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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 RELATORS BRYANT AND HERNANDEZ'S FIRST 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 RELATORS BRYANT AND HERNANDEZ'S FIRST 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 RELATORS BRYANT AND HERNANDEZ'S FIRST 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 RELATORS BRYANT AND HERNANDEZ'S FIRST 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 RELATORS BRYANT AND HERNANDEZ'S FIRST 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 RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT** Hearing Date: October 13, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

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I. INTRODUCTION

Relators' fraud claims rest on the thinnest of reeds—a few scattered allegations about the ACA risk-adjustment program sprinkled throughout a complaint focused on the Medicare Advantage risk-adjustment program.[1] Relators concede in their Opposition that "much of their Complaint focuses on the [Medicare Advantage] program," not the ACA. Opp'n at 6. But the Court dismissed all allegations of fraud on the Medicare Advantage program when it ruled on Defendants' motion to dismiss under the FCA's first-to-file bar. The remaining references to the ACA program—in just 11 of 201 paragraphs of the FAC—do not establish falsity or materiality with the plausibility and particularity required under the FCA and the Federal Rules of Civil Procedure. Relators' Opposition spends much time citing allegations that on their face apply to only the now-defunct Medicare Advantage fraud claims. But these allegations, concerning a different program established under a different statute and serving a different patient population, cannot save Relators' ACA allegations.

Relators' FAC suffers additional flaws that the Opposition does not adequately address. Relators' FCA claims against all Defendants except TPMG fail because the FAC improperly relies on group pleading, even though Relators' own allegations acknowledge that Defendants are distinct entities with different roles and functions and so they could not have plausibly engaged in the same conduct. For similar reasons, Relators' FCA conspiracy claim fails because Relators have not alleged the existence of an agreement between all Defendants to defraud HHS. The Opposition points to a single paragraph that does not even come close to alleging an agreement to defraud, and ignores multiple paragraphs in the FAC that evidence a lack of agreement among Defendants. Finally, Hernandez's remaining retaliation claims fail because she does not allege facts suggesting that TPMG was on notice that she was engaged in protected activity. Instead, Hernandez's allegations are consistent with her role as a coding and auditing professional.

For these reasons, and those discussed in the Motion, the Court should dismiss the FAC in its entirety.

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

II. ARGUMENT

A. Relators' FCA Claims Should Be Dismissed

The Court should dismiss Relators' remaining FCA claims, based entirely on a handful of references to the ACA, for failure to allege falsity and materiality. The claims against non-TPMG Defendants also independently fail because Relators rely on inappropriate group pleading to try to make out their claims. Finally, Relators' conspiracy claim falls flat because Relators have not affirmatively alleged any conspiracy to submit false claims.

1. Relators Do Not Allege Falsity with Respect to the ACA

All of Relators' FCA claims fail because the FAC does not meet Rule 8's plausibility and Rule 9(b)'s particularity standards for alleging the submission of false claims under the ACA. Relators do not contest that this Court's first-to-file ruling dismissed their allegations of fraud under the Medicare Advantage program. And in their Opposition, Relators explicitly "acknowledge that much of their Complaint focuses on the [Medicare Advantage] program." Opp'n at 6. Yet Relators nevertheless insist that the Court should excuse their failure to make specific allegations about the ACA and allow them to proceed based on passing references in fewer than a dozen paragraphs because, according to Relators' argument, "[n]early every allegation in the Complaint" applies to both the purported ACA and Medicare Advantage schemes. *Id.* at 2. That is incorrect.

Relators cannot satisfy their pleading burdens by simply arguing in the Opposition that their allegations about the Medicare Advantage program also apply to an alleged scheme under the ACA. Nor can Relators rely on the FAC's conclusory allegation that "Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program." FAC ¶ 10(b). As this Court recognized in the first-to-file ruling, the ACA and Medicare Advantage risk-adjustment programs are "entirely different" programs under different statutes involving different government entities and impacting different populations. Dkt. No. 171 at 44 ("The Affordable Care Act is an entirely different scheme, not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare."). As the Motion

