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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

NOTICE OF MOTION AND MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: May 4, 2023
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

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 **NOTICE OF MOTION AND MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: May 4, 2023 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 **NOTICE OF MOTION AND MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: May 4, 2023 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

NOTICE OF MOTION AND MOTION

TO THE COURT, ALL PARTIES, AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE that, on May 4, 2023, at 1:30 p.m., or as soon thereafter as counsel may be heard, in the courtroom of the Honorable Edward M. Chen (Courtroom 5) of the above-entitled Court, located at 450 Golden Gate Avenue, San Francisco, California 94102, Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Washington Permanente Medical Group, P.C.; and Northwest Permanente, P.C. (collectively, "Defendants") will and hereby do move this Court to dismiss Relators Gloryanne Bryant and Victoria Hernandez's Second Amended Complaint ("SAC"), Dkt. No. 238, under Federal Rule of Civil Procedure 12(b)(6).

Defendants bring this Motion on the grounds that Relators' SAC fails to cure the pleading deficiencies identified in the Court's November 14, 2022 motion-to-dismiss order, Dkt. No. 226, and also introduces new defects. The Court should dismiss Relators' claims for relief premised on their new allegations that Defendants manipulated tax credits provided under the Affordable Care Act ("ACA") as well as their jurisdictionally barred Medicare Advantage allegations. The Court did not permit leave to amend to add the tax-credit theory, and the Medicare Advantage allegations were previously dismissed without leave to amend. The Court should also dismiss all of Relators' FCA fraud claims for failure to plead falsity and materiality. Relators' FCA fraud claims against all Defendants other than The Permanente Medical Group must additionally be dismissed because they are premised on implausible group allegations. Likewise, the Court should dismiss Relators' conspiracy claim because they fail to allege the existence of an agreement among Defendants to defraud the U.S. Department of Health and Human Services ("HHS"). In sum, the Court should dismiss Relators' FCA fraud claims with prejudice.

The Motion is based on this Notice of Motion, the accompanying Memorandum of Points and Authorities, any reply memorandum, and such other written and oral argument as may be presented to the Court.

Dated: February 2, 2023

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

After two motions to dismiss whittled down the *qui tam* complaint filed by Relators Gloryanne Bryant and Victoria Hernandez ("Relators"), only a sliver remained: Hernandez's employment retaliation claims against The Permanente Medical Group ("TPMG"). As their Second Amended Complaint ("SAC") makes clear, those retaliation claims continue to be the sole basis for Relators' involvement in these consolidated False Claims Act ("FCA") actions.

In response to Defendants'[1] first motion to dismiss, the Court held that the FCA's first-to-file provision jurisdictionally barred Relators' allegations of fraud on the Medicare Advantage program. When Defendants then moved to dismiss Relators' remaining claims for failure to state a claim under Rule 12(b)(6), the Court concluded that Relators failed to allege two key FCA elements—falsity and materiality—to support their contentions that Defendants similarly defrauded the Affordable Care Act ("ACA"). Despite being allowed an opportunity to amend their fraud claims under the ACA, Relators have returned with an SAC that repeats the same defects while introducing several more. They now purport to describe how the ACA program functions, but still fail to allege with specificity how and when Defendants submitted or caused to be submitted false risk-adjustment attestations to the U.S. Department of Health and Human Services ("HHS"). Relators also for the first time assert that Defendants manipulated tax credits provided under the ACA program, supporting their new theory with a "hypothetical and simplified"—indeed, fictional—example untethered from reality. The Court should again dismiss Relators' FCA fraud claims and end their misguided attempt to allege fraud on the ACA program.

First, the Court should dismiss out of hand Relators' claims for relief premised on the new tax-credit theory as well as their barred Medicare Advantage allegations. The Court did not grant leave to add the tax-credit theory, and the Medicare Advantage allegations were previously

[1] "Defendants" are Kaiser Foundation Health Plan; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group; Southern California Permanente Medical Group; Colorado Permanente Medical Group; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Washington Permanente Medical Group; and Northwest Permanente.

dismissed without leave to amend.

