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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

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

REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT

Hearing Date: October 13, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT** Hearing Date: October 13, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT** Hearing Date: October 13, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT** Hearing Date: October 13, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

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

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

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

REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT

Hearing Date: October 13, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

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

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

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

REPLY IN SUPPORT OF MOTION TO DISMISS RELATOR TAYLOR'S SECOND AMENDED COMPLAINT

Hearing Date: October 13, 2022
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I. INTRODUCTION

In his Opposition, Taylor argues that he has alleged a wide-ranging "nationwide" fraud, but his SAC is rooted in conduct in Colorado, where he worked for nearly two decades for Colorado Permanente.[1] When he filed his SAC, Taylor dropped the Georgia and Northwest defendants that he named in his prior two complaints. And he now concedes that the Court's first-to-file order dismissed the two California Defendants: TPMG and SCPMG. The only defendants that remain are KFHP and the two Colorado Defendants: KFHP-Colorado and Colorado Permanente. Even so limited, Taylor's complaint largely fails to meet the requisite pleading standards, and only the narrowest set of claims against the Colorado Defendants should proceed to discovery.

As the Motion explained, the Court should dismiss KFHP from this lawsuit entirely. In his Opposition, Taylor points to fewer than 10 paragraphs in the SAC that even reference a KFHP employee and none that pleads an FCA violation with plausibility, let alone with particularity. Taylor also argues that his "collective allegations"—through which he indiscriminately lumps KFHP with the Colorado Defendants—suffice to state a claim against KFHP. But these allegations fail as well because Taylor does not plausibly allege that KFHP, a California-based health plan, engaged in exactly the same conduct as two Colorado entities for nearly two decades.

Taylor's Opposition also does nothing to rehabilitate the rest of his flawed allegations against the Colorado Defendants. He still cannot explain the undefined "errors" that he alleges form the basis for his external-provider and NLP claims, so he cannot plead falsity in support of these claims. Nor can he avoid the flawed materiality allegations that support most of his attestation-based and diagnosis code-based claims.[2] His carefully hedged statements about what CMS ***might*** have done had it known about the alleged fraud scheme do not satisfy the FCA's demanding materiality requirement. Finally, to argue that the ten-year statute of repose does not

[1] Defined terms and acronyms have the same meaning as in Defendants' Motion to Dismiss ("Motion"), unless otherwise specified.

[2] As discussed in the Motion and below, *infra* at 9–13, Defendants do not challenge the sufficiency of the materiality allegations as to diagnosis code-based claims premised on clinically inaccurate diagnoses.

apply to his allegations about the newly named Colorado Permanente, Taylor marshals a group of inapposite cases, none of which addresses whether the statute of repose permits relation back to an earlier complaint when a new defendant is named. The plain language of the repose provision prohibits relation back here, and the Court should dismiss claims against Colorado Permanente that predate November 15, 2011.

For these reasons, and those discussed in the Motion, the Court should dismiss Taylor's SAC, except to the extent he alleges that the Colorado Defendants submitted or caused to be submitted false diagnosis codes to CMS that reflected medical conditions that did not exist as a clinical matter, and should limit any such claims against Colorado Permanente to those accruing on or after November 15, 2011.

II. ARGUMENT

A. Taylor Fails to State Plausible FCA Claims Against KFHP with Particularity

Taylor acknowledges that the California Defendants (TPMG and SCPMG) were dismissed by the Court's first-to-file order, leaving only KFHP and the Colorado Defendants (KFHP-Colorado and Colorado Permanente). Opp'n at 1 n.1. But the Court also must dismiss all claims against KFHP because Taylor fails to state a plausible fraud claim against KFHP with particularity under Rule 9(b). Taylor's SAC fails to meet this heightened pleading standard with its sparse references to KFHP and use of imprecise group terms that encompass Defendants that could not have engaged, for almost two decades, in precisely the same conduct. Mot. at 12–14.

