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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA, *ex rel.*
RONDA OSINEK,

Plaintiffs,

v.

KAISER PERMANENTE, FOUNDATION
HEALTH PLAN, INC., and THE
PERMANENTE MEDICAL GROUP, INC.,

Defendants.

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

RELATOR TAYLOR'S OPPOSITION TO
DEFENDANTS' MOTION TO DISMISS
RELATOR TAYLOR'S SECOND
AMENDED COMPLAINT

Noticed Hearing Date: October 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

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

Plaintiffs,

v.

KAISER FOUNDATION HEALTH PLAN,
INC., KAISER FOUNDATION HEALTH
PLAN OF COLORADO, COLORADO
PERMANENTE MEDICAL GROUP, P.C.,
THE PERMANENTE MEDICAL GROUP,
INC., and SOUTHERN CALIFORNIA
PERMANENTE MEDICAL GROUP,

Defendants.

(Original N.D. Cal. Case No. 3:21-cv-
03894-EMC)

RELATOR TAYLOR'S OPPOSITION TO
DEFENDANTS' MOTION TO DISMISS
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1 Relator respectfully provides this Opposition to the Motion of Kaiser Defendants to
2 Dismiss Relator Taylor’s Second Amended Complaint (“Mot.”). In support thereof, Relator
3 relies upon his Second Amended Complaint and the arguments herein.

4 **INTRODUCTION**

5 Dr. Taylor, a physician and certified professional coder who held various high-ranking
6 positions at Kaiser relating to risk adjustment payments and compliance, alleges in detail a
7 nationwide fraud on the Medicare Advantage Risk Adjustment program (the “MA Program”) by
8 Kaiser Foundation Health Plan (“KFHP”), Kaiser Foundation Health Plan of Colorado (“KFHP-
9 Colorado”), and Colorado Permanente Medical Group (“CPMG”).¹ His Second Amended
10 Complaint lays out three primary frauds committed by Defendants against the Medicare program
11 that all, at a high level, involve submitting false diagnosis codes to CMS or failing to take
12 corrective action when learning certain codes were false.

13 First, he alleges that Kaiser fraudulently refused, in Colorado and nationally, to
14 investigate or delete diagnosis codes it knew to have consistent, high rates of falsity.²

15 Second, he alleges that Kaiser reviewed the medical records of patients of its external
16 providers in Colorado, then fraudulently and willfully ignored the results of this chart review that
17 revealed that it had overbilled, while acting on the results that gave it additional revenue.

18 Finally, he alleges that Kaiser knowingly used natural language processing software that,
19 because of its design and Kaiser’s implementation, did not assess the validity of previously
20 submitted diagnosis codes and caused the submission of false diagnosis codes.

¹ Claims against The Permanente Medical Group or the Southern California Permanente Medical Group were dismissed by the Court’s First-to-File Order (Dkt. 171).

² Any such allegations as to California have been dismissed by the Court’s First-to-File Order (Dkt. 171).

1 These frauds are alleged in detail in Taylor’s complaint, satisfying the Rule 9(b) standard
2 and holding up to Defendants’ challenges. Indeed, even Defendants concede that some of
3 Taylor’s FCA claims against Kaiser may proceed. Def. Mot. at 24. They contest only: (1) the
4 scope of Taylor’s claims as to geography and defendants that should be allowed to go forward;
5 (2) whether Taylor adequately pleaded falsity and materiality as to certain of these claims; and
6 (3) the application of the FCA’s statute of limitations to certain defendants. None of these
7 arguments provides a reason to narrow Taylor’s well-pleaded complaint.

8 As to scope, the Complaint clearly alleges a nationwide or corporate-wide fraud scheme
9 against not only KFHP-Colorado and CPMG (the “Colorado Defendants”), but their parent
10 company, KFHP, as well. Relator pleads the involvement of KFHP executives in organizing and
11 directing aspects of the fraud, and his collective pleading also appropriately puts KFHP on notice
12 of the allegations against it. Kaiser tries to hide behind its own organizational structure to avoid
13 liability, but it cannot do so.

14 As to falsity, Taylor has clearly laid out the who, what, when, where, and how of the
15 fraud schemes. Taylor also explains why the claims are false: various Kaiser audits, including
16 chart reviews, found errors in the diagnoses used by Kaiser to obtain Risk Adjustment payments
17 from CMS. Kaiser professes confusion as to the meaning of the word “error” in this context,
18 faulting Taylor for failing to allege why each specific false diagnosis was false. But that would
19 create, without legal support, a pointlessly high pleading standard. Relator’s complaint gives
20 Defendants enough information to defend against the claims and not just deny them. *See United*
21 *States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (“*Swoben*”).
22 Defendants’ desire for something more has no basis in the law.

1 As to materiality, Taylor has expressly alleged Kaiser submitted false codes to CMS and
2 that those submissions directly resulted in overpayments—a plain statement of materiality.
3 Additionally, Taylor pleaded that Kaiser’s knowledge of these false codes rendered its required
4 annual certifications false. Had CMS known that Kaiser was submitting false diagnosis codes, or
5 false certifications regarding the accuracy of its data, it would have refused to make risk-
6 adjustment payments or taken other actions to recoup money. Every court that has evaluated the
7 materiality of unsupported diagnosis codes to CMS has reached the conclusion that they are
8 material. *See United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 673 (9th Cir. 2018)
9 (“...if enrollee diagnoses are overstated, then the capitation payments to Medicare Advantage
10 organizations will be improperly inflated”); *Swoben*, 848 F.3d at 1167–68 (“These diagnosis
11 codes contribute to an enrollee’s risk score, which is used to adjust a base payment rate.”);
12 *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1085-86 (N.D. Cal. 2020)
13 (“When MA Participants submit false risk-adjusting diagnosis codes, CMS pays more money”);
14 *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, No. CV 16-08697 MWF, 2018 WL
15 1363487, at *9 (C.D. Cal. Feb. 12, 2018) (“[diagnostic] data is central to the calculation of the
16 amount of money CMS pays to Defendants”).

