allow collective allegations where each defendant has an identical role and functions in the exact same way, collective allegations are not permitted where the defendants presumably did not engage in the exact same conduct. *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").

Relators admit that the 15 Defendants they have named are not identical and have different functions. FAC ¶¶ 23–38. The health plans contract with the government and operate Medicare Advantage plans. *Id.* ¶ 24. The physician-run Permanente Medical Groups provide medical services to members. *Id.* ¶¶ 29–37. Kaiser Foundation Hospitals is a non-profit that owns and operates hospitals. *See id.* ¶ 28. Both the health plan entities and Permanente Medical Groups cover distinct regional areas and vary dramatically in membership size. *See id.* ¶¶ 23–38. Relators concede that these groups often diverge on operational and coding practices. *Id.* ¶¶ 140 (KFHP's National Compliance Office "has no power over the Permanente Medical Groups"), 107 (the Permanente Medical Groups have "significant control" over their own day-to-day operations), 124 (it was difficult for National Compliance Office employees "to get the medical

groups and CGG to understand the need to query AHA Coding Clinic directly and freely").

It is not plausible that each of these distinct entities would have engaged in alleged fraud in precisely the same way, given their different functions and approaches to coding. Yet throughout the complaint, Relators attempt to attribute specific allegations to "Kaiser" and "Kaiser Defendants," when in fact, their allegations largely refer to just a single Defendant: TPMG. Claims against all non-TPMG Defendants fail for that reason alone.

A close read of the allegations also reveals that Relators rely on implausible collective allegations to support all three categories of purported fraud claims. First, Relators' AA allegations focus exclusively on TPMG's determination that AA was systemic. While they cursorily allege that "TPMG's AA directive" applied in "other regions," *id.* ¶ 69, these allegations lack specificity to support the inference that different regions with different geographic scope and member populations approached AA coding exactly as TPMG did. And this allegation cannot apply to the health plan Defendants, which are health plans that do not see members directly and therefore never diagnosed this condition. Relators do not allege that KFHP suggested coding AA based on the clinical determination that the condition was systemic. To the contrary, Relators allege that KFHP's National Compliance Office issued an opinion on AA coding that at times conflicted with that of TPMG. *Id.* ¶¶ 60, 62, 67, 75.

Second, for their vent-dependence allegations, Relators rely on virtually identical group allegations. Relators describe alleged practices at only TPMG and SCPMG. But the only two paragraphs that refer to SCPMG allege merely that SCPMG had a 21-day vent-dependence policy, as compared to TPMG's 30-day policy, *see id.* ¶¶ 83, 97, and all remaining allegations refer to TPMG. As with the AA allegations, it is not plausible to infer that each of the 15 distinct Defendants acted in the same way as TPMG when diagnosing and coding vent dependence.

And third, Relators do not sufficiently allege that any Defendant other than TPMG relied on any of the business practices they describe. Indeed, Relators' allegation that "the Permanente Medical Groups have significant control over chart audit selection, accuracy rates, documentation guidance, [and] coding policy and practice[,]" *id.* ¶ 107, directly undermines their attempt to

impute TPMG's business practices to all Defendants.[4]

4. Relators Fail To Allege an Agreement Among Defendants To Support Their FCA Conspiracy Claim

Relators' FCA conspiracy claim fails for all the same reasons the other fraud claims fail, but it should be dismissed for the additional reason that Relators do not allege that Defendants had any agreement to defraud the government. A conclusory allegation that defendants "conspired" with one another does not support an FCA conspiracy claim if it is "unsupported by specific allegations of any agreement or overt act." *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1014 (11th Cir. 2005); *United States v. Toyobo Co.*, 811 F. Supp. 2d 37, 50–51 (D.D.C. 2011) (dismissing FCA conspiracy claim against certain defendants where complaint lacked factual allegations supporting the inference that the alleged conspirators had entered into any agreements for the purpose of getting the government to pay a claim). Here, Relators do no more than allege that Defendants "conspired with one another." FAC ¶¶ 167–68. They do not allege any facts that would support an inference that Defendants had an agreement to conspire to submit false claims to the government. To the contrary, Relators allege that KFHP's National Compliance Office often made recommendations that were inconsistent with TPMG's alleged schemes. *See, e.g.*, *id.* ¶¶ 75, 124, 140.

