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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 **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** Hearing: October 14, 2022 at 1:30 p.m. Location: Zoom videoconference

(captions continued on next page)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** Hearing: October 14, 2022 at 1:30 p.m. Location: Zoom videoconference
UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** Hearing: October 14, 2022 at 1:30 p.m. Location: Zoom videoconference
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:18-cv-01347-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS** Hearing: October 14, 2022 at 1:30 p.m. Location: Zoom videoconference

(captions continued on next page)

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

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

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

UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

Hearing: October 14, 2022 at 1:30 p.m.
Location: Zoom videoconference

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

Plaintiff,

v.

KAISER PERMANENTE, INC., et al.,

Defendants.

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

UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

Hearing: October 14, 2022 at 1:30 p.m.
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INTRODUCTION[1]

The United States' Complaint-in-Intervention ("Complaint") alleges in detail how various Kaiser Permanente affiliates (collectively "Kaiser") conspired to unlawfully obtain Medicare Advantage risk-adjustment payments.[2] Kaiser obtained these payments by systematically altering patient medical records, often long after a visit, to add diagnoses that were unrelated to the patient's visit, and sometimes did not exist. Kaiser knew that it could not submit such diagnoses for payment because they violated the ICD Official Guidelines for Coding and Reporting ("ICD Guidelines")—a core requirement of the Medicare Advantage risk-adjustment system and the national standard for diagnosis reporting for all of Medicare. Kaiser ignored its obligations and submitted thousands of these inaccurate diagnosis codes that violated the ICD Guidelines to the Centers for Medicare and Medicaid Services ("CMS") and received hundreds of millions of dollars in improper Medicare payments. Kaiser engaged in this scheme for money, pressuring and incentivizing physicians to add diagnoses improperly via addenda, especially at the end of the year as part of Kaiser's "dash for cash."

Notwithstanding that factual allegations are taken as true when deciding a motion to dismiss, Kaiser largely ignores the allegations in the Complaint and regularly substitutes its own counter-allegations.[3] A review of the allegations in the Complaint, however, reveals that Kaiser's arguments are premised on assertions that Kaiser knows to be false. Kaiser knew that it was required to comply with the Medicare Managed Care Manual. Kaiser knew that all diagnosis submissions for payment were required to be coded accurately according to the ICD Guidelines. Kaiser knew that accurate coding according to the ICD Guidelines was material to CMS and that it could face False Claims Act ("FCA") liability for failing to comply. Kaiser knew that the same standards that apply to the original medical record also apply to any addenda. Yet Kaiser argues in its motion that everything it knew to be true, is

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[1] The parties stipulated and jointly requested a five-page extension for the United States' opposition and for Kaiser's reply. Dkt. 192. The Court has not yet ruled on the parties' stipulation and joint request. Should the Court deny the request, the United States will refile its opposition.

[2] The United States alleges that the Kaiser defendants were engaged in a conspiracy, which Kaiser has not challenged for purposes of this motion. Because "[a]ll conspirators are jointly liable for the acts of their co-conspirators," *Beltz Travel Serv., Inc. v. Int'l Air Transp. Ass'n*, 620 F.2d 1360, 1367 (9th Cir. 1980), this opposition refers to Kaiser collectively.

[3] Kaiser's motion also includes various irrelevant, inaccurate, and self-serving statements, such as those regarding the investigation into Kaiser's fraud. The United States will not respond to these assertions here, but its silence should not be read as agreement to such statements.

actually false. Kaiser's post-hoc justifications for its conduct are without basis and fail to overcome the well-pleaded facts in the Complaint.

First, Kaiser's argument that it was not required to comply with the ICD Guidelines when submitting ICD codes for payment is wrong. Kaiser was required to comply through its contracts with CMS and binding regulation. And Kaiser's argument that it never submitted codes for diagnoses that did not exist ignores the allegations in the Complaint, including detailed examples of such false claims.

Second, Kaiser's argument that it did not knowingly submit diagnosis codes for conditions that did not exist is based on an incorrect legal standard and ignores detailed allegations to the contrary.

Third, Kaiser's claim that compliance with the ICD Guidelines was immaterial to CMS again ignores the allegations in the Complaint, which plausibly alleges both the fundamental importance of the ICD Guidelines to the risk-adjustment system *and* that Kaiser knew compliance was material to CMS.

Fourth, Kaiser's argument that the United States' claims are partially time-barred is contrary to the plain language of the FCA statute of limitations.

Fifth, the United States' right to recover funds erroneously paid—whether labeled payment by mistake or unjust enrichment—has long been established. *United States v. Wurts*, 303 U.S. 414, 415 (1938). Kaiser's attempt to dismiss these claims based on irrelevant state law misses the mark.

The Court should deny the motion to dismiss in its entirety.

BACKGROUND

I. The Medicare Advantage Program and Its Risk-Adjustment Payment System.

This case concerns Medicare Part C, commonly referred to as Medicare Advantage. Unlike traditional Medicare (Parts A and B), where CMS pays providers for services rendered (fee-for-service), the Medicare Advantage ("MA") program pays insurers, called MA organizations ("MAOs"), to provide health plans, which then contract with providers to care for their Medicare patients. Compl. ¶¶ 53-56. Kaiser operated as an MAO and offered several health plans, including in California and Colorado. *Id.* ¶ 55. CMS reimburses MA plans differently than traditional Medicare: MAOs receive a predetermined, capitated monthly payment for their Medicare patients regardless of services rendered, if any. *Id.* ¶ 57.

CMS "risk adjusts" the monthly capitated payments for each Medicare patient based on demographic factors and health status. *Id.* ¶ 58. The purpose of this risk adjustment is to ensure that

MAOs are paid more for sicker enrollees who are expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs. *Id.* ¶ 2. Since 2004, CMS has used the Hierarchical Condition Category ("CMS-HCC") model to risk adjust the capitated payments. *Id.* ¶ 59. The CMS-HCC model is prospective in the sense that it uses diagnoses made in a base year (the "service year"), along with current demographic information, to predict costs for Medicare benefits and adjust payments for the following year (the "payment year"). *Id.* ¶ 60.

The foundational component of the CMS-HCC model is the International Classification of Diseases ("ICD") standard, which includes the ICD codes and the ICD Guidelines. *Id.* ¶¶ 61-69. The Department of Health and Human Services ("HHS") has adopted the ICD standard as the national standard for diagnosis coding across the healthcare industry. *Id.* ¶¶ 61-62. The ICD Guidelines provide the basic rules regarding what diagnoses may be coded. *Id.* ¶ 82. In the outpatient setting at issue in this case, the ICD Guidelines only permit coding conditions "[1] that coexist at the time of the encounter/visit and [2] that require or affect patient care, treatment or management."[4] Dkt. 179-1 at 534; Compl. ¶¶ 82-86. A condition that either does not exist at the visit or does not require or affect patient care, treatment, or management may not be coded. Compl. ¶¶ 82-86.

The CMS-HCC model directly depends upon the ICD standard in two critical ways: (1) to calculate expected costs, called risk-adjustment factors; and (2) to make risk-adjustment payments to MAOs based upon the ICD diagnoses that they submit. *Id.* ¶¶ 63-68.

First, the risk-adjustment model calculates expected costs for MA patients based upon Medicare fee-for-service diagnosis data. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 874 (D.C. Cir. 2021), *cert. denied*, 142 S. Ct. 2851 (2022). Health care providers are required to comply with the ICD standard when submitting claims to Medicare. 68 Fed. Reg. 48805, 48806 (requiring compliance with the Health Insurance Portability and Accountability Act ("HIPAA") standards, including the ICD standard); *see also* 54 Fed. Reg. 30558, 30563-64 (pre-HIPAA requirement); 59 Fed. Reg. 10290. The same ICD standard—including the ICD Guidelines—applies across the healthcare industry, including both traditional Medicare and Medicare Advantage, and CMS relies upon this standardization for the risk-adjustment model. Compl. ¶¶ 61-63. Traditional Medicare providers are required to submit only

[4] The ICD Guidelines' rules for outpatient visits are in Section IV, covering roughly four pages and around 15 guidelines. Dkt. 179-1 at 531-35.

diagnoses reportable under the ICD Guidelines. The CMS-HCC model uses that traditional Medicare diagnosis data to estimate expected costs. As a result, the CMS-HCC model only predicts expected costs based upon diagnoses coded in conformance with the ICD Guidelines, not merely based on whether a patient has a condition. Compl. ¶ 68.

Second, CMS makes risk-adjustment payments to MAOs based directly on the diagnoses those organizations submit to CMS. *Id.* Because the CMS-HCC model relies on the ICD standard for its estimates, CMS only allows MAOs to submit diagnoses that are accurately coded in conformance with the ICD Guidelines. *Id.* ¶ 81. CMS has mandated this requirement both through contracts and regulation. *Id.* ¶¶ 78-81. Given the material impact of risk-adjustment diagnoses on payment, CMS has repeatedly stressed that MAOs must ensure the accuracy of diagnosis submissions, including by mandating as a condition of payment that MAOs certify the accuracy of submitted diagnoses. *Id.* ¶¶ 69, 79; 42 C.F.R. § 422.504(*l*). And CMS has made clear that such accuracy depends directly on compliance with the ICD Guidelines: "Diagnosis codes determine the risk scores, which in turn determine the risk-adjusted payments. As a result, MA organizations and providers must focus attention on complete, truthful, and accurate diagnosis reporting *according to the official ICD-10-CM coding guidelines*." 83 Fed. Reg. 54982, 55037 (emphasis added); *see also* 74 Fed. Reg. 54634, 54674; 79 Fed. Reg. 1918, 2001. CMS has repeatedly made this obligation clear, including through the binding Medicare Managed Care Manual and other publications. Compl. ¶ 81; *see also, e.g.*, Dkt. 179-1 at 164 (coding in accordance with ICD Guidelines is part of the risk-adjustment "guiding principle").