17 Defendants concede that certain of Taylor’s allegations are material, specifically those
18 that “reflect medical conditions that Taylor alleges did not exist as a clinical matter.” *See Mot.* at
19 3 n.3. But that is drawing a distinction without a difference. CMS has been consistent that, for a
20 diagnosis code to be acceptable under the MA Program, it must meet certain rules and be
21 documented in the medical record. *See SAC ¶¶ 57-70; UnitedHealthCare Ins. Co. v. Becerra*, 16
22 F.4th 867, 867 (D.C. Cir. Nov. 1, 2021) (“Neither Congress nor CMS has ever treated an
23 unsupported diagnosis for a beneficiary as valid grounds for payment”). Kaiser cites to no

1 distinction in the law that differentiates between conditions that did not exist as a clinical matter
2 versus those not supported in medical records for other reasons. Indeed, there is no such
3 distinction.³

4 Finally, invoking 31 U.S.C. § 3731(b)(2), Defendants attempt to limit Taylor's claims
5 against CPMG, which was recently added as a defendant, to on or after November 15, 2011, *i.e.*,
6 ten years before the date of the Second Amended Complaint. But Taylor's original complaint
7 was filed on November 3, 2014, and Courts have consistently held that the FCA statute of repose
8 does not bar relation back under Rule 15(c). Consequently, as for the other remaining Kaiser
9 Defendants, Taylor is entitled to pursue claims against CPMG back to November 3, 2004.

10 Kaiser's Motion to Dismiss Taylor's Complaint should be denied.

11 **FACTUAL AND PROCEDURAL BACKGROUND**

12 Through the MA Program, CMS allows private health insurers to set up managed care
13 plans to cover Medicare beneficiaries. All told, CMS currently has over 900 contracts with
14 different insurers, known as Medicare Advantage Organizations or MAOs.

15 CMS pays a monthly capitation rate for each beneficiary enrolled as a member of an MA
16 Program, known as a "per-member, per-month" payment. This predetermined base payment
17 varies for each MA Program depending on various factors, primarily demographics (age and sex)
18 and health status.

19 Individuals with multiple and/or serious health conditions account for more health care
20 costs than healthier members. Accordingly, CMS pays a substantially higher capitation rate for
21 members who have been recently treated for one or more serious, expensive diseases or

³ CMS audits of MA data, known as "Risk Adjustment Validation Audits," rely solely on the review of medical documentation, not an examination of beneficiaries to evaluate whether conditions existed as a "clinical matter." 42 C.F.R. § 422.310(e).

1 conditions. *See* 42 U.S.C. § 1395w-23(a)(1)(C). These increased payments are known as “risk
2 adjustment” payments. The only variable that determines a beneficiary’s health status is the
3 diagnosis codes an MAO submitted on that beneficiary’s behalf. *See* 42 U.S.C. § 1395w-
4 23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).⁴

5 Because diagnosis coding is inherently linked to payment, MAOs are bound by
6 regulation, contract, and CMS guidance to follow certain rules that dictate the conditions under
7 which they may submit codes for risk adjustment purposes. These rules include requirements that
8 the diagnosis code must be supported by the beneficiary’s underlying medical record, must come
9 from an acceptable provider type, must come from a face-to-face medical encounter,⁵ and must
10 come from a visit in the relevant timeframe determining that payment, among other
11 requirements.

12 A violation of any of these requirements can render a code false. The code might have
13 been derived from a visit with an unacceptable provider type, been from the wrong year, or
14 simply been fabricated—or, as the government’s various FCA litigations show, many, many
15 other alleged fraud schemes.

16 Taylor filed his suit in 2014. Following the government’s intervention on July 29, 2021,
17 Taylor filed a Second Amended Complaint (“SAC”) in 2021.

18 Defendants initially moved to dismiss Taylor based on the first-to-file rule in the False
19 Claims Act (“FCA”), 31 U.S.C. § 3730(b)(5), citing to the 2013 complaint filed by Ronda

⁴ Though this opposition focuses on Medicare Part C, Relator is pursuing analogous allegations under Medicare Part D, which covers prescription drugs. Diagnostic coding is also the basis for determining the amount of money insurers receive from the Part D program. *See* SAC ¶¶ 54-55, 60, 83; 42 C.F.R. §§ 423.504 & 423.505.

⁵ Certain exceptions to this rule were afforded as a result of the COVID-19 pandemic.

1 Osinek. On May 5, 2022, after argument, this court declined the motion with respect to the
2 majority of Taylor’s allegations, holding that:

3 (1) Taylor points to a nationwide or corporate-wide problem whereas Osinek is
4 local or regional (i.e., California-centric) in nature;

5 (2) Taylor has identified a fraud related to external providers rather than high-value
6 conditions; and

7 (3) Taylor asserts a problem with Kaiser failing to evaluate the True Positives
8 results yielded by the natural language processing program (“NLP”).

9 Order, Dkt. 171, at 38-39 (May 5, 2022). Defendants now seek to dismiss those claims.

10 RELATOR’S ALLEGATIONS

11 After the Court’s recent first-to-file order, Taylor pursues three sets of allegations that
12 plead different frauds committed by Defendants: that they engaged in “(1) a nationwide or
13 corporate-wide fraud [relating to “high-value” unsupported diagnosis codes]; (2) a fraud based
14 on improper coding by external providers; and (3) a fraud based on True Positive results from the
15 NLP program.” Order, Dkt. 171, at 46.

16 **I. Taylor Alleges Nationwide Fraud Relating to Unsupported Diagnosis Codes** 17 **Submitted by Internal Providers**

18 Relator’s complaint lays out a litany of instances in which Defendants failed to act to
19 correct false diagnoses after various types of audits revealed persistent problems with
20 Defendants’ diagnosis coding that resulted in the submission of false claims to CMS. Many of
21 these instances set out frauds that are encompassed within the Complaint in Intervention; to the
22 extent they do, Relator’s complaint is no longer operative and Defendants’ Motion against it is
23 irrelevant. *United States ex. rel. Dresser v. Qualium Corp.*, No. 5:12-cv-01745 BLF, 2016 WL
24 3880763, at *10 (N.D. Cal. July 18, 2016). (United States’ complaint is operative complaint for
25 the intervened claims).

1 Taylor identifies various medical conditions where Defendants had consistently high
2 rates of false submissions to CMS. SAC ¶ 147. These include cancer (often miscoding resolved
3 cancer as if it were still present) (¶¶ 148-162), stroke (often miscoding history of stroke as active
4 stroke) (¶¶ 163-170, 200), vertebral fracture (¶ 171), vascular disease (¶¶ 172-176), chronic
5 bronchitis (¶¶ 177-180), metastatic cancer (¶¶ 181-182), history of heart attack (often coding
6 from diagnostic tests, as opposed to face-to-face visits as CMS requires) (¶¶ 183-184),
7 malnutrition (¶¶ 185-187), decubitus ulcers (¶¶ 188-190), sick sinus syndrome (¶¶ 191-196), and
8 renal insufficiency (¶¶ 197-199).

