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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, *et al.*, Defendants.	Case No. 3:13-cv-03891-EMC (Consolidated) Hearing date: October 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

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UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel.* GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, *et al.*, Defendants.	Case No. 3:18-cv-01347-EMC **RELATORS BRYANT AND HERNANDEZ'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AMENDED COMPLAINT**

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I. INTRODUCTION

In their First Amended Complaint (ECF No. 117, the "Complaint"), Plaintiff-Relators Gloryanne Bryant and Victoria Hernandez ("Relators") describe in detail how Defendants – a group of 15 related medical providers, health insurers, and hospitals, all under the Kaiser Permanente umbrella, referred to collectively in this brief as "Kaiser" or "Defendants" – intentionally manipulated medical diagnosis codes to assign more serious conditions to their patients than warranted. The scheme bilked two government programs that reimburse based on those codes – the Medicare Advantage ("MA") program and the Affordable Care Act ("ACA") program – into paying more than they should. Relators describe in detail how Defendants' culture, programs, and policies encouraged this manipulation and silenced all efforts to stop it, leading to the presentation of patient bases to both programs that appeared, falsely, to be less healthy, greater health risks, and more costly to insure than they actually were.

With the ACA, the government spreads risks among insurers by shifting funds from those with more healthy patient bases to those with sicker patient bases. It makes the risk determination based on information that participants like Kaiser send to it about their patients, including medical diagnoses. Under the ACA, the government also provides federal funds, in the form of tax credits, that consumers can use to pay their insurance premiums. Health insurance plans with riskier patients receive more of these tax credits, because they receive a larger portion of the premiums as a whole. As a result of Kaiser's exploitation of medical diagnoses codes, it receives more funds from the government, in the form of tax credits and shifting premiums, than it would have had it submitted accurate information. What the Complaint describes is fraud, plain and simple, and fits squarely within the ambit of the False Claims Act ("FCA").

Through its Motion to Dismiss (ECF No. 182, the "Motion"), Kaiser asks this Court to hold that, as a matter of law, it cannot be held liable for this conduct under FCA. Kaiser improperly whittles down the 201-paragraph Complaint to a dozen paragraphs that, according to Kaiser, are the only ones that describe the ACA scheme, and on that basis

argues that the Complaint cannot satisfy Rule 9(b) as to Kaiser's ACA fraud. Kaiser is wrong. Nearly every allegation in the Complaint applies to Kaiser's ACA scheme *as well as* Kaiser's Medicare Advantage scheme, and should be considered in ruling on the Motion. Kaiser further trivializes its gross misconduct as no more than "technical violations" of "subregulatory guidance." This characterization glosses over the core of the Complaint's allegations – in violation of the ACA, Kaiser upcoded diagnoses, an axiomatic FCA violation. Finally, due to Kaiser's selective view of the Complaint, Kaiser argues that only one Kaiser Defendant can be liable for misconduct, again ignoring the plain allegations in the Complaint and applicable FCA law. Kaiser's attempts to exculpate itself from the consequences of defrauding the government fail, and its Motion should be denied, in full.

II. BACKGROUND

A. Kaiser Permanente's Structure

Kaiser Permanente is a massive healthcare consortium that: (1) operates one of the nation's largest health plans, serving over 11.5 million members; (2) is among the nation's largest physician and physician-service organizations; and (3) is one of the nation's largest hospital chains. Compl. ¶¶ 23, 25. *See also* Motion at 1 n.1; United States Complaint in Intervention (Case No. 3:13-cv-03891 EMC, ECF No. 110, "U.S. Compl.") ¶ 19.

On the physician practice side, Kaiser employs doctors and other medical professionals and provides direct medical services through its Permanente Medical Groups, a for-profit set of regional affiliates that includes eight defendants in this lawsuit, referred to herein as the "Kaiser PMGs").[1] Compl. ¶¶ 29-36. The Kaiser PMGs have a shared national leadership and consulting organization, the Permanente Federation, which is run by the leadership of the Kaiser PMGs. *Id*. ¶ 37. On the health plan side, Kaiser offers health insurance plans to residents all over the country. Kaiser's insurers include six defendants in

[1] The eight Kaiser PMGs defendants are: (1) The Permanente Medical Group ("TPMG"); (2) Southern California Permanente Medical Group ("SCPMG"); (3) Colorado Permanente Medical Group, P.C.; (4) The Southeast Permanente Medical Group, P.C.; (5) Hawaii Permanente Medical Group, Inc.; (6) Mid-Atlantic Permanente Medical Group, PC; (7) Northwest Permanente, P.C.; and (8) Washington Permanente Medical Group, P.C.

this case, referred to herein as the "Kaiser Health Plans."[2] *Id*. ¶¶ 27, 38. Among the Kaiser Health Plans, the Kaiser Foundation Health Plan, Inc. is the parent, and the other five are subsidiaries. *Id*.. ¶ 38. On the hospital side, Defendant Kaiser Foundation Hospitals ("Kaiser Hospitals") operates hospitals in California, the Northwest, and Hawaii. *Id*. ¶ 23. Kaiser Hospitals provide acute hospital care in these regions. *Id*. All three legs of the Kaiser stool share moneys received from federal and state governments. *Id*. ¶ 26. The Kaiser Health Plans receive the funds, and then pursuant to inter-company agreements, share them with the Kaiser PMGs and Kaiser Hospitals. *Id*. ¶ 26.

B. Overview of the ACA and Its Risk Adjustment Program

The ACA "aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012). The ACA required the creation of health benefit exchanges ("Exchanges") to facilitate patients' purchase of health care insurance plans. 42 U.S.C. § 18031(b). To lessen or eliminate the influence of risk selection on the premiums that health insurance plans participating in Exchanges could charge, Congress established a risk adjustment program for the ACA. Compl. ¶ 49. *See also*, *e.g.*, *New Mexico Health Connections v. United States Dep't of Health & Hum. Servs*., 946 F.3d 1138, 1146 (10th Cir. 2019) ("Congress included the risk adjustment program in the ACA to stabilize health insurance premiums, encourage health insurers to provide plans on the exchanges, and discourage insurers from eluding enrollment of sicker individuals."). As part of the risk adjustment program, the ACA authorizes the Department of Health and Human Services ("HHS") to utilize criteria and methods similar to those utilized under the Medicare Advantage program, including similar attestations/certifications from health insurance companies as to the accuracy and documentation of their risk adjustment data. Compl. ¶ 49. *See also*, *e.g.*, 42 U.S.C. §§ 18021 - 18024; 45 C.F.R. §§ 153.610 - 153.630.