B. The Court Should Dismiss Hernandez's Retaliation Claims

1. Hernandez Fails To Allege She Engaged in Protected Activity Under the FLSA

Hernandez cannot bring an FLSA claim premised on her complaints about documentation and coding practices. The FLSA makes it unlawful "to discharge or . . . discriminate against any employee because such employee" has complained about violations of the statute. 29 U.S.C. § 215(a)(3). Under the FLSA, "protected activity includes informal complaints about unlawful

[4] Relators make passing reference to Defendant Northwest Permanente Medical Group in their allegations about query templates, but that is not enough to sustain an FCA claim against that entity. *Id.* ¶¶ 113, 115, 118. As explained above, *see supra* 17, Relators do not allege that any false claims resulted from the use of purportedly leading queries, nor do they allege that the use of leading queries violated any binding coding requirements.

wage-and-hour practices, whether oral or written, presented to the employer itself." *Roces v. Reno Hous. Auth.*, 300 F. Supp. 3d 1172, 1205 (D. Nev. 2018) (citing *Lambert v. Ackerley*, 180 F.3d 997, 1007 (9th Cir. 1999)). Courts routinely dismiss FLSA retaliation claims based on alleged retaliation for complaints not covered by the FLSA—for example, complaints about unethical business practices, sex discrimination, and disability discrimination rather than wage-and-hour issues. *See, e.g.*, *Florida-Kaclik v. SSPC*, 124 F. App'x 707, 709 (3d Cir. 2005) (upholding dismissal of FLSA retaliation claim because plaintiff's allegation that she "was being retaliated against for her complaints about potential unethical business practices" were not within the scope of "'protected activities' under the FLSA"); *Lei Yin v. Thermo Fisher Sci.*, 2017 WL 6329613, at *2, 4 (D. Mass. Dec. 11, 2017) (dismissing FLSA retaliation claim based on complaints about age, race, ethnicity, and national origin discrimination and for pursuing unemployment benefits); *Dunn v. Sederakis*, 143 F. Supp. 3d 102, 110 (S.D.N.Y. 2015) (dismissing FLSA retaliation claims based on complaints about disability-based discrimination).

Here, Hernandez does not allege that she complained about wage-and-hour practices. Her allegations all concern purported clinical and coding practices. Her FLSA claim has nothing to do with the activities the FLSA protects and must be dismissed.

2. Hernandez Fails To Allege That Defendants Knew She Was Engaged in Purportedly Protected Activity and Retaliated

Hernandez also fails to plead an FCA retaliation claim under 31 U.S.C. § 3730(h).[5] She must show that (1) she engaged in protected activity (2) about which her employer was aware and (3) for which the employer retaliated. *Cafasso, United States ex rel. v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1060 (9th Cir. 2011). "[W]hen an employee is tasked with [monitoring and reporting] investigations, it takes more than an employer's knowledge of that activity to show that an employer was on notice of a potential *qui tam* suit." *United States ex rel. Campie v. Gilead*

[5] 31 U.S.C. § 3730(h) provides in full: "Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter."

Scis., Inc., 862 F.3d 890, 908 (9th Cir. 2017). Instead, an employer "is put on notice only where [the employee] has suggested that she intends to use the alleged noncompliance as the basis for an FCA claim, or else intends to report the misconduct to government officials." *United States v. Somnia, Inc.*, 2018 WL 684765, at *10 (E.D. Cal. Feb. 2, 2018).