explained, Congress created a separate risk-adjustment program—one distinct from Medicare Advantage—after it passed the ACA. Mot. at 4. The ACA and Medicare Advantage risk-adjustment programs differ in important ways. *Id.* at 5. The purpose of ACA risk adjustment, which Relators acknowledge, is to "shift[] funds" ***among health plans***, *see* Opp'n at 1, whereas Medicare Advantage risk adjustment calculates payments that MAOs receive ***from CMS*** for providing healthcare coverage to each member. Mot. at 5. ACA risk-adjustment calculations depend on the health plan's average risk score, whereas Medicare Advantage risk-adjustment payments are made based on each individual member's risk score. *Id.* The ACA risk-adjustment program also considers certain plan-specific costs relative to the market average when calculating transfer payments among health plans—this does not occur under Medicare Advantage. *Id.*

These differences matter when it comes to Relators' pleading burdens: They cannot plausibly allege a fraud on HHS under the ACA based on allegations about the Medicare Advantage program when those programs and their payment mechanisms operate differently. Nor can they establish the who, what, where, when, and why that Rule 9(b) requires by describing conduct relevant to the Medicare Advantage program and then vaguely asserting that the fraud on the ACA program was the same—it could not have been given the patent differences between the programs. The best Relators can muster is that both programs require the submission of claims data to calculate and make risk-adjustment payments—yet even Relators concede that "the nature of how those risk adjustments are then effectuated differs," *see* Opp'n at 16, even though the FAC does not fully describe those differences.[2]

Relators also attempt to muddy the waters by arguing that the FAC alleges an upcoding scheme, which they contend "is classic fraud actionable under the FCA." *Id.* at 11. But this

[2] Relators also argue that the Court's first-to-file order somehow forecloses Defendants from arguing that Relators cannot rely on allegations specifically about the Medicare Advantage program to allege fraud under the ACA. *See* Opp'n at 16 (citing Dkt. No. 171 at 44 (noting that Relators "have not pled themselves out of FCA claims based on the Affordable Care Act")). That argument distorts both the Court's holding and the relevant legal standards. In the first-to-file order, the Court found that Relators' ACA claims survived the first-to-file bar because the ACA and Medicare Advantage risk-adjustment programs ***are distinct***. Nothing about that holding suggests that Relators can rely on Medicare Advantage allegations to plead ACA claims. To the contrary, because the programs are different, Relators must allege the false claims separately with plausibility and particularity—which they have failed to do.

argument misses the mark: Defendants did not argue in the Motion that upcoding is not actionable under the ACA; rather, Defendants contend that Relators have not alleged facts suggesting with plausibility or particularity that any false claims were submitted to HHS under the ACA because Relators' allegations center on the Medicare Advantage program. Mot. at 13–18. In other words, they have not plausibly alleged that any upcoding occurred for data submitted to the ACA risk-adjustment program.

And though Relators try to brush aside Defendants' specific arguments about their failure to meet Rule 9(b)'s particularity standard with respect to their AA, vent-dependence, and business practices allegations, Relators' counterarguments fall short:

Aortic Atherosclerosis. The FAC does not allege that Defendants diagnosed AA in members who did not have that condition (nor does the FAC even allege that Defendants submitted a single AA diagnosis code to the ACA program). Instead, Relators' theory of AA fraud is that TPMG's internal coding policies were inaccurate because they were based on the clinical determination that AA is a systemic condition, *see* FAC ¶¶ 57, 60—a determination with which Relators disagreed. In their Opposition, Relators argue that Defendants' alleged failure to comply with non-binding coding guidance concerning AA is just an "example" of Defendants' alleged misconduct. Opp'n at 16–17. But Relators cannot deny that their allegations about the purported AA scheme are completely bound up with references to non-binding guidance from third-party coding agencies. *See* FAC ¶¶ 54, 58, 70–71. Because subregulatory documents such as the guidance cited in the FAC "do not have the force and effect of law," *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 97 (2015) (quotations omitted), they can "never form[] the basis for an enforcement action." *Kisor v. Wilkie*, 139 S. Ct. 2400, 2420 (2019) (quotations omitted). Accordingly, Relators cannot allege falsity based on Defendants' purported failure to comply with non-binding guidance about coding AA. *See United States ex rel. Yannacopoulos v. Gen. Dynamics*, 2007 WL 495257, at *3 (N.D. Ill. Feb. 13, 2007).