[2] The six Kaiser Health Plans defendants are: (1) Kaiser Foundation Health Plan, Inc.; (2) Kaiser Foundation Health Plan of Colorado; (3) Kaiser Foundation Health Plan of Georgia, Inc.; (4) Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; (5) Kaiser Foundation Health Plan of the Northwest; and (6) Kaiser Foundation Health Plan of Washington.

HHS uses the HHS-Hierarchical Condition Categories ("HHS-HCC") risk adjustment model for purposes of ACA risk adjusting. Compl. ¶ 49; 45 C.F.R. §§ 153.610 - 153.630. HHS-HCCs are adaptations of Medicare Advantage's hierarchical condition categories ("HCCs"). Compl. ¶ 49. The chief goal in the design of the HHS-HCC model is to ensure that premiums reflect differences in benefits and plan efficiency, and not health status of its members. *Id.*; *see also* 2014 Final Rule, 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013), amended by 2014 Final Rule, 78 Fed. Reg. 65,046 (Oct. 30, 2013). The more risk-adjusted diagnosis codes that are reported by insurers, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States. Compl. ¶ 49.

The United States contributes to premiums paid by individuals to private health insurance companies, including Kaiser's private health plans, under the ACA. Compl. ¶ 7. It provides tax credits and contributes to insurance premium payments by low-income individuals, based on a sliding scale calibrated to the poverty line. *Id.* ¶ 50; 42 U.S.C. § 18071; 26 U.S.C. § 36B. When premiums are artificially high due to documentation and coding fraud, both enrollees and the United States are harmed by the overcharges. *Id.* ¶ 52.

The HHS-HCC risk adjustment model considers a patient's medical diagnoses and demographics. Compl. ¶ 49. *See also* Motion at 4-5; *New Mexico Health Connections*, 946 F.3d at 1148. With respect to documenting medical data related to diseases, injuries, impairments, other health problems, as well as the diagnosis, treatment, and management of hospital inpatients, the ACA requires the use of the International Classification for Diseases ("ICD") standards. Before October 1, 2015, the ACA's standard was ICD-9-CM. *See* 45 C.F.R. § 162.1002(a) and (b). After that date, the ACA has required the use of ICD-10-CM. *See* 45 C.F.R. § 162.1002(c). *See also* 45 C.F.R. § 153.610 (requiring that all "risk adjustment data" be submitted in accordance with the procedures established by HHS). At all times, the ACA has further required that insurers in its Exchanges adhere to "The Official [ICD-9-CM or ICD-10-CM] Guidelines for Coding and Reporting." 45 C.F.R. § 162.1002(a), (b), and (c). The Official Guidelines themselves emphasize their mandatory

nature, reminding users that "Adherence to these guidelines when assigning [ICD-9-CM or ICD-10-CM] diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA)." *See, e.g.*, Ctrs. for Medicare & Medicaid Servs. (CMS), Nat'l Ctr. for Health Stats. (NCHS), ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING 2014 ("ICD-10 OFFICIAL GUIDELINES"), at 1.

The Official Coding Guidelines require insurers, for instance, to "[c]ode all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist." *See, e.g.*, ICD-10-CM OFFICIAL GUIDELINES at 104. Further, binding ACA regulations require entities participating in the Exchanges to validate the data that they submit to the government as part of the risk adjustment process, including ensuring that the documentation "align[s] with dates of service for the medical diagnoses, and reflect[s] permitted providers and services," and "[v]alidat[es] medical records according to industry standards for coding and reporting." 45 C.F.R. § 153.630(b)(7).

C. Kaiser's Scheme to Systematically Defraud the Government

Through nearly every aspect of its operations, Kaiser teaches, encourages, and demands that its employees utilize techniques to improperly diagnose and upcode patient encounters to capture high value codes, reaping the benefits of this fraudulent scheme in the form of inflated revenues from the government. *See, e.g.*, Compl. ¶¶ 51, 104-08, 126. Kaiser PMGs and Kaiser Hospitals see the patients, during and/or following which the fraudulent upcoding for these encounters occurs. *E.g.* ¶¶ 56-61; 83-85, 113-15. Kaiser Health Plans then transmit the upcoded patient data to the government for use in the HHS-HCC risk adjustment model. *E.g. id*. ¶¶ 7-8, 10, 49-50. The government, unknowingly using the fraudulently upcoded data, then computes the ACA risk adjustment. *Id*. ¶¶ 7-8, 152-55. Due to the upcoding, Kaiser Health Plans receive more government funds than they should under the ACA, in the form of risk adjustment payments and in the form of tax credits used to pay inflated premiums. *Id.* ¶¶ 49-50. Kaiser Health Plans then share these fraudulently obtained

funds with Kaiser PMGs and Kaiser Hospitals. *Id*. ¶ 26. All of the defendant Kaiser entities have a role in this scheme, and all benefit from it.

1. Kaiser's ACA Scheme is Similar to Its MA Scheme

As described in the Complaint, Kaiser's upcoding scheme has its genesis in a similar scheme to defraud the Medicare Advantage program. In 2000, the MA program instituted a risk adjustment process to determine how much funds entities like Kaiser would receive. Compl. ¶ 39; 42 C.F.R. § 422.310. As the Complaint lays out in detail, Kaiser exploited that program to increase revenue through over-documentation and upcoding. When the ACA introduced a similar risk adjustment program for the ACA a decade later, Kaiser seized on the opportunity to expand its scheme to target that program as well.

The government intervened in these consolidated cases and took over the prosecution of certain of the FCA claims related to Kaiser's Medicare Advantage fraud, and this Court dismissed the remainder of Relators' MA claims on first-to-file grounds. ECF No. 171, the "Order." Importantly, that dismissal was *not* a dismissal on the merits of Relators' MA claims, but due to a procedural issue that was entirely out of Relators' hands – Relators had no idea, and no way of knowing, that a different relator had filed similar claims before they did. Relators acknowledge that much of their Complaint focuses on the MA program, but, as alleged in the Complaint, Kaiser's ACA fraud utilizes essentially the same scheme as Kaiser's MA fraud, exploiting the ACA's risk adjustment process in the same way that it exploits MA's risk adjustment process. Compl. ¶¶ 7, 10, 49. The same company policies and trainings that stressed over-documentation and over-coding that permeated Kaiser apply equally to both government programs. *E.g. id*. ¶¶ 104-08. The underlying facts of Kaiser's MA fraud are thus equally applicable to the Relators' distinct ACA fraud claim, and are pleaded as such.

2. Kaiser Intentionally Ignored Coding Requirements

For example, Kaiser's policies and procedures emphasize profits over compliance with statutory and regulatory coding requirements. It labels its mandatory coding policies "Program Advisories," but these advisories are not optional. Compl. ¶ 105. They are

intentionally constructed to be less restrictive as to when serious diagnostic codes can be used, leading directly to improper documentation and fraudulent upcoding. *Id.* ¶ 106. As a result, more high-risk, high-value diagnoses are documented and coded, in contradiction to the mandatory coding requirements. This leads to more profit for Kaiser through increased shares of the ACA risk adjustment and tax credits. *Id*.

