

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

BEFORE THE HONORABLE EDWARD M. CHEN, JUDGE

UNITED STATES OF AMERICA, ex rel.	)	
RONDA OSINEK,	)	
	)	
Plaintiffs,	)	Consolidated Case
VS.	)	No. 13-cv-03891-EMC
	)	
KAISER PERMANENTE, FOUNDATION	)	And Related Cases
HEALTH PLAN, INC., and THE	)	Nos. 16-cv-1558-EMC
PERMANENTE MEDICAL GROUP, INC.,	)	16-cv-5337-EMC
	)	18-cv-1347-EMC
Defendants.	)	21-cv-3124-EMC
	)	21-cv-3894-EMC

San Francisco, California  
Thursday, October 13, 2022

**TRANSCRIPT OF PROCEEDINGS**

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(Appearances continued, next page)

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1 Tuesday - November 16, 2021

2:46 p.m.

2 P R O C E E D I N G S

3 **THE COURTROOM DEPUTY:** Osinek, et al. versus Kaiser  
4 Permanente, Case No. 13-3891. Counsel, please state your  
5 appearances for the record, beginning with plaintiffs.

6 **MR. CHOE:** Good afternoon, Your Honor. Shiwon Choe  
7 behalf of the United States

8 **THE COURT:** All right, thank you, Mr. Choe.

9 **MR. MOSKOWITZ:** Good afternoon, Your Honor. David  
10 Moskowitz on behalf of the United States.

11 **THE COURT:** Thank you.

12 **MS. ZEMAN:** Good afternoon, Your Honor. Amy Zeman on  
13 behalf of relator Osinek.

14 **THE COURT:** Good afternoon, Ms. Zeman.

15 **MR. VOLDMAN:** Good afternoon, Your Honor. Max Voldman  
16 on behalf of relator Taylor.

17 **THE COURT:** Thank you, Mr. Voldman.

18 **MR. LEWIS:** Good morning, Your Honor. Roger Lewis on  
19 behalf of relators Bryant and Hernandez.

20 **THE COURT:** Thank you, Mr. Lewis.

21 **MR. PORTNOI:** Good afternoon, Your Honor. Dimitri  
22 Portnoi on behalf of the defendants.

23 **THE COURT:** All right. Thank you.

24 **MR. BLALACK:** Good afternoon, Your Honor. Lee Blalack  
25 on behalf of defendants.

1           **THE COURT:** All right, thank you Mr. Blalack.

2           All right. We have a series of motions. Why don't we  
3 start with the government's -- motion to dismiss the  
4 government's complaint and intervention. And obviously I'm not  
5 going to be able to cover everything today, but I want to cover  
6 some issues that would be helpful to me to get some  
7 clarification on.

8           So, with respect to the falsity question and the theory of  
9 falsity based on inaccurate diagnoses as distinguished from the  
10 diagnosis that were not related to doctor visits, the question  
11 is whether or not there's been enough here under *Twombly* and  
12 *Iqbal* to establish a pattern or practice to add non-existence  
13 diagnoses to patient records.

14           There are some examples given -- Paragraphs 338, 339, 210  
15 through 211 -- of sort of three anecdotes about various  
16 examples. But it's not until you get to the -- I'm not sure  
17 how it's pronounced, "Kechetsia?" I'm probably pronouncing it  
18 wrong.

19           **MR. PORTNOI:** I believe it is "Kekeksia."

20           **THE COURT:** How's it pronounced?

21           **MR. PORTNOI:** I believe it's "Kekeksia."

22           **THE COURT:** Okay. It's not until we get to there that  
23 it seems to me that there is more of a -- more allegations  
24 about systemic, you know, system-wide non-anecdotal kind of  
25 evidence. So, that's my take. But I want to hear from the

1 government whether I've missed something here. Whether there's  
2 more to establish a pattern or practice beyond cachexia.

3 **MR. MOSKOWITZ:** Thank you, Your Honor.

4 So I would like to start off at the outset, because only  
5 in the reply brief did they raise this idea that you have to  
6 establish a scheme, and I think to begin with, they misstate  
7 the law.

8 And that's the *Ebeid* case that they cite, it's addressing  
9 an issue about what you do if you don't actually have  
10 allegations about specific claims that have been submitted that  
11 were false. There's no dispute that when you have specific  
12 example claims of what has been false, that establishes the  
13 falsity of those claims.

14 And so this is actually an issue before the Supreme Court  
15 that is going up. Can you just allege a scheme? Or do you  
16 need to allege specific examples? But there's never been a  
17 court that says when you have specific examples, that, alone,  
18 is not sufficient.

19 And if you go back to the statute, the provisions in the  
20 statute itself, 3729, they talk about whoever knowingly  
21 presents or causes to be presented a false claim. It can be a  
22 single claim. It doesn't have to be a scheme. Whoever makes  
23 or uses or causes to be made or used a false record or  
24 statement, that's another basis for a claim.

25 And so to start off with, the scheme requirement is not

1 actually a requirement in the statute. It doesn't exist.

2 **THE COURT:** Well, all right, I understand that you --  
3 it's actionable to have it on a specific claim, but the scope  
4 of the complaint and the relief may turn on how widespread --

5 **MR. MOSKOWITZ:** Sure. But we would demonstrate then  
6 based on these examples, these examples demonstrate what they  
7 were doing.

8 So, to go further, though, we have actually alleged a  
9 single scheme. And that scheme is this. Kaiser Permanente,  
10 they systematically mind patient data for diagnoses. They then  
11 pressed physicians to add these diagnoses. A large part of  
12 this involves diagnoses that just simply had nothing to do with  
13 the visit at all. In fact, all of them covered that. But many  
14 times, when those diagnoses, themselves, also didn't exist.

15 And this pattern or practice was a reckless conduct where  
16 there was no significant concern that existed to show that we  
17 should only be pressing physicians to add these if we've  
18 confirmed that the diagnosis exists.

19 And the cachexia example -- because we could have spent,  
20 you know, hundreds of pages here going through different types  
21 of conditions, but the cachexia example is a perfect example of  
22 what was going on. In cachexia, they created an algorithm that  
23 was completely flawed. It was searching for patients who were  
24 merely thin. It is not remotely what cachexia is.

25 The doctors were warning Kaiser, this is going to cause us

1 to submit a whole bunch of false claims; we're just going to be  
2 picking up thin patients who don't have cachexia. Kaiser  
3 ignored that warning. Kaiser did an audit. When Kaiser did  
4 that audit, it showed that 90 percent of what they were adding  
5 via addenda was not appropriate.

6 **THE COURT:** No, I get you. That's why I said that  
7 there is systematic --

8 **MR. MOSKOWITZ:** Yes.

9 **THE COURT:** You do that for at least the one example  
10 of cachexia.

11 **MR. MOSKOWITZ:** Sure.

12 **THE COURT:** I didn't see similar ones for other --

13 **MR. MOSKOWITZ:** We didn't do it for similar ones. But  
14 the point is, like with the obesity ones, and there's a couple  
15 of examples here, is that the patient isn't obese, and yet  
16 they're asking the providers to add diagnoses that, you know,  
17 involve -- they's are asking providers to add obesity-related  
18 diagnoses. And that's reckless. You shouldn't be asking a  
19 provider to add a diagnosis for obesity related conditions when  
20 the record shows they weren't obese.

21 **THE COURT:** So what suggests that that was more than a  
22 one-off on -- on the obesity thing, as an example?

23 How do we know that wasn't just one example that's not  
24 necessarily indicative of the large iceberg underneath?

25 **MR. MOSKOWITZ:** So we've shown -- there's actually --

1 we've given at least two examples in this complaint, alone.  
2 We've given a whole bunch of examples of how they were using  
3 the queries improperly, that there was not attention paid to  
4 whether or not that condition actually existed or not, or  
5 sufficient attention.

6 And so, you know, I am not going to suggest that this is  
7 the primary focus of our case. The primary focus is the first  
8 problem. But the second problem exists.

9 And, and I think it's also important, Your Honor, to note  
10 that these two issues are completely intertwined. And that's  
11 shown through the examples. You know, when the physicians are  
12 pressed to add a diagnosis that's contradicted by the record,  
13 there isn't two schemes going on here. It's a single query.

14 And there are two problems with the query. One, the  
15 condition didn't exist. And two, it didn't have anything to do  
16 with the visit. And those things are intertwined, right?  
17 Because also, whether or not something required or affected  
18 patient care, treatment or management at that visit, it turns  
19 in part on whether or not the condition existed. If the  
20 condition didn't exist, then the second part is not true.

21 And so, no matter what, all of these things are going to  
22 stay in the case, because when the medical records show the  
23 patient didn't have that condition, well, that also means that  
24 it didn't require or affect patient care, treatment or  
25 management.

1           So this is largely Kaiser rewriting our complaint from  
2 what we allege, which was a single scheme, to being two schemes  
3 about two different parts of the exact same guideline.

4           **THE COURT:** All right. So in other words, to put it  
5 differently, some of this other misconduct, this so-called  
6 first scheme which you say is part of the second scheme can be  
7 inferred from both cachexia example, the unrelated to visit  
8 press which came from the same kind of inquiry, together with  
9 the anecdotes, from that you could infer that this was -- this  
10 was systemic on both fronts.

11           **MR. MOSKOWITZ:** Yes, it's systemic. It's not as  
12 widespread as the first problem. But it is a significant  
13 problem that existed throughout.

14           **THE COURT:** All right. Let me hear the response to  
15 that.

16           **MR. PORTNOI:** Well, Your Honor, thank you. The  
17 government has -- has been trying to have its -- to eat its  
18 cake and have it too, as I recently learned is the way we're  
19 supposed to say it.

20           The government wants to put everything in the legal  
21 falsity bucket, but then wants to focus on examples of clinical  
22 falsity and wants to leave that door a little bit ajar, so that  
23 if down the line its legal falsity claim fails, they can keep  
24 those clinical falsity claims in.