Relators also seek to buttress their allegation about Defendants' increased rates of AA diagnoses between 2010 and 2016 by attempting to distinguish the Ninth Circuit's opinion in *Integra Med Analytics LLC v. Providence Health & Services*, 854 F. App'x 840 (9th Cir. 2021).

In *Integra*, the Ninth Circuit reversed the district court's order denying the defendant's motion to dismiss, finding that the relator offered only a "*possible* explanation . . . to explain a statistical trend that is consistent with a plausible alternative (and legal) explanation." *Id.* at 844. Though the relator's explanation—that the defendant's statistically higher rate of diagnoses compared to comparable institutions resulted from fraud—was possible, it did not rule out the "obvious alternative explanation" that the defendant "was simply ahead of others in its industry" and "at the forefront of a national trend toward coding [the diagnoses] at a higher rate." *Id.* at 844–45.

Relators' allegations here are similar to those rejected by the Ninth Circuit in *Integra*. Based on Relators' allegations, it may be *possible* to conclude that Defendants' increased rates of AA diagnoses resulted from a fraudulent scheme to upcode AA; but this trend of increased diagnoses is also consistent with a "plausible alternative (and legal) explanation"—that TPMG prioritized coding AA, a serious cardiac condition, among members with the condition in an effort to advance patient care. Under *Integra*, the existence of this plausible alternative explanation defeats Relators' AA allegations. *Id.*[3]

Ventilator Dependence. Relators' vent-dependence allegations likewise center on their personal disagreement with TPMG's internal coding policies. FAC ¶¶ 83–84. Relators do not contest that the FAC contains no allegations that Defendants coded vent dependence for a single member who was not on a ventilator. And as with the AA allegations, Relators cite only nonpublic statements by nongovernment entities in attempting to allege a fraudulent scheme based on vent-dependence diagnoses. *Id.* ¶¶ 81, 88. As with the guidance cited in support of Relators' AA allegations, these nonpublic, nongovernmental opinions cannot form the basis for an FCA action. *See Kisor*, 139 S. Ct. at 2420; *Yannacopoulos*, 2007 WL 495257, at *3. Nor can Relators' allegation about an increase in vent-dependence diagnoses, *see* FAC ¶ 101, save them

[3] Relators cite to *Starr v. Baca*, 652 F.3d 1202 (9th Cir. 2011) and *United States v. Chang*, 2017 WL 10544289 (C.D. Cal. July 25, 2017), in arguing that their AA allegations survive. Opp'n at 18–19. But those cases are not controlling where, as here, there is an obvious alternative explanation to the plaintiff's charge of misconduct. *Integra*, 854 F. App'x at 844 (explaining that the rule in *Starr* does not apply and a plaintiff's explanation is not plausible when there is an "obvious alternative explanation").

from a failure to allege falsity. *See Integra*, 854 F. App'x at 844.[4]

Business Practices. Relators do not seriously grapple with their failure to plausibly allege falsity with respect to the business practices criticized in the FAC. As argued in the Motion, *see* Mot. at 17–18, Relators' generalized allegations about TPMG's "policies and procedures," use of "quer[ies]," "emphasis on financial outcomes," and use of technology, *see* FAC ¶¶ 105–06, 109, 128, 135–36, 141–50; *id.* at 38, do not adequately allege any false claims. First, the FAC does not allege that these business practices resulted in any fraud on the ACA program—***all*** of these allegations are instead directed to the Medicare Advantage program. Second, the allegations rest on alleged noncompliance with non-binding coding guidance, which cannot form the basis for an FCA claim. The Ninth Circuit has rejected efforts to rely on allegations about the use of "leading queries" and similar efforts to encourage healthcare providers to completely and accurately diagnose all medical conditions as insufficient to state a claim for fraud. *Integra*, 854 F. App'x at 842, 844–45. Third, there is "nothing 'inappropriate, unethical or otherwise wrong'" with TPMG's alleged focus on revenue. *Id.* at 844 n.4 (citations omitted). Fourth, Relators' generalized and unspecific allegations about TPMG's use of certain technologies do not meet Rule 9(b). *See Vess v. Ciba-Geigy Corp.*, 317 F.3d 1097, 1108 (9th Cir. 2003).[5]