Kaiser has a National Compliance Office ("NCO"), a group ostensibly formed to ensure proper coding. In reality, the NCO is toothless. Kaiser PMGs flout NCO's authority, and undermine its mission by manipulating diagnosis codes and increasing government payments. *Id*. ¶ 107. Further, Kaiser PMGs pressure, intimidate, and try to silence the NCO when it tries to raise any concern with improper coding. *Id*.

Kaiser also manipulates the process by which its coding professionals are able to query health care providers for clarification and additional documentation prior to making a code assignment. *Id*. ¶ 109. This querying process, if properly implemented, can serve a useful purpose; but Kaiser does not use it as intended. Kaiser exploits its querying process to pressure Kaiser PMGs and Kaiser Hospitals into identifying additional, revenue-generating diagnoses directly linked to certain HCCs under the ACA. *Id*. ¶¶ 109-118. Specific conditions and codes improperly targeted through this process include morbid obesity, protein calorie malnutrition, pressure ulcer, neoplasm, emphysema, depression, adrenal mass, aortic atherosclerosis, vent dependence status, diabetes manifestations, neutropenia, and sepsis with organ dysfunction. *Id*. ¶ 117; Compl. Exs. 31 and 32.

Kaiser put up roadblocks to keep its employees from making proper coding classifications. After Ms. Bryant and her colleagues made inquiries to the sanctioned American Hospital Association Central Office for Coding Clinic ("Coding Clinic"), Kaiser chastised and reprimanded them. Compl. ¶ 119. Kaiser instituted an internal bureaucratic layer of the Coding Governance Group ("CGG"), a group comprised of non-coding experts from the Kaiser PMGs, and insisted that this group approve any questions before they were submitted to the Coding Clinic. *Id*. ¶¶ 120-21. Afraid that the Coding Clinic would give

answers to legitimate inquiries that would force Kaiser to change its HCC documentation and capture practices, the CGG deterred the submission of inquiries. *Id*. ¶¶ 123-124.

Another effort to increase the use of lucrative HCC's was Kaiser's development of Clinical Documentation Integrity ("CDI") programs in 2009. Kaiser designed the CDI programs to increase HCC capture and, correspondingly, HHS payments. *Id*. ¶127. Though CDI programs were supposed to be "payer agnostic," their focus was almost exclusively on risk-adjusted payers, such as HHS under the ACA program, and only on documentation impacting HCCs. *Id*. ¶ 128. Kaiser measured the success of the CDI programs not in terms of improved patient care outcomes and safety, but in terms of additional dollars captured. *Id*. ¶¶ 132-134, Compl. Exs. 11, 33.

Kaiser also uses technology to further its goals to increase lucrative HCC coding and corresponding revenue gains. TPMG's "data mining" team uses algorithms to identify and capture "missed opportunities" to code certain HCCs. Compl. ¶ 141. Kaiser also uses computer assisted coding ("CAC"), a natural language processing technology that selects ICD and CPT codes based on words and language in a medical record. *Id*. ¶ 146. Ms. Hernandez discovered in 2013, during the implementation of CAC in the NCAL region, that CAC overcoded diagnoses at an overall accuracy rate of 60% or less. *Id*. ¶ 147. Ms. Bryant concurred, and when they presented their findings at a meeting about CAC quality assurance, Kaiser took steps to scrub any evidence of CAC overcoding, and manipulated results to make it appear as though CAC was more accurate than it actually was. *Id*. ¶ 148.

3. Illustrative Example: Vent Dependence

Dependence on a ventilator (or respirator) status is a "status code" used when a patient requires long-term, continued ventilator support to breathe, beyond an acute care phase. Compl. ¶ 80. The code is HCC 82, and is tied to code V46.11 under ICD-9-CM, and code Z99.11 under ICD-10-CM; the vent dependence code is also used and reported under the ACA, and is referred to herein as the "VD HCC." *Id*.

Pursuant to proper coding practices, the VD HCC should not be used if a patient is weaned from a ventilator during or at the end of an acute short-term stay in the hospital (of

any length) and discharged home or to a post-acute care facility without clinically requiring ventilator support. Instead, the VD HCC should only be coded if a patient relies on a ventilator to live on a long-term basis. Compl. ¶ 82; Compl. Ex. 19. Whether or not a patient's condition merits a vent dependence diagnosis and coding of the VD HCC is not dependent on any set time frame; instead, it depends on the patient's needs. Compl. ¶ 82.

Kaiser instituted its own guidelines to maximize the diagnosis and coding of the VD HCC, improperly tied to the length of time someone was on a vent. *See id*. ¶¶ 83-84. For instance, TPMG initially set a threshold of 12 hours on a ventilator before a patient's status condition should be documented and coded irrespective of discharge status or disposition. *Id*. ¶ 83. By elevating set time periods over any actual long-term dependence on a ventilator, Kaiser manipulated the system to over-document and over-code for the VD HCC. *Id*. ¶ 84.

Indicative of Kaiser's scheme to increase vent dependence coding was its treatment of newborns, a patient population covered by the ACA (but not by the MA program). *Id*. ¶ 86. Kaiser assigned vent dependence status on newborns placed on ventilators temporarily in the hospital before being discharged home. *Id*. In November 2013, the American Health Information Management Association's ("AHIMA") Senior Director of Coding confirmed Relators' understanding that this practice was improper, as the code was "intended for 'dependence' on a ventilator – meaning long-term dependence (such as patients with spinal cord injuries or progressive neuromuscular diseases such as multiple sclerosis)." Compl. ¶ 88; Compl. Ex. 20. The Coding Clinic reinforced this interpretation, and also told Kaiser that it was not proper to code newborns on vent dependence status. Compl. ¶¶ 94-95. In light of this guidance, Kaiser senior coding managers agreed that vent dependence status was not appropriate for, among other improper uses by Kaiser, newborn initial clinic visits if the newborn had been weaned from the ventilator. *Id*. ¶ 89. Nonetheless, TPMG continued to flaunt the rules, dictating that vent dependence status must be coded simply if a newborn was placed on ventilation for at least 12 consecutive hours, even if the newborn was weaned from the ventilator and discharged without one. *Id*. ¶ 90. *See also* Compl. ¶ 93.

Kaiser's vent dependence scheme worked as intended – it led to a high volume of improper HHS-HCC codes under the ACA, even among patients who had been successfully weaned from ventilators and discharged home to self-care, after one or two-day visits to the hospital. *Id*. ¶¶ 99-101; Compl. Exs. 18, 25-28. For instance, in 2010, across all Kaiser regions there were 1,811 vent dependence diagnoses. Compl. Ex. 28. By 2016, that number had skyrocketed to over 10,000 – more than a five-fold increase. *Id*.