Second, the Court should again dismiss all of Relators' FCA fraud claims for failure to plead falsity. Critically, Relators have not alleged a false ***claim*** for money or property—their causes of action all rely on the submission of false risk-adjustment attestations to HHS, but they have not pleaded the any specific factual allegations about even one of these submissions. Nor have they explained why such an attestation constitutes a claim for money or property from HHS within the meaning of the FCA. The allegations of fraud on the ACA program fail for additional reasons: they are premised on implausible allegations that Defendants improperly diagnosed four specific medical conditions, and they do not plead specific facts to support an inference that all fifteen Defendants from several states across the country engaged in a widespread ***scheme*** to defraud the program. Relators do not even allege that Defendants received any funds under the ACA program. Their assertion that Defendants ***paid over $6 billion*** into the risk-adjustment program undermines any allegation of fraud. And Relators have done nothing to support their new—and procedurally improper—tax-credit theory other than make conclusory assertions that the alleged fraud somehow "caused the Government to overpay via ACA premium tax credits."

Third, Relators have again failed to allege materiality. As before, they rely on the part of the ACA that refers to a "material condition" of eligibility to participate in an ACA exchange, not materiality under the FCA. The Court rejected this argument once and should do so again. Relators also rely on regulatory language that references a "materiality threshold" for certain ACA data requirements, but that provision similarly does not concern materiality under the FCA.

Fourth, Relators' FCA conspiracy claim fails because they have not alleged facts that support the inference of an agreement among Defendants to defraud HHS through the ACA program. The Court previously directed Relators to "clarify in their amended pleading whether they are claiming one overarching conspiracy involving all Kaiser entities or rather multiple bilateral conspiracies (*i.e.*, between a health plan and its affiliated medical group)." Relators do no more than add boilerplate allegations of both types of conspiracies that do nothing to clarify their factual allegations.

Finally, Relators again rely on impermissible group pleading, lumping Defendants

together without making specific allegations against virtually any Defendant except The Permanente Medical Group ("TPMG").

II. BACKGROUND

A. The Affordable Care Act

In 2010, Congress enacted the ACA, which provides for "a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 576 U.S. 473, 478–79 (2015). Before the ACA, health plans could manage their risk by charging higher premiums or denying coverage to unhealthy individuals. Under the ACA, however, health plans can no longer deny coverage due to preexisting medical conditions. *See* 42 U.S.C. § 300gg-1; 45 C.F.R. § 147.108; *King*, 576 U.S. at 481. To encourage enrollment of both healthy and less healthy members,[2] Congress established the ACA's risk-adjustment program. *See* 42 U.S.C. § 18063. Both of these measures went into effect on January 1, 2014. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410-01. The risk-adjustment program redistributes funds from health plans with healthier-than-average members to those plans that have enrolled sicker-than-average members. 42 U.S.C. § 18063; *Vista Health Plan, Inc. v. U.S. Dep't of Health & Hum. Servs.*, 31 F.4th 946, 948 (5th Cir. 2022). In other words, the program transfers money ***among health insurers***—not between insurers and the United States. Congress did not authorize any appropriations for the program. *See* 42 U.S.C. § 18063 (not authorizing appropriations for ACA's risk-adjustment program). Each state can operate its own risk-adjustment program or rely on HHS to operate the risk-adjustment transfers on its behalf.

When HHS operates the risk-adjustment program, as it does in almost every state, it uses a multistep risk-adjustment methodology. *Vista Health Plan*, 31 F.4th at 948–49. For each member enrolled in a health plan, an actuarial risk score is calculated using demographic and diagnostic data to determine the predicted cost of insuring that enrollee. *Id.* To allow HHS to

[2] "Members" refers to the individual beneficiaries who are enrolled in the Medicare Advantage program or, where applicable, the ACA risk-adjustment program. Members become patients when they receive medical care as part of either program. Thus, for purposes of this Motion, the terms "members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

calculate this risk score, each health plan must "submit or make accessible all required risk adjustment data." 45 C.F.R. § 153.610(a). And each health plan "must engage one or more independent auditors to perform an initial validation audit of a sample of its risk adjustment data selected by HHS." *Id.* § 153.630. HHS then selects a subsample of the data validated by the independent auditor and conducts its own validation audit. *Id.* The health plans must also establish a "dedicated data environment" through which they provide HHS "access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data." *Id.* § 153.710.[3] The health plans must submit a final data report and confirm that the data in that report matches the data available to HHS (or describe any discrepancy between the two). *Id.* The risk scores for each member of a health plan are then aggregated to determine the plan's average risk score. *Vista Health Plan*, 31 F.4th at 948–49. Finally, a plan's average risk score is multiplied by the statewide average premium, yielding the dollar amount that a given health insurer will owe or receive for that plan for that year. *Id.* at 949.