2. Relators Fail to Allege Materiality with Respect to the ACA

The FAC does not allege that any claim for payment was material to HHS. Relators claim that "the language of the ACA itself" establishes materiality, *see* Opp'n at 14, pointing to the following language: "[c]ompliance with the requirements of this Act concerning eligibility for a

[4] Relators try to salvage their vent-dependence allegations by pointing out that the FAC includes allegations about coding vent dependence among newborns, a population that could be covered by the ACA but that Relators contend is not covered by Medicare Advantage. *See* Opp'n at 9. But regardless which program covers newborn populations, Relators' vent-dependence allegations fail because they are based on non-binding guidance from third parties. *See Kisor*, 139 S. Ct. at 2420; *Yannacopoulos*, 2007 WL 495257, at *3

[5] Relators also appear to take issue with Defendants' explanation that the ACA risk-adjustment program is budget neutral. Relators argue that just because the program is budget neutral does not mean that Defendants are automatically immune from FCA liability. Opp'n at 12. Defendants never argued otherwise. Rather, Defendants highlighted the program's budget neutrality to illustrate yet another important difference between the ACA and Medicare Advantage risk-adjustment programs. *See* Mot. at 4–5.

health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments . . . ." 42 U.S.C. § 18033(a)(6)(A). Setting aside the fact that the FAC does not even once reference this quoted language, the statute does not satisfy Relators' burden to plausibly plead materiality.

The ACA does not define the phrase "material condition," and Relators cite to no case law holding that "material" in the statute has the same meaning as materiality under the FCA. In any event, simply pointing to the language would not be enough to meet Relators' pleading burden. John T. Boese & Douglas W. Baruch, *Civil False Claims & Qui Tam Actions* § 2.04(B)(4) (5th ed. 2022-3 Supp.) (noting that the ACA's "material condition" language is "not dispositive" of the FCA's materiality element). As the Supreme Court has explained, "statutory, regulatory, and contractual requirements are not automatically material [for purposes of FCA liability], even if they are labeled conditions of payment." *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 191 (2016). "For a false statement to be material, a plaintiff must plausibly allege that the statutory violations are 'so central' to the claims that the government 'would not have paid the[] claims had it known of the[] violations.'" *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1121 (9th Cir. 2020) (quoting *Escobar*, 579 U.S. at 196).

Relators have not met this burden. The FAC's handful of materiality allegations focus entirely on the Medicare Advantage program and say nothing about purported fraud under the ACA. *See* FAC ¶ 152 ("***CMS would have refused to make risk adjustment payments***, in whole or in part, to the Kaiser Defendants if it had known that the Kaiser Defendants were falsifying documentation and coding as alleged in this Complaint." (emphasis added)), ¶ 153 ("If the Kaiser Defendants had complied with their obligation to delete invalid diagnoses from RAPS, ***Medicare*** would have processed the corrected data, recalculated the risk score for the beneficiaries, and the risk adjustment reconciliation payment system would have made the corresponding payment adjustment." (emphasis added)), ¶ 154 ("[I]f ***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."

(emphases added)).

Moreover, the very language from the ACA that Relators cite disproves their argument. The statute does not say that compliance with subregulatory coding guidance is "material." Instead, it expressly refers to "requirements . . . ***concerning eligibility for a health insurance issuer to participate*** in the Exchange . . . ." 42 U.S.C. § 18033(a)(6)(A) (emphasis added). In other words, the statute makes *eligibility* a "material condition" to payment under the ACA—it does not render compliance with any other requirements "material" for purposes of the FCA. If that were the case, then the statute would make ***any*** violation of ***any*** guidance document material under the FCA.

Relators do not even attempt to connect the dots between eligibility and Defendants' purported FCA violations. For instance, they do not allege that eligibility to participate in an ACA exchange hinges on compliance with diagnosis-coding guidelines or attestation requirements. Nor could they, as the statutory requirements for qualified health insurance issuers say nothing about either topic. *See id.* § 18021(a)(1).