III. LEGAL STANDARDS

To survive a motion to dismiss under Fed. R. Civ. P. 12(b)(6), a complaint must allege "sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 663 (2009). 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*. at 678. At this stage, the facts alleged in the complaint are assumed to be true. *See United States ex rel. Lee v. Corinthian Colls.*, 655 F.3d 984, 991 (9th Cir. 2011). An FCA complaint must satisfy the heightened pleading standard of Fed. R. Civ. P. 9(b), but to do so, it need not list every detail of the alleged fraud, nor provide representative examples. *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998-99 (9th Cir. 2010). This Complaint satisfies both Rules 12(b)(6) and 9(b), so the Motion must be denied. In the event the Court disagrees, any dismissal should be without prejudice. *See, e.g.*, *United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1182–83 (9th Cir. 2016); *Eminence Cap., LLC v. Aspeon, Inc.*, 316 F.3d 1048, 1052 (9th Cir. 2003) (dismissal without leave to amend is improper unless the complaint could not be saved by any amendment).

IV. ARGUMENT

A. Relators' Remaining FCA Claims Are Pleaded Sufficiently

The FCA prohibits an individual from "knowingly present[ing], or caus[ing] to be presented, a false or fraudulent claim for payment or approval," or "knowingly mak[ing], us[ing], or caus[ing] to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A) and (B). It also prohibits "knowingly

conceal[ing] or knowingly and improperly avoid[ing] or decreas[ing] an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G). In addition, the FCA prohibits anyone from "conspir[ing] to commit a violation" of any other section of the FCA. 31 U.S.C. § 3729(a)(1)(C). As alleged in the Complaint, Kaiser has violated the FCA in each of these four ways. It has submitted false claims for payment in the form of inflated diagnosis codes transmitted to the government as part of the ACA risk adjustment program, and corresponding attestations about the accuracy of such data. It has committed reverse false claims by retaining payments and moneys that it knows it is not entitled to keep. And the Defendants have engaged in a conspiracy to defraud the government in violation of the FCA.

1. The Complaint Sufficiently Alleges that Kaiser Submitted False Claims

The fraud scheme alleged in the Complaint is simple. Kaiser offers health care plans through the ACA Exchanges. The federal government pays a portion of these premiums through tax credits, and facilitates the movement of portions of the premiums to plans with a riskier pool of insureds from plans with a healthier pool of insureds. When Kaiser PMGs and Hospitals treat patients covered by these plans, they fraudulently upcode the patient encounter data associated with the treatments. When this upcoded patient encounter information is transmitted to HHS by Kaiser Insurers as part of the ACA risk adjustment process, Kaiser's insureds appear to have more health risks than they actually do. Kaiser benefits financially, at the expense of the federal government. This is classic fraud actionable under the FCA. *See, e.g.*, *Ruckh v. Salus Rehab., LLC*, 963 F.3d 1089, 1105 (11th Cir. 2020) ("At its core, the concept of upcoding is a simple and direct theory of fraud.").

In *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 673-74 (9th Cir. 2018), the Ninth Circuit unequivocally held that submitting upcoded records to the MA program in order to receive inflated risk adjustment payments is actionable under the FCA. *See also Swoben*, 848 F.3d at 1175 ("we hold that when, as alleged here, Medicare Advantage organizations design retrospective reviews of enrollees' medical records

deliberately to avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence, they can no longer certify, based on best knowledge, information and belief, the accuracy, completeness and truthfulness of the data submitted to CMS."); *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 497-98 n.2 (6th Cir. 2007) (describing upcoding as "a common form of Medicare fraud"); *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1082 (N.D. Cal. 2020) (citations omitted) (relator alleged "particular details of a scheme… to submit false diagnosis codes;" FCA claim properly alleged). In short, "[p]ayments based on unsupported diagnosis codes are 'improperly inflated.'" *Ormsby*, 444 F. Supp. 3d at 1068, citing *Silingo*, 904 F.3d at 673. The Ninth Circuit's reasoning applies equally to fraud in connection with upcoding diagnoses to the ACA's risk adjustment program, as Relators have alleged here. Just like with MA upcoding fraud, Defendants caused the submission of false diagnoses to the government, and received government funds that they were not entitled to as a result. Such conduct is fraud under the ACA for the same reasons it is fraud under the MA program. The Complaint establishes falsity as required by the FCA.[3]

Kaiser's argument that the risk adjustment payments go from one insurer to another through the ACA, and are "budget neutral" with respect to the government, miss the mark. Even if true, the violations still expose Kaiser to FCA liability. *See, e.g.*, *Bly-Magee v. Cal.*, 236 F.3d 1014, 1017 (9th Cir. 2001) ("We conclude that even if the government ultimately reallocates recovered funds, a qui tam plaintiff need not prove that the federal government will suffer monetary harm to state a claim under the FCA."). Indeed, Congress amended the FCA in 2009 to make crystal-clear that fraud against the government is actionable under the FCA regardless of whether the government "owns" the money at issue, and regardless

[3] Kaiser does not dispute that the Complaint sufficiently alleges scienter. *See* Motion at 12 (noting that the FCA requires allegations of falsity, scienter, and materiality, but arguing only that "Relators have failed to allege falsity or materiality"). For good reason – the Complaint is replete with allegations that Kaiser knew it had to submit accurate diagnostic data, knew that it was not doing so, and did nothing to correct its errors. That is more than enough to plead scienter. *See, e.g.*, *Swoben*, 848 F.3d at 1175 (allegations that defendants "were on notice that their data included a significant number of erroneously reported diagnosis codes" and "turn[ed] a blind eye to the over-reporting errors" were sufficient).

of whether a payment of government funds is made. Among the changes to the FCA's language, Congress defined "claim" as "any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property." 31 U.S.C. § 3729(b)(2). Kaiser's fraud, even if "budget neutral," is actionable under the FCA, as Kaiser receives a higher share of federal money than it is entitled to through the ACA Exchange program. In any event, the tax credits and payments the government provides on behalf of citizens to make premium payments are indisputably government funds, with more going to Kaiser the more it over-codes, thus causing the government to lose money. Kaiser's misconduct is actionable under the FCA.