In addition to adopting a risk-adjustment model, the ACA contains another significant reform—it "seeks to make insurance more affordable by giving refundable tax credits to individuals[.]" *King*, 576 U.S. at 482. This tax credit is paid to members or directly to health plans to offset the cost of insurance. *Id.*; 26 U.S.C. § 36B. Eligible members can use the credit to purchase insurance on an exchange in their home state—"basically, a marketplace that allows people to compare and purchase insurance plans." *King*, 576 U.S. at 479. Each health plan available on the exchange must provide a minimum level of essential health benefits. *Cmty. Health Choice, Inc. v. United States*, 970 F.3d 1364, 1367–68 (Fed. Cir. 2020). The ACA also categorizes plans as "bronze, silver, gold, and platinum, which are based on the percentage of essential health benefits that the insurer covers under each type of plan," with insurers paying the most under platinum plans and the least under bronze plans. *Id.*

Each taxpayer's credit is the lesser of either (1) the member's actual monthly premium or (2) an amount based on the member's income and the cost of the monthly premium for the

[3] If the health plan fails to provide access to this data—or provides data that fails to meet data-quantity and data-quality thresholds—HHS assesses a default risk-adjustment charge. 45 C.F.R. § 153.710(g).

"benchmark" plan in that member's market. *Id.* at 1369; 26 U.S.C. § 36B(b). The "benchmark" plan is always the second-cheapest silver plan available for purchase. *Id.*

B. Procedural History

Relators filed their original complaint on March 1, 2018. On June 6, 2021, this Court consolidated their suit with five related *qui tam* actions, including the first-filed *Osinek* action. Dkt. No. 61. The United States partially intervened in all six actions in July 2021. Dkt. No. 65. On November 15, 2021, Relators amended their complaint. Dkt. No. 117 ("FAC"). Their FAC, like the original complaint before it, alleged fraud on the Medicare Advantage risk-adjustment program. *See, e.g.*, *id.* at 2 (summarizing complaint as alleging a scheme to submit "false 'risk adjustment' information to [CMS] in order to improperly increase the amounts CMS pays" Defendants). The FAC barely referenced the ACA. *See, e.g.*, *id.* ¶ 51. The FAC focused on alleged diagnosis coding practices for two medical conditions—aortic atherosclerosis ("AA") and ventilator dependence—as well as general business practices at TPMG that Relators alleged resulted in the submission of false claims to the United States.

On January 18, 2022, Defendants moved to partially dismiss *Bryant* and the four other later-filed *qui tam* actions under the FCA's first-to-file bar, 31 U.S.C. § 3730(b)(5). Dkt. No. 141. As relevant, Defendants argued that the earlier-filed *qui tam* actions, which also focused on an alleged Medicare Advantage fraud, barred Relators' fraud claims relating to the Medicare Advantage program. *See id.* The Court granted the motion in part and dismissed all claims except: (1) claims of fraud related to the ACA's risk-adjustment program and (2) Hernandez's employment claims. Dkt. No. 171 at 46.

On June 21, 2022, Defendants moved to dismiss Relators' remaining causes of action for failure to state a claim under Rule 12(b)(6). Dkt. No. 182. The Court granted the motion as to the FCA claims involving the ACA program, finding that Relators failed to adequately allege both falsity and materiality. Dkt. No. 226 at 9 ("Order"). The Court held that Relators did not sufficiently plead that any false claims were submitted to HHS under the ACA program. *Id.* at 7. It also "found the claim of falsity problematic to the extent [Relators] assert that the scope of their case extends to upcoding a number of diagnoses made under the ACA program beyond the AA

and vent dependence codes described in the complaint." *Id.* at 8. The Court noted "the need for greater specificity in alleging a systemic scheme." *Id.* As to materiality, the Court again emphasized that Relators did not plead that false claims were submitted to HHS, and disagreed that the ACA's reference to materiality in the context of eligibility to participate in a healthcare exchange equated to materiality under the FCA. *Id.* at 8–9 (citing 42 U.S.C. § 18033(a)(6)(A)). The Court granted Relators "leave to amend their complaint to correct the deficiencies." *Id.* at 9.