Relators' argument is not only at odds with the statute's plain language, it is also contrary to the case law. Multiple courts have concluded that conditions for participation are not the same as prerequisites for payment. *Hawaii ex rel. Torricer v. Liberty Dialysis-Hawaii LLC*, 512 F. Supp. 3d 1096, 1115–16 (D. Haw. 2021) (collecting cases holding that there is no FCA liability for violations of conditions of participation); *United States ex rel. Modglin v. DJO Glob. Inc.*, 114 F. Supp. 3d 993, 1019–20 (C.D. Cal. 2015) (same). In *Torricer*, the court dismissed FCA claims for failure to allege materiality where the relator alleged that the defendant violated specific "conditions for coverage" set forth in federal regulations that an ESRD facility was required to meet "to provide services and thus *qualify* to be paid." 512 F. Supp. 3d at 1114. As the court explained, "just because [the regulation] labels the conditions for coverage as 'qualifications for *payment*' does not mean a violation of such conditions was material"; the regulation simply "establish[ed] requirements so that a facility *can* be paid"—it did not render the conditions "prerequisites for payment of claims," nor did it render noncompliance with the regulation "material" for purposes of FCA liability. *Id.* at 1114–15. Similarly here, section 18033(a)(6)(A)

simply addresses what a health insurance issuer must do in order to qualify to receive payments under the ACA; it does not establish materiality under the FCA.

Relators next quibble with Defendants' citation to *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487 (C.D. Cal. Feb. 12, 2018), arguing that they have alleged the materiality of both upcoded diagnoses and attestations. *See* Opp'n at 14–15. But the single paragraph of the FAC that Relators cite expressly concerns "***CMS's risk adjustment payments***"—*i.e.*, Medicare Advantage, not the ACA. FAC ¶ 154 (emphasis added). Not one paragraph in the FAC's materiality section references the ACA or HHS. Relators therefore have not done even the bare minimum to plead the "magic words" necessary to allege the materiality of any claim to HHS under the ACA. *See Poehling*, 2018 WL 1363487, at *10; *United States v. Scan Health Plan* ("*Swoben II*"), 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017).

Finally, as argued in the Motion, Relators' allegation that the United States' partial intervention in this case establishes materiality, *see* FAC ¶ 155, is illogical and unfounded. First, the United States did not intervene on any of Relators' ACA claims. Second, even if the United States had intervened on Relators' ACA claims, that alone would not establish materiality, as "intervention decisions are, at best, of minimal relevance" to materiality. *United States ex rel. Int'l Bhd. of Elec. Workers Loc. Union No. 98 v. Farfield Co.*, 5 F.4th 315, 346 (3d Cir. 2021). That rule makes sense, as any complaint-in-intervention is subject to dismissal for failure to plead materiality, and any other rule would "work[] 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); *see also Poehling*, 2018 WL 1363487, at *9–10 (finding the United States failed to plead materiality as to attestations); *Swoben II*, 2017 WL 4564722, at *6 (finding the United States failed to plead materiality where the complaint-in-intervention "include[d] only conclusory allegations").

3. Relators Fail to Allege Any Claims Against Non-TPMG Defendants

Relators argue that their group pleadings are sufficient to allege claims against the 15 different Defendant entities named in the FAC. Opp'n at 19. But collective allegations are only appropriate if the defendants are alleged to have "engaged in precisely the same conduct." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016) ("*Swoben*"). By

Relators' own admission, that is not the case here.

Both the FAC and Relators' Opposition make clear that the named Defendants had distinct functions in the alleged scheme: The health plan Defendants were responsible for transmitting diagnosis codes to CMS, the hospital Defendants allegedly upcoded hospital patient data, and the medical group Defendants allegedly upcoded medical record data after patient encounters. *See* Opp'n at 19 (citing FAC); *id*. at 5–6 (describing the different functions of the health plans, hospitals, and medical groups); *see also* FAC ¶¶ 23–38 (same). As noted in the Motion, Relators' allegations further show that the health plan entities and medical groups cover distinct regional areas and vary in membership size, *see* FAC ¶¶ 23–38; and that the Defendants often had different operational and coding practices, *see id.* ¶¶ 107, 124, 140. But despite these critical differences, Relators' allegations about AA, vent dependence, and certain business practices focus almost exclusively on TPMG's conduct. *See id.* ¶¶ 60, 62–65, 67, 69, 75, 83, 96, 116. Relators do not address these points in the Opposition. By Relators' own allegations and admissions, Defendants could not have engaged in "precisely the same conduct."