9 The SAC also describes several remedial steps that Relator suggested to improve the
10 accuracy of the diagnosis codes Kaiser submitted to CMS, including a filter to pause the
11 submission of certain high-risk codes (¶¶ 145, 202-209); a “pop-up” alert, that queried, in real
12 time, whether a physician was sure about the current state of a disease (¶¶ 156-159); and the
13 hiring of an external consultant to review charts for accuracy for certain hospital-generated
14 diagnosis codes (¶ 162). Kaiser ignored, failed to follow through on, or shut-down these various
15 remedial measures when it became apparent that they would reduce revenue.⁶

16 **II. Taylor Alleges Fraud Based on Improper Coding by External Providers**

17 Taylor also alleges what the Court called “a fraud based on improper coding by external
18 providers.” Order, Dkt. 171, at 46. In this scheme, the Colorado Defendants reviewed all hospital
19 records of their beneficiaries discharged from a certain chain of hospitals to identify the
20 appropriate coding as part of their search for additional diagnosis codes to submit to CMS. They
21 knew that the original, hospital-submitted diagnosis codes were riddled with errors, but they

⁶ Apart from Defendants’ arguments regarding the materiality of MAO submissions and the FCA’s statute of limitations, which can apply to all of Relator’s theories, Defendants do not address this theory in their Motion.

1 focused only on the upside of this review. In other words, the Colorado Defendants’ project gave
2 them information about how all the patients should have been coded. Yet they did not investigate
3 or delete previously submitted codes that were hospital-generated and not substantiated by their
4 review, even though they had all the necessary information at their fingertips. Instead, they only
5 submitted the additional codes, and they retained all the codes the hospitals had previously
6 submitted, including those the review revealed were false. (SAC ¶¶ 119-136).

7 **III. Taylor Alleges Fraud Based on NLP ‘True Positive’ Results**

8 Finally, Taylor alleges that Kaiser used NLP software that failed to determine the validity
9 of previously submitted diagnosis codes and caused the submission of false diagnosis codes that
10 did not follow CMS rules. This resulted in the submission of false codes due to the software
11 design and implementation limitations, of which Kaiser was acutely aware. (SAC ¶¶ 224-234.)
12 As the Court put it, part of “Taylor’s point is that there is a high error rate associated with the
13 NLP program’s True Positives, but Kaiser still submits claims based on True Positives without
14 any further inquiry.” Order, Dkt. 171, at 38.

15 **STANDARD OF REVIEW**

16 Under Fed. R. Civ. P. 12(b)(6), a district court takes the facts alleged in the complaint as
17 true. *See United States ex rel. Lee v. Corinthian Colls.*, 655 F.3d 984, 991 (9th Cir. 2011). The
18 court must draw all reasonable inferences in favor of the plaintiff. *See Turner v. City and Cnty. of*
19 *San Francisco*, 788 F.3d 1206, 1210 (9th Cir. 2015).

20 Fraud must be pleaded with particularity under Fed. R. Civ. P. 9(b). For an FCA
21 complaint, that standard is satisfied if the complaint identifies the “who, what, when, where, and
22 how” of the misconduct charged. *Cafasso, United States ex rel. v. Gen. Dynamics C4 Sys., Inc.*,
23 637 F.3d 1047, 1055 (9th Cir. 2011). But while Rule 9(b) requires particularity for the
24 “circumstances constituting fraud or mistake,” its heightened standard is limited to those aspects;

1 all “other facts may be plead[ed] generally, or in accordance with Rule 8.” *Corinthian Colls.*,
2 655 F.3d at 991, 992.

3 ARGUMENT

4 Defendants make a scattershot attack on a variety of Taylor’s claims, but none of their
5 arguments overcome the specific pleading of allegations in the complaint, which satisfies the
6 relevant standards. Nor do their novel statute of limitations arguments succeed, as the relation
7 back doctrine applies to the FCA. Their motion should be denied.

8 **I. Relator Adequately Pleads that the Kaiser Foundation Health Plan Violated the** 9 **FCA**

10 Although Defendants attempt to dismiss KFHP, the California-based parent of the
11 Colorado plan, Taylor’s allegations plainly encompass fraud committed by that entity.

12 KFHP’s employees, some of whom were stationed in Colorado, participated in planning
13 and perpetrating fraud on behalf of Kaiser in Colorado and nationwide, just like their colleagues
14 employed at the Colorado-based entities. KFHP employees were involved in the attestation
15 process (SAC ¶ 75) and spearheaded the push for additional MA revenue that led to the creation
16 of the fraud schemes Relator alleges (SAC ¶ 86). Chris Tholen, for instance, was a KFHP
17 employee who was embedded at the Colorado plan and drove for higher revenue on KFHP’s
18 behalf. (SAC ¶¶ 86-90). One of those revenue-boosting programs was the Chart Review scheme
19 Taylor alleges. (SAC ¶88). Likewise, KFHP employee Kathy Lancaster was involved in
20 submitting false Risk Adjustment attestations to CMS on Kaiser’s behalf (SAC ¶75), and KFHP
21 employee Diane Morrisette directed various audits of data Kaiser was submitting to CMS, one of
22 those audits revealed high rates of false submissions with diagnosis codes generated by external
23 providers (SAC ¶¶ 92, 113). In short, many KFHP employees were the “who” of the “who, what,
24 when, where, and how” analysis required by Rule 9(b). *Cafasso*, 637 F.3d at 1055.

1 Even ignoring these specific pleadings, Taylor adequately pleads against KFHP through
2 collective pleadings. As Defendants acknowledge, collective allegations against multiple
3 defendants are appropriate where each defendant has allegedly “engaged in precisely the same
4 conduct.” Mot. at 13, *quoting Swoben* 848 F.3d at 1184. That is exactly what Taylor has
5 repeatedly alleged in the SAC. Taylor defined the term “Kaiser” in his SAC to include KFHP,
6 KFHP-Colorado, and CPMG. SAC ¶ 21.

7 KFHP sits at the center of the Kaiser universe, “the national collaboration among the
8 various Defendant health plans, hospitals, and medical groups.” Def. Reply in Support of Mot. to
9 Dismiss on First-to-File at 2 (Dkt. 165) (“FTF Reply”). KFHP is the parent of all Kaiser MAOs
10 in the seven states in which the company operates, including KFHP of Colorado. As a result,
11 KFHP and the Colorado Defendants are intertwined, serving for the benefit of each other. Kaiser
12 effectively conceded this point in their previous motion to dismiss, when they argued that Kaiser
13 was such a unified national organization that Osinek’s complaint was sufficient to put the United
14 States on notice of all subsequent fraud allegations across the country. Now, KFHP argues that it
15 has somehow not been put on adequate notice of its role in the alleged fraud scheme, because
16 Kaiser is such a fragmented, disparate entity that it does not understand what collective
17 allegations referencing “Kaiser” refer to it. This is willfully obfuscatory.