Kaiser's coding of aortic atherosclerosis ("AA") provides a helpful illustration of the importance of consistent adherence to the ICD standard. *See* Motion to Dismiss, Dkt. 178 ("MTD") at 6. According to the ICD Guidelines, patients with clinically insignificant AA are not permitted to be coded with the condition because it does not "require or affect patient care, treatment or management." *See* Compl. ¶ 258. Under this standard, approximately 2% of traditional Medicare patients have been diagnosed with AA—about the same percentage as Kaiser MA patients before Kaiser implemented its scheme. *Id.* ¶ 267. Based on this 2% of traditional Medicare patients, the CMS-HCC model estimates the expected following-year medical costs for a patient diagnosed with AA according to the ICD Guidelines. *Id.* ¶ 68. This means that for all other patients, including patients who may have had clinically insignificant AA

(which the ICD Guidelines do not permit to be coded because it does not "require or affect patient care, treatment or management"), the model estimates $0 in marginal expected costs.

Kaiser, however, pressured its physicians to addend an AA diagnosis to medical records for patients with clinically insignificant AA, even though the diagnosis did not require or affect patient care, treatment, or management, in violation of the ICD Guidelines. *Id.* ¶¶ 244-68. Through this scheme, in just a few years, Kaiser went from 2% of its MA patients diagnosed with AA to more than 40%, a roughly 2000% increase. *Id.* ¶ 267. By illegally submitting clinically insignificant diagnoses in violation of the ICD Guidelines, Kaiser was able to increase its payments from CMS by $2500-$3000 for each of these patients, totaling hundreds of millions of dollars. *Id.* ¶ 260. Notably, Kaiser removed many of these same patients from its cardiovascular disease treatment program because it did not believe they would likely need care, treatment, or management for clinically insignificant AA. *Id.* ¶¶ 250-52.

The meteoric increase in AA diagnoses among Kaiser patients demonstrates why adherence to the ICD Guidelines is critical to the CMS-HCC model. The same Guidelines provision prohibits the coding of conditions a patient does not have at a visit *and* conditions that do not require or affect patient care, treatment, or management at that visit. *Id.* ¶ 83. And because costs are calculated only for conditions coded according to the ICD Guidelines, in both circumstances the CMS-HCC model estimates no costs. *Id.* ¶ 68. When an MAO submits an inaccurate ICD code that violates the ICD Guidelines, it falsely claims entitlement to additional risk-adjustment payments.

II. Kaiser Knew the Standard for Submission of Risk-Adjustment Diagnoses.

CMS denoted four critical requirements for accurate risk-adjustment diagnosis submission. Each submitted diagnosis must be: (1) established by a qualified physician, (2) based on a face-to-face medical visit between the patient and physician, (3) documented in the medical record, and (4) coded in compliance with the ICD Guidelines, including the requirement that the condition must have existed and required or affected patient care, treatment, or management for the visit. Compl. ¶¶ 83, 87.

The Complaint alleges Kaiser knew that it needed to comply with each of these requirements, and that these same standards applied equally to both the original medical record and any addendum. *Id.* ¶¶ 88-96, 270-75. Kaiser's own internal Program Advisory, as well as other materials, demonstrate that Kaiser knew that it was required to comply with the ICD Guidelines, including the specific guideline at

issue, when submitting risk-adjustment diagnoses. *Id.* ¶¶ 88-96. Those documents could not have been clearer: "**Documentation Must Comply with ICD-9-CM Coding Guidelines.**" *Id.* ¶¶ 90, 94 (emphasis in original). Kaiser knew that under the specific guideline at issue, if it did not consider, evaluate, or treat the condition—that is, if that condition did not require or affect patient care, treatment, or management—then it could not submit the diagnosis to CMS. *Id.* ¶¶ 90-95. In other words, Kaiser knew that the condition had to *matter* to the visit in order to submit the diagnosis for payment. Kaiser similarly recognized the need to adhere carefully to the Guidelines—and specifically to the guideline it systemically violated—when adding diagnoses via addenda. *Id.* ¶¶ 270-75. Kaiser knew if a condition was not considered, evaluated, or treated at the visit, it could not be added via addenda or submitted for payment. *Id.* Kaiser knew that failure to comply with this requirement was material and could result in liability under the FCA. *Id.* ¶ 272.

Rather than accept the truth of these allegations with all inferences in favor of the plaintiff, as required at the motion to dismiss stage, Kaiser replaces them with its own statement of (inaccurate) counter-allegations about how CMS allegedly provided limited guidance. MTD at 5-8.

III. Kaiser Knowingly Submitted Fraudulent Diagnosis Codes.

Kaiser knowingly submitted thousands of diagnoses for payment that had no relevance to the patient visit and sometimes where the condition did not exist at all, both in contravention of the ICD Guidelines. Compl. ¶ 97. Kaiser knew that the amount CMS paid to Kaiser for an MA patient depended directly on the diagnoses that it submitted to CMS for that patient. Internally, executives stressed the importance of these risk-adjustment payments to the financial health of Kaiser, emphasizing that "risk adjustment is by far the biggest lever we have to change our revenue from Medicare. If we don't do this well, our financial health could be seriously impacted." *Id.* ¶¶ 100-02. Kaiser created coordinated programs to increase its risk-adjustment payments. *Id.* ¶¶ 105-20. Those programs were extremely successful, achieving a roughly 30% increase in Kaiser's Medicare revenue per patient. *Id.* ¶ 120.

Kaiser increased risk-adjustment payments through its systematic efforts to add lucrative risk-adjustment diagnoses *after* a patient visit via an addendum to the medical record. *Id.* ¶¶ 121-32. Kaiser mined an MA patient's medical file for potential additional diagnoses, regardless of their relevance to the visit. *Id.* ¶¶ 122-23, 126-28. Kaiser then sought to have the physician add the new diagnoses to the

medical record retrospectively using an addendum, as if the new diagnoses had affected patient care, treatment, or management in some way during the patient visit, when in fact they had not. *Id.* Often, these addenda were added months or even a year or more after the visit. *Id.* ¶¶ 126, 281-88. Kaiser's data demonstrates that its physicians often created addenda to medical records (especially long after the visit) as part of its year-end activities, sometimes referred to as the "dash for cash." *Id.* ¶¶ 283-87.

Kaiser's initiatives included "data mining" and "chart review," where Kaiser used automated algorithms and/or human reviewers to identify new diagnoses for a patient. *Id.* ¶¶ 133-50, 166-83. Such never-before-diagnosed conditions should rarely, if ever, have resulted in addenda because these diagnoses were, almost by definition, not relevant to the visit, i.e., they represented conditions that did not require or affect patient care, treatment, or management. *Id.* ¶ 127. Yet Kaiser routinely added these diagnoses to medical records using addenda and submitted them for payment, often without even telling patients about these brand-new diagnoses. *Id.*

Kaiser also employed a related data-mining program called "refresh," through which Kaiser mined patient medical files to find old diagnoses that had not yet been submitted in the current service year. *Id.* ¶¶ 151-65. If a physician failed to add any of these old diagnoses at a patient visit, the physician would be provided a list of these "missed opportunities"—i.e., opportunities for risk-adjustment payment—to create an addendum for the purpose of retrospectively adding these diagnoses to the medical record. *Id.* ¶ 159. Kaiser closely tracked these diagnoses and expected physicians and facilities to meet increasingly high targets, causing physicians to improperly addend diagnoses. *Id.* ¶¶ 163-64.

Kaiser regularly brought these mined diagnoses to the physician's attention via a "query"— a communication tool used in the healthcare industry to clarify documentation in the health record. *Id.* ¶¶ 185-216. Queries present significant risks for improper diagnosis coding, and there are national standards guiding and limiting the use of queries. *Id.* ¶¶ 129-31. Kaiser routinely violated these national standards and used queries not to clarify medical records, but instead to press physicians to retrospectively add new diagnoses via addenda that had nothing to do with the visit, so that Kaiser could then seek payment from CMS for these diagnoses. *Id.*

Kaiser employed numerous tactics to pressure physicians to improperly add these diagnoses. In addition to improper queries, Kaiser required its physicians to meet certain metrics related to its risk-

adjustment program. *Id.* ¶¶ 234-43. Kaiser tracked and monitored these metrics across physicians, facilities, and regions. *Id.* Physicians who scored high were praised and rewarded. *Id.* Those who did not would often be required to meet with supervisors about their risk-adjustment performance and could face financial consequences. *Id.* Kaiser similarly forced physicians who declined to add diagnoses to justify their decision in burdensome ways to higher-ups, while providing no review if the physician simply followed Kaiser's requests to add the diagnosis. *Id.* ¶¶ 226-33.

Kaiser knew that its addenda practices were widespread and unlawful. *Id.* ¶¶ 269-331. Kaiser ignored numerous red flags and internal warnings that it was violating Medicare rules, including concerns raised by its own physicians that these were false claims, *id.* ¶¶ 289-301, and audits by its own compliance office identifying the issue of inappropriate addenda, *id.* ¶¶ 302-31.