Taylor argues that his specific allegations about KFHP are sufficient to meet Rule 9's standard, citing to fewer than 10 paragraphs of his 247-paragraph SAC. Opp'n at 2, 9. The cited paragraphs do not suggest—either plausibly or with particularity—that KFHP engaged in a scheme to defraud CMS:

Paragraph 75. This paragraph merely lists two individuals who were "involved in . . . attestations"—Rick Newsome and Kathy Lancaster. The paragraph does not allege that Newsome or Lancaster even signed the attestations, much less what their actual role was in the risk-adjustment attestation process and whether they had any role in the alleged fraud. And Newsome was employed by KFHP-Colorado, not KFHP. *See* SAC ¶ 86.

Paragraphs 86–90. These paragraphs discuss alleged actions of "Colorado Health Plan leadership"—*i.e.*, KFHP-Colorado leadership—to allegedly prioritize revenue and "increase[] risk scores." *See, e.g.*, *id.* The paragraphs repeatedly describe alleged activities of "Kaiser Colorado," which are the two Colorado Defendants, not KFHP. *See id.* ¶¶ 25, 87–88, 90. While these paragraphs allege that Chris Tholen, a former KFHP employee, presented a report about tracking "risk score . . . to capture as much revenue as possible," *id.* ¶ 88, this allegation does not plausibly suggest that KFHP engaged in fraud. At most, the allegation suggests that a single KFHP employee acted with rational business interests in mind in seeking to increase revenue, which is not improper. *See Eclectic Props. E., LLC v. Marcus & Millichap Co.*, 751 F.3d 990, 996 (9th Cir. 2014) (in evaluating plausibility, "courts must also consider an 'obvious alternative explanation' for [the] defendant's behavior" (citations omitted)); *Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 n.4 (9th Cir. 2021) ("CMS has acknowledged that there is nothing 'inappropriate, unethical or otherwise wrong with [healthcare providers] taking full advantage of coding opportunities to maximize [the] Medicare payment that is supported by documentation in the medical record.'" (citations omitted)). No allegations state with particularity that Tholen knowingly engaged in a fraudulent scheme.

Paragraphs 92 & 113. These paragraphs concern the actions of a single KFHP employee, Diane Morrissette. Paragraph 92 alleges that Morrissette ran an audit of "2004/2005 data." There is no allegation about what that audit found and whether Morrissette knew about any ***actual*** improper data submissions to CMS following the audit. In fact, according to Taylor, the audit took place "prior to the risk adjustment system being fully implemented" and, notably, before any risk-adjustment data was submitted to CMS. SAC ¶ 92 (alleging that the audit was a "pre close" audit). Paragraph 113 alleges that a single 2009 audit of external-provider diagnosis codes headed by Morrissette showed that such codes "were less well monitored than those of Kaiser internal physicians and were likely to have higher error rates." But, again, this says nothing about KFHP's involvement in an alleged years-long scheme to submit false diagnosis codes to CMS.

Unable to point to any specific allegations about KFHP that withstand scrutiny, Taylor is left with only his "collective allegations." *See* Opp'n at 10. But these allegations also fail to

make out a claim against KFHP. As the Motion explained, collective allegations against multiple defendants are appropriate only where each defendant has allegedly "engaged in ***precisely*** the same conduct." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016) ("*Swoben*") (emphasis added). But the collective allegations must still satisfy the plausibility and particularity standards of Rules 8 and 9 as to each Defendant.

Here, the Defendants—KFHP and the two Colorado Defendants—are distinct entities with distinct functions that could not plausibly have engaged in precisely the same fraudulent conduct. Taylor himself recognizes that KFHP contracts with CMS to operate a Medicare Advantage plan ***in California***, whereas KFHP-Colorado contracts with CMS to operate a Medicare Advantage plan ***in Colorado***, Dkt. No. 156 at 20 n.20; and he alleges that Colorado Permanente is a "multi-specialty physician group" that contracts with KFHP-Colorado to "provide medical care to its members" ***in Colorado***. SAC ¶ 24. It is not plausible that these disparate entities engaged in precisely the same conduct and did so for nearly two decades. Taylor has no response to Defendants' argument that his collective allegations are insufficient because of the confusing and inconsistent ways that he defines and uses certain collective terms, such as "Kaiser" and "Kaiser Colorado." *See* Mot. at 13–14. Indeed, that he defines "Kaiser" to include KFHP and the Colorado Defendants, but separately defines "Kaiser Colorado" to include only the Colorado Defendants suggests these three Defendants did not engage in precisely the same conduct. *See id.*