Hernandez was employed as a coding and auditing professional. FAC ¶ 21. Identifying and reporting potential coding errors or problems such as the ones described in the complaint through audits and similar reviews were part of her job. Because investigating and reporting coding errors were part of Hernandez's job, she must show that TPMG was aware that she was engaged in protected activity beyond her typical duties. But she fails to allege that she disclosed to TPMG her intention "to use the alleged noncompliance as the basis for an FCA claim" or "to report the misconduct to government officials." *Somnia, Inc.*, 2018 WL 684765, at *10. She merely alleges that she "question[ed]" TPMG's approach, that she had "concern[s]," and was "disturbed and troubled." FAC ¶¶ 68, 70, 77, 86, 96. Even if accepted as true, such allegations would not be enough to give TPMG notice that Hernandez understood the conduct at TPMG to be fraudulent. Without such allegations, Hernandez's retaliation claim "does not show any connection to the FCA" and should be dismissed. *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1270 (9th Cir. 1996) (affirming summary judgment and holding that "unless the employer is aware that the employee is investigating fraud, the employer could not possess the retaliatory intent necessary to establish a violation of § 3730(h)"); *United States ex rel. Lockyer v. Haw. Pac. Health*, 490 F. Supp. 2d 1062, 1085 (D. Haw. 2007) ("[W]hen an employee voices complaints but does not refer to any allegations of fraudulent conduct against the government, the employer lacks the requisite knowledge to make out a FCA retaliation claim.").

3. Hernandez Fails To Allege Retaliation Under California Law

Hernandez's California Labor Code claims fail for similar reasons. Under California law, "[t]o establish a prima facie case of retaliation, a plaintiff must show that she engaged in protected activity, that she was thereafter subjected to adverse employment action by her employer, and there was a causal link between the two." *Guthrey v. State of California*, 63 Cal. App. 4th 1108, 1125 (1998). "The retaliatory motive is proved by showing that plaintiff engaged

in protected activities, that ***his employer was aware of the protected activities***, and that the adverse action followed within a relatively short time thereafter." *Morgan v. Regents of Univ. of Cal.*, 88 Cal. App. 4th 52, 69, 73 (2000) (quotations omitted) (emphasis added) (granting summary judgment and dismissing plaintiff's claims under Cal. Lab. Code § 1102.5 where there was "an absence of evidence" showing that the employer was aware of the engagement in protected activity); *Dowell v. Contra Costa Cnty.*, 928 F. Supp. 2d 1137, 1151 (N.D. Cal. 2013) (dismissing retaliation claim under California law where plaintiff failed to adequately allege that employer was aware of the protected activity); *Killgore v. Specpro Pro. Servs., LLC*, 2019 WL 6911975, at *7 (N.D. Cal. Dec. 19, 2019) (dismissing California whistleblower retaliation claims because "[p]laintiff's communications . . . do not qualify as protected disclosures because the communications were part of his normal duties and were made through normal channels").

Here, as with her FCA retaliation claim, Hernandez has not pleaded sufficient facts to show that TPMG knew that she was engaged in any protected activity, given the nature of her job. The Court should dismiss her California Labor Code claims for that same reason.

V. CONCLUSION

The Court has already dismissed the core of Relators' FAC, and it should dismiss what remains. Relators fail to allege both materiality and falsity to support their FCA fraud claims under the ACA—a risk-adjustment program their complaint scarcely mentions and their claims for relief omit. Relators' claims against non-TPMG Defendants additionally fail because they are based on implausible group allegations. Their conspiracy claim must be dismissed because Relators have alleged no FCA violations and no agreement among Defendants to commit any FCA violation. Finally, Hernandez has not stated a claim for retaliation under the FLSA, FCA, or California law, either because she has not alleged a protected activity or because she does not allege that TPMG knew that she was engaged in any protected activity.

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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 RELATORS BRYANT AND HERNANDEZ'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 Relators Bryant and Hernandez'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