25           But Your Honor hit the nail on the head in the sense that

1 there is no scheme to put in, to have a false -- to have  
2 clinically false diagnoses submitted to CMS. And simply  
3 holding onto the idea that we can maybe keep a clinically false  
4 -- clinical falsity claim here, that is not the way to litigate  
5 a False Claims Act case. And it doesn't comport with  
6 Rule 9(b).

7 A clinical falsity scheme, Your Honor, is a dangerous  
8 indictment of a company. Part of the reason we have heightened  
9 pleading standards is so that defendants don't spend years with  
10 the title of an alleged fraudster. There's valid reason to  
11 have these standards, when you're accusing a company in a  
12 public document filed by the government of something so  
13 drastic.

14 And to understand, Mr. Moskowitz said -- said that part of  
15 the scheme was not having attention by doctors. But doctors  
16 are the ones making the diagnosis. And what is a query, but a  
17 request to a doctor to consider a diagnosis?

18 And to understand the scheme the government is proposing,  
19 they'd like to say that the complaint adequately alleges a  
20 scheme where hundreds, if not thousands, of doctors sat at  
21 their desks, looked at a medical chart, knew that a patient did  
22 not have a medical condition, and knowingly lied about that.

23 **THE COURT:** Well --

24 **MR. PORTNOI:** And that's not just --

25 **THE COURT:** What about -- what about with respect to

1 cachexia? I mean, there's a lot of systemic stuff there.  
2 You're not saying there was not -- there weren't allegations of  
3 a systemic data-mining query sent to doctors finding, cachexia  
4 added via addenda 120 times more than physicians in southern  
5 California that didn't have this initiative. Audits finding  
6 that the -- these diagnoses were invalid. I mean, that sounds  
7 pretty systematic to me.

8 **MR. PORTNOI:** Well, Your Honor, first off, if that  
9 were the case, then the clinical falsity would be limited  
10 there. But the cachexia data-mining initiative allegations  
11 don't show falsity.

12 What they show is that TPMG identified cachexia as a  
13 medical condition that could increase revenue if diagnosed.  
14 That TPMG created a data-mining algorithm to identify those  
15 potential cachexia diagnoses. That providers were sent those  
16 results to see if they should add potentially missed cachexia  
17 diagnoses to medical records, and that some providers expressed  
18 concern the algorithm incorrectly identified cachexia  
19 diagnoses.

20 What we don't have, Your Honor, after eight years of  
21 investigation, is one patient diagnosed with cachexia who did  
22 not have cachexia. Not one, Your Honor. And after eight years  
23 of investigation, we should be able to put that into a  
24 complaint, even as a conclusory allegation. But they don't  
25 even say that there's an unidentified person -- an unidentified

1 person --

2 **THE COURT:** Not one instance of an alleged  
3 misdiagnosis?

4 **MR. PORTNOI:** Nowhere in this complaint, Your Honor.  
5 What we have is an allegation that we took profit-driven steps  
6 to identify these diagnoses. But the Ninth Circuit said in  
7 *Integra* that CMS has acknowledged that there is nothing  
8 inappropriate, unethical or otherwise wrong with healthcare  
9 providers taking full advantage of coding opportunities to  
10 maximize the Medicare payment that is supported by  
11 documentation in the medical record.

12 And that's all this shows, is something that has already  
13 been described by the courts --

14 **THE COURT:** So what about -- what about Paragraph 321?  
15 As part of the audit, the internal audit, found that over  
16 90 percent of the time, a physician added cachexia diagnosis  
17 based on the query from Kaiser, but the documentation was  
18 either, quote, "lacking, or contradicted the definition of  
19 cachexia."

20 **MR. PORTNOI:** Your Honor, we don't know what that  
21 means to say documentation is lacking or -- or not. That could  
22 -- documentation being lacking doesn't say that a patient did  
23 not have the diagnosis. It could be that a name was  
24 transposed. It could be that dates are wrong. There are many  
25 documentation errors that can exist that have nothing to do

1 with the patient not having cachexia.

2 If the government wants to say --

3 **THE COURT:** So 90 percent of the time, you think it  
4 was a mistyped name?

5 **MR. PORTNOI:** There's no reason to believe -- if the  
6 government believes that somebody was diagnosed with cachexia  
7 who doesn't have it, why can't they allege that?

8 **THE COURT:** All right, let me stop you right there.  
9 Let me get the government response to that.

10 What about that?

11 **MR. MOSKOWITZ:** So there have been a lot of  
12 misstatements there about our complaint.

13 First off, in Paragraph 346, we specifically alleged one  
14 of the examples of cachexia. And it was a person who had the  
15 flu. And they lost a few pounds. That's not cachexia.

16 Cachexia is a complex syndrome involving an underlying  
17 condition that is causing the body to physically waste away.  
18 You get \$6,000 from Medicare to pay for that, because it's an  
19 extremely significant condition. It's not somebody having the  
20 flu who lost a couple of pounds. And the record shows exactly  
21 what happened.

22 And this record, not only did it say this person wasn't  
23 wasting away, it says they had no general disability. They're  
24 well appearing. He's clear that the weight loss is just a  
25 temporary issue related to the flu. That's not cachexia. But

1 that's one example of what is going on here.

2 Second, we are not saying that the doctors are sitting  
3 around being liars. That's not the allegation. The allegation  
4 is that the company was generating these. That the company was  
5 pressuring physicians to do things. That the company told  
6 these physicians "Don't spend more than a minute on this.  
7 We've already looked at this for you. Just go ahead and add  
8 this."

9 If you're going to spend a minute or less per diagnosis,  
10 you're not going through the records to look at them. You're  
11 just adding the diagnosis. And that's the problem here.  
12 There's pressure and -- from the company. The company is  
13 driving this, not the doctors.

14 If the doctor added the condition during the original  
15 visit, if all we had here was: Hey, Kaiser wants doctors to pay  
16 attention to cachexia, and if they actually see it in the visit  
17 then that's -- you know, please make sure to diagnose it, that  
18 would be one thing. What we have here is a systematic adding  
19 of these conditions after the fact, when the doctor saw the  
20 patient, and didn't diagnose them with it.

21 And that's similar problems with these other things. That  
22 the doctors aren't actually doing any work to do the check,  
23 because they were told: We, Kaiser -- Kaiser's already done  
24 this. You need to get through however many hundreds of addenda  
25 through the year that you're supposed to look at. It became a

1 problem. And especially a problem because the doctor has to  
2 then -- if they want to say no, they have to justify it. If  
3 they just do what Kaiser wanted them to do, it gets added.

4 And so all --

5 **THE COURT:** I understand the theory. I understand the  
6 theory. The question is --

7 **MR. MOSKOWITZ:** Okay, but it's all a reckless scheme.  
8 And it's one scheme.

9 **THE COURT:** And the question, I think ultimately, is  
10 under *Twombly* and *Iqbal*, is there enough specificity here to  
11 put meat on the bones, to show that there was this practice?  
12 And it seems to me that, cachexia, there's a number of systemic  
13 allegations here about the audit, about the communications,  
14 about the results, supplemented by anecdotes.

15 It's the area outside of that where I'd have to look twice  
16 to see whether there's enough there, frankly, to meet the  
17 *Twombly* kind of standard.

18 **MR. MOSKOWITZ:** And I think, Your Honor, you should  
19 look, because they've never been able to point to a case that  
20 actually gave examples that was not sufficient to move forward.  
21 And their argument is essentially it wasn't as systematic as  
22 the other parts of the claim. And that may bear out, and may  
23 be something that's addressed at summary judgment.

24 But even if it turns out that only, you know, 10,000 of  
25 the claims had this problem, as opposed to hundreds of

1 thousands of the claims having the other problem, well, those  
2 are still all false claims. And we'll have to prove that they  
3 were done knowingly, but that's a different question than  
4 whether it's false.

5 **THE COURT:** Well, you'll also have to prove it's more  
6 than one area, and more than three anecdotes outside the area  
7 of cachexia.

8 **MR. MOSKOWITZ:** Sure, right. But we would prove that.  
9 But there's not been a case where we provide specific examples  
10 of what happened, specific examples that, themselves, are false  
11 claims, but the court dismissed it because we didn't provide  
12 enough examples. And that's -- that is what, you know, at  
13 least, you know, Kaiser has not pointed to those cases. I'm  
14 not aware of them.

15 And, and so, the main issue has been: Do you need to  
16 point to examples? Or can you rely on other indicia to  
17 establish that false claims were submitted? And that's what's  
18 before the Supreme Court. That's what the *Ebeid* decision that  
19 they rely on says.

20 But, what is covered by this act is very broad amounts of,  
21 you know, any type of false claim or false statement. And so  
22 the fact that these are alleged to have been false is enough to  
23 show that they were false.

24 **THE COURT:** Let me get to the second group. I know  
25 there's a lot to be said.

1           **MR. PORTNOI:** Your Honor, may I be very brief --

2           **THE COURT:** Very brief, and then I want to get to the  
3 second category.

4           **MR. PORTNOI:** The first thing I want to note with  
5 respect to the example that's given on Paragraph 346, at  
6 cachexia, again, that paragraph does not allege that the  
7 patient did not have cachexia. It says that there's  
8 inconsistent data in the file. And they don't state what  
9 clinical indicator is necessary to show cachexia.

10           That's because on Paragraph 295 -- and we have to treat  
11 this as true -- the government alleges that cachexia is based  
12 on clinical judgment, not clinical indicators. It is something  
13 that is more or less subjective to the doctor. Which, again,  
14 not only means that to prove cachexia you have to show that the  
15 doctor --

16           **THE COURT:** Well, the allegation says that the health  
17 plan was not entitled to this risk adjustment, because cachexia  
18 did not exist. Now, you may take some issue. I guess you're  
19 saying now, to back that up we'd have to have more specific  
20 evidence of clinical indicators to show that it did not exist.

21           I'm not sure if *Twombly* and *Iqbal* go that far. I don't  
22 have to necessarily see medical records on a 12(b)(6) to make a  
23 conclusion. There's a specific allegation that it didn't  
24 exist.