C. Relators' Second Amended Complaint[4]

Relators filed a second amended complaint on December 12, 2022. Dkt. No. 238 ("SAC"). Like the FAC, the SAC names fifteen Defendants and retains allegations about TPMG's business practices and allegedly improper diagnosing of AA and vent dependence, even though Relators now readily concede that AA is not even risk-adjusted under the ACA program. *Id.* ¶ 93. The SAC also adds a few paragraphs accusing Defendants of improperly coding three additional medical conditions: arrhythmia, major depression, and malnutrition. *Id.* ¶¶ 142–52. Though the Court dismissed without leave to amend Relators' claims based on false submissions to the Medicare Advantage program, *see* Dkt. No. 171, the SAC retains all of the Medicare Advantage allegations—and even expands on them by, for example, alleging that Defendants' practices related to arrhythmia, major depression, and malnutrition applied to patients under both the Medicare Advantage and ACA programs. SAC ¶¶ 142–52. The most significant change between the FAC and the SAC is that Relators now describe in more detail how the ACA program works. *Id.* ¶¶ 51–87. Notably, these allegations largely purport to describe the regulatory structure of the program, rather than Defendants' conduct under the program.[5] *Id.*

[4] For the Court's convenience, **Exhibit A** to the Declaration of Kyle M. Grossman includes a redline comparing Relators' FAC to their SAC.

[5] Many of these new allegations either misstate or misconstrue the regulations. As one example, Relators state that "[b]inding ACA regulations require entities participating in the Exchanges to validate the data that they submit to the Government." SAC ¶ 69. But the regulation they cite outlines the requirements for the initial data validation, which is performed on only a "sample" of data by an independent auditor, not the health plans themselves. *See* 45 C.F.R. § 153.630(b). As another example, Relators assert that "[t]he insurer confirms that the data . . . is accurate by way of an attestation that legally and financially binds the insurer." SAC ¶ 71. But the provision that they cite merely requires the health plan to confirm that the data in the final data report matches the underlying data made accessible to HHS. 45 C.F.R. § 153.710(d). Nothing in that provision says anything about attesting to the accuracy of the underlying data or states that any

The SAC contends that Defendants' conduct under the ACA program defrauded the government in two ways. First, Relators allege that Defendants' "risk-adjustment payments are skewed." *Id.* ¶ 206. They contend that Defendants have "generally . . . reported ***a healthier patient base*** than other insurers," and as a result ***have paid over $6 billion into the ACA program*** from 2014 to 2021. *Id.* ¶ 208 (emphasis added). But according to Relators, Defendants' ACA members were even healthier than reported. *Id.* ¶ 209. So Defendants should have paid even more money into the ACA risk-adjustment pool than they did. *Id.* ¶¶ 209–10. Relators contend that, as a result, Defendants "unlawfully kept" government funds. *See id.* ¶ 210. Relators also assert—without pointing to any specific facts—that in some unspecified markets and unspecified years Defendants were "net recipient[s]" of funds under the ACA program, and for those markets and years, Defendants "unlawfully received Government funds." *Id.* ¶¶ 208, 210.

Second, the SAC adds a new theory of liability based on how tax credits are calculated under the ACA. *Id.* ¶¶ 211–19. This novel theory relies on a multi-step and complex causal chain:

- Defendants purportedly "upcoded" certain diagnoses to make their ACA members appear less healthy than they actually were.
- As a result, Defendants either paid less funds or received more funds than they otherwise would have from the ACA's risk-adjustment transfer program.
- Because of Defendants' alleged upcoding, other health plans paid more or received less than they otherwise would have.
- With the extra money that Defendants received or retained from the risk-adjustment pool, they lowered the cost of the premiums that they charged their ACA members.
- As a result, Defendants' "competitors [] unknowingly artificially raise[d] their own premium prices." *Id.* ¶ 214.