2. The Complaint Sufficiently Alleges that Kaiser Violated the FCA by Retaining Fraudulently Obtained Payments

In addition to the direct FCA claim, the Complaint also alleges a reverse FCA claim, where Defendants failed to report and to return overpayments received as a result of their upcoding scheme. As this Court found in *United States v. Mariner Health Care, Inc*., 552 F. Supp. 3d 938, 953-54 (N.D. Cal. 2021), a reverse false claim is a separate wrong from a "direct" false claim. The Court found the reverse false claim had been adequately alleged, as the defendant refused to pay back fraudulently obtained money after it was alerted to the fraud, and went so far as to silence any whistleblower. *Id*. Relators allege the same conduct here: every time they tried to stop the fraud that they witnessed, they were silenced, intimidated, and otherwise deterred. *See, e.g.*, Compl. ¶¶ 58, 107, 108, 181. Further, even if Defendants did not receive any extra payments from the ACA risk adjustment program, their upcoded diagnoses would have caused them to transfer less money to the ACA Exchange program for disbursement to insurers with a more risky patient base. Thus, the fraud had the effect of "decreas[ing] an obligation to pay or transmit money or property to the Government," and was a reverse false claim. *See* 31 U.S.C. § 3729(a)(1)(G). *See, e.g.*, *United States v. Bourseau*, 531 F.3d 1159, 1169-70 (9th Cir. 2008) (false reports submitted to government violated reverse false claims provision because they "concealed and

decreased the amounts that [defendants] were obligated to repay to Medicare"). Defendants make no argument to the contrary in their Motion.

3. The Complaint Sufficiently Alleges that Kaiser's Fraud Was Material

Kaiser further asserts that the Complaint fails to sufficiently allege materiality under the FCA, but in doing so takes a distorted view of the allegations and turns a blind eye to the language of the ACA.

The Court need look no further than the language of the ACA itself, which explicitly provides that "[c]ompliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange **shall be a material condition of an issuer's entitlement to receive payments**, including payments of premium tax credits and cost-sharing reductions, through the Exchange." 42 U.S.C. § 18033(a)(6)(A) (emphasis added). This is the same section of the ACA wherein Congress stated that payments related to any ACA exchange are subject to the FCA. *Id*. Plainly, Congress had the FCA in mind when enacting the ACA, expressly making failure to comply with the ACA's requirements material to the government's payment decisions. Even without Congress establishing materiality, the Complaint explains why manipulating the risk adjustment process would be material to a government payor's decision-making process. Compl. ¶¶ 152-155.

Kaiser misplaces reliance on *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, No. CV 16-08697-MWF (SSx), 2018 WL 1363487 (C.D. Cal. Feb. 12 2018). *Poehling* was an upcoding Medicare Advantage fraud case, and the court found that relators adequately alleged that fraud related to upcoded diagnoses would be material to the government's payment decision. *Id*. at *10. However, the complaint did not include the "magic words" that false attestations about those upcoded diagnoses were also material, so the court dismissed the causes of action depending on the attestations, and gave relators an opportunity to replead. *Id*.

Unlike in *Poehling*, Relators here allege that both the upcoded diagnoses were material, and that the attestations were as well. *See, e.g.*, Compl. ¶ 154 ("if CMS knew that

the Kaiser Defendants' attestations were false, CMS's risk adjustment payments would have changed in that CMS would have refused to make risk adjustment payments to the Kaiser Defendants, in whole or in part."). To the extent this Court feels any "magic words" are necessary, the Complaint has them, and *Poehling* is inapposite.

4. Relators' FCA Claims Satisfy Rule 9(b)

Just last year, this Court had occasion in *Mariner* to address what needs to be pleaded to satisfy Rule 9(b) in an FCA case. Importantly, as this Court observed, a relator does not have to "'identify representative examples of false claims to support *every* allegation,' but must 'allege with particular details of a scheme to submit false claims paired with *reliable indicia* that lead to a *strong inference* that claims were actually submitted." 552 F. Supp. 3d at 946, quoting *Ebeid*, 616 F.3d at 998-99 (9th Cir. 2010) (emphasis supplied by Court). The Court found that the relator satisfied Rule 9(b):

> [Relator] has provided specific details concerning the fraudulent scheme, including the "who" (Mariner management and Mariner employees at the 22 Defendant SNFs); the "what" (billing for medically unnecessary services, or services that were not provided at all); the "when" (claims for patients admitted on or after January 1, 2011, and prior to October 1, 2016); the "where" (at each of the 22 Defendant SNFs); and the "how" (charging a higher rate of UHR therapy to fraudulently maximize Medicare reimbursement).

Id. at 949. As set forth above, and like the relator in *Mariner*, Ms. Bryant and Ms. Hernandez have alleged particular details of Kaiser's scheme: the *who* (Kaiser management and employees at the 15 defendant entities); the *what* (using improper diagnostic codes on patient encounters – *i.e.*, upcoding); the *when* (beginning in 2010, and going through the date of the Complaint); the *where* (at each of the 15 defendants – upcoding at the Kaiser PMGs and Kaiser Hospitals, and sending upcoded data to the government by Kaiser Insurers); and the *how* (submitting upcoded data to fraudulently receive increased payments through the ACA's risk sharing program). Relators were insiders at Kaiser, and privy to myriad internal communications and documents supporting these allegations (many of them

attached to the Complaint) and have first-hand knowledge of the events described in the Complaint, giving their allegations the requisite indicia of reliability.

Kaiser nevertheless argues that the Complaint fails to meet Rule 9(b) because it contains, according to Kaiser, "passing references to the ACA in fewer than a dozen paragraphs." Motion at 13. It claims that, even though the Complaint explicitly alleges that Kaiser's upcoding scheme affects the ACA risk adjustment program the same way that it affects the MA risk adjustment program, Relators cannot rely on any allegation pertaining to MA because they are two distinct statutes. Motion at 13-14. Kaiser made a similar argument in its first-to-file motion, and this Court rightly rejected it (Order at 44). Like the ACA, the MA program requires the submission of accurate claims data, and relies on the data submitted to it in order to calculate and make risk adjustments. Though the nature of how those risk adjustments are then effectuated differs – by calculating the proper per-member payment under MA, or calculating the proper premium shifting and related tax credits under the ACA – Kaiser's scheme to falsify documentation and coding was the same.

Accordingly, the allegations in the Complaint about Kaiser's upcoding apply equally to MA and the ACA, and Relators are not limited to what Kaiser has deemed "fewer than a dozen paragraphs" of the Complaint in stating their ACA claims against Kaiser. Moreover, the Complaint describes in detail Kaiser's fraud related to the vent dependence diagnosis in newborns, a scheme unrelated to MA but entirely relevant to Kaiser's ACA fraud. Kaiser's ACA fraud, as alleged in the Complaint, is set forth with sufficient specificity.