The United States brings claims under the FCA to obtain treble damages and penalties against Kaiser for its systematic submission of false claims, as well as alternative claims for payment by mistake and unjust enrichment to recover monies erroneously paid to Kaiser. *Id.* ¶¶ 347-64.

LEGAL STANDARD

In considering a motion to dismiss, a court must accept as true all well-pleaded allegations in the complaint, construing them in the light most favorable to the plaintiff. *United States v. Corinthian Colleges*, 655 F.3d 984, 991 (9th Cir. 2011). The court determines whether the complaint contains "sufficient factual matter that, taken as true, state a claim for relief [that] is plausible on its face." *Id.* (cleaned up). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.*

Rule 9(b) requires a party "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). "Rule 9(b) requires only that the *circumstances of fraud* be stated with particularity; other facts may be plead[ed] generally, or in accordance with Rule 8." *Corinthian Colleges*, 655 F.3d at 991 (emphasis in original). Rule 9(b)'s standard does not apply to knowledge, which may be pleaded generally. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 679 (9th Cir. 2018). "[S]tatements of the time, place and nature of the alleged fraudulent activities are sufficient" to meet the 9(b) standard. *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (*Swoben*) (cleaned up). "Because this standard does not require absolute particularity or a recital

of the evidence, a complaint need not allege a precise time frame, describe in detail a single specific transaction or identify the precise method used to carry out the fraud." *Id* at 1180 (cleaned up). Representative examples are not required. *Id.*

ARGUMENT

I. The Complaint Plausibly Alleges Falsity.

Kaiser systematically submitted false claims in the form of inaccurate ICD diagnosis codes that violated the ICD Guidelines to improperly obtain risk-adjustment payments. Compl. ¶¶ 1-11, 121-83, 269-331. Kaiser knew that every diagnosis code submitted to CMS had to comply with the ICD Guidelines or else it could face FCA liability. *Id.* ¶¶ 73-96, 270-75. Kaiser does not contest, for purposes of this motion, that it systematically submitted ICD diagnosis codes that violated the ICD Guidelines. Instead, Kaiser dispenses with the Guidelines in their entirety, claiming that CMS never required MAOs to comply with them. As discussed below, by contract and regulation, Kaiser was required to submit accurate risk-adjustment data coded in accordance with the ICD Guidelines, and its failure to do so resulted in the submission of false claims. Those same contracts and regulations render *Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019), the principal case upon which Kaiser relies, inapposite. Equally misplaced is Kaiser's objection that the United States relies upon generally applicable requirements, rather than addenda-specific ones. Finally, the United States plausibly alleged that Kaiser submitted false claims for diagnoses that did not exist. The Court should reject Kaiser's falsity arguments.

A. Kaiser's contracts with CMS required Kaiser to submit accurate risk-adjustment data coded in accordance with the ICD Guidelines.

Contrary to Kaiser's argument, its contracts with CMS require that all risk-adjustment codes it submits must comply with the ICD Guidelines. To participate in the MA program, every MAO, including Kaiser, must execute a written contract with CMS for the MA plans it operates. Compl. ¶ 74; 42 U.S.C. § 1395w-27(a). Kaiser does not contest it executed such contracts, an example of which Kaiser attached as Exhibit I to its MTD. The very first page of the contractual terms specifies Kaiser's central obligation: to operate its plans "in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.)." Dkt. 179-1 at 603. The Medicare Managed Care Manual (the

"Manual") details the operations of the MA program, including CMS's instructions regarding the specific obligations imposed on MAOs. Chapter 7 covers risk adjustment and specifies the core responsibilities of MAOs with respect to risk-adjustment submissions. The very first responsibility unequivocally mandates that MAOs "must":

> Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*.

Dkt. 179-1 at 353-54; Compl. ¶¶ 75, 78-81.

These contracts present a classic example of the doctrine of incorporation by reference. Terms are incorporated by reference "where the underlying contract makes clear reference to a separate document, the identity of the separate document may be ascertained, and incorporation of the document will not result in surprise or hardship." *Teamsters Loc. Union No. 783 v. Anheuser-Busch, Inc.*, 626 F.3d 256, 262 (6th Cir. 2010); *Standard Bent Glass Corp. v. Glassrobots Oy*, 333 F.3d 440, 447 (3d Cir. 2003) (same); Williston on Contracts § 30.25 (4th ed. 1999) ("So long as the contract makes clear reference to the document and describes it in such terms that its identity may be ascertained beyond doubt, the parties to a contract may incorporate contractual terms by reference to a separate, noncontemporaneous document . . . ."); *see also, e.g.*, *Fortier v. Anthem, Inc.*, No. 20-56361, 2021 WL 5277099, at *1 (9th Cir. Nov. 12, 2021) (contract stating that Anthem "uses clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies" incorporated the documents by reference because it informs a reader that the medical policies were substantive documents and would "guide the reader to the incorporated document").

The contracts expressly require Kaiser to operate its plans in compliance with the Manual, thereby incorporating the Manual as a binding part of the contracts, including the mandate that Kaiser must ensure risk-adjustment data it submits to CMS is accurate and coded according to the ICD Guidelines. Dkt. 179-1 at 603; *see also Silingo*, 904 F.3d at 672-73 (recognizing MAOs must comply with the Manual requirements). The contracts make clear reference to Kaiser's obligation to comply with the Manual; the identity of the Manual is easily ascertained; and there is no basis to claim surprise or hardship. Indeed, the Complaint details that Kaiser was fully aware of its obligations to comply with

the Manual, knew that diagnosis codes had to be coded according to the ICD Guidelines, and knew that submitting diagnoses that did not comply with the ICD Guidelines could lead to FCA liability. Compl. ¶¶ 88-96, 270-75.

Kaiser's various arguments to avoid the plain and unmistakable language of its contracts are unavailing. For example, Kaiser argues that it is not bound by this term because it appears at the beginning of the contracts rather than in the payment section, but there is no such rule of contract law.[5] Kaiser similarly argues that because the Manual is referenced inside parentheses, the clear language is somehow unenforceable. Again, no such rule of contract interpretation exists. To the contrary, black-letter contract law strongly disfavors rendering terms mere surplusage. *Flores v. Barr*, 934 F.3d 910, 915 (9th Cir. 2019) ("Courts interpreting the language of contracts 'should give effect to every provision,' and 'an interpretation which renders part of the instrument to be surplusage should be avoided.'").

Nor do Kaiser's concerns about hypothetical policies CMS might post on its website without notice relieve Kaiser of its express obligation to comply with the Manual. MTD at 17. In the scenario Kaiser posits, Kaiser might have a defense under contract law that a hypothetical surprise policy would not be incorporated into the contracts by reference. But these are not the allegations in the Complaint: the contracts to which Kaiser agreed state specifically that Kaiser must comply with the Manual, Compl. ¶ 75, and Kaiser knew that its agreement with CMS imposed this requirement, *id.* ¶¶ 88-96, 270-75. Kaiser cannot skirt its obligation to comply with the Manual by claiming it might lack notice of other, hypothetical requirements that CMS has not imposed and that are not before the Court.

Finally, Kaiser is wrong that the Supreme Court's decision in *Allina*, 139 S. Ct. 1804, somehow voids terms in its contracts with CMS. *Allina* does not apply to contractual obligations. *Allina* interprets 42 U.S.C. § 1395hh(a)(2), which authorizes the Secretary of HHS to issue regulations, with the limitation that any "rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing . . . the payment for services" must go through notice and comment. *Id.* But § 1395hh(a)(2) does not address the government's ability to contract, nor suggest that contractual terms must first go through notice and comment. The statute applies to the Secretary's rulemaking authority, not his contracting authority.

[5] Moreover, the contract's payment section reiterates the importance of accurate risk-adjustment data, delineating certification of accuracy as a condition of payment. Dkt. 179-1 at 607.

Moreover, with respect to the MA program, Congress not only authorized but *mandated* that the Secretary execute contracts with MAOs. 42 U.S.C. § 1395w-27(a). Congress specified certain required terms and further provided that any contract "shall contain such other terms and conditions not inconsistent with this part . . . as the Secretary may find necessary and appropriate." *Id.* § 1395w-27(e)(1). Nothing requires that those terms and conditions go through notice and comment. The only statutory limitation is that contractual terms cannot be "inconsistent with this part," but § 1395hh(a)(2) is not even in "this part" (i.e., Part C). Kaiser complains that this means it can be bound through contract to comply with terms that have never gone through notice and comment—but that is true for any government contract and is exactly what § 1395w-27 provides.[6]

The analysis begins and ends with the plain language of Kaiser's contracts. Kaiser's arguments to the contrary fail.

B. Regulations required Kaiser to comply with the ICD Guidelines.

Kaiser was also required to comply with the ICD Guidelines by regulation. CMS mandated that when MAOs submit risk-adjustment data, they must conform to "all relevant national standards." 42 C.F.R. § 422.310(d)(1). Through regulation, HHS adopted the ICD standard as *the* national standard for diagnosis coding. 45 C.F.R. § 162.1002(a)(1) ("The Secretary adopts the . . . International Classification of Diseases, 9th Edition, Clinical Modification, (ICD-9-CM), Volumes 1 and 2 (including The Official ICD-9-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions: (i) Diseases.").[7] Thus, when MAOs submit risk-adjustment diagnosis codes, they must conform to the national standard for diagnosis coding—the ICD standard.