Taylor's retort that KFHP "sits at the center of the Kaiser universe" does nothing to save his allegations and mischaracterizes Defendants' first-to-file briefing. *See* Opp'n at 10. Defendants simply acknowledged that the ***trade name "Kaiser Permanente"*** describes "the national collaboration among the various Defendant health plans, hospitals, and medical groups." Dkt. No. 165 at 2. Defendants never conceded that ***KFHP's*** conduct can somehow be imputed to other Defendants. Taylor's assertions that KFHP is the "parent" of other Kaiser Permanente-affiliated health plans and that Defendants are "intertwined" does not mean that they engaged in precisely the same conduct. *See* Opp'n at 10. Taylor notably does not plead that KFHP controls

or was the alter-ego of any other Defendant.[3]

In a last-ditch effort to save his claims against KFHP, Taylor points to his allegation that Defendants "have perpetuated a systemic fraud" because they "routinely submit false claims" to CMS. *Id.* at 10 (citing SAC ¶ 2). That conclusory allegation cannot satisfy the particularity requirement. *See Vess v. Ciba-Geigy Corp.*, 317 F.3d 1097, 1108 (9th Cir. 2003).

In addition, Taylor's case citations only highlight the flaws in his collective allegations because they demonstrate the limited circumstances where collective allegations are appropriate. In *Kuzma*, the court found collective allegations appropriate for an alleged Anti-Kickback Statute violation because the relator alleged that the defendants engaged in a ***single*** kickback and also identified the role of each defendant in the kickback. *United States ex rel. Kuzma v. N. Ariz. Healthcare Corp.*, 2020 WL 5819568, at *5 (D. Ariz. Sept. 30, 2020). The court noted "this was not a series of events over a prolonged period, but one transaction completed on a specific date." *Id.* Permitting collective allegations for a single kickback completed on a set date is a far cry from Taylor's allegations of a purported scheme lasting almost two decades. *See* SAC ¶ 2.

Prime Healthcare also supports Defendants' position because the court allowed collective allegations only for defendants that had the same role. *See* Opp'n at 11 n.7 (citing *United States v. Prime Healthcare Servs. Inc.*, 2020 WL 11884833, at *5 (C.D. Cal. Apr. 14, 2020)). There, the court permitted collective allegations for two defendants only because the relator sufficiently alleged that these entities "essentially [do] the same work (operate networks of hospitals), share the same billing department, and engaged in the same wrongful activity." 2020 WL 11884833, at *5. In other words, the court permitted collective allegations because the complaint alleged facts giving rise to an inference that the two entities would act identically. But the court rejected the relator's use of the collective term "Prime" for the other defendants even though one was a subsidiary of another and the relator had alleged "substantial overlapping ownership and control."

[3] And Defendants did not, as Taylor argues, "effectively concede[]" the interrelatedness of KFHP and the Colorado Defendants in their first-to-file briefing. *See* Opp'n at 10. Defendants' first-to-file motion argued that the United States was on notice of "the essential facts" of an alleged national fraud scheme based on allegations in a different complaint that named ***only*** the "Kaiser Permanente" trade name, which could have referred to any entity affiliated with the trade name. Dkt. No. 165 at 2.

Id. at *6 (quoting relator's complaint). The court concluded that these defendants did not "act monolithically," and refused to impute conduct from one defendant to the subsidiary, highlighting facts that showed "independence within Prime's corporate structure," such as different billing practices. *Id.* So too here, Taylor does not allege that the Defendants acted "monolithically" and recognizes their different corporate forms and functions, as noted above. In fact, he explicitly describes how different Kaiser Permanente-affiliated entities had different billing and coding practices. SAC ¶ 230 (alleging that "Kaiser" permits "various regions to decide how to use [] information [gathered through the NLP program]"), ¶ 114 (alleging that the Colorado region does not subject diagnosis codes submitted by an external provider to "enhanced scrutiny," whereas the Northern California region does).