25           **MR. PORTNOI:** And if so, Your Honor, then that's one

1 claim. And it goes no further. It doesn't show a scheme.  
2 And -- I'm not saying that there need to be more examples.  
3 That's a distortion of our argument.

4 But, there hasn't been a case that has said: We gave you  
5 three examples, now let's go forward on 10,000 claims because  
6 we believe that there's -- with no allegation of the scheme.  
7 There are usually allegations.

8 And again, after eight years of investigations, it's  
9 usually not hard to find them. Meetings in which people talked  
10 about: Hey, let's get diagnoses, even though they're false. As  
11 opposed to: Let's send queries to doctors. That is simply not  
12 in the complaint. And after eight years of investigation, you  
13 would think it could be, by this time.

14 **THE COURT:** All right. Let me get to the next group  
15 that the government asserts.

16 Is the government asserting, besides sort of the legally  
17 false claim of compliance with ICD guidelines, is there a claim  
18 also of just factual falsity in this regard?

19 **MR. MOSKOWITZ:** Yes. So, all of these claims are  
20 factually false. Right? Each and every one of these false  
21 claims entails an ICD code that is inaccurate. It's  
22 inaccurate, according to the ICD guidelines. And that fact, in  
23 and of itself, makes it factually false. It's inherently a  
24 misrepresentation to use ICD codes but disregard the  
25 guidelines, the standard that gives those codes some meaning.

1 Right?

2 So Kaiser is not submitting diagnoses. If they submitted  
3 a diagnosis to CMS, they said: Patient X has cancer. They  
4 would get zero dollars for that.

5 What they're submitting is encounter-level data. This is  
6 data for a particular patient who saw a particular provider on  
7 a particular date. And a list of the ICD codes, numbers that  
8 have no meaning other than against the ICD standard. Right?  
9 So instead of "aortic atherosclerosis" they're submitting  
10 "I70.0." That means nothing. What it means and what gives it  
11 meaning is the ICD standards. And when you are not complying  
12 with the ICD standard, with the ICD guidelines that give the  
13 meaning to that code, you are misrepresenting the code.

14 And that was decided directly in the *Moncrief* case, in  
15 completely identical circumstances, where the Court says: If  
16 you're going to submit a CPT code, then you need to comply with  
17 the CPT manual. Because the CPT manual is what gives the  
18 meaning. It says what that CPT code means.

19 And so, yes, they're both factually and legally false.

20 **THE COURT:** And the non-compliance is that it's  
21 unrelated to a doctor visit. Is that the --

22 **MR. MOSKOWITZ:** So, right. It's actually that that  
23 ICD guideline has two requirements. It has to coexist at the  
24 visit, so it needs to be a condition that existed at the visit,  
25 and it needed to have required or affected patient care,

1 treatment or management. Both of those conditions have to be  
2 met in order to report it. If you don't have both of those  
3 conditions, you can't report it.

4 And that same rule applies across Medicare. It applies to  
5 traditional Medicare, and it applies to Medicare Advantage.  
6 And that's really important, because the way that the Medicare  
7 Advantage model works is it uses the data from traditional  
8 Medicare to calculate the payments in Medicare Advantage.

9 And the whole idea of this is that the same standards  
10 apply. Because you use that for the model to calculate one to  
11 the other. And it is factually false, on its own, when you  
12 misrepresent an ICD code that doesn't comply with the ICD  
13 guidelines.

14 **THE COURT:** So how is that distinguished from the  
15 legally false claim of assertion of compliance with the ICD  
16 guidelines, when in fact, there wasn't -- seems like that's two  
17 sides of the same coin.

18 **MR. MOSKOWITZ:** So in this case, they both apply. And  
19 we've never -- we've never -- this wasn't our argument, right,  
20 this was something that the plaintiff -- or that Kaiser  
21 Permanente came up with in their briefing, right? Our point is  
22 they are both factually and legally false. Something that is  
23 factually false is, it appears on the face of the claim, that  
24 is an incorrect description of the code, itself.

25 And that's what *Moncrief* said, right? *Moncrief* said that

1 was -- CPT codes that were inaccurate were both factually and  
2 legally false. Something that's legally false is, if you're  
3 relying on some other thing that's not on the face of the  
4 complaint but you're saying they certified compliance with  
5 that, and our point is for this case it's a distinction without  
6 a meaning. It is both factually false and legally false.

7 **THE COURT:** All right. So let me hear the response to  
8 the -- to that.

9 **MR. PORTNOI:** Well, Your Honor, first off, the  
10 distinction between clinically false and legally false is not  
11 something that Kaiser created. This is something that exists  
12 across the case law.

13 The court in *Moncrief* was clear to point out that the type  
14 of falsity at issue in that case was factual falsity, whether  
15 the defendants actually performed the service that they billed  
16 for. The Court concluded that sub-regulatory guidance was  
17 relevant to help answer that question.

18 Here, DOJ's theory with respect to what we're calling  
19 legally false claims is that defendant's right to payment is  
20 premised on his complete compliance with the ICD guidelines.  
21 That was not the argument in *Moncrief* at all, and that's not  
22 the argument that's being made here.

23 **THE COURT:** Why isn't it analogous, though? The idea  
24 is that you've rendered an ICD code that requires coexistence  
25 and effect, effect --

1           **MR. PORTNOI:** Well --

2           **THE COURT:** -- in management. And if the code were in  
3 fact rendered without even a visit, why isn't that factually  
4 false?

5           **MR. PORTNOI:** Because, Your Honor, there's not --  
6 there's nothing here to say that -- we don't have a  
7 certification, for instance, here, that says that with each  
8 diagnosis, every time we sent it in, that we said this requires  
9 or affects care. What we're doing is we're incorporating by  
10 reference something into a contract that then incorporates by  
11 reference another level.

12           This, this is -- this is classic legal falsity, because  
13 what we're -- what the government is alleging is that -- is  
14 that what we have is a scheme where the contract requires  
15 something. And so there's an implicit statement when diagnoses  
16 are sent, that this subsequent -- that this subsequent -- what  
17 is in the ICD guidelines, which is not referenced in the  
18 contract, is going to be followed in every single of the 115  
19 pages, and every line.

20           And that's just not plausible, in reading the contract in  
21 this case to show that that's something that represents the  
22 statement. You have to figure out, Your Honor, what is the  
23 false statement that Kaiser made? And --

24           **THE COURT:** The false statement is that: This  
25 diagnosis was rendered in connection with an actual visit for a

1 condition that co-existed and was a condition that was subject  
2 to -- affected the course of treatment and management.

3 **MR. PORTNOI:** But that's not something that Kaiser  
4 ever said. And that's the problem. Kaiser --

5 **THE COURT:** You have to use those words? You're  
6 saying there's no falsity unless they use those exact words?  
7 Is that your theory?

8 **MR. PORTNOI:** What I'm saying is that when we render a  
9 diagnosis we're, of course, representing that the diagnosis  
10 exists. But what we -- what we are denying is that the  
11 contract or any regulation requires Kaiser to follow every inch  
12 of the ICD guidelines, much less the Medicare managed care  
13 manual, such that it renders every diagnosis false, if you  
14 hadn't followed every page in the 800 pages of the Medicare  
15 care manual or the ICD guidelines, themselves.

16 There's simply -- the contract doesn't support that  
17 interpretation, and they don't compel compliance with the  
18 require-or-affect requirement. It doesn't reference the  
19 requirement that --

20 **THE COURT:** Well, maybe this goes to materiality.  
21 Maybe this overlaps with materiality. But isn't -- this is not  
22 every inch. This is, like, pretty important. Right?

23 If it says you've got to -- in order to render this kind  
24 of diagnosis, you've got -- it's got to be based on something  
25 that's concurrent. And, current.

1 I mean, that's not rocket science. That's not searching a  
2 manual for some footnote. It's pretty central. It's common  
3 sense.

4 **MR. PORTNOI:** Well --

5 **THE COURT:** And, Kaiser's own internal documents  
6 recognize the need to comply with ICD guidelines. So surely,  
7 surely, Kaiser can't feign ignorance of that requirement, can  
8 it?

9 **MR. PORTNOI:** Well, Your Honor --

10 **THE COURT:** That's not plausible, counsel.

11 **MR. PORTNOI:** Your Honor, a few answers to those  
12 questions. First off, the fact --

13 **THE COURT:** Yeah, give me a few answers, will you?

14 **MR. PORTNOI:** First off, the fact that Kaiser's  
15 internal documents talk about complying with the ICD  
16 guidelines -- and with a lot of guidance that isn't issued by  
17 the government, as the ICD guidelines isn't -- isn't something  
18 that goes to whether our statements to the government are  
19 false.

20 Second --

21 **THE COURT:** Well, yes, it does. It indicates that  
22 this is not, quote, your words, "every inch of the guidelines."  
23 This is something that's important, material, and central. If  
24 Kaiser recognized it, that's pretty good evidence that this is  
25 pretty important stuff, isn't it?

1           **MR. PORTNOI:** Well, Your Honor, it's not -- that  
2 simply -- that simply isn't the case.

3           And also, part of the response, too, to note, is that what  
4 the ICD guidelines state is simply that you must diagnose all  
5 conditions that co-exist and that require or affect care. They  
6 don't state any -- there is no prohibition in there, in the  
7 negative, just to be clear on that point. And as a result,  
8 that's part of what is there.

9           But, again, what we are talking about here is what does --  
10 and the fact that something is a requirement doesn't make every  
11 time we submit a diagnosis a false statement, Your Honor.

12           There are many -- there are many situations where that simply  
13 -- where that simply isn't the case. And what we have here is:  
14 Did we believe every time, or was it the case that every time  
15 we submitted a diagnosis, it was clear on its face that we were  
16 making a statement that every single diagnosis required or  
17 affected care?

18           All -- what the government relies on is the fact that in  
19 the contract, the MA organizations agree to follow the Medicare  
20 managed care manual, which is an 800-page document itself,  
21 which references in one instance the ICD guidelines which later  
22 has the "require or affect care."