The Motion further attempts to recast Relators' entire case as hinging on Kaiser's failures to adhere to what it deems as "subregulatory documents, such as advice from the AHA Coding Clinic or AHIMA." Motion at 14-15. Not so. The ACA required Kaiser to submit accurate patient encounter data, including the requirement that the data be coded pursuant to ICD-9 and ICD-10 guidelines and requirements. Fully aware of this requirement, Kaiser instead intentionally over-diagnosed and over-coded in order to receive more funds. That is fraud. Kaiser's failures to follow the AHA Coding Clinic Guidance are just examples of Kaiser's plethora of violations. *See, e.g.*, Compl. ¶ 54 (citing Kaiser's

failure to follow AHA Coding Clinic Guidance as an "example" of Kaiser's fraud related to upcoding). Because Relators' case does not hinge on the violation of "subregulatory documents," Kaiser's argument fails. *See, e.g.*, *United States ex rel. Harris v. Bernad*, 275 F. Supp. 2d 1, 7 (D.D.C. 2003) (rejecting similar argument because the "allegations of administrative violations in those paragraphs are not the sole basis for its FCA counts").

The Motion cites *United States ex rel. Yannacopoulos v. Gen. Dynamics*, No. 03 C 3012, 2007 WL 495257 (N.D. Ill. Feb. 13, 2007), for the proposition that noncompliance with a "guidance document" cannot establish FCA liability. *See* Motion at 15, 17. In *Yannacopoulos*, the relator's entire theory was that the defendant failed to comply with two paragraphs of a 1985 version of guidelines issued by the Defense Security Assistance Agency. Yet the two paragraphs in the guidelines were referenced nowhere in defendant's contract with the government, nor on any certification provided by the defendant, meaning the plaintiff could not show that compliance with them was a condition of receiving payment giving rise to FCA liability.

Here, in contrast, Congress has made it crystal-clear that the failure to adhere to the ACA's requirements subjects an entity to FCA liability:

> Payments made by, through, or in connection with an Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include any Federal funds. Compliance with the requirements of this Act [the ACA] concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange.

42 U.S.C. § 18033(a)(6)(A). And failure to adhere with the ACA's requirements – namely, the failure to code conditions in accordance with ICD standards – is exactly what Relators allege. *Yannacopoulos* is inapposite.

Kaiser also attempts to blunt the impact of the overwhelming evidence cited and relied upon in the Complaint. For instance, with respect to Kaiser's scheme related to upcoding aortic atherosclerosis ("AA"), the Complaint cites evidence of, *inter alia*, Kaiser intentionally and knowingly ignoring coding guidance, implementing an initiative to

increase the frequency of AA being documented improperly, changing internal coding practices so that AA would always be coded in certain situations, mining its records for opportunities to improperly code encounters as AA, and finally, the fact that these efforts worked and culminated in increased rates of the diagnosis. Compl. ¶¶ 54-78. Kaiser argues that this last bit of evidence, which it deems "statistical analysis," has been rejected by the Ninth Circuit. *See* Motion at 16-17 (relying on *Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 (9th Cir. 2021)).

But *Integra* does not support Kaiser's argument. Unlike Relators here, the plaintiff in *Integra* had no evidence of the defendant knowingly and intentionally ignoring coding requirements; all it had was a hunch based on statistical analysis, and queries that stopped short of leading physicians to diagnose in a certain way. *Integra*, 854 F. App'x at 842. The court found this hunch to be implausible and the queries to be sufficiently compliant, and thus dismissed the claim. In stark contrast, Relators here allege that Kaiser designed its leading inquiries to target certain diagnoses and *to direct* medical staff to code encounters using these diagnoses. *See, e.g.*, Compl. ¶ 115, 118 (queries included "leading language introducing a diagnosis to the physician").

As to the explosion of high-value codes and claims in, for example, AA, Kaiser posits, without any support or evidence, that the increased diagnoses could have resulted from an effort "to prioritize coding a serious cardiac condition that could be dangerous or deadly to members." Motion at 16. Whether or not this explanation is plausible, it is immaterial on a motion to dismiss, as Relators have offered a plausible (indeed probable) explanation as well – that Kaiser had more AA diagnoses because of its efforts to commit fraud through over-coding. "If there are two alternative explanations, one advanced by defendant and the other advanced by plaintiff, both of which are plausible, plaintiff's complaint survives a motion to dismiss under Rule 12(b)(6)." *Starr v. Baca*, 652 F.3d 1202, 1216 (9th Cir. 2011). *See also United States v. Chang*, No. CV 13-3772-DMG (MRWx), 2017 WL 10544289, at *12 (C.D. Cal. July 25, 2017) ("'[Relators'] complaint may be

dismissed only when [Defendants'] plausible alternative explanation is so convincing that [Relators'] explanation is *implausible*.'").

5. Relators Have Sufficiently Alleged Misconduct by All Defendants

The Motion argues that all Defendants except TPMG should be dismissed due to purportedly improper "group pleading." Motion at 20-22. This argument ignores the role that, as alleged in the Complaint, the six Kaiser Health Plans had in transmitting the fraudulently upcoded patient encounter data to the government for purposes of the ACA risk adjustment process. *E.g. id.* ¶¶ 7-8, 10, 49-50. TPMG did not make this transmission. The Motion ignores the role that, as alleged in the Complaint, the Kaiser Hospitals had in upcoding hospital patient data, including ventilator status. *Id.* ¶¶ 85-86, 100-101. TPMG did not make these coding decisions. And the Motion ignores that the Complaint plausibly alleges that all Kaiser PMGs engaged in the same conduct as TPMG – they all improperly upcoded data after patient encounters. *See, e.g.*, Compl. ¶ 72 ("the Permanente Medical Groups in Kaiser's other regions were following TPMG's practices to always document and code AA…"), ¶ 98 ("Kaiser's improper practice for coding the ventilation status code was migrated systemically throughout the Kaiser regions and adopted by all of Kaiser's Permanente Medical Groups…"), ¶ 101 ("Data from all Kaiser Regions confirms that the vent dependence coding volume skyrocketed across Kaiser."). This is entirely proper, as this Court already recognized applying Ninth Circuit law in an FCA case: "a complaint alleging fraud 'need not distinguish between defendants that had the exact same role in a fraud.'" *Mariner*, 552 F. Supp. 3d at 952 n.6, quoting *Silingo*, 904 F.3d at 677.

Indeed, Kaiser's own authority recognizes that "[t]here is no flaw in a pleading, however, where collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct." *Swoben*, 848 F.3d at 1184. In *Swoben*, the relator alleged fraud by four different, distinct, and unrelated health insurers, and the court held it was improper to lump them together without any allegations that they engaged in the same conduct. In another case cited by Kaiser, the

defendants were an unrelated law firm, accounting firm, bank, and advisory services company. *Swartz v. KPGM LLP*, 476 F.3d 756, 764 (9th Cir. 2007). Both *Swoben* and *Swartz* are factually distinguishable due to the related nature of the Defendants here and how they worked together to engage in the same course of conduct.