Accordingly, the Court should dismiss all claims against KFHP. At the very least, the Court should limit any claims against KFHP to Colorado-based conduct. With California-based claims eliminated by virtue of the first-to-file order, *see* Mot. at 11–12; Opp'n at 1 nn.1 & 2, there are no specific allegations about KFHP's conduct in any other region besides Colorado, and certainly none that satisfies Rule 9(b). While Taylor has scattered references to activities in Georgia, Hawaii, and the Northwest, he does not tie these allegations to any specific Defendant, including KFHP. *See* SAC ¶¶ 18, 20, 82, 93, 103, 114, 165, 200, 230–31, 233.

B. Taylor Fails to Plead Falsity as to His External-Provider and NLP Allegations

Based on the first-to-file order and the SAC, Taylor's allegations are limited to: (1) upcoding by internal providers in Colorado; (2) improper coding by external providers in Colorado; and (3) True Positive results from the NLP program. His external-provider and NLP allegations should be dismissed for failure to plead falsity.

1. Taylor's External-Provider Allegations

Taylor's theory of fraud for his external-provider claims is that Defendants uncovered "errors" in diagnosis-code data but failed to correct those errors. *See id.* ¶ 105. But he does not define what these errors were. As the Motion explained, his failure to identify what is false about the diagnosis codes means that the SAC falls short of Rule 9(b)'s requirements. Mot. at 14–15.

In his Opposition, Taylor relies on flawed reasoning to argue that all he must do to meet

the requirements of Rule 9(b) is allege that Defendants failed to correct "false" codes. Opp'n at 13. He contends that he does not need to plead the reason why the diagnosis codes underlying his external-provider claims were erroneous; it is enough to allege that "Defendants became aware of a discrete set of ***codes that were false*** that they had already submitted—and then they knowingly failed to correct" those codes. *Id.* (emphasis added). If such non-specific allegations were sufficient, FCA plaintiffs would need to allege only that claims were false to survive a motion to dismiss. That is not the law—Taylor must "set forth ***what is false or misleading*** about a statement, and ***why it is false***." *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010) (quotations omitted; emphases added). Otherwise, his allegations amount to conclusory recitations of the pleading standard.

Indeed, without more explanation about "what is false or misleading" about the allegedly erroneous diagnosis codes, Defendants do not know what type of falsity to defend against. The codes could have been "erroneous" for myriad reasons—for example, because they reflected medical conditions that did not exist; their submission certified compliance with a coding requirement that Defendants failed to follow; the underlying medical record lacked a signature, date stamp, or contained a typographical error.[4] These are all different types of issues that would require different strategies and proof to defend against. Not only is identifying the "what" and "why" of the falsity relevant to whether falsity has been sufficiently pleaded, but, as discussed below, without an explanation for why the diagnosis codes are false, Taylor cannot plead materiality because it is unclear if CMS would have considered the falsity material to its payment decision. *See infra* at 9–13.

While Taylor attempts to rely on *Swoben* to save the lack of specific falsity allegations in

[4] The Opposition provides an example of a typographical error in a diagnosis code that could lead to an overpayment, because the error would have mistakenly indicated a member had leukemia instead of diabetes without complications. *See* Opp'n at 17 n.13. But the reverse of the error that Taylor describes, coding diabetes without complications rather than leukemia, would have resulted in an underpayment. There are also typographical errors that would not have led to any change in payment: for example, mistakes in diagnosis codes that have no impact on risk-adjustment payments (*e.g.*, coding history of breast cancer rather than history of thyroid cancer, neither of which risk-adjusts). The universe of possible typographical errors and their differing effects on payments further emphasizes why it is critical for Taylor to allege what was "erroneous" about the codes.

his complaint, *Swoben* does not apply broadly to all chart-review allegations as he suggests. *Swoben*'s holding was specific and narrow: when MAOs "***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." *Swoben*, 848 F.3d at 1175 (emphases added). *Swoben* acknowledged that "passively forward[ing] to CMS ***unsupported*** diagnosis codes . . . . would not necessarily result in false § 422.504(*l*) certifications." *Id.* at 1173 (emphasis added). It even acknowledged that "one-sided retrospective reviews" do not "necessarily always" result in false certifications. *Id.* at 1175. In short, *Swoben* held that the specific design of the chart-review program in question rendered the attestations false.[5] *Id.*