23           That's not enough to get to a place where the state --  
24 where the diagnoses that we're making are statements that are  
25 indicating every single time that every diagnosis requires or

1 affects care.

2           **THE COURT:** All right, because it's a reference to a  
3 reference, it is incorporation by reference two degrees away,  
4 it is part of 800 pages, it's too minute to be implied as part  
5 of the representation.

6           **MR. PORTNOI:** Sure.

7           **THE COURT:** What's the response to that? Let me hear  
8 the government's response to that.

9           **MR. MOSKOWITZ:** First off, I want to correct one  
10 thing, because we actually say that there are three things here  
11 that make the ICD guidelines and make this a false claim.

12           First, it is correct that that contract requires Kaiser to  
13 follow the ICD guidelines.

14           Second, the Medicare Advantage regulations require Kaiser  
15 to follow the ICD guidelines.

16           But, third, even if they didn't exist, when you use an ICD  
17 code, that, in and of itself, is a misrepresentation if you  
18 haven't complied with the standard. And this is exactly what's  
19 involved in *Moncrief*; it's what happened in *Escobar*.

20           In *Escobar*, they were using MPI codes, and they were using  
21 payment codes that were half-truths. Were misleading. They  
22 didn't have to make an express statement because, in context,  
23 the statement is: I'm reporting what are the ICD codes that  
24 are reportable for this patient visit that happened here.

25           It is a significant misrepresentation and half-truth in

1 context to not -- to reveal -- to use codes to submit them for  
2 payment that didn't comply with the standard. But the --

3 **THE COURT:** What if one of the standards is one of 800  
4 standards? Any, any, any, any not-compliant --

5 **MR. MOSKOWITZ:** That's certainly not what we have  
6 here, right? So we have -- this is -- as you hit right on the  
7 point, this is the central standard for an outpatient  
8 encounter.

9 So I want to be clear here. Kaiser -- Kaiser didn't just  
10 like get lucky and identify this particular standard. They  
11 were hit over the head with it along with every other MAO, who  
12 were trained on it, who were given participant guides and all  
13 sorts of other guidance that identifies this particular  
14 standard as the number-one standard they need to look out for.  
15 So it's not just a: They got lucky. They had this in their  
16 own internal guidance, because CMS pointed it out to them.

17 But, the contract is clear. Right? The contract says  
18 that they have to operate in compliance with the Medicare  
19 managed care manual. Doesn't say Chapter 1. It says all of  
20 the Medicare managed care manual.

21 Now, they make a big deal about this Medicare managed care  
22 manual being 800 pages long. The vast, vast, vast majority of  
23 this are about how CMS is going to run the program.

24 So if you take Chapter 7, for example, that is the only  
25 chapter on risk adjustment payments, which is a huge part of

1 the program. Kaiser gets tens of billions of dollars a year  
2 from risk adjustment payments.

3 And in Chapter 7 -- it's 70 pages long. But of that  
4 chapter, if you look at the first couple of pages, that  
5 identifies specifically for the MAOs what their obligations  
6 are. And it couldn't be clearer.

7 That obligation, the first obligation they have, it says  
8 (As read):

9 "MAOs must ensure the accuracy and integrity  
10 of risk adjustment data submitted to CMS."

11 And it says:

12 "The diagnosis must be coded according to the  
13 international classification of diseases,  
14 modification guidelines for coding and  
15 reporting. The ICD guidelines."

16 It couldn't be clearer that every diagnosis has to be in  
17 compliance with that.

18 They also make a big deal about how long the ICD  
19 guidelines are. Well, the actual guidelines for an outpatient  
20 visit happen to be about four pages long. And this is the most  
21 important guideline.

22 They take advantage of the fact that the vast majority of  
23 the ICD guidelines involve specific guidance about how to treat  
24 particular conditions. What do you do with COVID? What do you  
25 do with West Nile Virus? What do you do in a hurricane? All

1 sorts of random things that just don't have anything to do with  
2 it.

3 The outpatient rules are simple and clear, and they went  
4 over them in all of the participant guides. Kaiser attached  
5 that guide. In Chapter 6, you can see for yourself how this  
6 particular guide is the first -- or this particular guideline  
7 is the first one identified for it.

8 And the participant guide also noted to each MAO that the  
9 guiding principle of risk adjustment has four different parts  
10 which happen to mirror exactly what Kaiser's own internal  
11 advisory shows. And one of those four key parts is that  
12 diagnoses must be coded according to the ICD guidelines. This  
13 was the most -- up there among the most crucial requirements.

14 But, second, they also were required by the regulations to  
15 comply with the ICD codes. The regulations, the Medicare  
16 Advantage regulations, specifically require them to submit  
17 equivalent data to traditional Medicare. Right?

18 So traditional Medicare submits encounter-level data,  
19 including ICD diagnoses, coded according to the ICD guidelines.  
20 MA organizations must submit data that conforms to these data  
21 requirements for equivalent Medicare fee-for-service data and  
22 to all relevant national standards.

23 And, obviously, when you're submitting ICD codes, the  
24 relevant national standard is the ICD standards. The ICD  
25 guidelines.

1 The idea that you can submit data that -- ICD codes that  
2 don't comply with the standard and that you've complied with  
3 all relevant national standards is nonsensical, and it  
4 undermines the entire merits -- the entire system, in and of  
5 itself. And there is nothing in that regulation that says  
6 "only according to data form."

7 And finally, I would note that we have pointed to numerous  
8 authoritative guidance from the agency, including statements in  
9 the Federal Register that identify the ICD standard as the  
10 chief standard that applies to this regulation.

11 And under *Kisor v. Wilkie*, what the Court's job to do in  
12 interpreting this regulation is, first, you use the ordinary  
13 tools of construction to identify that. To identify what it  
14 means.

15 We think unambiguously it shows this is not limited to  
16 data form. Kaiser's been able to point to no case or any law  
17 that would support their position. But even if Kaiser were  
18 correct that there was some ambiguity, at that point in time,  
19 then the Court defers to the authoritative position of the  
20 agency about its specific views on the statute.

21 And in *Kisor v. Wilkie* they say: What are those? Those  
22 are the -- the positions that emanate from those actors using  
23 those vehicles understood to make authoritative policy.

24 And no one has ever suggested that statements, policies  
25 from the Secretary of HHS in the preamble to rules is not, in

1 fact, authoritative positions of the agency. This has been the  
2 position of the agency for decades. No one has ever challenged  
3 this before, in two decades, until Kaiser did it.

4 We've litigated numerous cases like this. No one has ever  
5 suggested that the ICD guidelines don't apply. In fact, many  
6 parties outright come out and say: We acknowledge the ICD  
7 guidelines apply. Because they do.

8 **THE COURT:** And in that regard, are you advocating  
9 *Chevron*? *Auerbach*? What kind of deference are you suggesting?

10 **MR. MOSKOWITZ:** Yeah. So the deference, because it is  
11 a regulation, would be under *Kisor v. Wilkie*. And the first --  
12 it's basically a two-step process similar to *Chevron*, but it's  
13 not *Chevron* because it's not an interpretation of a statute.

14 And so the first is you look at this regulation and say:  
15 Using all the tools of construction, what's the right  
16 interpretation? And we think our interpretation is -- is  
17 clearly correct, because it is related to all relevant national  
18 standards, not relevant to national standards related to data  
19 format.

20 This was -- the rule at issue was about substantive data  
21 that's submitted to CMS that is equivalent to traditional  
22 Medicare data.

23 And in order to take Kaiser's position to be correct, you  
24 would need to add words or limitations that don't appear in the  
25 text, itself. If CMS wanted to limit it, they would have done

1 that.

2 But if the Court determines that there is ambiguity, then  
3 it looks to the authoritative statements of the agency in the  
4 Federal Register and elsewhere.

5 **THE COURT:** All right. Let me -- I'll give you a  
6 brief chance to respond, and then I have got to go on to the  
7 next motions.

8 **MR. PORTNOI:** Thank you, Your Honor. I have just a  
9 few points here to make.

10 First off, there's nothing in the complaint that makes  
11 clear that this particular provision that appears three pages  
12 before the appendix of the ICD guidelines is the central  
13 provision.

14 In fact, there's another provision in the general -- near  
15 the general coding guidelines that states that (As read):

16 "The assignment of a diagnosis code is based  
17 on the provider's diagnoses statement that  
18 the condition exists; the provider's  
19 statement that the patient has a particular  
20 condition is sufficient."

21 And that is the more general statement. There's nothing  
22 in here -- there's nothing here to state that this particular  
23 "require or affect" sentence is the key sentence in the entire  
24 ICD guidelines or that it's -- or that somehow it is the key  
25 thing incorporated into the Medicare managed care manual, into

1 the contract, or into these regulations.

2 If CMS wanted -- I just heard Mr. Moskowitz start a  
3 sentencing that way. If CMS wanted to make clear that the  
4 second of the ICD guidelines or the ICD guidelines as a whole  
5 were required, they could do so, in the contract, itself. And  
6 they could also cite this particular provision in regulations.

7 I also want to respond briefly to the issue regarding the  
8 regulations, because the regulations, very clearly, we don't  
9 have to get to deference. They very clearly don't apply. The  
10 two sets of regulations are cited in the opposition.

11 Part 162 states:

12 "Part 162 applies only when covered entities  
13 are conducting a transaction covered by this  
14 part."

15 In a footnote -- in our brief, we noted that there are  
16 nine transactions that are covered by this part. And we listed  
17 the nine transactions covered by this part.

18 We asked the government to state which of these nine  
19 transactions does it believe occur in this case. And the  
20 government, in their opposition, chose to not respond. To  
21 simply ignore that statement, entirely.

22 And when we go to the regulatory history -- this is also  
23 cited in our briefs -- it also makes clear the dataset from a  
24 private managed-care organization to a state agency equivalent  
25 to an MAO setting CMS data does not need to be a standard

1 transaction.