18 Even setting aside Defendants’ gameplaying, Taylor alleges specifically that since 2004,
19 all the named Defendants, including KFHP, “have perpetrated a systematic fraud” on the MA
20 Program by “routinely submit[ting] false claims” to CMS “when they know, or in the exercise of
21 reasonable care should know, that their beneficiaries’ medical records do not support the
22 diagnoses for which a risk adjustment claim was submitted.” SAC ¶ 2. That fraud was driven by
23 KFHP employees working together with those of the Colorado plan and Medical Group to

1 perpetuate schemes that knowingly overbilled the government and padded many Kaiser entities'
2 bottom lines, plainly meeting the *Swoben* standard.⁷

3 **II. Relator Alleges Facts Sufficient to Show Direct and Reverse FCA Violations under**
4 **Rule 9(b)**

5 Relator's complaint sets out the specifics of distinct fraudulent schemes that each meet
6 the standards of Rule 9(b). That rule "requires only that the circumstances of fraud be stated with
7 particularity; other facts may be plead[ed] generally." *Corinthian Colls.*, 655 F.3d at 992 (citing
8 *Ashcroft v. Iqbal*, 556 U.S. 662, 687 (2009)). A complaint must identify "the who, what, when,
9 where, and how of the misconduct charged," along with "what is false or misleading ... and why
10 it is false." *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010).

11 It need not, however, list every detail of the alleged fraud. *Ebeid*, 616 F.3d at 998-99. A
12 complaint satisfies Rule 9(b) if it provides enough detail about the particular misconduct that is
13 alleged as fraud to permit Defendants to defend against the claims. *Swoben*, 848 F.3d at 1180.
14 Relator's complaint meets this standard, pleading all facts necessary to know exactly what is

⁷ Defendants' reliance on *Hausauer v. City of Mesa*, No. CV-20-00653 PHX, 2020 WL 2735970, at *3 (D. Ariz. May 26, 2020), a police misconduct case, is misplaced. That Court held that six police officers could not have engaged in the exact same conduct, a far cry from the coordinated, corporate-driven fraud scheme alleged here. In similar fraud cases, courts have held that collective allegations meet Rule 9(b) if several Defendants are engaged in the same fraud scheme. *See e.g., United States ex rel. Kuzma v. N. Arizona Healthcare Corp.*, CV 18-8041-PCT-DGC, 2020 WL 5819568, at *5 (D. Ariz. Sept. 30, 2020) (sufficient to allege "that all three Defendants engaged in a single kickback"); *United States v. Prime Healthcare Services Inc.*, No. 5:18-v-00371-RGK-SHK, 2020 WL 11884833, at *5 (C.D. Cal. April 14, 2020) ("Relator's allegations are sufficient against [Defendant 1] and [Defendant 2] without more particular differentiation because he alleges that they both do essentially the same work ...and engaged in the same wrongful activity.").

1 being alleged. Indeed, Defendants challenge under Rule 9(b) only the pleading of falsity, yet
2 Taylor has met the standards there as well.⁸

3 *A. Relator's Chart Review Claims Meet Rule 9(b)*

4 Relator's complaint clearly lays out a scheme of one-way chart reviews that resulted in
5 Kaiser's knowing submission of false claims because of what the Court called "problematic
6 coding by external providers." Order, Dkt. 171, at 37 (May 5, 2022). His allegations give Kaiser
7 more than enough notice to defend against the complaint. The specifics of this scheme and the
8 universe of false claims that result are identified in the complaint; indeed, the claims have
9 already been identified as false by Defendants' own review processes.

10 Under its chart review program, the Colorado Defendants reviewed all hospital records of
11 their beneficiaries discharged from a certain chain of hospitals, then known as Exempla. They
12 did this to search for additional diagnosis codes to submit to CMS. Kaiser knew that the original,
13 hospital-submitted diagnosis codes were riddled with errors—in other words, Kaiser knew that it
14 was being paid by CMS for false codes. (SAC ¶¶107-110, 113, 116-117). Despite this
15 knowledge, Kaiser did not investigate or delete these previously submitted codes that were not
16 substantiated by its own review, even though it had all the necessary information at its fingertips
17 and the analytical ability to compare these two sets of codes. (SAC ¶¶118, 121, 125).

18 At the same time that it was ignoring these overpayments revealed by the review, Kaiser
19 sought payment for the additional codes that its reviews found.

20 Relator identifies the Kaiser employees who knew about and perpetrated this fraud (SAC
21 ¶¶ 113, 116, 128) and when the fraud scheme began (SAC ¶¶120, 128, 131, 133). In other words,

⁸ Defendants do not challenge under Rule 9(b) Taylor's allegations about their nationwide failure to act to correct false diagnoses after audits revealed persistent problems, resulting in the submission of false claims to CMS.

1 the “who, what, when, where, and how” of the misconduct alleged are clearly identified. *Cafasso*
2 637 F.3d at 1055. Defendants do not challenge this clear and specific pleading, which easily
3 meets Rule 9(b).

4 Contrary to Defendants’ assertions, Relator also pleads *why* these claims are false. The
5 complaint alleges a pattern of Defendants themselves identifying codes as false and then
6 knowingly not deleting them from CMS systems (and thus retaining overpayments in violation
7 of the FCA). Relator alleges that a discrete set of diagnoses Defendants submitted to CMS were
8 identified as false by Defendants themselves and that Defendants did nothing to return the ill-
9 gotten revenues.⁹

10 Relator need not plead the specific reasons for each false code, because the fraud scheme
11 is not based on the reasons that Defendants identified them as false. It is not fraudulent because
12 of any particular type of false coding; it is fraudulent because Defendants became aware of a
13 discrete set of codes that were false that they had already submitted—and then they knowingly
14 failed to correct it.

15 All of the Courts examining similar schemes under the MA Program have held that no
16 explanation of why diagnoses are false is necessary under the pleading standards. See *Swoben*,¹⁰

⁹ While Defendants attempt to characterize Relator’s allegations as merely conclusory allegations of “error rates” (Mot. at 14-15), Relator’s citations to error rates are part of pleading scienter: they are indicative of Kaiser knowingly and repeatedly submitting false diagnostic data to CMS.

¹⁰ Defendants attempt to distinguish *Swoben* by claiming that Taylor’s allegations are only about hypothetical claims, while the claims in *Swoben* were “actual.” Mot. at 15-16. The attempt to distinguish fails on its face. Taylor pleads that Kaiser’s one-way chart review revealed actual false claims, as evidenced by the results of each audit Defendants performed on this category of codes. (SAC ¶¶107-110, 117). Using an illustrative, hypothetical example at SAC ¶ 126 has no bearing on the fact that Kaiser identified a concrete universe of actually false claims. Additionally, the *Swoben* plaintiffs themselves did not identify the reasons each code might have been false.