Taylor does not base his claims on the design of Defendants' chart-review program. His theory is far simpler: that Defendants "did not submit deletes to remove its previously submitted codes that this review ***demonstrated were erroneous***." *See* SAC ¶ 130 (emphasis added). In other words, Defendants did look at the diagnosis codes and found them to be erroneous. So while both Taylor and the relator in *Swoben* describe a chart-review program, the similarities end there. The *Swoben* relator alleged that the defendants' deliberate choice to avoid looking at potentially erroneous codes rendered the attestations false; Taylor asserts that Defendants' actual discovery of erroneous codes led to the submission of false diagnosis-code data and false attestations. To proceed on such a theory, Taylor must explain ***why*** the codes were erroneous. *Swoben* does not relieve him of this obligation. As explained above, ***why*** the codes are erroneous matters because not all errors lead to false claims. Taylor's description of a singular hypothetical example of a mistaken diabetes diagnosis does not get him there. *See* Mot. at 15 (citing SAC ¶ 126). Taylor argues that his hypothetical "has no bearing on the fact" that Defendants allegedly "identified a concrete universe of actually false claims." Opp'n at 13 n.10. But, again, Taylor

[5] Notably, *Swoben* did not hold that the ignored diagnosis codes themselves were false claims. *See Swoben*, 848 F.3d at 1183. Such a limit makes sense: in a large pool of ignored diagnoses, some may be erroneous but many more are likely not. Assigning FCA liability to every diagnosis code based on an ignored diagnosis would necessarily lead to FCA liability for truthful claims.

does not explain how or why claims within this alleged universe are false.

2. Taylor's NLP Allegations

Taylor's NLP allegations similarly fail to allege falsity because they are premised on undefined alleged "errors" in audits of True Positive results. As the Motion explains, Taylor does not allege with particularity what these "errors" were or connect alleged error rates to the submission of any false claims to CMS that resulted in overpayments. Mot. at 16. The Opposition further highlights this deficiency. Taylor argues that his SAC "alleges that Defendants reviewed their diagnosis coding using NLP that identified both substantiated and unsubstantiated codes [*i.e.*, those that caused an error]," and when codes that caused an error were purportedly ignored, Defendants allegedly violated the FCA. Opp'n at 15. But both Taylor's allegations and Opposition fail to explain what was "unsubstantiated" about the diagnosis codes.

Taylor also wrongly insists that Defendants have attacked the merits of his allegations, rather than their sufficiency. *See id.* at 15–16. The Motion criticized Taylor's hedged allegation that the NLP program "***appears***" to improperly pick up "diagnoses that appear in problem lists" based on his personal review of 100 True Positive claims for the Colorado region. Mot. at 16; *see also* SAC ¶ 232 (emphasis added). Given Taylor's hedging, this allegation is insufficient on its face to plead falsity with particularity. The SAC does not otherwise state that the NLP program actually led to the submission of false diagnosis codes generated from problem lists. Taylor also does not allege that any Kaiser Permanente-affiliated region other than Colorado followed this allegedly improper problem-list practice. SAC ¶¶ 230–33. He argues in his Opposition that he alleged "a larger audit of the same software output." Opp'n at 15 (citing SAC ¶ 231). But the allegation he cites concerns the Hawaii region, which allegedly audited all True Positives unlike Defendants in Colorado; so even according to Taylor, that region would not have passed on flawed diagnosis codes based on True Positives to CMS. *See* SAC ¶¶ 231–32. In any case, Taylor does not allege any specific facts about any Defendant's operations in Hawaii to support Hawaii-based claims.

C. Taylor Fails to Plead Materiality

Taylor's primary materiality argument—that "accurate coding . . . directly determines the

amount of payment" and so is "plainly . . . material"—also misses the mark. *See, e.g.*, Opp'n at 16. Defendants do not dispute that CMS relies on diagnosis coding to determine payment. But if that basic truth were enough to satisfy the FCA's materiality element, then materiality would be a foregone conclusion in every Medicare Advantage FCA case. That is not the law, and courts grant motions to dismiss for failure to plead materiality in such cases. *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487, at *9–10 (C.D. Cal. Feb. 12, 2018) (finding a failure to allege materiality in a Medicare Advantage FCA case); *United States v. Scan Health Plan* ("*Swoben II*"), 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017) (same).