2 So we don't have something there. And when we come to  
3 42 C.F.R. 422.310, this provides rules for risk adjustment data  
4 formatting. It is not about MAO's right to payment, nor does  
5 it restrict healthcare providers' ability to diagnosis medical  
6 conditions.

7 It is simply talking about that the data has to -- has to  
8 -- that the data has to be formatted in a particular way in  
9 order to enable data to be able to upload to the system.

10 In no way, based on simply the use of the word "national  
11 standards" when we're talking about data formatting do we get  
12 the elephant in a mouse hole, that every inch of the ICD  
13 guidelines -- which is not even mentioned in the regulation --  
14 is referenced there.

15 **THE COURT:** So are you suggesting that the guidelines  
16 with respect to the co-existence and the doctor visit and the  
17 diagnoses having to do with -- having to affect treatment, does  
18 not apply at all? Is that your position?

19 Not that it's not important and not noticeable, but not --  
20 not even applicable? Is that what you're arguing?

21 **MR. PORTNOI:** The Court doesn't need to reach whether  
22 it's there, because the fact is, Your Honor, if the ICD  
23 guidelines apply but there's no false statement, CMS has many  
24 other tools in its toolbox to enforce the ICD -- to enforce the  
25 ICD guidelines, or to enforce the Medicare managed care manual.

1           It's not the case that the government cannot do anything  
2 when a claim is based on sub-regulatory --

3           **THE COURT:** Well, but if I have to explore the limits  
4 of your argument, the law to the extent of your argument, if  
5 you're saying the regulations of 42 C.F.R. only applies to form  
6 of data, has nothing to do with actual outpatient visits and  
7 all that, that suggests there are no regulations requiring what  
8 the government says is required.

9           **MR. PORTNOI:** The regulations can require it, but  
10 without it being a pre-condition for payment, Your Honor. And  
11 that's what we're talking about here. That goes to falsity and  
12 it goes to materiality, when we're talking -- when what we're  
13 dealing with is a sub-regulatory requirement that isn't placed  
14 directly into the contract or into regulations.

15           **THE COURT:** The hour is late. Let me get to the -- I  
16 want to address the Taylor --

17           **MR. MOSKOWITZ:** Can I make one small point on the  
18 HIPAA rules?

19           **THE COURT:** Quickly, yeah.

20           **MR. MOSKOWITZ:** So we have not argued that the HIPAA  
21 rules are what applies. We said the Medicare Advantage rules  
22 are what require Medicare Advantage -- MAOs to comply with the  
23 standard. What CMS has said is that the providers have to  
24 comply with the ICD guidelines when they transmit stuff.

25           So Kaiser's argument is actually: The ICD guidelines

1 apply when the providers transmit the codes to the MAOs. But  
2 then when the MAOs get it, all rules are off. There literally  
3 is nothing, that they could submit anything as long as it's,  
4 quote, "clinically accurate." Which also doesn't appear in the  
5 regulations.

6 And so our argument is that the MA regulations, those  
7 specifically require the MAOs to submit the data that conforms  
8 to the relevant national standard. And if you're submitting  
9 ICD codes, the relevant national standard is the ICD standard,  
10 the ICD guidelines.

11 **THE COURT:** All right. Thank you. Let me go to the  
12 Taylor question here. And I guess one of the questions is what  
13 the basis of liability is for Kaiser Foundation Health Plan.  
14 Especially in terms of the wider breadth of error claimed.

15 And so let me hear from the relator exactly where --  
16 what's the basis here --

17 **MR. VOLDMAN:** Thank you.

18 **THE COURT:** -- of broader liability.

19 **MR. VOLDMAN:** Thank you, Your Honor.

20 So as our opposition laid out, KFHP employees ran these --  
21 set goals and ran the projects that led to the violation of  
22 FCA. For example, Mr. Tholen set goals for financial targets  
23 that were unattainable, without the schemes that Kaiser decided  
24 to implement to attain them.

25 It's true that there's nothing wrong with setting

1 financial goals, and that for-profit healthcare companies are  
2 welcome to do everything legal to make money. But the reaction  
3 wasn't to do everything legal to make money. It was to design  
4 something like a (Inaudible) team of external providers to hit  
5 artificially high goals that Mr. Tholen presented. He was a  
6 KFHP employee in Colorado. Similarly, Diane Morissette, a KFHP  
7 employee not based in Colorado, was aware, and as KFHP  
8 generally was aware that the external providers had  
9 extraordinarily high error rates.

10 Kaiser did nothing to address the error rates, except in  
11 the direction that helped them financially, and ignored the  
12 downside of these error rates that would -- that the correction  
13 of which would have hurt them financially. These were driven  
14 from the parent health plan. It's true that some of these  
15 schemes were implemented in the Colorado region, but that's not  
16 where they initiated. And that's not why they initiated,  
17 either.

18 **THE COURT:** Well, what are the allegations that, one,  
19 the action and knowledge of these, two, can be attributed and a  
20 basis to find essentially a nationwide policy of the  
21 organization itself?

22 And, and exactly, besides sort of ignoring, for instance,  
23 high error rates, is there anything affirmative here that's  
24 alleged?

25 **MR. VOLDMAN:** So, Kaiser was aware of high error rates

1 and external providers, yet they did nothing to correct them.  
2 Instead, only correcting the upside for them. With the  
3 knowledge of high error rates in external provider coding, that  
4 is definitionally knowledge of false claims, as our external  
5 chart review scheme lays out. Because when there were  
6 mismatches in the data, correcting one way means the other way  
7 that's not corrected is false claims.

8 And --

9 **THE COURT:** How did they know that these wrong-way  
10 error rates were the result of inappropriate diagnoses or  
11 violations of ICD guidelines, or the result of false diagnoses,  
12 et cetera, et cetera?

13 **MR. VOLDMAN:** Sure. So we allege that Kaiser, in  
14 blind chart reviews -- meaning that Kaiser coders didn't know  
15 what providers previously submitted -- were told to follow  
16 coding guidelines as required by the ICD and the industry. And  
17 that the result of them following coding guidelines were  
18 mismatches between its provider-submitted codes and Kaiser  
19 coder-generated codes. Those mismatches were, again, only  
20 submitted when they benefited Kaiser, and not deleted from CMS  
21 systems when they would have cost Kaiser money.

22 With the combination of knowing that external providers --  
23 which is the chart review program's focus -- were  
24 extraordinarily high error rates from various audits, including  
25 year-to-year audits in several regions and Ms. Morrisette's

1 KFHB audit that went back as early as 2009, that is a violation  
2 of the False Claims Act.

3 It's true that Kaiser could have not matched up those two  
4 sets of data, but that is a classic example of an ostrich  
5 burying its head in the sand.

6 **THE COURT:** So the systemic behavior is doing  
7 something about under-reporting errors, and ignoring  
8 over-reporting errors, even though they were clearly extant.

9 **MR. VOLDMAN:** Correct. And that is FCA's scheme  
10 recognized by the courts in *Anthem*, *Poehling*, *Ormsby* and  
11 *Swoben*.

12 **THE COURT:** Is there anything more in terms of  
13 recognizing what the cause of the -- the downside error rates  
14 were?

15 **MR. VOLDMAN:** Sure. So we allege that the cause of  
16 all the downside error rates was non-compliance with ICD  
17 guidelines, and lack of support in the medical record. That is  
18 the reason they're false; that is the reason that Kaiser  
19 audits, year after year, identified this set of codes as false.

20 It's correct that there's a myriad of specific ways that  
21 these codes could be false. They could be not clinically  
22 supported, as Kaiser pointed out. They could be typos, which  
23 is the same thing, because if it's the wrong ICD code, it's not  
24 clinically supported.

25 But it could be the wrong provider type. It could be a

1 not face-to-face visit. It could be a provider excluded from  
2 Medicare. It could be someone that's not a doctor diagnosed  
3 it, or an NP, or anything else like that. It could be  
4 something that didn't affect patient care.

5 It's true there's going to be a myriad of reasons. But  
6 audit after audit identified this set of codes as having  
7 downside risk for Kaiser, and they chose to ignore it.

8 **THE COURT:** So, so you call it this sort of willful  
9 blindness, essentially, that's the basis of culpability and  
10 attribution to KFHP here.

11 **MR. VOLDMAN:** Yes. Despite knowing of high error  
12 rates and this set of data, they did nothing to fix them, and  
13 they kept signing attestation after attestation saying that  
14 their risk adjustment data was accurate, complete and truthful.  
15 Something that *Swoben* said, when a scheme like this was  
16 running, is impossible to attest to truthfully.

17 **THE COURT:** Is it necessary that KFHP had to know what  
18 the error rates were of, let's say, external providers versus  
19 internal, or any more details as to what percentage of the  
20 errors were due to certain causes?

21 **MR. VOLDMAN:** Not necessarily. But the fact here is  
22 they did do specific audits of external providers, and then did  
23 -- set up a chart review program designing a review of those  
24 external providers, while not fixing any of those downside  
25 errors, as you put it.

1 And, but, like the *Swoben* court recognized in its  
2 collective pleading allegation, like, these -- KFHB and Kaiser  
3 Health Plan of Colorado are in the same business. They run  
4 health plans that try to maximize profit and maximize revenue  
5 generation from CMS. They are in the same business, much like  
6 the *Prime* case recognized, of running health plans. They are  
7 identical actors in terms of running health plans.

8 **THE COURT:** What about on the question of materiality,  
9 especially under *Escobar*? Wouldn't it be necessary to  
10 establish materiality to know what the -- what the basis of  
11 errors were?

12 **MR. VOLDMAN:** So the basis of the errors is the fact  
13 that the diagnosis codes aren't supported. It's true that the  
14 underlying reason for their lack of support could vary from  
15 code to code, and most likely, does. But the basis of the  
16 errors, that they did not meet medical record documentation  
17 support as required by the ICD guidelines, the contract and  
18 other CMS regulations.