Relators' reliance on this Court's decision in *Mariner* to defend its group pleadings is misplaced. *See* Opp'n at 19. In *Mariner*, this Court found group pleadings appropriate where each of the skilled nursing facility defendants "had the exact same role in the alleged scheme" and each "implemented this scheme in the same way." *United States v. Mariner Health Care, Inc.*, 552 F. Supp. 3d 938, 952 n.6 (N.D. Cal. 2021). The Court noted how the complaint alleged that one defendant oversaw the fraudulent scheme and owned all of the 22 skilled nursing facilities that were also named as defendants. *Id.* But the complaint in *Mariner* is distinguishable from the FAC here for two reasons. First, Relators' own allegations show that Defendants do not have "the exact same role," nor could they have "implemented [the alleged] scheme in the same way." Second, unlike in *Mariner* where the various skilled nursing facilities were owned and overseen by a single defendant, here Defendants do not share the same ownership and control.

Relators' allegations are instead similar to those in *United States v. Prime Healthcare Services Inc.*, 2020 WL 11884833 (C.D. Cal. Apr. 14, 2020), in which the court rejected the collective term "Prime" for certain Prime entity defendants despite the fact that one of the Prime

defendants owned another and the relator alleged "substantial overlapping ownership and control." *Id.* at *5–6. In rejecting the collective allegations, the court found that the Prime entities did not "act monolithically," highlighting facts that showed independence within Prime's corporate structure. *Id.* at *6. Relators' allegations here likewise show independence among the Defendants and Defendants' distinct functions and business roles. *See, e.g.*, FAC ¶ 107 ("the Permanente Medical Groups have ***significant control*** over chart audit selection, accuracy rates, documentation guidance, coding policy and practices" (emphasis added)), ¶ 140 ("the National Compliance Office ***has no power*** over the Permanente Medical Groups" (emphasis added)), ¶ 83 ("Kaiser's directives on vent dependence documentation and coding differ region by region").

Given their different functions, roles, and responsibilities, Defendants could not have plausibly engaged in or implemented the alleged scheme in exactly the same way. Accordingly, all non-TPMG Defendants should be dismissed.

4. Relators Have Not Alleged a Conspiracy Under the FCA

Relators' FCA conspiracy claim must fail because they have not alleged an agreement to defraud between the 15 different Defendants named in the FAC. To satisfy Rule 9(b), Relators "***must allege the existence of an agreement*** between the defendants to violate the FCA." *United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *4 (N.D. Cal. July 24, 2015) (emphasis added). "'Conspire' in this context requires a meeting of the minds 'to defraud the government.'" *United States v. LifePath Hospice, Inc.*, 2016 WL 5239863, at *8 (M.D. Fla. 2016) (citations omitted).

Although Relators argue that the FAC is "replete with allegations" of an alleged conspiracy, they tellingly cite to ***only one paragraph*** of the complaint. *See* Opp'n 20–21 (citing FAC ¶ 26). That paragraph states only that "[p]ursuant to inter-company agreements," Defendants "share moneys received from federal and state governments" such that "all of the named Kaiser Defendants possess financial interests in maximizing the amounts claimed to and paid by the governments." FAC ¶ 26. This allegation does not plausibly allege a "meeting of the minds" among Defendants to submit false claims for payment under the ACA—in fact, it does not even mention the ACA.