The materiality analysis instead turns on whether CMS would have refused to pay the underlying claims had it known of the specific falsity at issue. In other words, the "***misrepresentation*** about compliance with a statutory, regulatory, or contractual requirement must be material to the Government's payment decision." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 181 (2016) (emphasis added). So simply because Taylor's allegations implicate diagnosis codes does not mean he satisfies materiality; he must allege that the type of falsity at issue would have caused CMS to deny payment. He has failed to make this allegation for his attestation-based claims and his diagnosis code-based claims to the extent those claims rely on purported violations of coding guidance (rather than the submission of diagnosis codes for medical conditions that did not exist).

1. Taylor's Attestation-Based Claims

Taylor does not sufficiently allege that CMS would have denied Defendants payment if it had known that Defendants' attestations were false. In his SAC, and again in his Opposition, Taylor merely cites to a litany of possible options for CMS to take had it known of Defendant's allegedly fraudulent practices—CMS "would have refused to make risk-adjustment payments . . . ***and/or*** taken other appropriate actions" such as "recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions." SAC ¶ 238 (emphasis added); *see also* Opp'n at 18–19. He argues that "alleg[ing] exactly what CMS would have done" had it known of allegedly false claims "is beside the point." Opp'n at 22. But it is precisely the point. As the *Poehling* court explained, this type of equivocal allegation is

insufficient to plead materiality: "It is not enough to allege that Defendants were obligated by various regulations and contracts to comply with the Attestation requirements" or that CMS would "have had the option to decline to pay" if it were aware of a failure to comply with such requirements. *Poehling*, 2018 WL 1363487, at *9 (citations and quotations omitted). The *Swoben II* court similarly held that "the complaint must allege that the violations at issue 'are so central . . . that the [Government] ***would not*** have paid these claims had it known of these violations.'" *Swoben II*, 2017 WL 4564722, at *6 (emphasis added) (citations omitted).

Because Taylor's materiality allegations suggest only possible responses CMS might have had, he does not adequately allege materiality. The United States' intervention decision does not cure that pleading deficiency. If the United States' decision to bring an FCA lawsuit were sufficient to establish materiality, the materiality element would lose all meaning in every case in which the United States filed FCA claims, "working an end-run around *Escobar*." *United States ex rel. Mei Ling v. City of Los Angeles*, 2018 WL 3814498, at *20 (C.D. Cal. July 25, 2018). In addition, the United States in this case proceeds on a different theory than Taylor and focuses on whether Defendants' medical-record addenda comply with the ICD Guidelines. *See* Dkt. No. 110 ¶ 126. By definition, Taylor's complaint does not include any such claims, which have been superseded by the United States' complaint. *United States ex rel. Sansbury v. LB & B Assocs., Inc.*, 58 F. Supp. 3d 37, 47 (D.D.C. 2014) ("[T]he Government's complaint in intervention becomes the operative complaint as to all claims in which the government has intervened."). The United States has in fact declined to intervene on the claims that Taylor now proceeds on.

For the same reasons, Taylor is wrong to argue that the United States' similar materiality allegations in its intervention complaint here and in a different case against a different defendant bolster his materiality allegations. *See* Opp'n at 19 (referring to the United States' complaint-in-intervention, Dkt. No. 110, and in *United States v. Anthem, Inc.*, Case No. 1:20-cv-02593 (S.D.N.Y), Dkt. No. 1). These cases say nothing about whether Taylor's materiality allegations are sufficient as Taylor proceeds on different claims. And as Taylor knows, the defendants in both cases also have challenged the sufficiency of the United States' materiality allegations. *See Anthem*, Dkt. No. 37; DOJ MTD (Dkt. No. 178) at 18–20. And neither this Court nor the *Anthem*

court has ruled on whether the United States has sufficiently alleged materiality yet. So the United States' materiality allegations do not bear on Taylor's allegations.