1 848 F.3d at 1168; *Ormsby*, 444 F. Supp. 3d 1010, 1077.¹¹ This reasoning accords with the
2 principles behind the pleading standards. Defendants have more than enough information to
3 defend against the complaint. While the particular reasons the codes were false vary, especially
4 with many thousands of such diagnoses at issue, the reason that their submission and the
5 retention of the associated overpayment were false is the same. And that reason was pleaded by
6 Relator. (SAC ¶¶ 125, 136).

7 Defendants would require a plaintiff not only to plead the fraud scheme with
8 particularity, but also to identify *why* each implicated false code was unsupported, even though it
9 was Defendants who initially identified them as unsupported. Such a requirement would far
10 exceed the Ninth Circuit’s standard on Rule 9(b) laid out in *Ebeid*, and it would be needless
11 under the circumstances, given that this knowledge is uniquely Defendants’. Relator’s pleading
12 already satisfies the goals of Rule 9(b), to avoid an allegation that “identifies a general sort of
13 fraudulent conduct but specifies no particular circumstances of any discrete fraudulent
14 statement.” *Cafasso*, 637 F.3d at 1057. Here, Relator pleads all the relevant circumstances to
15 know exactly what the false statements are and the reason they are false (lack of support in the
16 medical record). He need not provide a laundry list of every false code and the reason for it. *See*
17 *Ebeid*, 616 F.3d at 998 (to withstand a motion to dismiss, “it is sufficient to allege ‘particular
18 details of a scheme to submit false claims paired with reliable indicia that lead to a strong
19 inference that claims were actually submitted’”) (citations omitted).

20 *B. Relator’s NLP Claims Meet Rule 9(b)*

21 As a separate theory, Relator also alleges that Kaiser knowingly used NLP software in a
22 similar way to its chart reviews: Kaiser acted on results that claimed new diagnosis codes but set

¹¹ The *Poehling* Court did not analyze Rule 9(b) in making its decision.

1 aside results that would have revealed that previously submitted codes were false, thus
2 fraudulently retaining overpayments from CMS. Kaiser’s knowing failure to prevent the
3 submission of false codes and correct those it knew it had submitted was due not only to the
4 design of the software, but how Kaiser implemented it, which Kaiser knew.

5 As with the chart review allegation, Relator identified the necessary specifics: when the
6 program began (SAC ¶ 224), the specific software product Kaiser used (SAC ¶228), the specific
7 regions at issue (SAC ¶¶ 229-231), clearly identifying the “who, what, when, where, and how”
8 of the fraud, as well as the why. *Cafasso* 637 F.3d at 1055.

9 Defendants’ two Rule 9(b) arguments against Relator’s NLP allegations each fail. First,
10 Defendants deliberately misconstrue the allegations and then argue that error rates are not a
11 sufficient basis for FCA liability. Mot. at 16. But Relator does not allege that error rates are the
12 sole basis of Defendants’ liability. Relator alleges that Defendants reviewed their diagnosis
13 coding using NLP that identified both substantiated and unsubstantiated codes. When Defendants
14 willfully ignored the unsubstantiated codes, they violated the FCA.¹² These allegations are set
15 out in the complaint. (SAC ¶¶ 228-234). Thus, as with the chart review allegations, Relator
16 clearly isolates a universe of codes he claims are false and puts Defendants on clear notice of
17 what’s in that universe, meeting the requirements of Rule 9(b).

18 Second, Defendants seem to argue that Relator’s review of the NLP outputs was not
19 statistically representative of a larger problem, Mot. at 16, but that ignores that Relator pleaded a
20 larger audit of the same software output (SAC ¶231). More importantly, Defendants here are
21 attacking the merits of the allegations, not their sufficiency. At this stage, all reasonable

¹² Defendants’ knowledge of their error rates via various audits is further evidence of their knowledge of falsity.

1 inferences must be drawn in the Relator’s favor, see *Turner*, 788 F.3d at 1210, and Defendants
2 have identified no pleading standard of any sort implicated by their claims about the statistical
3 validity of certain audits. When courts have been faced with similar audit-based allegations, they
4 have allowed FCA cases to proceed past the motion to dismiss stage without delving into
5 mathematical analyses. See e.g., *United States v. Lakeshore Med. Clin., LTD.*, No. 11-CV-00892,
6 2013 WL 1307013 at *3 (E.D. Wis. Mar. 28, 2013) (denying a Motion to Dismiss where a
7 “defendant ignored audits disclosing a high rate of upcoding” because that “plausibly suggests
8 that defendant acted with reckless disregard for the truth and submitted some false claims”).

9 **III. Relator Adequately Alleges Materiality**

10 Relator alleges that Kaiser submitted unsupported diagnosis codes that led to false claims
11 for payment and the unlawful retention of overpayments, and that also rendered the annual
12 certifications of accuracy that MAOs submit to CMS false. The requirement to submit accurate
13 coding is at the heart of the Medicare program, as it directly determines the amount of payment.
14 It is plainly—and definitionally—material.

15 In *Universal Health Servs., Inc. v. United States ex rel. Escobar*, the Supreme Court
16 noted that both the FCA and “common-law antecedents” applied in other federal fraud statutes
17 define materiality as “having a natural tendency to influence, or be capable of influencing, the
18 payment or receipt of money or property.” 579 U.S. 176, 182 (2016) (quoting 31 U.S.C.
19 § 3729(b)(4)). The Court then explained that, under any understanding of this concept,
20 “materiality ‘look[s] to the effect on the likely or actual behavior of the recipient of the alleged
21 misrepresentation.’” *Id.* at 2002. The Supreme Court’s main concern was that FCA liability
22 should not occur “where noncompliance is minor or insubstantial” or be based on “insignificant
23 regulatory or contractual obligations” just because the government labelled them as conditions of
24 payment and could theoretically decline to pay. That is not the case here, where both the

1 attestations and the diagnosis codes themselves are essential to the CMS decision to pay Kaiser's
2 capitation payments. Based on the holistic analysis prescribed in *Escobar*, both the risk
3 adjustment attestations and the underlying diagnosis codes themselves are material to CMS
4 payment decisions. The United States has repeatedly taken this position in various FCA cases,
5 and courts have agreed.