Kaiser's argument that this requires that it use ICD codes *but not follow the ICD Guidelines* lacks any basis. *See* MTD at 15 (arguing that MAOs may be required to use the "code sets" but not the "coding principles"). The regulation states explicitly that HHS's adoption of the ICD standard "includ[es] The Official ICD-9-CM Guidelines for Coding and Reporting." 45 C.F.R. § 162.1002(a)(1).

[6] A false claim can be premised upon statutory, regulatory, or contractual violations. *See Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 190 (2016). Kaiser's reliance on the Justice Manual, MTD at 12, is puzzling, because the specific section Kaiser cites recognizes that any document can be made "binding by operation of grant award or contract," contradicting Kaiser's position here. Dkt. 197-1 at 623, Justice Manual § 1-19.000.

[7] HHS later adopted the ICD-10, "including The Official ICD-10-CM Guidelines for Coding and Reporting" as the national standard using identical language. 45 C.F.R. § 162.1002(c).

HHS explained when it adopted the ICD Guidelines as part of the ICD standard that the standardization provided by the ICD Guidelines was "highly desirable and beneficial." 65 Fed. Reg. 50312, 50323. Therefore, it adopted not only the ICD "data set" but also the ICD Guidelines "as part of the standard." *Id.* There is only one ICD standard, which is *the* national standard, and it includes both the codes and the ICD Guidelines.

CMS has identified the ICD standard as the "chief national standard" under 42 C.F.R. § 422.310(d)(1), explaining: "the current risk adjustment methodology relies on enrollee diagnoses and encounters, as specified by the [ICD] guidelines, to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee." 83 Fed. Reg. at 55037; *see also* 74 Fed. Reg. at 54673. Indeed, absent the basic rules contained in the ICD Guidelines, there would be nothing for MAOs to certify as accurate. *See* 42 C.F.R. § 422.504(*l*). That is why CMS has repeatedly emphasized "accurate diagnosis reporting *according to the official ICD-10-CM coding guidelines*." 83 Fed. Reg. at 55037 (emphasis added); *see also* 79 Fed. Reg. at 2001 (same); 74 Fed. Reg. at 54674 (same). When MAOs submit ICD codes, they are required to comply with the ICD Guidelines that, as noted above, are integral to the ICD standard—the relevant national standard. *Accord United States ex rel. Montcrieff v. Peripheral Vascular Assocs.*, 507 F. Supp. 3d 734, 762 (W.D. Tex. 2020) ("if one agrees to use the CPT Codes to bill Medicare, one must meet all the requirements set forth by the CPT Manual"; non-compliance with the CPT Manual renders CPT code submissions false). Were there any doubt, the MA regulations further require that MAOs comply with 45 C.F.R. Part 162, which as explained above establishes the ICD (and ICD Guidelines) as *the* national standard. 42 C.F.R. § 422.504(h)(2); *see also* 45 C.F.R. § 162.1002.

MA risk adjustment depends upon the ICD standard—including the ICD Guidelines—because it applies equally to traditional Medicare fee-for-service and Medicare Advantage. For this reason, the regulations require: "MA organizations must submit data that conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards." 42 C.F.R. § 422.310(d)(1). Adherence to the same ICD standard in both traditional Medicare fee-for-service and Medicare Advantage is important because, as explained above, the risk-adjustment model calculates expected costs for MA patients based upon Medicare fee-for-service diagnosis data. *See*

UnitedHealthcare, 16 F.4th at 874.

Kaiser is incorrect that its obligation to follow "relevant national standards" under § 422.310(d)(1) applies only to data "form" and does not impose the "substantive coding requirements" contained in the ICD Guidelines. *See* MTD at 16. In pressing this argument, Kaiser relies solely on a misquote from *United States ex rel. Rasmussen v. Essence Grp. Holdings Corp.*, No. 17-3273-CV-S-BP, 2020 WL 4381771, at *6 (W.D. Mo. Apr. 29, 2020). While Kaiser quotes *Rasmussen* as if the case addressed § 422.310(d)(1), the actual quote discussed an entirely different (and irrelevant) provision—§ 422.310(g), entitled "Deadlines for submission of risk adjustment data." *Id. Rasmussen* actually states: "§ 422.310(g) appears to address the deadline for submitting risk adjustment data. It is not directed toward specifying the procedure for properly coding patients' medical conditions . . . ." *Id. Rasmussen* says nothing about § 422.310(d), and nothing in § 422.310(d) limits "relevant national standards" to data "form."[8] The ICD standard is the "relevant national standard" when submitting ICD codes.[9]

* * *

In sum, the Complaint contains well-pleaded allegations sufficient to show that Kaiser was required by contract and regulation to comply with the ICD Guidelines. As a result, Kaiser's reliance on *Allina* is a red herring: *Allina* has no relevance here because Kaiser's obligations arise from both binding contract terms and notice-and-comment regulations.[10] The ICD standard is core to the functioning of the MA program and the CMS-HCC model. *See, e.g.*, Compl. ¶¶ 63, 68, 69, 81. Kaiser's post-hoc

[8] *Rasmussen* is a non-intervened *qui tam*, and the court did not examine the relevant provisions of the ICD Guidelines, as the relators did not rely on them. But even *Rasmussen* understood the ICD Guidelines apply.

[9] Kaiser's argument that it was exempted from complying with the ICD standard by a Federal Register publication issued in 2000, before the CMS-HCC model even existed, is equally misplaced. *See* MTD at 15-16. That publication addresses only when a managed care organization "submits a bill to the State Medicaid agency for payment for all the care given to all the persons covered by that MCO for that month under a capitation agreement." 65 Fed. Reg. at 50318. This case does not involve the submission of monthly bills to Medicaid state agencies; it involves the submission of encounter data to the MA program.

[10] Kaiser's suggestion that other guidance documents are irrelevant absent notice and comment is also wrong. Those documents "may be entitled to deference or otherwise carry persuasive weight with respect to the meaning of applicable legal requirements." Justice Manual § 1-19.000. Put differently, they are relevant in understanding the legal obligations imposed by contract and regulation addressed above as well as to knowledge and materiality under the FCA. *Allina* has no relevance to them because § 1395hh(a)(2) only applies where "establish[ing] or chang[ing] a substantive legal standard." 42 U.S.C. § 1395hh(a)(2); *see also Agendia, Inc. v. Becerra*, 4 F.4th 896, 902 (9th Cir. 2021) (guidance documents that do not establish or change the substantive legal standard are not subject to § 1395hh(a)(2)).

justification that it could obtain risk-adjustment payments by submitting ICD codes without complying with the ICD Guidelines is meritless. Kaiser was aware of its obligation to comply with the ICD Guidelines when submitting ICD codes to CMS and knew that failure to do so could give rise to FCA liability. *Id.* ¶¶ 88-96, 270-75. Kaiser's knowing and systematic submission of diagnosis codes that violated the ICD Guidelines were all false claims.

C. There is no "addenda exception" in the contracts, regulations, or ICD Guidelines.

Kaiser asserts that it cannot be held liable for violating obligations that do not specifically "address addenda." MTD at 11, 13, 14, 15, 16, 17, 18. This argument is without basis. As the Complaint alleges, an addendum is merely a change to the medical record for a patient visit made after the close of that visit record. Compl. ¶ 124. Nothing in Kaiser's contracts, the relevant regulations, or the ICD Guidelines indicates that diagnoses added after patient visits are subject to different standards.

Indeed, the Supreme Court has rejected this "canon of donut holes" argument, which is premised on the fallacy that a general rule somehow contains tacit exceptions if it does not address every specific circumstance in which the rule might apply. *See Bostock v. Clayton Cty.*, 140 S. Ct. 1731, 1747 (2020). Instead, the Court recognized that if a general rule contains no exception, the rule applies without exception. *Id.* That principle applies here. Kaiser can point to nothing that would exempt diagnosis codes from the ICD Guidelines merely because they were added through an addendum rather than an original visit record. This is for good reason—it would be nonsensical to require providers to adhere to the ICD Guidelines until they close a visit record but relieve them of that obligation if they addend the record moments (or, as was often the case with Kaiser, months or years) after. Rather, the same ICD Guidelines apply equally the minute before a provider closes a medical record as the minute after.

Notably, Kaiser's own policies demonstrate that it knew its newly invented distinction does not actually exist. Those policies emphasized the need to adhere carefully to the Guidelines—and specifically to the guideline Kaiser systematically violated—when adding diagnoses via addenda. Compl. ¶¶ 270-75. And Kaiser knew that failure to comply with the ICD Guidelines in such circumstances could result in liability under the FCA. *Id.* In short, the "addenda exception" Kaiser proposes is a fiction with no basis in either the relevant rules or Kaiser's own understanding of those rules. The Court should reject Kaiser's post-hoc rationalization of its fraudulent conduct.

D. The United States plausibly alleged that Kaiser's submission of ICD codes for non-existent conditions are false claims.

Kaiser does not contest that if the ICD Guidelines apply, the United States has pleaded the falsity element. While Kaiser states it may later dispute the United States' interpretation of the ICD Guidelines, MTD at 13 n.5, it does not do so here, nor does it contest that the Complaint pleads violation of those Guidelines. This fully resolves the falsity element for all of the United States' claims, which are all premised on the submission of inaccurate diagnosis codes in violation of the ICD Guidelines. Each claim involves the submission of diagnoses that did not require or affect patient care, treatment, or management, in violation of the ICD Guidelines. Sometimes such conditions did not even exist, also a violation of the Guidelines.[11] But because all of the claims at issue violated at least the first of these two requirements, the Court need not reach Kaiser's argument that the Complaint fails to allege Kaiser submitted "factually false" claims for non-existent diagnoses. *See* MTD at 20-21.