None of Taylor's cited cases saves his pleading failures. The Ninth Circuit's *Swoben* decision (cited at Opp'n at 19) is irrelevant because it rested on falsity—not materiality. *See Swoben*, 848 F.3d at 1175. Instead, as noted, *Swoben II* evaluated the United States' materiality allegations later in that same case and found them lacking as to the United States' attestation-based claims. Taylor also cites *Campie* to argue that the United States' continued payments to Defendants should not necessarily dictate the materiality analysis. Opp'n at 20 n.15 (citing *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 906 (9th Cir. 2017)). Defendants do not argue that the United States' continued payment should be dispositive in every case, but rather point to the deficiencies in Taylor's own allegations that make clear that had CMS known about the allegedly false attestations here, it may have still decided to make risk-adjustment payments. And unlike *Godecke*, where a relator sufficiently pleaded materiality because the United States did not have an option to deny payment in light of the alleged falsity, Taylor's allegations on their face allege that CMS had the option to deny payment. *See United States ex rel. Godecke v. Kinetic Concepts, Inc.*, 2016 WL 11688146, at *9 (C.D. Cal. Dec. 29, 2016); *see also* SAC ¶ 238.

2. Taylor's Diagnosis Code-Based Claims

Taylor fails to plead materiality for his diagnosis code-based claims to the extent that they rely on purported violations of coding guidance to establish the falsity of the codes, as opposed to diagnosis codes submitted for medical conditions that did not exist. Taylor argues that Defendants' distinction between the two types of diagnosis code-based claims is irrelevant, *see* Opp'n 3–4, but it is important: It is obvious that CMS would deny payment for a condition that does not exist. So there is no question that CMS's payment decision would be affected by a diagnosis code reflecting a ***clinically inaccurate*** condition. But CMS's response is not clear for what Taylor alleges are "process-based" coding violations—*i.e.*, the failure to code diagnoses in compliance with coding guidance.

Like his attestation-based claims, Taylor's diagnosis code-based claims that rely on

purported violations of coding guidance fail to plead materiality because they ***at best*** allege that CMS had merely an option to deny payment. *See, e.g.*, SAC ¶ 242. Taylor does not refute this, and claims that the SAC's list of the "myriad options" that CMS may have taken "underscore[s] the materiality." Opp'n at 22. This is far from the standard adopted by the Supreme Court in *Escobar*, which held that it is ***not*** "sufficient for a finding of materiality that the Government ***would have the option*** to decline to pay if it knew of the defendant's noncompliance." *Escobar*, 579 U.S. at 194 (emphasis added). By asserting that the allegations about CMS's options are enough, Opp'n at 22, Taylor effectively concedes that the SAC does not meet *Escobar*'s demanding materiality standard.

Bourseau does not compel a different conclusion for Taylor's reverse false claims.[6] *See United States v. Bourseau*, 531 F.3d 1159, 1171 (9th Cir. 2008). As *Poehling* recognized, *Bourseau* "applied a materiality standard quite similar to the one articulated by the Supreme Court in *Escobar*." *Poehling*, 2018 WL 1363487, at *11. A magistrate judge in this District has similarly noted that the materiality standards "are the same for the reverse-FCA provision and the direct-FCA provision." *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1056 (N.D. Cal. 2020). Both *Escobar* and *Bourseau* "suggest that a claim ***must be based on a violation that is likely to affect whether and how much*** the Government would have paid to a defendant." *Poehling*, 2018 WL 1363487, at *11 (emphasis added). Whether under *Escobar* or *Bourseau*, Taylor fails to allege materiality because he neither specifically identifies the violation nor alleges that the violation at issue would have affected CMS's payment decision.

D. The FCA's Statute of Repose Requires the Dismissal of Claims Against Colorado Permanente Accruing Before November 15, 2011

The FCA's statute of repose prohibits Taylor from pursuing claims against the newly

[6] Following the Supreme Court's decision in *Escobar*, *Bourseau* only applies insofar as it is consistent with *Escobar*. While the claims at issue in *Escobar* were not reverse false claims, there is no reason to believe that the Supreme Court intended to create two different materiality standards. Indeed, courts have applied *Escobar* to reverse false claims. *See, e.g.*, *Jacobs v. Bank of Am. Corp.*, 2017 WL 2361943, at *12 (S.D. Fla. Mar. 21, 2017) ("Under the FCA and the U.S. Supreme Court's decision, a requirement is 'material' for the same reasons as under a theory of reverse false claim[.]").

added Defendant Colorado Permanente for conduct that occurred before November 15, 2011 (*i.e.*, more than ten years before the SAC's filing). Mot. at 20–23. While Taylor argues that relation back under Rule 15 saves these claims, that argument fails because the FCA's statute of repose is exception-free, foreclosing relation back. 31 U.S.C. § 3731(b) ("in no event" may an FCA claim be brought "more than 10 years after the date on which the violation is committed"); *see also Baldain v. Am. Home Mortg. Servicing, Inc.*, 2010 WL 2606666, at *6 n.6 (E.D. Cal. June 28, 2010) (finding that the Truth in Lending Act's similar statute of repose "cannot be extended through tolling, estoppel, ***relation back***, or related doctrines" (emphasis added)).