6 Oddly, Defendants draw a distinction between diagnosis codes that violated coding rules
7 and diagnosis codes for conditions that did not exist. Mot at 3 n.3; Mot. at 19 n.7. For the latter,
8 they concede that Relator has adequately pleaded his allegations. There is no basis for this
9 distinction. As discussed above, from the perspective of CMS, a properly coded condition means
10 that the condition exists for the purposes of payment under the MA Program. If it is improperly
11 coded, it is a false claim, regardless of the reason for it being an inappropriate claim, whether it
12 was not properly diagnosed because it does not exist or because it was from a prohibited provider
13 type, from an impermissible addendum, or because of any of the other myriad ways codes can
14 violate Medicare rules. See SAC ¶¶ 64-68. The MA payment system is based on these rules
15 because CMS is not an omniscient surveyor of millions of beneficiaries' health status.
16 Defendants point to no authority that would support any relevance of this difference, nor do they
17 explain their position.¹³

¹³ Defendants try to write off false codes as potential "typographical" errors. Mot at 2, 15. But, because of the way diagnosis coding works, even typographical errors have the same effect as diagnosing conditions a patient does not have—both constitute false codes. For instance, for a period, the diagnosis code for diabetes without complications was 25000 and the code for a type of leukemia was 20500. Leukemia draws a reimbursement of over \$20,000 more than diabetes. A true typo, of course, would not meet the FCA's knowledge standard on its own, but if Kaiser became aware of a typo and refused to correct it, that would give rise to liability. Here, there is ample pleading of Kaiser's knowing actions.

1 A. *Risk Adjustment Attestations Are Material to CMS Payment Decisions*

2 CMS, as an explicit condition of payment, has required the CFO or CEO of each MAO to
3 sign an attestation certifying the accuracy, completeness, and truthfulness of the diagnostic data
4 the MAO submits to CMS. 42 C.F.R. § 422.504(l). In *Swoben*, the Ninth Circuit called these
5 attestations a “bulwark against fraud.” 848 F.3d at 1168. Defendants’ knowingly submitting false
6 diagnosis code, or failing to delete them once they were discovered, rendered the annual
7 attestations necessarily false. The falsity of the attestation, an explicit condition of payment, is
8 material to CMS’s payment decision.

9 The attestation warns of the serious legal implications of making false representations
10 about the validity of diagnoses. It states that the MA Organization acknowledges “that
11 misrepresentations to CMS about the accuracy of such information may result in Federal civil
12 action and/or criminal prosecution.” See CMS Manual System, Pub. 100-16 Managed Care,
13 Transmittal 33 (Oct. 3, 2003). This is a plain statement, executed by Defendants, that evidences
14 materiality to a claim for payment under § 3729(a)(1)(A) and (B) or to an obligation to repay
15 under the false statement provisions of § 3729(a)(1)(G).

16 Although Defendants cite to *United States v. Scan Health Plan*, 2017 WL 4564722, at *6
17 (C.D. Cal. Oct. 5, 2017) (“*Swoben II*”) and *Poehling*, those decisions do not support their
18 position here. As they acknowledge, those decisions turned on pleading issues, not
19 determinations about the materiality of the required attestations. *Poehling*, for example, only
20 held that the government, in that case, failed to plead that CMS would have declined payment, or
21 recouped money, had it known the attestations were false. *Poehling*, 2018 WL 1363487, at *10.

22 Relator makes no such omission here and pleads the required allegations. See e.g., SAC
23 at ¶¶238, 242, discussing several mechanisms by which CMS would have refused to pay and/or

1 recouped prior payments had the agency known the truth about Defendants’ risk adjustment
2 programs.¹⁴ Without pleading issues like those in *Poehling* and *Swoben II*, the Ninth Circuit
3 concluded, on very similar facts to the present case, that false attestations are an FCA violation.
4 *See Swoben*, 848 F.3d at 1175 (“[W]e hold that when, as alleged here, Medicare Advantage
5 organizations design retrospective reviews of enrollees’ medical records deliberately to avoid
6 identifying erroneously submitted diagnosis codes that might otherwise have been identified with
7 reasonable diligence, they can no longer certify, based on best knowledge, information and
8 belief, the accuracy, completeness and truthfulness of the data submitted to CMS.”).

9 The government makes similar allegations. Whatever it chose to plead, or not plead, in
10 prior years in *Swoben II* and *Poehling*, is not relevant to the present case. The government, in its
11 complaints in this case and a different case against another MAO, Anthem, clearly pleads the
12 materiality of the attestations to the CMS payment decision. *See Kaiser CII* at ¶ 79 (quoting the
13 condition of payment language in 42 C.F.R. § 422.504(l)), ¶ 354 (explaining that CMS would
14 have refused or recouped payment in pleading an FCA violation under § 3729(a)(1)(B)); *see*
15 *Anthem Compl.* (Dkt. No. 1 *United States v. Anthem, Inc.*, (No. 1:20-cv-02593, S.D.N.Y.)) at ¶ 83
16 (quoting the condition of payment language in 42 C.F.R. § 422.504(l)), ¶151 (“the false
17 attestations submitted by [Defendant] caused CMS to move forward with final reconciliation for
18 [Defendant’s] Part C plans and disburse reconciliation payments to Anthem...”), ¶ 162 (“false
19 Part C annual attestations that enabled [Defendant] to evade its obligation to refund CMS under
20 the Medicare Part C’s final reconciliation process”). The specific reasons why the attestations are

¹⁴ Additionally, as discussed in more detail below, the *Poehling* court found the diagnosis themselves material to payment and allowed an FCA case, brought under an extremely similar theory to the present case, proceed past the motion to dismiss stage. *Poehling*, 2018 WL 1363487, at *12.

1 false may differ in Relator Taylor’s case than the reasons in the government’s cases against
 2 Kaiser or Anthem, but the materiality analysis is identical. The government is clearly
 3 representing that CMS would have taken action to stop or recoup payment had it known
 4 Defendants’ attestations were false, remedying the pleading issues in *Swoben II* and *Poehling* on
 5 which Defendants so heavily rely.¹⁵

¹⁵ The cases Defendants cite to argue Relator’s materiality allegations are conclusory and all clearly distinguishable from Taylor’s allegations.

United States v. Vora, No. 4:20-cv-66 BJB, 2022 WL 89177, at *4–5 (W.D. Ky. Jan. 7, 2022) is an out of circuit case Defendants cite to argue that continued payment denies materiality. When faced with a similar question, the Ninth Circuit plainly held that a myopic focus on the government’s continued payment should not be used to shield Defendants from liability for their fraud. *See United States ex rel. Campie v. Gilead Sciences, Inc.*, 862 F.3d 890, 906 (9th Cir. 2017) (stating that “to read too much into the FDA’s continued approval [of the drugs after it learned of certain compliance issues] – and its effect on the government’s payment decision – would be a mistake” because it would allow the defendant to “use the allegedly fraudulently-obtained FDA approval as a shield against liability for fraud”). Additionally, the *Vora* court lists factors beyond continued payments as parts of a holistic materiality analysis, including whether the government identified a provision as a condition of payment, and whether the noncompliance goes to the essence of the bargain. *Vora*, 2022 WL 89177, at *4. The attestation requirement is plainly identified as a condition of payment in 42 C.F.R. § 422.504(l) and Relator’s factual allegations show that the attestation requirement went to the very “essence of the bargain” between Defendants and CMS. *See Swoben*, 848 F.3d at 1168 (recognizing that the attestation requirement is “a bulwark against fraud”). Even *Poehling* concluded that the risk adjustment attestations “go to the ‘essence of the bargain’ between CMS and [MAOs]” under Medicare Part C. *See* 2018 WL 1363487, at *9.