Moreover, Kaiser's attempt to split the Complaint into allegations of either "factual" or "legal" falsity is unavailing. The Complaint alleges a single scheme through which Kaiser knowingly and systematically submitted inaccurate diagnosis codes in contravention of the ICD Guidelines' critical requirement that, in order to be coded, a condition must both "[1] coexist at the time of the encounter/visit and [2] require or affect patient care, treatment or management." Dkt. 179-1 at 534; Compl. ¶¶ 83, 86. It makes no sense that violations of the first half of this requirement are "factually false," whereas violations of the second are "legally false." As another court concluded in analogous circumstances involving CPT codes, when a party submits for payment a CPT code that violates the CPT manual, that is a factually false claim. *Montcrieff*, 507 F. Supp. 3d at 758-68.[12] So too here. When

[11] As set forth in the Complaint, the bottom-line allegation is: "Despite its obligations to the contrary, Kaiser knowingly submitted or caused to be submitted diagnoses that had no relevance to the patient visit and sometimes did not exist at all and sought risk-adjustment payments based on such fraudulent diagnoses." Compl. ¶ 97. These are all violations of the ICD Guidelines—indeed of the same guideline. In every circumstance where the United States alleges a diagnosis did not exist at the visit, the United States *also* alleges it did not require or affect patient care, treatment, or management. This is shown in various example false claims. *Id.* ¶¶ 338 (non-existent active cancer did not require or affect patient care, treatment, or management), 339 (same for non-existent severe obesity), 346 (same for non-existent cachexia). The United States acknowledges that two sentences of the Complaint may be read to suggest that Kaiser violated either one "or" the other part of this guideline. *Id.* ¶¶ 1, 11. However, the United States does not believe that this requires amendment based on the remainder of the Complaint.

[12] Further, as *Montcrieff* recognizes, when a party that submits inaccurate codes to Medicare—there, CPT codes in violation of the CPT manual—those factually false claims do not implicate *Allina*. 507 F.

Kaiser submitted for payment inaccurate ICD codes in contravention of the ICD Guidelines, those were factually false claims because they incorrectly described the valid ICD codes for the patient visit. *See id.*; *see also Silingo*, 904 F.3d at 675 (recognizing that claims involving "incorrect description of goods or services provided" are "factually false").

In any event, the United States has plausibly alleged that Kaiser submitted ICD codes for conditions that did not exist. As the Background section explains, the Complaint provides voluminous detail about Kaiser's scheme and how that scheme led to widespread submission of diagnosis codes that violated the ICD Guidelines, including for conditions that did not exist at all. The Complaint contains numerous examples, including the cachexia data-mining initiative, where Kaiser submitted diagnosis codes for patients that Kaiser knew did not have cachexia. Compl. ¶¶ 294-300, 321-23. Cachexia is a severe condition associated with physical wasting and muscle atrophy; for each diagnosis, MAOs receive *more than $6,000* because it is expected to have substantial treatment costs. *Id.* ¶¶ 207, 346.j. Numerous Kaiser physicians sounded alarms that Kaiser was merely mining for thin patients and that such efforts would result in "inappropriate assignment of this diagnosis." *Id.* ¶¶ 97-99. Kaiser's own internal audit showed over 90% of the addenda adding cachexia were not accurate, yet Kaiser persisted with the initiative and submitted numerous cachexia diagnosis codes where the condition did not exist. *Id.* ¶¶ 300, 321-22.

The Complaint offers other examples of ways in which Kaiser continually submitted ICD codes for conditions that did not exist:

- A Kaiser physician saw a patient for a blood pressure check and lab results (unrelated to cancer). In the medical history, the Kaiser physician noted that the patient had a prior history of prostate cancer, not active. Six months later, the physician received a query from Kaiser identifying various diagnoses, unrelated to the visit, that the "region thinks should be picked up." One was for active prostate cancer, which the record itself documented that patient did not have. But the Kaiser physician nevertheless followed Kaiser's requests, adding all of the diagnoses via addenda, including active prostate cancer. *Id.* ¶ 338.

- A patient was seen for shortness of breath and diagnosed with exacerbation of chronic obstructive pulmonary disease. There is no indication that the Kaiser physician considered, evaluated, or treated any other condition. The Kaiser physician later addended the medical record three times (up to nine months later) to add 13 conditions, none of which required or affected patient care, treatment, or management at the visit. One of those conditions was

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Supp. 3d at 759-61. In other words, even if there were no binding regulations and contractual terms, as there are here, *Allina* still would not apply to factually false claims. Kaiser appears to recognize this principle—making no *Allina* arguments regarding factually false claims. But Kaiser is wrong that only some of the inaccurate diagnosis codes are factually false.

severe obesity equivalent, which was contradicted by the medical record. *Id.* ¶ 339.

- As part of a yet another data-mining scheme, Kaiser sent a query to a Kaiser physician that instructed him that his diagnosis was insufficient for appropriate Medicare reimbursement and that he needed to add one or more additional diagnoses to the medical record, suggesting obesity hypoventilation syndrome and another condition. The physician followed Kaiser's instructions to addend the record to add obesity hypoventilation syndrome, even though the medical record indicates the patient was *underweight. Id.* ¶¶ 210-11.

The allegations that Kaiser submitted claims for risk-adjustment diagnoses that did not exist—and that those non-existent conditions did not require or affect patient care, treatment, or management at the visit—easily meet the requirements of Rule 9(b). "Because this standard does not require absolute particularity or a recital of the evidence, a complaint need not allege a precise time frame, describe in detail a single specific transaction or identify the precise method used to carry out the fraud." *Swoben*, 848 F.3d at 1180 (cleaned up). The Complaint far exceeds these standards, alleging details about the time, place, and nature of the scheme, including dates, individuals and entities, and methods of fraud. The Complaint also provides detailed examples showing that Kaiser submitted false claims for diagnoses that did not exist. When compared with other MA allegations deemed sufficient by the Ninth Circuit, the allegations easily suffice. *See, e.g.*, *Silingo*, 904 F.3d at 678-79; *Swoben*, 848 F.3d at 1181.

II. The Complaint Plausibly Alleges Kaiser's Knowledge.

Kaiser does not contest that the United States plausibly alleged that Kaiser knowingly submitted risk-adjustment codes that violated the ICD Guidelines. Instead, Kaiser disputes knowledge only as to its submission of diagnosis codes for non-existent diagnoses. *See* MTD at 21-22. As an initial matter, because *all* the alleged false claims involve violations of the ICD Guidelines' requirement that conditions require or affect patient care, treatment, or management, Kaiser's argument that it lacked knowledge that some of these conditions also did not exist is irrelevant. Nevertheless, should the Court reach this issue, Kaiser's arguments are also meritless because the United States plausibly alleged that Kaiser knowingly submitted false claims for diagnoses that did not exist.

The FCA employs a broad definition of "knowingly": (1) actual knowledge of the information; (2) deliberate ignorance of the truth or falsity of the information; or (3) reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(b)(1)(A). "[N]o proof of specific intent to defraud" is required. *Id.* § 3729(b)(1)(B). "Instead of pleading specific intent to defraud, it is sufficient to plead that

the defendant knowingly filed false claims, or that the defendant submitted false claims with reckless disregard or deliberate ignorance as to the truth or falsity of its representations." *Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1211 (9th Cir. 2019). The latter standard is intended to cover "'the ostrich type situation where an individual has buried his head in the sand and failed to make simple inquiries which would alert him that false claims are being submitted.'" *Id.* (quoting *Swoben*, 848 F.3d at 1174). Congress determined that entities, like Kaiser, which receive public funds, have "some duty to make a limited inquiry so as to be reasonably certain they are entitled to the money they seek." *Id.* Thus, as relevant here, "where [an] organization turns a blind eye to [diagnostic-code] over-reporting errors, it exhibits reckless disregard and deliberate ignorance toward the truth or falsity of the data submitted to CMS." *Swoben*, 848 F.3d at 1175-76; *see also United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1083 (N.D. Cal. 2020). Moreover, knowledge may be pleaded generally, with all inferences in favor of the plaintiff. *Silingo*, 904 F.3d at 679.

Kaiser's motion, in contrast, is premised on an incorrect legal standard. According to Kaiser, the FCA requires an intentional, palpable lie. MTD at 21-22. That is contrary to the plain language of the FCA, 31 U.S.C. § 3729(b)(1)(A), as well as the Ninth Circuit cases applying the knowledge standard to MA risk-adjustment submissions, which Kaiser tellingly omits. *See, e.g.*, *Swoben*, 848 F.3d at 1175-76; *Silingo*, 904 F.3d at 679-71. The sole case that Kaiser relies upon concerns the unique context of promissory fraud, based on claims of a false certification to comply with the law *in the future*. *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996). This case does not involve promissory fraud, and as a result *Hopper* is irrelevant. The FCA is not limited to intentional lies.