Relators assert that this ricochet of events all resulted in the United States paying more in tax credits, an outcome they illustrate with a "hypothetical and simplified example" consisting of dollar amounts that Relators' counsel admittedly invented. *Id.* ¶¶ 215–16.

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confirmation is "financially and legally binding." *Id.*

III. LEGAL STANDARD

To survive dismissal under Federal Rule of Civil Procedure 12(b)(6), Relators' complaint must "state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). This standard requires "more than a sheer possibility" that Defendants have acted unlawfully—Relators must plead "factual content that allows the court to draw the reasonable inference that [Defendants] [are] liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). In evaluating plausibility, "courts must also consider an 'obvious alternative explanation' for [the] defendant's behavior." *Eclectic Props. E., LLC v. Marcus & Millichap Co.*, 751 F.3d 990, 996 (9th Cir. 2014) (quoting *Iqbal*, 556 U.S. at 682). Dismissal is proper where there is a "lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1990). While well-pleaded facts must be accepted as true, the Court need not "'assume the truth of legal conclusions merely because they are cast in the form of factual allegations.'" *Fayer v. Vaughn*, 649 F.3d 1061, 1064 (9th Cir. 2011) (citations omitted).

Relators' fraud allegations also must comply with the heightened pleading standard of Rule 9(b), which requires a party to "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). The allegations must be "specific enough to give [a defendant] notice of the particular misconduct which is alleged to constitute the fraud so that [the defendant] can defend against the charge and not just deny that [it has] done anything wrong." *Bly-Magee v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001) (quotations omitted).

IV. ARGUMENT

Rule 9(b) does not permit Relators to proceed on their claims of fraud without specific factual allegations that support the plausible inference that such a fraud actually existed. Yet, in their SAC, Relators again rely on generalities and conclusory statements. Relators not only replead and supplement their jurisdictionally barred Medicare Advantage claims, but also add pages of statements on the ACA's regulatory structure without including a single non-conclusory allegation about Defendants' specific ACA business practices or diagnosis-coding protocols. Relators' reliance on the Medicare Advantage allegations has caused them to ignore important

differences in the two programs, such that Relators even have failed to allege with sufficient facts what the relevant "claim" for payment was under the ACA. Because Relators have again failed to clear Rule 9(b)'s hurdles, the Court must dismiss their FCA fraud claims entirely.

A. The Court Should Dismiss Claims for Relief Based on Relators' Medicare Advantage Allegations and Tax-Credit Theory as Beyond the Scope of the Court's Permitted Amendment

The Court should dismiss both Relators' new theory of liability premised on ACA tax credits and their previously dismissed Medicare Advantage allegations, both of which exceed the scope of the permitted amendment. Courts within the Ninth Circuit are clear that "amended pleadings may not exceed the scope of leave granted by the district court. When leave is granted to amend certain claims against specific parties, the Court may dismiss and strike any portions of the amended pleading not expressly permitted." *Barnes v. Sea Hawai'i Rafting, LLC*, 493 F. Supp. 3d 972, 978–79 (D. Haw. 2020), *aff'd*, 2022 WL 501582 (9th Cir. Feb. 18, 2022). That rule "applies even if the court did not expressly bar amendments other than the one(s) it *did* allow." *Raiser v. City of Los Angeles*, 2014 WL 794786, at *4 (C.D. Cal. Feb. 26, 2014) (emphasis in original). "[W]here leave to amend is given to cure deficiencies in certain specified claims, courts have agreed that new claims alleged for the first time in the amended pleading should be dismissed or stricken." *DeLeon v. Wells Fargo Bank, N.A.*, 2010 WL 4285006, at *3 (N.D. Cal. Oct. 22, 2010). When a party's ability to amend as of right expires, "a party may amend its pleading ***only*** with the opposing party's written consent or the court's leave." Fed. R. Civ. P. 15 (emphasis added). And because Relators' October 25, 2022 deadline to move for leave to amend has passed, *see* Dkt. No. 184, any such request must meet Rule 16's good-cause standard. *See Johnson v. Mammoth Recreations, Inc.*, 975 F.2d 604, 607–08 (9th Cir. 1992).