The single conclusory paragraph considered in *Knudsen v. Sprint Commc’ns Co.*, No. C13-04476-CRB, 2016 WL 4548924, at *13 (N.D. Cal. Sept. 1, 2016) contrasts to the numerous and detailed allegations in this case, including the fact that courts have found the attestations both to go to the benefit of the bargain and to be an explicit condition of payment. Courts have distinguished *Knudsen* itself on similar grounds, such as where a Relator relies on more than a single conclusory reference to a regulation. Here, Taylor cited to statutes, regulations, CMS contract, and CMS guidance. *See United States v. Kinetic Concepts inc.*, No. CV 08-6403-GHK, 2016 WL 11688146, at *10 (C.D. Cal. Dec. 29, 2016) (finding materiality due to the variety of sources cited in the complaint). Additionally, *Poehling* points out that *Knudsen* and its progeny do not apply to the reverse false claims act claims, which are an independent theory of liability here. *See* 2018 WL 1363487, at *11.

Defendants’ reliance on *Dresser*, 2016 WL 3880763, at *6 is equally misplaced. There, a claim was immaterial because of a failure to explain why that claim was material. Here, in

1 Relator pleads the materiality of the attestations sufficiently, and the United States has
2 stated as much in nearly identical situations.

3 *B. The Diagnosis Codes are Material to CMS Payment Decisions*

4 The materiality of the codes is nearly definitional. As explained above, when an MAO
5 submits diagnostic data to CMS systems, CMS systems automatically adjust payments based on
6 that information. Had Kaiser not submitted false diagnosis codes, or had it deleted false
7 diagnosis codes, it would have automatically been paid less by CMS. Every court that has
8 examined the issue to date has concluded that inaccurate diagnostic data is material to CMS
9 payments. *See e.g., Swoben*, 848 F.3d at 1167 (explaining that “[t]he risk adjustment
10 methodology relies on enrollee diagnoses”); *Silingo*, 904 F.3d 667, 673 (“if enrollee diagnoses
11 are overstated, then the capitation payments . . . will be improperly inflated”); *Ormsby*, 444 F.
12 Supp. 3d at 1087 (“Diagnosis codes are the only factors that CMS uses to determine a
13 beneficiary's health status to calculate Medicare Advantage payments . . . This establishes that the
14 diagnosis codes are material.”); *Poehling*, 2018 WL 1363487, at *9 (“the sole determinant in the
15 calculation of any risk adjustment payments based on a beneficiary’s health status” and that
16 CMS adjusts payments upwards or downwards based on addition or deletion of diagnosis codes
17 sufficiently pleads that diagnosis codes are material).

18 Relator’s complaint explains the materiality of these codes repeatedly, including in
19 language Defendants point to, Mot. at 19-20, citing SAC ¶¶ 238, 242, 246. Relator also alleges
20 that health status is a direct input into the capitation rate (SAC ¶¶ 49-50) and that had Defendants
21 correctly conducted a retrospective program, CMS would have paid them less (SAC ¶ 125).

contrast, in the case of Part C attestations, several courts have found that they are a fraud prevention mechanism and go to the essence of the bargain between CMS and MAOs.

1 Defendants' argument that Relator failed to allege exactly what CMS would have done is
2 beside the point. Defendants focus on language in Relator's complaint that listed several
3 mechanisms for CMS to recover money from Defendants. Mot. at 19. Each of the actions listed
4 in SAC ¶¶ 238, 242, 246 demonstrates materiality. Relator alleges that CMS would not have paid
5 for false diagnosis codes or would have recouped improper payments. Whether CMS would have
6 done that via stoppage of payment, payment adjusts, or enforcement actions is not relevant to
7 how material it is to CMS.¹⁶ If anything, CMS' myriad options to address it underscore the
8 materiality of the issue.

9 Finally, Defendants' materiality arguments do not apply at all to Relator's claims under
10 the "reverse" false claims provision of the FCA, which are an independent theory of liability
11 here. § 3729(a)(1)(G). *Escobar* did not address materiality under this section of the FCA. Under
12 the false statement provisions of § 3729(a)(1)(G), the inquiry focuses on the materiality of the
13 false statement – here, Defendants' Attestations – on Defendants' "obligation to pay," which
14 includes repaying for an overpayment. Likewise, under the second part of § 3729(a)(1)(G), the
15 concealment of an obligation to pay the government, an implied materiality requirement
16 logically would also focus on Defendants' obligation to repay the overpayment. It would not be
17 connected to any false statement, however, as a false statement is not an element of a violation of
18 the second part of § 3729(a)(1)(G).

¹⁶ Defendants' reliance on *United States ex rel. Mei Ling v. City of Los Angeles*, No. CV 11-974 PSG, 2018 WL 3814498, at *20 (C.D. Cal. July 25, 2018) is non-responsive to Relator's complaint. First, given that Relator is pursuing this case on a declined basis, he is not relying on the government's intervention decision to demonstrate materiality. Second, the Housing program at issue in *Mei Ling* was not well-treaded ground in terms of FCA cases. Here, every court to examine the issue concluded that diagnosis codes are material under the MA Program.

1 In *United States v. Bourseau*, 531 F.3d 1159 (9th Cir. 2008), the Court addressed the
2 application of the pre-FERA version of the reverse false claims provision.¹⁷ Similar to this case,
3 that case involved interim payments made periodically throughout a year with a final
4 reconciliation payment made based on the Defendants' submission of reports at the end of each
5 year. *Id.* at 1162. The Court explained that the inquiry under the reverse false claims provision
6 was whether the false cost reports were material to avoid or decrease paying money owed the
7 government or repaying the government for an overpayment. *Id.* at 1170-71. It concluded that
8 the false reports "concealed and decreased amounts that [the defendants] were obligated to repay
9 to Medicare" even though the cost reports were not reviewed by the government. *Id.* Here, the
10 known, false diagnosis codes submitted by Defendants formulaically increased the amounts paid
11 to Defendants. Kaiser's failure to delete those codes resulted in the retaining of overpayments,
12 analogous to the situation in *Bourseau*.