19 And in case after case -- *Swoben*, *Poehling*, *Ormsby*,  
20 *Anthem* -- the government or relators that have been allowed to  
21 proceed past the pleading stage do not list out a code-by-code  
22 or even a bucket-by-bucket reasoning of why every code isn't  
23 true. The health plan has that information. They identified  
24 this as a universe of codes that isn't supported, and refused  
25 to correct it.

1           **MR. PORTNOI:** Your Honor, may I be heard?

2           **THE COURT:** Yes.

3           **MR. PORTNOI:** So, a few things here, because you've  
4 covered a number of topics with Mr. Voldman just now.

5           The first is Mr. Voldman has said many times they did  
6 something or Kaiser did something, but the crux of your  
7 question is: What did KFHP do, versus what did Kaiser Colorado  
8 do.

9           And KFHP was not involved, was not -- is not alleged to  
10 have set up this one-way chart review program. And the actual  
11 allegations in Dr. Taylor's complaint made clear that there was  
12 very little actual knowledge or participation by KFHP.

13           Mr. Tholen presented a report about tracking risk score to  
14 capture as much revenue as possible. That's on Paragraph 88.  
15 But the allegation does not plausibly suggest that Mr. Tholen  
16 or KFHP engaged in fraud.

17           Ms. Diane Morrissette, who Mr. Voldman just referenced at  
18 Paragraphs 92 and 113, had one audit in 2004-2005, where there  
19 was no allegation about what the audit found. And, whether  
20 Ms. Morrissette knew about any actual improper data submissions  
21 to CMS following the audit.

22           Significantly, that audit took place before the risk  
23 adjustment system was fully implemented. Before any risk  
24 adjustment data was submitted to CMS.

25           And then in 2009, Ms. Morrissette simply stated that

1 external provider codes were less well-monitored than those of  
2 Kaiser internal physicians, and more likely to have higher  
3 error rates, which is just a truism. It's just a fact that  
4 when you are talking about external providers, providers that  
5 are not your employees, you are going to have less control over  
6 that, to begin with.

7 Turning, though, however, to more fundamentally the Taylor  
8 materiality and falsity issue with respect to external  
9 providers, there's really a remarkable statement Mr. Taylor has  
10 made in the briefs and has made here, which is that they don't  
11 -- is that relators don't have to describe anything about the  
12 false claims, including the basic facts about why there's an  
13 error, and why something is in error.

14 It's an essential statement that in a False Claims Act  
15 case, Rule 9(b) doesn't apply. You don't need to say how  
16 something was false. You don't need to say why something was  
17 false. You don't need to identify a false statement. You  
18 simply need to say: My opponent is a fraudster. They have the  
19 information in their files. They can go look for it.

20 That's not the way Rule 9(b) works. And that's not the  
21 way -- and that simply turns everything, not just with respect  
22 to the False Claims Act, but with respect to Rule 9(b), on its  
23 head.

24 **THE COURT:** Well, the assertion isn't quite that broad  
25 The claim is that there were -- as I understand it, that there

1 were submissions that were not -- that were not -- the  
2 diagnostic codes, themselves, were erroneous. There may be a  
3 variety of reasons why they're erroneous, such as not being  
4 diagnosed as a current condition, or misdiagnosed.

5 But, so I wouldn't say it was just saying: You're a  
6 fraudster. I mean, there's something to it. The question is  
7 what level of detail needs to be explicated in order to have a  
8 -- state a cause of action here.

9 **MR. PORTNOI:** Right. And some of those reasons ought  
10 to be alleged. That's the how of fraud. And at Footnote 13 of  
11 their brief, Mr. Voldman even goes so far as to say any typo,  
12 no matter how insignificant and regardless of how described, is  
13 enough to allege a False Claims Act case. I'm describing the  
14 theory that they are presenting.

15 And, that is simply not the case. There needs to be some  
16 understanding for both the external provider claims and the  
17 natural language processing claims about what is actually false  
18 when it comes -- so that we have some ability to defend against  
19 this.

20 And there -- you know, there's not a rule that one-way  
21 chart review is inherently wrong. And I agree that that is a  
22 practice that is more specific that is alleged in the Taylor  
23 complaint. But the holding in the Ninth Circuit's decision in  
24 *Swoben* upon which Mr. Voldman just relied was narrow. Because  
25 what it alleged was that the MAOs in that case "designed

1 retrospective reviews --" I'm quoting now, "of enrollees'  
2 medical records deliberately to avoid identifying  
3 erroneously-submitted diagnoses that might otherwise have been  
4 identified with reasonable diligence."

5       And doing so -- I finished the quotation -- with  
6 substantial error rates that were already present. And this is  
7 something that's very significant here, when we're talking  
8 about this, is that *Swoben* relies on the idea that the one-way  
9 chart review was designed after the defendant in that case had  
10 very poor -- what are called CMS risk adjustment validation  
11 audits or RADV audits, and error rates in excess of 20 percent.  
12 Having error rates in excess of 20 percent, they designed this  
13 program. And that's how you got to something that was false,  
14 knowingly false, materially false. Because -- in the face of  
15 that.

16       Now, RADV audits are conducted against every single MAO.  
17 And in almost any case I've ever seen, RADV audits are cited in  
18 the complaint of every relator and in every DOJ complaint.  
19 We're not -- and in this case, not a single -- not the DOJ, not  
20 any of the three relators that are here today, nor Ms. Osinek,  
21 nor the relators that were dismissed on first to file, chose to  
22 say anything about the RADV audits of Kaiser's.

23       And as a result, that's something that the Court can take  
24 in as an inference. That this is very different from *Swoben*,  
25 specifically because you don't have a program designed after

1 having these high error rates already placed at issue.

2 **THE COURT:** Instead, you have an after-the-fact  
3 turning a blind eye, is what is essentially alleged.

4 **MR. PORTNOI:** Well, if turning -- turning a blind eye,  
5 but we don't know what they are turning a blind eye to because  
6 we don't know what the errors are. And that's the issue, is  
7 that there has to be some allegation of in what way they were  
8 false. Otherwise, the requirement of how in Rule 9(b) has no  
9 meaning.

10 **THE COURT:** Does it matter?

11 If there's a wrong diagnostic code, if it's erroneous for  
12 one of a number of reasons, does it matter precisely why?

13 If you know that there are -- 40 percent of these codes  
14 are inaccurate, and that money is being -- and these are being  
15 submitted, and money is being paid by the federal government  
16 for erroneous codes, does it matter whether it's due to failure  
17 to comply with the existing condition requirement, or simply a  
18 misdiagnosis or something else?

19 **MR. PORTNOI:** Of course it does, Your Honor, because  
20 the False Claims Act only goes to preconditions for payment.  
21 It could be wrong because it violates an internal Kaiser  
22 standard. It could be wrong because it violates sub-regulatory  
23 guidance that isn't something that is seen as a condition of  
24 payment. This is -- this goes to falsity.

25 It also goes to materiality, Your Honor. This is exactly

1 the argument that the United States made in *Escobar*, where a  
2 question was posed as a hypothetical there, and this made it  
3 into the opinion, where the -- where the Supreme Court, one of  
4 the justices asked: Well, what if the contract said that you  
5 -- that the company had to buy American-made staplers only?  
6 And they went out and they bought foreign-made staplers. And  
7 then they signed an attestation that stated that they've  
8 followed all the rules.

9 And the Supreme Court described this ex- -- and the United  
10 States said in a response: That would violate the False Claims  
11 Act. And that would give rise to a False Claims Act claim.

12 And the Supreme Court treated that as an absurd  
13 proposition. That there has to be some evidence, some facts at  
14 this stage that give rise to an inference that the government  
15 thought of this as material. And that the -- and, and in  
16 addition, that there was some way in which we know the error.

17 We can't get to materiality. We don't know the error.  
18 The question is: Does the government find this kind of error  
19 material? And we don't know what "this kind of error" is in  
20 the Taylor complaint.

21 **THE COURT:** Let me hear the response to that, that you  
22 need to know the nature of the error to know whether it's  
23 material.

24 **MR. VOLDMAN:** Sure. So first, as Mr. Portnoi pointed  
25 out, it's true that CMS does RADV audits. And when CMS asked

1 for money back in RADV audits, they asked for money back for a  
2 myriad of reasons, not making a distinguishment between which  
3 reason of violating ICD coding guidelines or other CMS guidance  
4 it's being asked back for.

5 Second, on the *Swoben* point, I just want to point out that  
6 this case -- *Swoben* controls this case. In Paragraph 107, we  
7 alleged that starting in 2007, high error rates were shown in  
8 Kaiser's internal audits.

9 It's true that RADV is not mentioned -- or Kaiser's RADV  
10 audits are not mentioned in that case. But it's also true that  
11 not every MAO, not every contract is RADV'ed every year, and  
12 these things are relatively rare occurrences.

13 So since 2007, we're showing error rates of 22 percent,  
14 67 percent, 17 percent in the Colorado region with Kaiser's own  
15 audits.

16 Then, at Paragraph 119, we allege that they designed a  
17 retrospective chart review system, ignoring these error rates  
18 and only correcting the error rates that help them.

19 It's true, again, that the *Swoben* decision used the  
20 language that it's deliberate design. But that's not a  
21 standard False Claims Act. Intent is not a requirement.  
22 Knowledge is.

23 Kaiser, through its own audits, and through industry  
24 knowledge, knew of high error rates. They decided to correct  
25 only the ones that would help them. They decided to ignore the

1 ones that wouldn't.

2 And that's been held to be an FCA violation, nearly every  
3 time a court has seen this. Be it *Poehling*, *Swoben Ormsby*, or  
4 *Anthem*, most recently.

5 **THE COURT:** What about the question of materiality?  
6 Why wouldn't the cause of those error rates -- you're saying  
7 it's irrelevant. As long as it's error, that's it?

8 **MR. VOLDMAN:** So I'm saying that as long as Kaiser  
9 knows that it violated CMS or ICD guidelines, it's true that  
10 there's going to be several reasons that is. Whenever that's  
11 true in a RADV audit, there's no distinguishment in whether  
12 they take money back because it was the wrong provider type, or  
13 whether it was a clinical condition, or whether it wasn't  
14 diagnosed in the medical record.