Relators have neither requested leave to add new theories of fraud nor demonstrated good cause for the allegations that exceed the scope of the Court's leave. Even if they had done so, Relators' Medicare Advantage claims are jurisdictionally barred and have been dismissed without leave to amend. Dkt. No. 171 at 46. As this Court recognized, asking for leave to amend "is a futile request" where FCA claims are dismissed based on the first-to-file bar. *Id.* at 41. And, as explained *infra* at 18–20, Relators' new tax-credit theory does not plead an FCA violation in any

event, so any effort to amend would be futile.

B. Relators Fail to Allege Any Fraud Claims Under the FCA

1. Relators Fail to Allege Falsity

Relators again fail to allege the falsity of any claims for payment submitted to HHS. "Evidence of an actual false claim is the *sine qua non* of a False Claims Act violation." *United States ex rel. Aflatooni v. Kitsap Physicians Serv.*, 314 F.3d 995, 1002 (9th Cir. 2002) (quotations omitted). "The FCA does not define false. Rather, courts decide whether a claim is false or fraudulent by determining whether a defendant's representations are accurate in light of applicable law." *United States v. Bourseau*, 531 F.3d 1159, 1164 (9th Cir. 2008). Claims for payment under the FCA must be pleaded with the particularity required by Rule 9(b), so the falsity allegations must give a defendant "notice of the particular misconduct which is alleged to constitute the fraud charged" and "supply reasonable indicia that false claims were actually submitted." *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 999 (9th Cir. 2010) (quotations omitted). Neither the ACA risk-adjustment theory nor the newly added tax-credit theory assert facts supporting the plausible inference that any of the Defendants submitted false claims for payment to HHS under the ACA program.

a. Relators Do Not Identify Any False Claims for Payment

Relators do not identify with specificity the false ***claims*** at issue, an omission fatal to all their FCA fraud claims under both the risk-adjustment and tax-credit theories. The FCA defines a "claim" as "any ***request or demand . . . for money or property*** and whether or not the United States has title to the money or property, that (i) is presented to an officer, employee, or agent of the United States[.]" 32 U.S.C. § 3279(b)(2)(A) (emphasis added). Rule 9(b) requires Relators to allege "the who, what, when, where, and how" of the purported fraud. *See Ebeid*, 616 F.3d at 998 (quotations omitted). Thus, they must allege the facts surrounding the submission of false claims for payment to the government. *See Aflatooni*, 314 F.3d at 1002 (holding that it is "not enough" for a relator "'to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted'" (citations omitted)). Relators have not met their burden here under Rule 9(b).

Relators base their fraud allegations on the purported submission of "a false or fraudulent Risk Adjustment Attestation to the United States," *see* SAC ¶¶ 234, 239, 245, 249—in other words, they contend that the "claim" at issue is an attestation submitted to HHS. But Relators fail to allege with specificity the most basic facts about the submission of attestations to HHS under the ACA risk-adjustment program. They do not allege what employees at which Defendants submitted these attestations, when the attestations were submitted, whether they were submitted once a year for all Defendants or periodically, or what Defendant entities and geographic regions were covered by the attestations. And most significantly, Relators never allege that the "Risk Adjustment Attestations" requested or demanded money or property from HHS, so the Court cannot determine on the facts alleged that such attestations constituted "claims for payment" within the meaning of the FCA.

The allegations that Relators do plead suggest that such attestations were ***not*** claims for payment at all. Relators assert that 45 C.F.R. § 153.710(d) requires health plans to submit an attestation under the ACA program confirming the accuracy of diagnostic data provided to HHS. SAC ¶¶ 72–73. That regulation reads in relevant part: "the issuer must, in a format specified by HHS, either: (1) Confirm to HHS that the information in the final report accurately reflects the data to which the issuer has provided access to HHS . . . or (2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data environment report." 45 C.F.R. § 153.710(d). Nothing in that regulation states that such an attestation is a precondition to payment under the ACA program or a request or demand for money or property from HHS or any other entity. It merely requires the health plan to confirm that the data in the report matches the data separately submitted to HHS. Similarly, the snapshot of an attestation that Relators include in their complaint says nothing about requesting or demanding money or property. SAC ¶ 73.