Under the correct standard, the Complaint plausibly alleges that Kaiser "knowingly" submitted diagnosis codes for conditions that did not exist. As the Complaint explains, Kaiser sent queries asking physicians to code diagnoses that did not exist and were contradicted by the medical record. For example, numerous physicians warned Kaiser that its cachexia initiative would lead to improper diagnosis assignment, and an internal audit confirmed these fears, showing that over 90% of the addenda adding cachexia were not accurate. Ignoring these results and warnings, Kaiser persisted with the initiative, submitting numerous cachexia diagnosis codes where the condition did not exist. Compl. ¶¶ 97-99, 300, 321-22. Just as in *Swoben*, Kaiser was "on notice that [its] data included a significant

number of erroneously reported diagnosis codes." 848 F.3d at 1175. The Complaint alleges other examples of reckless disregard for or deliberate ignorance of the truth or falsity, such as Kaiser asking a physician to add obesity hypoventilation syndrome for a patient who was *underweight* (telling the physician his real diagnosis did not yield sufficient reimbursement), Compl. ¶¶ 210-11, and Kaiser requesting a physician addend active cancer when his note showed the patient did not have active cancer at the visit, *id.* ¶ 338.

Kaiser's reckless behavior directly led to the submission of diagnoses that did not exist. Not only did Kaiser send queries to add diagnoses that contradicted the medical record, Kaiser sent such requests long after patient visits, when physicians' memories had faded. *Id.* ¶¶ 276-88. This directly contravened Kaiser's own internal advisories and training, which discouraged adding diagnoses not documented in original visit records (and certainly not long after the visit), recognizing that inaccurate information could result in FCA liability and stating that any such addenda needed to be closely monitored. *Id.* ¶¶ 88-96, 271-73. Throwing caution to the wind, Kaiser took the opposite approach: rather than monitoring added diagnoses, Kaiser required physicians who *resisted* a requested diagnosis to justify that decision to higher-ups, with no monitoring if the physician simply added the diagnosis. *Id.* ¶¶ 226-33. Kaiser instituted numerous mechanisms to pressure and incentivize physicians to add diagnoses, while also telling physicians not to spend any significant time evaluating the requested new diagnoses. *Id.* ¶¶ 176, 234-43. These were not instances of a physician mistakenly clicking on the wrong diagnosis; they resulted from a deliberate and reckless scheme to alter patient records to obtain money.

These allegations plausibly allege that Kaiser acted, at a minimum, with reckless disregard or deliberate ignorance to the truth or falsity of submitted diagnoses. *Swoben*, 848 F.3d at 1175-76.

III. The Complaint Plausibly Alleges Materiality.

The Complaint plausibly alleges that Kaiser's submission of false risk-adjustment diagnosis codes was material. Kaiser's arguments to the contrary: (1) misconstrue compliance with the ICD Guidelines as separate from accurate ICD coding; and (2) disregard the Complaint's allegations regarding the importance CMS attaches to accuracy according to the ICD Guidelines.

Materiality is defined by the FCA to mean "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4). The Supreme

Court and the Ninth Circuit have identified some factors relevant to materiality, including: whether the requirement concerns a condition of payment; whether the requirement goes to the essence of the bargain or is minor or insubstantial; the magnitude of the violation; whether the government regularly pays claims despite knowledge that the requirement is violated; and whether the defendant knows that the requirement is material to the government's decision to pay. *See Escobar*, 579 U.S. at 181, 193-95 & n.5; *Godecke*, 937 F.3d at 1213; *United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1022 (9th Cir. 2018); *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1121 (9th Cir. 2020). None of these factors is dispositive as to materiality. *Id.*

As the Complaint alleges, submitting accurate ICD diagnosis codes is material because CMS makes risk-adjustment payments based directly on the codes submitted by MAOs. Compl. ¶¶ 66-69, 349-50; *see also Ormsby*, 444 F. Supp. 3d at 1085-86 ("When MA Participants submit false risk-adjusting diagnosis codes, CMS pays more money . . . . This establishes that the diagnosis codes are material."). Kaiser does not argue to the contrary. Instead, Kaiser again claims a distinction between accurate ICD codes and compliance with the ICD Guidelines. *See* MTD at 18. But as detailed above, no such distinction exists. An ICD code that violates the ICD Guidelines because the condition had nothing to do with a patient visit is not an accurate ICD code—it is no less "false" than a code based on a non-existent condition. Neither represents a valid ICD code, and both are material.

The Complaint alleges the foundational importance of the ICD Guidelines to the CMS-HCC model and the MA risk-adjustment system. Compl. ¶¶ 59-71. The CMS-HCC model does not predict any costs associated with a patient merely having a condition; rather, the CMS-HCC model predicts expected costs based upon diagnoses *coded in conformance with the ICD Guidelines*. *Id.* ¶ 68. Given this foundational importance and its material impact on payments, CMS has mandated that MAOs must ensure the accuracy of their risk-adjustment data, conditioning payment on certification of accuracy, *id.* ¶ 79; 42 C.F.R. § 422.504(*l*), and CMS has made clear that such accuracy directly depends on compliance with the ICD Guidelines. Compl. ¶¶ 81, 83-87; Dkt. 179-1 at 353-54 (Manual) (MAO must ensure the "accuracy and integrity of risk adjustment data" coded "according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*"). "Diagnosis codes determine the risk scores, which in turn determine the risk-adjusted payments. As a

result, MA organizations and providers must focus attention on complete, truthful, and accurate diagnosis reporting *according to the official ICD-10-CM coding guidelines*." 83 Fed. Reg. at 55037 (emphasis added); *see also* 79 Fed. Reg. at 2001; 74 Fed. Reg. at 54674. Indeed, CMS has told MAOs that "[t]he risk adjustment *guiding principle* states that all diagnoses submitted for payment (i.e., used for HCCs) must be . . . [c]oded in accordance with the ICD-9-CM Guidelines for Coding and Reporting."[13] Dkt. 179-1 at 164 (emphasis added).

Because accurate diagnoses coded according to the ICD Guidelines are fundamental to payment, "[i]f CMS had known that [Kaiser] 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 [Kaiser] did not receive or retain risk-adjustment payments to which they were not entitled." Compl. ¶ 350. The United States' efforts to recover such payments through this lawsuit is further evidence that the agency views compliance with the ICD Guidelines to be material.

The Complaint also alleges that Kaiser knew that compliance with the ICD Guidelines was material.[14] Kaiser's own internal advisories stated that all diagnosis codes must comply with the ICD Guidelines to be submitted to CMS for payment and failure to do so could lead to FCA liability. *Id.* ¶¶ 90-95, 270-75. Kaiser's conduct further demonstrated that it knew compliance with the ICD Guidelines was material. After Kaiser employed a chart review program that resulted in the submission of diagnoses that violated the ICD Guidelines, *id.* ¶¶ 168-83, Kaiser later redacted these improper diagnoses, reflecting Kaiser's awareness of the materiality and the prohibition against submitting these diagnoses for payment. *Id.* ¶ 330. Kaiser also redacted diagnoses that audits found were based on

[13] Guidance documents may be highly relevant to materiality as they may inform participants of the key requirements of a program. *See, e.g.*, *United States ex rel. Prather v. Brookdale Senior Living Cmties., Inc.*, 892 F.3d 822, 835-36 (6th Cir. 2018) (finding materiality based in significant part on agency guidance). The risk-adjustment guiding principle appears in numerous CMS documents and identifies other core requirements, including that the diagnosis must be documented in the medical record based on a face-to-face visit from an acceptable physician provider. Dkt. 179-1 at 164. It is no coincidence that Kaiser's documents identify the same core requirements because CMS consistently identified the core, material requirements for accurate diagnosis submission. *See, e.g.*, Compl. ¶¶ 88-94.

[14] Kaiser's argument that its own knowledge "says nothing about whether compliance was material," MTD at 20, is wrong. *Escobar* directly recognizes that the defendant's knowledge of materiality is relevant to the inquiry. 579 U.S. at 193 ("What matters is not the label the Government attaches to a requirement, but whether the defendant knowingly violated a requirement that the defendant knows is material to the Government's payment decision.").

addenda and were "not addressed" in or had "no link" to patient visits, in violation of the ICD Guidelines. *Id*. ¶¶ 304-18.[15] Although Kaiser declined to disclose its broader misconduct, had Kaiser fully disclosed the facts and scale of its unlawful addenda practices, CMS would have taken appropriate action to ensure Kaiser did not receive or retain risk-adjustments payments for these improper diagnoses, which it has now done through this lawsuit. *Id.* ¶ 331. Tellingly, after Kaiser redacted the improper diagnoses, CMS collected back the payments for those diagnoses. *Id.* ¶ 330.

Taken together, these facts state a plausible claim that compliance with the ICD Guidelines was far from a "minor, insubstantial" requirement. *See Escobar*, 579 U.S. at 193 n.5, 194-95. Rather, because submitting diagnosis codes according to the ICD Guidelines is synonymous with submitting accurate ICD codes, such compliance "went to the very essence of the bargain," *id.*, under which CMS agreed to pay for risk-adjustment diagnoses submitted by MAOs. MAOs are allowed to be paid only for diagnoses coded *accurately according to the ICD Guidelines*. The Complaint alleges that CMS made accuracy a condition of payment and consistently stressed its importance in public pronouncements. Kaiser's own policies and conduct demonstrate it knew that ICD codes were valid only if they adhered to the ICD Guidelines. Finally, the magnitude of the violations here—another relevant factor, *Rose*, 909 F.3d at 1022—is substantial, with Kaiser reaping thousands of dollars for each inaccurate diagnosis code and hundreds of millions of dollars for its scheme. Compl. ¶¶ 335, 337-46. Collectively, these allegations easily establish "more than the mere possibility that the government would be entitled to refuse payment if it were aware of the violations, sufficiently pleading materiality at this stage."[16] *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 907 (9th Cir. 2017).