15 And when OIG does similar audits, they ask for money back  
16 for the same reasons. Because they didn't meet the type of  
17 guidance and documentation standards set up by CMS.

18 **MR. PORTNOI:** Your Honor, briefly?

19 **THE COURT:** Yeah, briefly. Then I'm going to move on  
20 to the next --

21 **MR. PORTNOI:** Absolutely.

22 **THE COURT:** Yeah.

23 **MR. PORTNOI:** Your Honor, Mr. Voldman's complaint  
24 doesn't match what he just said. There is no allegation that  
25 the errors necessarily were violations of CMS guidelines or ICD

1 guidelines. They're just errors.

2 They're just: We don't -- far from what ought to be  
3 there, which is that they violate a particular kind, they --  
4 they instead are -- they simply are error rates without any  
5 subsequent, subsequent explanation.

6 And keep in mind, Dr. Taylor was effectively the director  
7 of coding. He knows what these errors are. He states that he  
8 looked personally at 100 claims, and found that ten of them had  
9 errors. He knows what they are. He just does not want to  
10 allege them, for reasons that I don't know. But this complaint  
11 has already been amended before. There was the opportunity to  
12 do so.

13 So Your Honor, there needs -- there does need to be an  
14 allegation regarding the why of falsity, and the error.

15 **MR. VOLDMAN:** I'm sorry, Your Honor --

16 **THE COURT:** In particular, you're saying that there is  
17 no allegation of, for instance, an ICD guideline violation. Or  
18 the reg.

19 **MR. PORTNOI:** When they're talking about error rates,  
20 they don't explain anything about what those error rates mean.

21 **THE COURT:** All right. Brief response to that.

22 **MR. VOLDMAN:** Sure. In the complaint, we explain the  
23 CMS rules, the CMS need for accuracy, and the attestation  
24 standard for accuracy. And then, it's true, we reference  
25 errors obviously against that standard.

1           It's true if you pick it apart paragraph by paragraph, we  
2 don't redefine what "error" means in each paragraph. But the  
3 complaint, seen as a whole, clearly lays out a standard for  
4 accuracy as required by CMS. And "error" means a violation of  
5 that standard of accuracy.

6           **MR. PORTNOI:** But Your Honor, they're quoting --  
7 they're quoting supposed Kaiser employees, whether it's KFHP or  
8 Kaiser Colorado, and saying that there's an error here. But  
9 they don't -- they're not saying that that error that the  
10 person is talking about in some audit relates to a CMS or ICD  
11 guideline. They don't know.

12           They do know that Dr. Taylor reviewed some of these  
13 charts, and they know what Dr. Taylor thought when he reviewed  
14 those charts, and what kind of errors were there. They just  
15 don't allege it.

16           **THE COURT:** Let me ask counsel for Taylor, can you  
17 identify it so I can look at it later, what are the paragraphs  
18 that state that these high error rates, these one-sided error  
19 rates that weren't adjusted for, were those that violated, for  
20 instance, ICD guidelines or regs?

21           **MR. VOLDMAN:** So beginning at Paragraph 93, we state  
22 that a lot of these audits were simulated RADV audits, which is  
23 clearly the same standard as Mr. Portnoi pointed out that is  
24 pled in other complaints.

25           And then, by Paragraph 107, we go on and -- 106, we go on

1 to compare internal versus external providers against that  
2 standard. "Error" clearly means in a hypothetical practice  
3 RADV audit here.

4 It doesn't mean -- and Mr. Portnoi, of course, isn't  
5 laying out what else it could mean. He's just saying that we  
6 didn't define "error" every time we used it.

7 **THE COURT:** I mean, it has error rates, but where does  
8 it say that the error rates were for -- were the result of, for  
9 instance, non-compliance with ICD guidelines?

10 **MR. VOLDMAN:** So the RADV standard is the standard  
11 that CMS puts out for plans to comply with CMS standards, and  
12 that's discussed in Paragraph 93 as what the probe audits are  
13 preparation for. And then, the results of the probe audits, or  
14 least amalgamations of them to show year-by-year trends, come  
15 in Paragraphs 106 and 107, for example.

16 And there are other places in the complaint as well where  
17 specific hospitals, for example, in 109, show that the probe  
18 audit found very high error rates. In, for example,  
19 St. Joseph, one of the hospitals in the chart review program.

20 But probe audits begins to be defined in Paragraph 93 as  
21 the reason -- they match RADV standards, or are meant to  
22 simulate RADV standards.

23 **THE COURT:** All right. I'll take a closer look at  
24 that. Thank you.

25 **MR. VOLDMAN:** Thank you.

1           **THE COURT:** Let's go on to the Bryant and Hernandez  
2 motion here.

3           Let me make sure I understand what the scope of the  
4 complaint is in this particular instance. There's a lot of  
5 focus on aortic atherosclerosis, and vent dependence.

6           Is that the focus in terms of the problem areas here? Or  
7 is it a broader focus on all sorts of other things?

8           **MR. LEWIS:** It is a broader focus, Your Honor. I  
9 think when we were pleading the Medicare Advantage part of our  
10 case, or actually amending our complaint to plead it, we  
11 recognized that we weren't the first to file on a number of  
12 diagnoses, so we pleaded it, AA and vent dependence in  
13 particular, as to Medicare Advantage.

14           But now that we're limited by the first-to-file order to  
15 Affordable Care Act, certainly those two diagnoses are relevant  
16 to the Affordable Care Act, as well as are all our other  
17 allegations that there was systemic fraud on the ACA program --  
18 and on Medicare Advantage, frankly, but obviously Your Honor  
19 has limited our claims at this point to ACA -- arising from  
20 Kaiser's, you know, systemic over-coding, over-documenting,  
21 over-submitting, of a whole bunch of codes impacting their risk  
22 adjustment portfolio and rating relevant to the Affordable Care  
23 Act.

24           **THE COURT:** So your complaint under the ACA is not  
25 restricted to AA and vent dependence; those are just examples?

1           **MR. LEWIS:** Those are just examples, Your Honor. And  
2 the vent dependence is a particularly good one for the  
3 Affordable Care Act, because it was a scheme that was  
4 implemented particularly on newborns, a population that would  
5 not be relevant to Medicare Advantage, but is certainly  
6 relevant to Affordable Care Act

7           Risk adjustment of newborns is a -- and gaming that system  
8 would be an Affordable Care Act issue, in particular. It was  
9 migrated eventually to Medicare Advantage as well, so it's  
10 relevant there. But, certainly as to Affordable Care Act.

11           **THE COURT:** All right. Let me hear defendant's  
12 response.

13           **MR. PORTNOI:** Your Honor, the main issue here is that  
14 we don't have -- we don't have -- as said in our papers, the  
15 relators don't identify a single allegedly fraudulent code or a  
16 single attestation that was submitted to HHS under the ACA's  
17 risk adjustment program.

18           Your Honor recognized in the first-to-file order that the  
19 ACA claims state causes of action entirely different and  
20 distinct from the Medicare Advantage claims. It's not enough  
21 to simply describe conduct that mostly related to the Medicare  
22 Advantage program -- as Mr. Lewis just described, the amendment  
23 was made to migrate, to bring it over to the Medicare Advantage  
24 program -- and then simply allege that the fraud on the ACA  
25 program was the same. That we have simply tacked on

1 allegations that fail to satisfy both Rules 8 and 9.

2 And so, no, Your Honor, I don't -- it simply doesn't work.  
3 And especially, for instance, doesn't work for materiality  
4 allegations. We don't have any statement here that HHS finds  
5 these materials. We don't have a statement that HHS has ever  
6 brought a single enforcement action or sought a single refund  
7 from anyone for an ACA claim. And that makes good sense.  
8 There's a reason that it would be different.

9 The materiality analysis would be different, Your Honor.  
10 And that's because the government doesn't keep the money. The  
11 money goes to HHS, and then HHS distributes it to other  
12 providers.

13 In fact, Your Honor, with respect to the ACA commercial  
14 risk adjustment program, some -- some -- some companies receive  
15 funds out of this, and some companies give funds in. The  
16 complaint doesn't even allege that for any particular year,  
17 Kaiser received a penny out of this program.

18 **THE COURT:** Well, net. I mean, net-wise. But there  
19 is -- there is some transfer of payment. There is payment, is  
20 there not?

21 **MR. PORTNOI:** If your population in a particular  
22 state, Your Honor, is -- is less healthy than the average, then  
23 you -- then you are -- then you are a recipient. If you are  
24 more healthy, then you -- then you provide -- then you pay --  
25 then you pay money in.

1           There simply isn't even that allegation to allege that  
2 Kaiser made a claim, much less a false claim, here. And that's  
3 simply -- that's fatal to this complaint.

4           With respect to AA and vent dependence, Your Honor, it's  
5 important to note that what the complaint is alleging is not in  
6 this case a violation even of the ICD guidelines. What we're  
7 talking about is a HEMA guidance, guidance of a third party,  
8 often in emails that were simply sent on, not in something that  
9 was published.

10           This would require -- under the relators' theory, the  
11 company could be sued under the False Claims Act for violating  
12 any standard posted to the internet by anybody. And that  
13 similarly does not get you to a False Claims Act claim with  
14 respect to either aortic atherosclerosis or vent dependence.

15           **THE COURT:** Let me hear the response, that given the  
16 ACA context, there are lots of elements missing here. Payment,  
17 materiality.

18           **MR. LEWIS:** Yes, Your Honor. Thank you.

19           Well, first of all, Kaiser would have the Court ignore all  
20 the details in our complaint that are true-up and apply to both  
21 ACA and Medicare Advantage fraud.

22           You know, while we are foreclosed at this time by the  
23 Court's first-to-file order from pursuing claims based on  
24 Medicare Advantage fraud, the mechanics of the fraud is  
25 essentially the same. Committed by the same Kaiser personnel,

1 corporate entities, and the same --

2 **THE COURT:** But the payments, it's a different source,  
3 and a different submission source.