13 **IV. The FCA's Statute of Limitations Allows Relation Back under Rule 15(c)**

14 Defendants attempt to limit claims against certain Defendants first named in Relator's
15 Second Amended Complaint to the ten years prior to its filing, but that amendment relates back
16 to his original complaint under Fed. R. Civ. P. 15(c)(1)(B). Thus, the relevant statutes of
17 limitations run from the date of his original filing.

18 All of the fraud schemes Relator alleges in the SAC arise out of "out of the conduct,
19 transaction, or occurrence set out—or attempted to be set out—in the original pleading." *Id.*
20 Defendants admit as much. *See Mot.* at 22 ("It makes no difference that Taylor might seek to

¹⁷ The *Poehling* Court held that *Escobar* did not overturn *Bourseau*. 2018 WL 1363487, at *11-12.

1 relate the SAC’s allegations back to his own prior complaint, or that he does not seek to add new
2 relators or new theories of liability stemming from the same conduct as his original complaint”).

3 Defendants’ only argument on this point is that Rule 15(c) should not apply in the context
4 of 31 U.S.C. § 3731(b)(2), sometimes identified as the FCA’s supposed statute of repose. To
5 buttress this argument, Defendants attempt to rely on a lengthy string cite of cases interpreting
6 superficially similar language in unrelated statutes, the Securities and Truth in Lending Acts. *See*
7 *Mot.* At 21-22. Tellingly, Defendants completely ignore jurisprudence under the FCA that
8 reaches the opposite conclusion and allows relation back under Rule 15(c).¹⁸ *See e.g., United*
9 *States v. Kaplan, Inc.*, 517 F. Appx. 534, 536 (9th Cir. 2013) (allowing relation back generally
10 while finding some of relator’s allegations failed to meet the test); *United States ex rel. Bledsoe*
11 *v. Community Health Sys., Inc.*, 501 F.3d 493, 517–18 (6th Cir. 2007) (allowing relation back
12 pursuant to Rule 15(c)); *United States ex rel. Rigsby v. State Farm Fire and Casualty Company*,
13 No.1:06 cv 433 HSO-JCG, 2021 WL 1170086, at *16-17, (S.D. Miss. 2021) (applying the
14 relation back analysis to an amended complaint filed 15 years after the original); *United States ex*
15 *rel. Carter v. Halliburton Co.*, 315 F.R.D. 56, 63 (E.D. Va. Feb. 17 2016) (“[T]he Court finds
16 that the statute of repose does not prevent relation back.”); *United States ex rel. Cericola v.*
17 *Federal Nat’l Mortg. Ass’n*, 529 F. Supp. 2d 1139, 1148–49 (C.D. Cal. Dec. 28 2007) (“The
18 court finds nothing in the FCA legislation that precludes application of the relation back doctrine
19 to qui tam complaints.”). Even in the context of the laws Defendants rely on, some Courts have
20 held that statutes of repose do not bar relation back under Rule 15(c). *See e.g., Southeastern*
21 *Pennsylvania Transportation Auth. v. Orrstown Financial Servs. Inc.*, 12 F.4th 337, 345-347 (3d

¹⁸ While some of these cases consider Rule 15 (b)(1), none find anything unusual about the limitations scheme in the FCA that would suggest a different result. Those that explicitly considered (b)(2), or considered all of (b), permitted the relation back.

1 Cir. 2021) (in the context of the securities act, “statutes of repose themselves are no barrier to
2 relation back under Rule 15(c)”¹⁹).

3 Here, Defendants concede that the scheme pleaded in the amended complaint arises out
4 of the same conduct as the schemes pleaded in the original complaint. Defendants’ only issue is
5 that Taylor initially named the wrong members of “the national collaboration among the various
6 Defendant health plans, hospitals, and medical groups.” Def. FTF Reply at 2 (Dkt. 165). Yet the
7 medical groups at issue were on notice of the existence of the suit and are not prejudiced in any
8 way by Relator’s relation back under Rule 15(c). Accordingly, this is no grounds for dismissal.

9 **V. Any Dismissal Should Be Without Prejudice and with Leave to Amend**

10 Should the Court grant Defendants’ Motion, in whole or in part, Relator requests that the
11 dismissal of any of his claims be without prejudice and that he be granted leave to amend. *See*
12 Fed. R. Civ. P. 15(a)(2); *see, e.g., Eminence Capital, LLC v. Aspeon, Inc.*, 316 F.3d 1048, 1052
13 (9th Cir. 2003) (holding that dismissal without leave to amend is improper unless the complaint
14 could not be saved by any amendment).

15 **CONCLUSION**

16 This Court should deny the motion. In the alternative, any dismissal should be without
17 prejudice and with leave to amend.

¹⁹ Defendants’ arguments under the Rules Enabling Act are also unpersuasive, and their reliance on *Indymac* is misplaced. There, the Second Circuit explicitly declined to determine whether Rule 15(c) was categorically inapplicable to statutes of repose. *See Police & Fire Retirement Sys. of City of Detroit v. IndyMac MBS, Inc.*, 721 F.3d 95, 110 n.18 (2d Cir. 2013). The *Carter* court addressed this argument explicitly, noting that Rules that “incidentally affect litigants’ substantive rights do not violate this provision if reasonably necessary to maintain the integrity of that system of rules.” 315 F.R.D. at 65 (citing *Burlington N. R. Co. v. Woods*, 480 U.S. 1, 5 (1987)).

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,

Plaintiffs,

v.

KAISER PERMANENTE, FOUNDATION
HEALTH PLAN, INC., and THE
PERMANENTE MEDICAL GROUP, INC.,

Defendants.

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

[Proposed] Order

Noticed Hearing Date: October 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

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

Plaintiffs,

v.

KAISER FOUNDATION HEALTH PLAN,
INC., KAISER FOUNDATION HEALTH
PLAN OF COLORADO, COLORADO
PERMANENTE MEDICAL GROUP, P.C.,
THE PERMANENTE MEDICAL GROUP,
INC., and SOUTHERN CALIFORNIA
PERMANENTE MEDICAL GROUP,

Defendants.

(Original N.D. Cal. Case No. 3:21-cv-
03894-EMC)

[Proposed] Order

Noticed Hearing Date: October 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

[PROPOSED] ORDER

This matter coming to be heard on this 14th day of October 2022, upon consideration of MOTION TO DISMISS RELATOR TAYLOR’S SECOND AMENDED COMPLAINT, and the Court being fully advised in the premises.

IT IS HEREBY ORDERED the Defendants’ Motion is Denied.

DATED:

HON. EDWARD M. CHEN
United States District Judge