By contrast, the attestations that health plans submit under the Medicare Advantage program specifically relate to payment. The applicable regulation states: "***As a condition for receiving a monthly payment*** under subpart G of this part, the MA organization agrees that . . . [a relevant employee] must ***request payment*** under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of

relevant data that CMS requests." 42 C.F.R. § 422.504(*l*) (emphases added). Thus, while the Medicare Advantage program attestation certifies data for the express purpose of requesting payment, the ACA program attestation confirms that data generated in HHS's report matches data made available separately to HHS.

These fundamental differences between the two programs are precisely why Relators again cannot plead a violation of the FCA by asserting that the alleged fraud on the Medicare Advantage program was the same as the alleged fraud on the ACA program. Relators have pleaded no facts that would suggest that Defendants used attestations to request payment from HHS under the ACA program. And Relators do not plausibly allege any such payment ever occurred. They instead allege that Defendants were required to pay over $6 billion into the risk-adjustment program, *see* SAC ¶ 208, money that was then distributed to other health insurers participating in the ACA. Because Relators do not contend that Defendants received any money or property based on these alleged attestations, they fail to allege how such attestations were requests for money or property and thus "claims" within the meaning of the FCA.

b. ACA Risk-Adjustment Program Claims

Relators' claims for relief based on risk-adjustment transfer payments fail because Relators have not sufficiently alleged the facts surrounding the submission of any claims for payment, as noted *supra*, but they also fail for independent reasons. Relators premise their theory of falsity on the submission of false diagnostic data to HHS that was then allegedly certified as accurate in the attestations, *id.* ¶¶ 73, 90, but Relators' allegations do not support a plausible inference that Defendants submitted false data to HHS. Relators also have not alleged with specific facts a plausible ***scheme***—spanning nearly a decade and involving fifteen Defendants across the country—to defraud the ACA risk-adjustment program.

i. Relators Do Not Plausibly Allege the Submission of False Diagnostic Data to HHS Relating to the ACA Program

Relators' specific factual allegations comprise threadbare recitals of fraud on the ACA risk-adjustment program that do not suffice to plead falsity. For example, even though the relevant ACA regulations require an annual audit by an independent validator and a subsequent

HHS audit, 45 C.F.R. § 153.630, Relators say nothing about these audits, what the results were, and whether any actions were ever taken in response to the audits. Instead, Relators add conclusory phrases such as "and the ACA program" to allegations about the Medicare Advantage program in a vain attempt to graft their defunct Medicare Advantage allegations onto an ACA fraud theory. *See, e.g.*, SAC ¶¶ 103, 128, 134, 136, 139. Such incomplete allegations do not support the plausible inference that the conduct that Relators allege about the Medicare Advantage program actually occurred in the context of the ACA program.

Even so, none of Relators' specific allegations about various medical conditions plausibly suggests that Defendants submitted any false claims for payment to HHS based on Defendants' diagnosis-coding practices:

Ventilator Dependence. The vent-dependence allegations do not plead falsity. Relators rely on their own disagreement—based on their own interpretation of nonbinding coding guidance—with Defendants' internal policies about when to code vent dependence. *Id.* ¶¶ 121–22. They do not allege that Defendants diagnosed vent dependence for members who were not on a ventilator. Instead, Relators argue that TPMG and Southern California Permanente Medical Group ("SCPMG") impermissibly relied on time-based standards to code vent dependence, while proposing no alternative standard. *Id.*

Relators do not plausibly suggest that Defendants violated any legally binding requirements when diagnosing and coding vent dependence for ACA members. They cite only nonpublic statements by the American Hospital Association's Coding Clinic and by one employee of the trade organization American Health Information Management Association, both issued in response to inquiries from Relators themselves. *Id.* ¶¶ 119, 125–26. But these nonpublic opinions issued by nongovernmental organizations cannot form the basis for an FCA action. *See Kisor v. Wilkie*, 139 S. Ct. 2400, 2420 (2019); *United States ex rel. Yannacopoulos v. Gen. Dynamics*, 2007 WL 495257, at *3 (N.D. Ill. Feb. 13, 2007) (where guidance documents "were not promulgated pursuant to any rulemaking power of the agency[,] . . . [t]hey do not have the force of law, and therefore evidence that [an FCA defendant] may have failed to technically comply . . . does not establish an FCA violation").