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[15] Kaiser claims such redactions are irrelevant because they "focus narrowly on compliance with query 'practice briefs' issued by AHIMA." *See* MTD at 20. This argument is incorrect for two reasons. First, it contradicts the Complaint's allegations (which must be accepted as true) that Kaiser redacted diagnoses because they were "not in" or "not addressed [in]" patient visit records, Compl. ¶ 314, had "no justification in the original [visit] note," *id.*, or were "not previously mentioned by the provider," *id.* ¶ 326, and thus violated the ICD Guidelines. *See also id.* ¶¶ 168-83. Second, as the Complaint alleges, Kaiser stressed compliance with the AHIMA query requirements not because they were legally binding, but because Kaiser knew that failure to comply would lead to "inappropriate upcoding," *see id.* ¶ 195—which is exactly what happened when Kaiser disregarded those guidelines, *see id.* ¶¶ 200-09.

[16] Kaiser cites cases for the unremarkable proposition that threadbare recitals of materiality without factual support are insufficient. Those cases have no relevance because the Complaint is full of factual allegations relevant to materiality. Further, Kaiser's suggestion that the United States was required to allege facts about *past* payment or enforcement practices is simply not the law. *See Prather*, 892 F.3d at 834 (rejecting such argument as "illogical" and contrary to *Escobar*); *see also Campie*, 862 F.3d at 907 (recognizing that such allegations are not required to plead materiality).

IV. No Claims Are Time-Barred.

Kaiser next argues that the FCA's statute of limitations bars the United States from pursuing FCA claims prior to October 2011. Kaiser misunderstands the law and bases its argument on a Ninth Circuit decision, *United States ex rel. Hyatt v. Northrop Corp.*, 91 F.3d 1211, 1218 (9th Cir. 1996), which was abrogated by the Supreme Court in *Cochise Consultancy, Inc. v. United States ex rel. Hunt*, 139 S. Ct. 1507 (2019). The claims alleged in the United States' Complaint, dating back to 2009, fall within the six-year statute of limitations from when the relators filed suit. As the Supreme Court explained in *Cochise Consultancy*:

> At issue here is the [FCA's] statute of limitations, which provides:
>
> (b) A civil action under section 3730 may not be brought—
>
> (1) more than 6 years after the date on which the violation of section 3729 is committed, or
>
> (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed,
>
> whichever occurs last. [31 U.S.C.] § 3731(b).

Id. at 1510-11 (cleaned up). The plain text sets forth "two limitations periods." *Id.* at 1511-12. The United States may rely on either one. The FCA further provides that when the government intervenes, "[f]or statute of limitations purposes," any government pleading "shall relate back to the filing date of the complaint of the person who originally brought the action," including "any additional claims" so long as they "arise[] from the same conduct, transactions, or occurrences." 31 U.S.C. § 3731(c). Kaiser did not contest that the United States' claims arise out of same conduct, transactions, or occurrences. Instead, Kaiser argues that this relation-back provision only applies to *part* of the FCA's statute of limitations. Kaiser claims that the last clause of (b)(2), containing a ten-year limitation, is actually not part of the statute of limitations at all, and that Congress exempted it from the relation-back provision.

At the outset, the Court need not reach Kaiser's argument. As noted earlier, the FCA statute of limitations sets forth two limitations periods. A claim is timely if it meets the limitations period under either prong. Here, the United States may rely solely on the (b)(1) prong. The United States' claims cover a narrowed subset of claims that the *Osinek* and *Taylor* complaints— which were filed on August

22, 2013 and October 22, 2014, respectively—attempted to set forth. The United States' claims, which date back to 2009, are all within six years of those complaints. Consequently, under the relation-back provision, the United States' claims are all timely under (b)(1). *See United States ex rel. Ling v. City of L.A.*, No. CV 11-974 PSG, 2018 WL 3814498, at *23 (C.D. Cal. July 25, 2018). As *Ling* recognized, Kaiser's argument is not relevant to whether a claim is timely under (b)(1). *Id.* Under the plain language of the statute, the ten-year clause in (b)(2) does not apply to (b)(1). *Id.* Because the United States' claims are all timely under (b)(1), the Court should deny Kaiser's motion on that basis alone.

In any event, Kaiser is also wrong that, through the clause "[f]or statute of limitations purposes," Congress exempted part of the statute of limitations. As the unanimous Supreme Court recognized in *Cochise Consultancy*, the FCA's statute of limitations encompasses *all* of § 3731(b). 139 S. Ct. at 1510; *see also Ling*, 2018 WL 3814498, at *22 (concluding § 3731(b) is a single provision that must be read together). Thus, § 3731(c)'s "for statute of limitations purposes" clause refers to all of the FCA's statute of limitations, not part of it. Given the plain language, numerous courts have correctly understood that § 3731(c)'s relation-back provision applies to all of § 3731(b) and allowed the United States to pursue claims for conduct more than ten years prior. *See, e.g.*, *United States ex rel. Miller v. Bill Harbert Int'l Constr.*, 608 F.3d 871, 879-80 (D.C. Cir. 2010); *Ling*, 2018 WL 3814498, at *22.

Kaiser's interpretation is perplexing because § 3731(c)'s relation-back provision does not modify or toll the time limitations in § 3731(b); rather, it specifies when claims are deemed to be "brought"—i.e., the filing date of the original complaint.[17] But under Kaiser's reading, the same claim is "brought" on different dates for different parts of the same statutory provision—indeed, for different clauses within the same subsection. Such a reading is contrary to ordinary statutory construction, which gives the same words the same meaning. *See Clark v. Martinez*, 543 U.S. 371, 378 (2005) ("To give these same words a different meaning for each category would be to invent a statute rather than interpret one."). Absent clear indication otherwise, a claim is "brought" on the same date for all parts of the same statute.

Moreover, nothing in the text or structure of the statute or its legislative history supports Kaiser's position. When Congress added the (b)(2) prong, it called the entire provision a statute of limitations.

[17] The statute refers to when an "action" has been brought, but the Supreme Court has clarified that in the context of statute of limitations, this language refers to claims. *See Jones v. Bock*, 549 U.S. 199, 220-21 (2007); *see also United States ex rel. Schumann v. Astrazeneca Pharm. L.P.*, 769 F.3d 837, 846 (3d Cir. 2014) (concluding "FCA's reference to 'action' may reasonably be read to mean 'claim'").

See, e.g., H.R. Rep. No. 99-660, at 32 (June 26, 1986) (§ 3731(b) provides "a dual statute of limitations"); 132 Cong. Rec. S11238-04 (daily ed. Aug. 11, 1986) (statement of Sen. Grassley). There is no indication Congress later decided that (b)(2) was not a statute of limitations or intended to hyper-technically parse it. This is consistent with Ninth Circuit precedent and elsewhere that has found, with regard to federal statutes, Congress often uses the term statute of limitations to cover all time limitations.[18] *See NCUA Bd. v. RBS Sec., Inc.*, 833 F.3d 1125, 1130-35 (9th Cir. 2016); *FHFA v. Nomura Holding Am., Inc.*, 873 F.3d 85, 113 (2d Cir. 2017); *FDIC v. First Horizon Asset Sec., Inc.*, 821 F.3d 372, 379-80 (2d Cir. 2016).

Kaiser's reading is contrary to the text, contravenes the purposes of the relation-back provision, and makes no logical sense because it does not even provide repose to an FCA defendant—it merely shifts *who* prosecutes those claims (relators instead of the government). Congress expressed a desire for the United States to prosecute claims and take primary responsibility when it intervenes. *See* 31 U.S.C. § 3730(c); *Cochise Consultancy*, 139 S. Ct. at 1510. The relation-back provision was intended to avoid forcing the United States "to forgo a thorough investigation of the merits of *qui tam* allegations in order to ensure that it does not lose claims." 155 Cong. Rec. E1295-03 (2009) (statement of Rep. Berman). Under Kaiser's reading, this purpose would regularly be lost. Even less logical, if the United States intervenes beyond ten years and merely adopts the relator's complaint as its own, then the United States could prosecute the claims in full. But if it chooses to file its own pleading narrowing the claims, then the United States could not. And regardless, the defendant would receive no repose because the relator would still be authorized to pursue the relator's original complaint. There is no reason to believe Congress wanted to split prosecution of such claims in this manner. The far better reading is that the relation-back statute applies to all of the FCA's statute of limitations, not part of it.[19]

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[18] *CTS Corp. v. Waldburger*, 573 U.S. 1 (2014), is not to the contrary. The Court recognized that Congress often uses the term "statute of limitations" to mean "any provision restricting the time in which a plaintiff must bring suit." *Id.* at 13. In that case, based on the specific text, and that Congress considered but rejected covering statutes of repose, the Court determined that Congress specifically referred only to state statutes of limitations, not repose. But none of those facts exist here.