The cases Taylor cites do not support his argument that courts have "consistently" held that the FCA's statute of repose does not bar relation back. *See* Opp'n at 4, 23–25. Not a single case addresses whether claims against a newly named defendant relate back for statute of repose purposes. In *Kaplan*, the Ninth Circuit did not address the FCA's statute of repose. *United States v. Kaplan, Inc.*, 517 F. App'x 534, 536 (9th Cir. 2013). Nor did it address relation back under Rule 15 for claims against a newly added party. *Id.* Similarly, in *Bledsoe*, the Sixth Circuit did not address the statute of repose and focused much of its relation-back analysis on whether amended allegations arose from the same conduct set forth in the relator's original pleading and the relator's disclosure statement to the United States. *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 515–19 (6th Cir. 2007). Similarly, *Rigsby* and *Cericola* did not address the FCA's repose provision. *See United States ex rel. Rigsby v. State Farm Fire & Cas. Co.*, 2021 WL 1170086, at *15–17 (S.D. Miss. 2021) (does not analyze the statute of repose); *United States ex rel. Cericola v. Fed. Nat'l Mortgage Ass'n*, 529 F. Supp. 2d 1139, 1147–51 (C.D. Cal. 2008) (same, focusing on the FCA's six-year statute of limitations in § 3731(b)(1) and not the ten-year statute of repose in § 3731(b)(2)).

The only other FCA case that Taylor cites is out of circuit and factually distinguishable. In *Carter*, the Eastern District of Virginia concluded that the FCA's statute of repose did not prohibit relation back of revised allegations—***but did not address the question of newly added Defendants***. *United States ex rel. Carter v. Halliburton Co.*, 315 F.R.D. 56, 64 (E.D. Va. 2016). The court concluded that the application of Rule 15 "in [that] case" did not violate the Rules

Enabling Act, noting that the impact on defendants' substantive rights was "minimal" since the relator's amendment merely clarified its original pleading. *Id.* at 64–65. The narrow amendment added only additional details about award fees which were similar to allegations found in the original complaint. *Id.* at 62. The same is not true here. Taylor seeks to rely on relation back to hold ***a newly named Defendant*** liable for misconduct dating back more than 17 years. The *Halliburton* court's reasoning does not apply here because the impact on Colorado Permanente's substantive rights is not minimal—to the contrary, it is being belatedly dragged into a lawsuit asserting wide-ranging allegations of fraud.

Taylor's citation to *Southeastern Pennsylvania Transportation Authority* fails for the same reason. *See Se. Pa. Transp. Auth. v. Orrstown Fin. Servs. Inc.*, 12 F.4th 337, 350–52 (3d Cir. 2021). There, the court specifically declined to answer "whether a plaintiff may use relation back in th[e] [statute of repose] context to add new parties" and left those "tougher questions for another time." *Id.* at 350. Because Taylor seeks to use relation back to add a new party, the court's conclusion that "relation back does not offend the Rules Enabling Act when a plaintiff merely seeks to amend a timely filed complaint ***without adding entirely new claims or parties***" is inapplicable. *Id.* at 352 (emphasis added).

Colorado Permanente is Taylor's previous long-time employer, and there is no reason that he could not have added Colorado Permanente to one of his original ***two*** complaints. He chose not to do so and should not be able to undo that decision seven years after the fact without any consequence.

III. CONCLUSION

For the foregoing reasons, and the reasons explained in the Motion, the Court should dismiss Taylor's SAC except to the extent he alleges that the Colorado Defendants submitted or caused to be submitted false diagnosis codes to CMS that reflected medical conditions that did not exist as a clinical matter, and must limit any such claims against Colorado Permanente to those accruing on or after November 15, 2011.

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Respectfully submitted,

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