Kaiser's reliance on *Hausauer v. City of Mesa*, No. CV-20-00653-PHX-DWL, 2020 WL 2735970 (D. Ariz. May 26, 2020), is also misplaced. That case is not about fraud or Rule 9(b) at all, but addressed a pro se plaintiff's complaint regarding injuries sustained at the hands of six police officers after a tricycle accident. *Hausauer*, 2020 WL 2735970 at *1. The plaintiff in that case did nothing to separate allegations as to which officer did what, and thus the complaint was dismissed. *Id*. Here, unlike in *Hausauer*, the Defendants did engage in the same conduct, are all part of the Kaiser empire, and the Complaint plausibly alleges that they all participated in the misconduct described in the Complaint. The same was true of the defendants in *Mariner*, 552 F. Supp. 3d at 952, and the same result holds here: Relators have properly stated claims against all Kaiser Defendants.

6. The Complaint States a Claim for FCA Conspiracy

The Complaint also alleges a classic conspiracy. The Defendants engaged in a scheme whereby the Kaiser PMGs and Kaiser Hospital Defendants created false medical records, and the Kaiser Health Plan Defendants submitted them to the government for payment. They all shared in the financial spoils of the scheme, and all willingly participated in it. *See, e.g.*, Compl. ¶ 26.

In arguing to the contrary, Kaiser once again turns a blind eye to the allegations of the Complaint and misconstrues the case law. Per Kaiser, there can be no conspiracy unless there are allegations of an "agreement to defraud the government." Motion at 22. But there does not need to be a formal agreement to break the law in order for there to be a conspiracy. Instead, overt acts in furtherance of a shared goal are more than adequate to state a claim. *See, e.g.*, *United States v. Bouchey*, 860 F. Supp. 890, 894 (D.D.C. 1994) (complaint stated claim for FCA conspiracy because it alleged defendants conspired with one another to collect deliberately inflated payments from the government).

The Complaint is replete with allegations of how the Kaiser PMGs and Hospital Defendants agreed to upcode patient encounters, how the Kaiser Health Plans agreed to submit these false claims to the government, and how all Defendants shared in the spoils of their joint endeavor. In the case cited by Kaiser, there were simply no allegations of overt acts by the defendants in support of the bare legal conclusion that they conspired with each other. *See Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1014 (11th Cir. 2005). The Complaint here is different, with numerous details about the concerted effort among the Defendants.

B. Ms. Hernandez Has Stated Viable Retaliation Claims

Ms. Hernandez, who went from a stellar performer at Kaiser to being reprimanded in a negative review by her TPMG supervisors in 2015 in retaliation for having reported Defendants' coding errors and systemic fraud to the attention of TPMG leadership, easily meets the liberal standards under Rule 8(a)(2) for properly pleading retaliation causes of action under the FCA (Count 5) and similar claims under California law (Counts 6 and 7).[4] Although the Motion references Rule 9(b), retaliation claims must only be pleaded under the more liberal pleading standard under Rule 8(a)(2). *See United States ex rel. Campie v. Gilead Sciences, Inc.*, 862 F.3d 890, 907 (9th Cir. 2017) (reversing decision granting motion to dismiss FCA retaliation claim). Under Rule 8(a)(2), a party is only required to make a "short and plain statement of the claim showing that the pleader is entitled to relief." *Iqbal*, 556 U.S. at 678 (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). Thus, the allegations supporting a retaliation claim need only "be enough to raise a right to relief above the speculative level" such that a claim to relief "is plausible on its face." *Twombly*, 550 U.S. at 555; *Iqbal*, 556 U.S. at 663.

1. Ms. Hernandez Sufficiently Pleads an FCA Retaliation Claim

Ms. Hernandez, a coding professional with 25 years of experience in the healthcare field, Compl. ¶ 21, adequately pleads an FCA retaliation claim under 31 U.S.C. § 3730(h) in Count 5 of the Complaint. "To state a claim for retaliation, a plaintiff must demonstrate

[4] Ms. Hernandez agrees to voluntarily dismiss with prejudice Count 8 for violation of the FLSA.

that: (1) he 'engaged in activity protected under the statute'; (2) the employer knew the plaintiff engaged in a protected activity; and (3) the employer discriminated against the plaintiff 'because he …engaged in protected activity.'" *Campie*, 862 F.3d at 907,quoting *Mendiondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1103 (9th Cir. 2008). Here, TPMG only challenges the second prong, contending that Ms. Hernandez failed to put her employer on notice that she was engaged in protected activity. Motion at 23-24. But, as the 9th Circuit has held, the "allegation of knowledge is not a high bar." *Campie*, 862 F.3d at 908.

TPMG's argument reflects the type of factual inquiry that is inappropriate at this stage of the pleadings, as the Motion depends exclusively on its construction of the scope of Ms. Hernandez' job and cherry-picked snippets of her allegations as not being "enough to give TPMG notice that Hernandez understood the conduct at TPMG to be fraudulent." Motion at 24. The Court should look no further than the cases TPMG cites to glean that the Motion is a disguised summary judgment motion. *See, e.g., United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1270 (9th Cir. 1996) (affirming summary judgment decision); *United States ex rel. Lockyer v. Haw. Pac. Health*, 490 F. Supp. 2d 1062, 1085 (D. Haw. 2007) (granting motion for summary judgment); *see also United States v. Somnia, Inc.*, No. 1:15-cv-00433-DAD-EPG, 2018 WL 684765, at *13 (E.D. Cal. Feb. 2, 2018) (denying motion to dismiss). The Court should reject TPMG's Motion on this basis alone.

TPMG's argument also fails as Ms. Hernandez was not tasked with investigating and reporting fraud, and she had conversations outside of her chain of command regarding her concerns. *Campie*, 862 F.3d at 908. As one example, Kaiser's NCAL TPMG region directed Regional Health Information Management ("Regional HIM") coding leaders, including Ms. Hernandez, to instruct and train to "always code" AA on the basis that it was supposedly a systemic condition and should always be coded. Compl. ¶ 57. After receiving guidance from the AHA Coding Clinic on AA, Ms. Hernandez assisted Ms. Bryant in drafting a memorandum sent in March 2012 to all Regional HIM Directors and hospital coding staff which clarified that AA should not be coded if it was discovered in an "incidental finding." *See id.,* Ex. 2. TPMG leaders, including director Anne Cadwell and

Physician Liaison Dr. David Bliss, reacted negatively to the memorandum. They asserted that AA was a systemic condition and should therefore be put on the "always code" list. *Id.* ¶ 63. Ms. Hernandez felt pressured by leadership to ignore coding guidelines, especially when Ms. Cadwell emailed them to set up a call to "get everyone on the same page that AA is **not** an incidental finding from a clinical perspective." *See id.*, Ex. 4. By January 2013, TPMG leadership issued a new directive that AA should *always* be coded. *Id.* ¶ 67.