Relators' other allegations evidence ***the lack of an agreement*** among Defendants. For example, the FAC describes in detail a disagreement between TPMG and KFHP's National Compliance Office ("NCO") about when to code AA. *See id.* ¶ 60 ("Kaiser NCO announced that a . . . clinical review overruled NCAL TPMG's clinical determination that AA is a chronic, systemic condition"), ¶¶ 62–63 (discussing disagreement between KFHP and TPMG about the proper convention for coding AA), ¶ 67 (discussing how Bryant "alert[ed] NCO" about TPMG's position on coding AA, yet NCO "did nothing to stop" it), ¶ 74 (detailing how Bryant "felt compelled to go to NCO" for advice about what she believed to be TPMG's improper practices for coding AA), ¶ 75 (describing how NCO formally disagreed with TPMG's convention for coding AA after conducting a clinical review). The FAC also alleges discord between KFHP's NCO and the medical groups, *see id.* ¶ 107 ("[T]he Permanente Medical Groups have significant control over chart audit selection, accuracy rates, documentation guidance, coding policy and practices," and "NCO is pressured and intimidated by the relevant Regional PMG to change the audit's accuracy results"), and that NCO had "no power" over the medical groups, *id.* ¶ 140. Relators do not even attempt to explain how these allegations could be squared with the existence of an agreement among all Defendants to submit false claims under the ACA.

The sole case cited by Relators, *United States v. Bouchey*, 860 F. Supp. 890 (D.D.C. 1994), is not to the contrary. In *Bouchey*, the complaint "describe[d] in detail the actions allegedly undertaken by the conspirators" to further their aim of deliberately submitting inflated claims for consulting services. *Id*. at 894. Relators, in contrast, allege in conclusory fashion that "Defendants conspired with one another" to violate the FCA and "to defraud the United Sates ***by getting risk adjustment payments from the Medicare Program***." *See* FAC ¶¶ 167–68 (emphasis added). That type of perfunctory allegation is insufficient under Rules 8 and 9(b) to plausibly and with particularity plead a conspiracy under the Medicare Advantage program; and absent any reference at all to HHS or the ACA, it is certainly insufficient to plead a conspiracy to defraud HHS under the ACA risk-adjustment program. *See Marion*, 2015 WL 4512843, at *4 (dismissing FCA conspiracy claim because "[t]here [were] no factual allegations about the time, place or specific language used by the defendants to form their agreement"); *see also LifePath Hospice*,

2016 WL 5239863, at *9 (rejecting relator's conclusory allegation that defendants had "conspired" and finding that relator had not alleged a "specific agreement" between certain defendants "for the purpose of defrauding the government").

Finally, Relators cite to *Bouchey* for the proposition that they need not allege "a formal agreement to break the law." *See* Opp'n at 20. But this argument misses the point: Defendants do not contend that Relators must allege a ***formal*** agreement, only that Relators must allege ***an agreement*** to submit false claims. For all the reasons noted in the Motion and above, Relators have not done so, and their conspiracy claim should be dismissed.

B. Hernandez's Retaliation Claims Should Be Dismissed

Hernandez concedes that her FLSA retaliation claim should be dismissed. Opp'n at 21 n.4. Thus, only her retaliation claims under the FCA and the California Labor Code remain at issue. As set forth in the Motion, these claims fail because the FAC does not allege that TPMG was on notice that Hernandez was engaged in purportedly protected activity.

1. Hernandez's FCA Retaliation Claim Fails Because She Does Not Allege TPMG Had Notice of Protected Activity

To allege TPMG was on notice of a potential *qui tam* suit, it is not enough for Hernandez to allege TPMG's knowledge that she identified, investigated, and reported potential coding errors. That is because identifying, investigating, and reporting potential errors were part of Hernandez's core responsibilities as a coding and auditing professional. *See* FAC ¶ 21. Instead, Hernandez must allege facts showing she communicated her intent to either (i) "use the alleged noncompliance as the basis for an FCA claim," or (ii) "report the misconduct to government officials." *United States v. Somnia, Inc.*, 2018 WL 684765, at *10 (E.D. Cal. Feb. 2, 2018).[6]

Here, the FAC does neither. The Opposition asserts that Hernandez "was not tasked with