[19] The lone case Kaiser relies upon, *United States v. Scan Health Plan*, No. CV 09-5013-JFW, 2017 WL 4564722, at *8 (C.D. Cal. Oct. 5, 2017), did not have the benefit of *Cochise Consultancy*'s guidance. Moreover, its analysis is based on improper application of legislative history, relying on the non-passage of a bill in a *prior* Congress. The Supreme Court has emphasized that such "'mute intermediate legislative maneuvers' are not reliable indicators of congressional intent." *Mead Corp. v. Tilley*, 490

Finally, where, as here, the United States' interests are at stake, the Supreme Court has long held that limitations periods "must receive a strict construction in favor of the Government." *See Badaracco v. Comm'r*, 464 U.S. 386, 397 (1984); *E.I. DuPont De Nemours & Co. v. Davis*, 264 U.S. 456, 462 (1924). Any doubt must be construed in favor of the United States. *Ling*, 2018 WL 3814498, at *22.

In sum, because the United States' claims are timely under the (b)(1) prong, the Court need not address Kaiser's arguments further. But for the reasons explained above, Kaiser is wrong that section (c)'s relation-back provision applies to only part of the FCA's statute of limitations.

V. The United States May Pursue Its Payment By Mistake and Unjust Enrichment Claims.

Lastly, Kaiser argues that the United States is precluded from pursuing its payment by mistake or unjust enrichment claims because: (1) the United States allegedly failed to state a FCA violation; and (2) the claims are allegedly precluded by an express contract. Neither argument is correct.

First, Kaiser's assertion that the claims are "purely derivative" of the FCA and therefore rise and fall together is wrong. The Ninth Circuit (and every other circuit) recognizes that such claims may be viable even where the United States is unable to prove every element of an FCA violation—for example, knowledge. *United States v. Mead*, 426 F.2d 118, 124 & n.6 (9th Cir. 1970). Because Kaiser identifies no element of these claims that the United States has failed to plead, instead relying on the mistaken premise that the claims rise and fall together as "derivative," the Court should reject Kaiser's argument.

Second, Kaiser incorrectly argues the United States' claims are precluded by the existence of a contract. Kaiser's argument is flawed because it flows from the mistaken belief that the United States brings traditional state common law claims. Not so. The United States' claims arise from its inherent authority under federal law to recover funds wrongfully, erroneously, or illegally paid.

The right to recover erroneously paid funds, whether through lawsuit or set-off, has long been recognized by the Supreme Court. "The Government by appropriate action can recover funds which its agents have wrongfully, erroneously, or illegally paid. 'No statute is necessary to authorize the United States to sue in such a case. The right to sue is independent of statute.'" *Wurts*, 303 U.S. at 415 (quoting

U.S. 714, 723 (1989). *Scan Health* compounds the error by finding intent based solely on testimony of a witness on behalf of the Chamber of Commerce, who testified that Congress should not amend the statute of limitations and should not allow any relation back. *See* Hearing before the S. Comm. on the Judiciary, 110th Cong. 101 (2008) (statement of John T. Boese) at 27-28. Such testimony is wholly unreliable as to a later Congress' intent when it rejected the witness's views *against* relation back. And Kaiser's reliance on the same witness's book as additional support is equally unpersuasive.

United States v. Bank of the Metropolis, 15 Pet. 377, 401 (1841)); *see also Grand Trunk W. Ry. Co. v. United States*, 252 U.S. 112, 120-21 (1920); *Wis. Cent. R.R. Co. v. United States*, 164 U.S. 190, 210-12 (1896). This right to recover erroneously paid funds is absolute "unless Congress has 'clearly manifested its intention' to raise a statutory barrier." *Wurts*, 303 U.S. at 416; *see also Mead*, 426 F.2d at 124-25.

The United States' right to recover erroneously paid funds differs substantially from traditional state common law claims. *See, e.g.*, *United States v. Lahey Clinic Hosp., Inc.*, 399 F.3d 1, 15-16 & n.16 (1st Cir. 2005) ("*Wurts* and the cases it relies on do not refer to the government's power to collect money wrongfully paid as a construction of the common law," explaining it is based upon "something more intimately tied with the power of the United States"). In contrast to state common law, the United States may recover based upon any error—mistake of fact or law.[20] *See, e.g.*, *Kingman Water Co. v. United States*, 253 F.2d 588, 590 (9th Cir. 1958); *DiSilvestro v. United States*, 405 F.2d 150, 155 (2d Cir. 1968); *Heidt v. United States*, 56 F.2d 559, 560 (5th Cir. 1932). Absent a statute to the contrary, the United States' recovery is "not barred by the passage of time." *Wurts*, 303 U.S. at 416. The only limitation is where Congress "'clearly manifested its intention' to raise a statutory barrier." *Id.* As the Federal Circuit recently summarized, in a case involving an express contract,

> When a payment is erroneously or illegally made, as is alleged here, it is in direct violation of the Constitution. To correct for this violation, the United States may exercise its well-established right to sue for money wrongfully or erroneously paid from the public treasury, a right arising separate and apart from statute, regulation, or contract. The only time the United States is barred from exercising its inherent right to recover overpayments is when Congress has clearly manifested its intention to raise a statutory barrier.

Agility Pub. Warehousing Co. K.S.C.P. v. United States, 969 F.3d 1355, 1365-66 (Fed. Cir. 2020) (cleaned up); *see also, e.g.*, *United States v. Indep. Sch. Dist. No. 1*, 209 F.2d 578, 580-81 (10th Cir. 1954) (United States could recover overpayments under valid contract through "restitution for unjust enrichment" because "the right to recover under controlling federal law is plain").

Rather than identifying any clearly manifested statutory barrier to recovery, Kaiser instead relies solely on irrelevant cases applying state law. *See, e.g.*, *Paracor Fin., Inc. v. Gen. Elec. Cap. Corp.*, 96 F.3d 1151, 1167 (9th Cir. 1996) (applying California state common law); *Luxul Tech. Inc. v. NectarLux,*

[20] Traditional state common law claims are limited to mistake of fact. Not so for the United States. Thus, the United States may recover any erroneous payments, regardless of whether it is based on a mistake of fact (e.g., monies erroneously paid based upon invalid diagnosis submissions) or a mistake of law (e.g., if Kaiser were correct that the ICD standard does not apply, any monies erroneously paid based upon the Government's mistaken belief that the standard applied).

LLC, No. 14-CV-03656-LHK, 2015 WL 4692571, at *7 (N.D. Cal. Aug. 6, 2015) (same). None of the cases addresses the scope of the United States' unique authority to recover erroneous payments under *Wurts*.[21]

Finally, even if Kaiser were correct about the applicability of state common law—which it is not—Kaiser has no argument that claims against its entities that were not parties to the contracts should be dismissed. *See First Choice Armor & Equip.*, 808 F. Supp. 2d at 78 (refusing to dismiss non-parties).

Nor does Kaiser have any argument that the United States cannot bring these claims premised on violation of a regulation, as opposed to violation of a contract. Here, the United States also alleges that Kaiser violated obligations imposed by regulation, and the United States paid Kaiser based upon the mistaken belief that Kaiser complied with those MA regulations. *See Mead*, 426 F.2d at 124-25 (allowing the United States to recover funds based on mistaken belief that the defendants "had complied with the applicable regulations"). At most, the cases relied upon by Kaiser suggest that quasi-contract claims cannot be brought to enforce contractual obligations. None suggest the United States cannot bring such claims to recover erroneous payments premised on violation of statute or regulation.

In sum, pursuant to *Wurts*, whether labeled as payment by mistake or an unjust enrichment remedy, the United States has the clear right to recover any funds erroneously paid.

CONCLUSION

For the foregoing reasons, the Court should deny Kaiser's motion to dismiss. To the extent any claim or portion of claim is dismissed, the United States requests leave to amend.

[21] The most broadly worded of these cases, *United States v. First Choice Armor & Equip., Inc.*, 808 F. Supp. 2d 68, 77 (D.D.C. 2011), for example, relies upon a D.C. Circuit case, *Albrecht v. Comm. on Emp. Benefits of Fed. Reserve Emp. Benefits Sys.*, 357 F.3d 62, 69 (D.C. Cir. 2004), which itself applies state common law and does not address the United States' unique inherent authority. *See also Lee v. Canada Goose US Inc.*, No. 20 Civ. 9809 (VM), 2021 WL 2665955, at *9 (S.D.N.Y. June 29, 2021) (same); *United States ex rel. Reeves v. Mercer Transp.*, 253 F. Supp. 3d 1242, 1255-56 (M.D. Ga. 2017) (same). The United States is also permitted to bring claims under state common law. It does not appear that *Wurts* was even raised in any of the cases cited, in most of which the United States was not involved.

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DATED: August 5, 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 DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION**

(captions continued on next page)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **[PROPOSED] ORDER DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **[PROPOSED] ORDER DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:18-cv-01347-EMC **[PROPOSED] ORDER DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION**

(captions continued on next page)

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

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

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

[PROPOSED] ORDER DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION

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

Plaintiff,

v.

KAISER PERMANENTE, INC., et al.,

Defendants.

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

[PROPOSED] ORDER DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' COMPLAINT-IN-INTERVENTION

[PROPOSED] ORDER

The Court hereby DENIES Defendants' Motion to Dismiss United States' Complaint-in-Intervention, Dkt. 178, in its entirety. The United States' Complaint-in-Intervention sufficiently pleads that Kaiser submitted false claims in the form of inaccurate ICD diagnosis codes that violated the ICD Guidelines, that Kaiser acted knowingly, and that Kaiser's submission of false diagnosis codes was material. Additionally, no claims are time-barred. The United States may pursue both its False Claims Act claims and its claims for payment by mistake and unjust enrichment.

IT IS SO ORDERED.

DATED: _______________, 2022

____
HON. EDWARD M. CHEN
United States District Judge