Ms. Hernandez observed similar practices with vent dependence diagnoses and coding. *Id.* ¶ 87. She provided the AHIMA guidelines to TPMG that the vent-dependence code for short-term ventilator use by newborns quickly weaned and discharged home was improper, but leadership rejected the guidance and issued a directive that vent dependence could be coded "if a hospital newborn was placed on ventilation for at least 12 continuous hours." Compl. ¶ 90. In the same month, Ms. Hernandez was asked by Clinical Documentation Improvement ("CDI") Physician Director Dr. Shirley Cachola to review a PowerPoint presentation on vent dependence and join a call with Dr. Bliss to discuss her views on the coding guidelines. *See id.*, Ex. 20. Critically, during the call, Ms. Hernandez was placed "**in the line of fire**" by Dr. Bliss for assisting Ms. Bryant in making inquiries outside the organization for vent dependence coding guidance. *See id.*, Ex. 21 (emphasis added). Ms. Hernandez was reprimanded and pressured by Dr. Bliss and others, and told not to place inquiries outside Kaiser anymore since "outside inquiry would create risk for Kaiser." *Id.* ¶ 92. Like the AA situation, Ms. Hernandez continued to have deep concerns about these practices, especially in late December 2013 when she and her audit team concluded that 100% of a sample of TPMG vent dependence cases were invalidly coded. *See id.*, Ex. 27. Indeed, Ms. Hernandez alleges that she discovered that TPMG Revenue Cycle managers "manipulated the actual audit records to indicate a higher accuracy rate," and reported her concerns to NCAL Revenue Cycle Leadership and Kaiser's NCO leadership. *Id.* ¶ 148.

TPMG leadership, however, regularly dismissed Ms. Hernandez's concerns about Kaiser's unethical practices, even when they were backed by other internal compliance

organizations that reflected HCC payment errors. For example, during an NCO audit in 2015, while Ms. Hernandez was directly employed by TPMG, Ms. Hernandez alerted Ms. Cadwell that she agreed with NCO's report that there were instances where the diagnosis and coding of sepsis was not properly backed by medical records or other documentation. Ms. Cadwell told Ms. Hernandez "never to agree" with an NCO audit, and to just say "thank you." Ms. Cadwell then told Ms. Hernandez "not to talk at the audit exit call and to only speak when Ms. Cadwell asked Ms. Hernandez to say something." *Id.* ¶ 143.

In the face of these allegations and all reasonable inferences that this Court may draw in Ms. Hernandez's favor from them, there is no basis to dismiss the FCA retaliation claim in Count 5. As in *Campie*, when Dr. Bliss learned that Ms. Hernandez and Ms. Bryant had begun placing inquiries outside the organization about the unethical coding tactics employed by Defendants, practices that he knew were used to submit claims to the government for Medicare payments, he reprimanded them because reporting these ethical violations created "risk" for Kaiser and directed them not to make any additional reports outside the organization, placing Ms. Hernandez "in the line of fire." When Ms. Hernandez later reported to Ms. Caldwell that she agreed with NCO audit findings, Ms. Caldwell removed her from the audit review process by telling Ms. Hernandez "not to talk at the audit exit call," just as in *Campie* where the plaintiff was told that "certain regulatory compliance actions, such as issuing a quarantine, were 'not in his job description.'" *Campie*, 862 F.3d at 908. And as in *Campie*, Ms. Hernandez alleges that she often "had conversations outside of [her] chain of command regarding [her] concerns." *Id.*

Tellingly, TPMG does not challenge that Ms. Hernandez engaged in protected conduct when raising her complaints. The Ninth Circuit has clarified "that an employee engages in protected activity where (1) the employee in good faith believes, and (2) a reasonable employee in the same or similar circumstances might believe, that the employer is possibly committing fraud against the government." *Id.*, quoting *Moore v. Cal. Inst. of Tech. Jet Propulsion Lab.*, 275 F.3d 838, 845-46 (9th Cir. 2002). And just as the *Campie* court found that the plaintiff sufficiently alleged facts showing the employer knew of

Campie's protected activity, so too should this Court find that Ms. Hernandez has sufficiently demonstrated that TPMG knew of her protected activity. By complaining regularly to upper management about systemic upcoding practices and other related unethical conduct, Ms. Hernandez was exercising "a general ethical obligation to report alleged fraud" not simply fulfilling her job duties. *Hardin v. Mendocino Coast Dst. Hosp.*, No. 17-cv-05554-JST, 2018 WL 2984834, at *3 (N.D. Cal. June 14, 2018) (denying motion to dismiss FCA retaliation claim and rejecting defendant's argument that it was not on notice of plaintiff's protected conduct); *see also United States ex rel. Garrett v. Kootenai Hosp. Dist.*, No. 2:17-cv-00314-CWD, 2020 WL 3268277, at **9-10 (D. Idaho June 17, 2020) (denying motion to dismiss FCA retaliation claim).

The Court should deny the Motion as to Count 5. If, however, the Court determines that Ms. Hernandez needs to allege additional facts to overcome her minimal pleading burden, then it should grant Ms. Hernandez leave to amend the Complaint to provide such additional allegations.

2. Ms. Hernandez Sufficiently Pleads California Retaliation Claims

The arguments raised above as to the FCA retaliation claim are equally applicable to the California retaliation claims brought in Counts 6 and 7. Indeed, TPMG seems to agree, as its argument is limited to contending that "as with her FCA retaliation claim, Hernandez has not pleaded sufficient facts to show that TPMG knew that she was engaged in any protected activity, given the nature of her job." Motion at 25. For all of the reasons argued above, therefore, the Court should also deny the Motion as to Counts 6 and 7.

V. CONCLUSION

As the Complaint alleges, Defendants engaged in a classic upcoding scheme that defrauded the government under the FCA. Defendants cannot escape this litigation through a motion to dismiss; it should be required to answer for its ACA fraud, and for its illegal retaliation against Ms. Hernandez for trying to stop it. The Motion should be denied, in full.

Dated: August 5, 2022

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, *et al.*, Defendants.	Case No. 3:13-cv-03891-EMC (Consolidated) Hearing Date: October 14, 2022 Time: 1:30 p.m. Judge Hon. Edward M. Chen Courtroom: 5, 17th Floor

(caption continued on next page)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel.* GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, *et al.*, Defendants.	Case No. 3:18-cv-01347-EMC **[PROPOSED] ORDER**

[PROPOSED] ORDER

This matter coming to be heard on this 14th day of October 2022, upon consideration of **DEFENDANTS' MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT**, and the Court being full advised in the premises**;**

IT IS HEREBY ORDERED that Defendants' Motion is DENIED.

HON. EDWARD M. CHEN
United States District Judge