4 **MR. LEWIS:** Yeah.

5 **THE COURT:** How do you deal with that?

6 **MR. LEWIS:** So, what -- what Kaiser benefited from,  
7 from its risk adjustment fraud, the same fraud as it relates to  
8 the ACA, is that it got more of the pool than it should have  
9 gotten.

10 Sometimes it got payments from the pool or sometimes it --  
11 and those payments were too high. Sometimes it had to pay into  
12 the pool, but those payments were too low. Either way, it  
13 benefited. And that pool is populated in part by federal  
14 funds. In the form of premium -- premium contributions and tax  
15 breaks that the government provides to beneficiaries. That's  
16 the false claim. It happens at least every year when Kaiser  
17 submits what it's owed or not owed from the fund.

18 And frankly, Your Honor, it may be that there are many  
19 false claims that underlie it, every time, for example, they  
20 submit a risk adjustment code that's non-bona fide. But, at  
21 least those claims are false.

22 And they are also material, Your Honor. The ACA, itself,  
23 makes clear that payments under the ACA are subject to the  
24 False Claims Act. And it goes on to say in that same section,  
25 that payments are material. That -- I'm sorry -- that the idea

1 of qualification of the entity is material to payment.

2 So, defendants would say that's not a sufficient statement  
3 of materiality under the statute, and we would take issue with  
4 that. Because payments are subject to the False Claims Act,  
5 and are thus, per se, material.

6 We do allege in our complaint, Your Honor, in Paragraphs  
7 152 and 154 that the United States, unaware of the falsity of  
8 the record statements and claims made, has paid money that it  
9 otherwise would not have paid.

10 In 154 we say that the risk adjustment attestation  
11 submitted by the Kaiser defendants each year are a reminder to  
12 the Kaiser defendants that -- their obligation to submit valid  
13 data and to promptly correct invalid data. They also have a  
14 direct impact on the government's risk adjustment payments.

15 Now, we use CMS and the Medicare Advantage program as  
16 examples in those paragraphs. It's true. But we were alleging  
17 more broadly that they're material to both programs.

18 **THE COURT:** What's an example of a false statement  
19 submitted to -- I guess it goes to HHS?

20 **MR. LEWIS:** Yes, Your Honor. Yeah.

21 **THE COURT:** Where do I see that in this -- I know you  
22 do it by analogy to CMS and Medicare Advantage, but that's by  
23 analogy. What -- where is you have to allege a false payment  
24 and false submission of a claim here to the funding agency?

25 Where do I find that?

1           **MR. LEWIS:** I think the best source, Your Honor, would  
2 be in some of the opening paragraphs. And if our language is  
3 inadequate, we can certainly amend.

4           Paragraphs 7 and 8, 10(b), and 49 and 50 all allege sort  
5 of the basic mechanics of how the ACA works. Including that  
6 the insurer makes claim into the pool for funds that it's owed,  
7 or less funds that it's not owed, based on its risk adjustment  
8 portfolio as --

9           **THE COURT:** What is the role of the ICD guidelines  
10 with respect to the ACA and submission to HHS?

11           **MR. LEWIS:** Yeah, the ACA makes clear in its  
12 regulations that they're incorporating ICD and the Medicare  
13 Advantage standards into the acts. And we cite the CFR  
14 sections for that proposition, Your Honor.

15           Let me get --

16           **THE COURT:** So that is the source of the falsity? I  
17 mean, that's the connection. That if it's false -- if it was a  
18 false claim -- would have been a false claim with respect to  
19 CMS, because the same requirements under the Medicare Advantage  
20 and the ICD standards apply, that submission in violation of  
21 those standards, HHS was also false claims.

22           **MR. LEWIS:** I think that's right, Your Honor.

23           **THE COURT:** There's no independent -- that's your  
24 bridge. The incorporation of Medicare Advantage and the ICD  
25 guidelines.

1           **MR. LEWIS:** At this time, Your Honor, that's what we  
2 have.

3           **THE COURT:** All right. So what's -- let me ask  
4 defendant, what's wrong with that?

5           **MR. PORTNOI:** Well, Your Honor, these regulations are  
6 not cited in the complaint as demonstrating the falsity, so  
7 this is something that -- and there's -- they don't say  
8 anything saying that there's an ACA regulation that applies the  
9 ICD guidelines, in total.

10           But going to materiality, which makes this a much easier  
11 case for you, Your Honor, *Escobar* stated that a threadbare  
12 recital that the government would not have paid a claim if it  
13 had known of the conduct is insufficient.

14           We don't have a threadbare recital, Your Honor. We don't  
15 have a single paragraph, we don't have a single sentence, we  
16 don't have a single word that says that HHS would not have done  
17 something, that HHS might not have done something, that HHS had  
18 the power not to do something. The latter of which would be  
19 far from sufficient.

20           Again, in all of those things, if that threadbare recital  
21 were present, the complaint would still be insufficient,  
22 because it would lack facts that meet what the Supreme Court  
23 called the very demanding standard of materiality. Facts that  
24 give rise to an inference that HHS, in fact, would not have  
25 paid the claim. Facts that would include situations where HHS

1 has asked for money back in the past, situations where HHS has  
2 taken enforcement actions, situations where HHS has issued  
3 advisories on this issue, or situations where there have been  
4 prior FCA actions on this.

5 And they don't have that. I'm not hearing that they plan  
6 to amend to add those in. And on that basis, any amendment  
7 would be futile.

8 **MR. LEWIS:** Your Honor, just to respond quickly?

9 **THE COURT:** Yeah, I take it your assertion is that:  
10 Well, if it's material under -- with respect to CMS, under,  
11 under Medicare Advantage program, it would be -- you can infer  
12 it would be material to HHS, under the ACA.

13 **MR. LEWIS:** If they're material under one program  
14 they're material to both, because the HHS, which by the way CMS  
15 is a division of, said at 45 C.F.R. 153.610 that it herits  
16 (Phonetic) to the criteria and methods of the Medicare  
17 Advantage program, are mandated for ICD compliance under the  
18 ACA.

19 So yes, the answer, in short, is yes. And in terms of  
20 amendment and futility, Your Honor, obviously if Your Honor  
21 finds what we have already alleged to be insufficient, which we  
22 don't believe to be true, we would certainly review contracts,  
23 language and the regs even more thoroughly, and find  
24 potentially some more things to put in the amendment.

25 **THE COURT:** I guess, you know, you're asking for an

1 inference and an equation, but how do we know that? I mean, we  
2 don't -- there's no history cited. There's no -- I don't  
3 remember if you cited a regulation from HHS.

4 **MR. LEWIS:** Yes, we do. We do in our brief,  
5 Your Honor, 45 C.F.R. 153.610.

6 **THE COURT:** That's not in the complaint.

7 **MR. LEWIS:** That's correct.

8 **THE COURT:** And you would cite that that reg enforces  
9 your equation, your ability to sort of import CMS/Medicare  
10 Advantage.

11 **MR. LEWIS:** That's a reg that gives the folks that are  
12 contracting with our issuers like Kaiser the ability to import  
13 ICD rules into their contracts, just like they do for Medicare  
14 Advantage. And if given the chance, I think we can establish  
15 that those terms, in fact, wound up in those contracts.

16 **THE COURT:** All right. Well, this is helpful. At  
17 least I understand the parties' position.

18 **MR. PORTNOI:** Your Honor, may I make a brief point?

19 **THE COURT:** Yeah, briefly.

20 **MR. PORTNOI:** Well, the first issue is, again, none of  
21 that -- even if the regs say what he says, again, having not  
22 been pleaded, that none of that gets to materiality. These are  
23 still two entirely different programs.

24 And critically, that is what got this complaint past the  
25 first to file, is the idea that these are different programs

1 that make different calculations, and that there are  
2 fundamentally different schemes that Kaiser engaged in for  
3 both.

4 And to be honest, there's a potential judicial estoppel  
5 problem here, and there's a problem where potentially what we  
6 have is that the first-to-file order may have been based on the  
7 premise that these are entirely different programs and entirely  
8 different schemes, and we may -- and that, as a result, that  
9 may be something based on these new representations that  
10 requires a different result for the first-to-file order.

11 **MR. LEWIS:** All we said, Your Honor, is they were  
12 entirely different victims. A risk adjustment scheme was  
13 perpetrated on two different government victims, in much the  
14 same way. And we said that in the prior briefing, and in this  
15 one.

16 **THE COURT:** Well, all right. I'm not sure I see a  
17 judicial estoppel question, but I do see a potential factual  
18 question, that you're presuming that what is material in one  
19 context is material to an agency in a different context. And  
20 perhaps that can be inferred, but it's -- that does take an  
21 inference here.

22 **MR. PORTNOI:** And Your Honor, we just heard, there are  
23 two completely different victims.

24 **THE COURT:** Well, different victims, but it may be a  
25 parallel program, so one could presume or infer that they might

1 act in the same way.

2 If, for instance, ICD, particularly the -- you would say  
3 it's not important, they would say important -- aspects of the  
4 IDC (sic) guidelines is central to documenting entitlement.

5 You know, whether it is as important to HHS as it is to  
6 CMS, you know, I guess they would say the regs indicate so.  
7 But I'm not sure. I'll have to take a closer look at that.

8 **MR. PORTNOI:** Thank you, Your Honor.

9 **THE COURT:** Thank you, counsel. I know there's a lot  
10 of other things we didn't cover, but this was very helpful in  
11 at least covering the high points. And I needed to hear from  
12 the parties. So I thank you for your input.

13 I'll take the matter under submission. Thank you.

14 (Counsel thank the Court)

15 (Proceedings concluded)

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**CERTIFICATE OF REPORTER**

I, BELLE BALL, Official Reporter for the United States Court, Northern District of California, hereby certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

*Belle Ball*

\_\_\_\_\_  
/s/ Belle Ball

Belle Ball, CSR 8785, CRR, RDR

Monday, November 21, 2022