[6] Hernandez takes issue with *Somnia* and two other cases cited by Defendants, *United States ex rel. Hopper v. Anton*, 91 F.3d 1261 (9th Cir. 1996), and *United States ex rel. Lockyer v. Haw. Pac. Health*, 490 F. Supp. 2d 1062 (D. Haw. 2007), arguing these citations purportedly indicate that the Motion is "a disguised summary judgment motion." *See* Opp'n at 22. But as Hernandez points out, *Somnia* was decided at the motion-to-dismiss stage. *See id.* And there is nothing improper with Defendants' citations to the other two decisions, decided at the summary-judgment stage, to illustrate points of law.

investigating and reporting fraud," Opp'n at 22, but that is not the relevant standard. Hernandez does not deny that she held "various coding leadership positions" in coding and auditing groups, *see* FAC ¶ 21, and so she must allege more than her disagreement with TPMG's coding practices. *See Somnia*, 2018 WL 684765, at *10; *see also United States ex rel. Mooney v. Fife Dermatology, PC*, 2022 WL 3715763, at *1, *3 (D. Nev. Aug. 29, 2022) (finding, on summary judgment, that defendant had no notice of protected activity where employee was hired to manage finances, ensure compliance with Medicare and Medicaid billing regulations, and report compliance failures since "there was no indication that [the employee] was doing anything other than his job—notifying [defendant] that it might be non-compliant with Medicare and Medicaid regulations"). But the FAC contains no such allegations. Indeed, the paragraphs cited in the Opposition as being supposedly illustrative of TPMG's notice allege only that Hernandez disagreed with TPMG's conventions for coding AA and vent dependence and use of computer assisted coding. Opp'n at 22–23 (citing FAC ¶¶ 57, 63, 67 (AA) and ¶¶ 87, 90, 92 (vent dependence) and ¶ 148 (computer assisted coding)).

Hernandez attempts to salvage her retaliation claims by relying on *Campie v. Gilead Sciences, Inc.*, 862 F.3d 890 (9th Cir. 2017). In *Campie*, the court found that the relator adequately pleaded the notice element because the relator alleged he had conversations "outside of his chain of command," was selectively excluded from certain projects, and threatened his employer that he would inform the government of the alleged fraud. *Id.* at 908. But unlike the relator in *Campie*, Hernandez has not alleged that she informed TPMG that she would disclose her concerns to HHS, CMS, or any other governmental entity. Instead, she alleges that she had "concern[s]," was "disturbed and troubled," and "question[ed]" TPMG's approach. FAC ¶¶ 68, 70, 77, 86, 96. This is insufficient. *See Somnia*, 2018 WL 684765, at *10.

The allegations in *United States ex rel. Garrett v. Kootenai Hospital District*, 2020 WL 3268277 (D. Idaho June 17, 2020), and *Hardin v. Mendocino Coast District Hospital*, 2018 WL 2984834 (N.D. Cal. June 14, 2018), two other cases on which Hernandez relies, are also distinguishable. In *Garrett*, the court found that the relator adequately pleaded notice because she reported more than "mere regulatory violations" to her employer, and instead made "numerous

complaints" to officers and directors to attempt to "correct the illegal practices" and "remediate" the problems. 2020 WL 3268277, at *9. Unlike the relator in *Garrett*, Hernandez does not allege that she reported any misconduct to officers and directors in an effort to correct purportedly illegal activity; instead, her complaints were limited to her job scope and her duties to identify and report potential coding issues.

Hardin is also inapposite. In that case, the court applied a lower notice standard because the relator's reporting stemmed from a "general ethical obligation" and was not done as part of her job duties. 2018 WL 2984834, at *3. In contrast here, Hernandez does not deny that she was involved in coding and auditing; identifying the alleged coding issues set forth in the FAC therefore was within Hernandez's job function, and accordingly she must plead more.

2. Hernandez's Retaliation Claims Under California Law Fail

Hernandez does not dispute that her pleading obligations under California law are similar to those for stating a claim for FCA retaliation. *See* Opp'n at 25. As with her FCA retaliation claim, Hernandez has not pleaded sufficient facts to show that TPMG knew she was engaged in any protected activity, given the nature of her job. The Court should dismiss her California Labor Code retaliation claims for that same reason.

III. CONCLUSION

For the foregoing reasons, and the reasons explained in the Motion, the Court should dismiss Relators' FAC in its entirety.

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Respectfully submitted,

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