Moreover, much of the conduct underlying Relators' vent-dependence allegations predates the implementation of the ACA risk-adjustment program, meaning that it could not have resulted in the submission of false diagnosis codes for ACA members. *See, e.g.*, SAC ¶¶ 124–38. For example, Relators allege that "[i]n a ***December 2013*** validation audit, Ms. Hernandez and her NCAL audit team concluded that 100% of a sample of TPMG vent dependence cases were invalid." *Id.* ¶ 138 (emphasis added). But ***none*** of those diagnoses could have been submitted to the ACA risk-adjustment program as all would have been diagnosed before the risk-adjustment program was implemented on January 1, 2014. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410-01.

Malnutrition. Relators now reallege their malnutrition allegations, which they had asserted in their original complaint but dropped from the FAC. SAC ¶¶ 142–49. Some of these allegations do not relate to the ACA program at all because they concern conduct from "October and November 2012," which is before the ACA risk-adjustment program was implemented. *Id.* ¶ 143. Relators also fail to allege any facts that would allow the Court to infer that Defendants misdiagnosed malnutrition. The thrust of their allegations is instead that TPMG "targeted protein-calorie malnutrition HCC as one of the top risk-adjustment opportunities." *Id.*

But the pursuit of valid diagnoses is not fraudulent and there is nothing improper about seeking to maximize revenue by legal means. As this Court has recognized, "Looking for ways to increase revenue is not in and of itself illegal." Dkt. No. 225 at 9–10; *see also Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 n.4 (9th Cir. 2021) ("CMS has acknowledged that there is nothing inappropriate, unethical or otherwise wrong with [providers] taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record." (quotations omitted)).[6] And while Relators complain repeatedly about TPMG's use of "leading queries," queries are not submissions to CMS or HHS—they are merely inquiries to healthcare providers. Dkt. No. 179-1, Ex. H at 1. Absent factual allegations that the healthcare provider entered a false diagnosis into the medical record or

[6] Moreover, given the complex risk-adjustment calculations used in the ACA program and the transfer system, it is not clear that a single additional diagnosis for malnutrition (or any other medical condition) would result in any financial gain to Defendants.

that a false diagnosis code was transmitted to HHS for an ACA member, accusations of improper coding queries are insufficient by themselves to allege falsity. *Integra*, 854 F. App'x at 844–45 (holding that allegations that "staff incentivized doctors to use language conducive to coding higher-paying secondary diagnoses through their documentation tips and queries" did not support the conclusion that "doctors recorded unsupported medical conditions").

Only a single allegation purports to identify "inaccurate" malnutrition diagnoses: a Northwest Permanente Medical Group employee allegedly provided Bryant with a "***short*** list" of "inpatient medical record accounts," which Bryant's staff determined had "no supporting documentation or clinical indicators." SAC ¶ 145 (emphasis added). This vague allegation falls far short of Rule 9(b)'s requirements. There are no allegations about what documentation was required and missing. There are no facts to suggest that these diagnoses were the result of any systematic effort to code inaccurate malnutrition diagnoses; to the contrary, this list contained only a small number of handpicked diagnoses. And, notably, ***there are no specific allegations that these diagnoses were ever submitted to HHS or were even diagnosed for ACA members***.

Arrhythmia. Relators add two paragraphs about the coding of arrhythmia by TPMG and Colorado Permanente Medical Group ("CPMG") for members who have pacemakers, *id.* ¶¶ 150–51, but these allegations are also insufficient. As a threshold matter, there are no factual allegations that these members actually participated in the ACA program or that any false diagnosis codes for arrhythmia were submitted to the ACA's risk-adjustment program. Nevertheless, Relators assert that "it would be atypical for a patient to have a pacemaker but to continue to suffer from arrhythmia, unless there is a rare pacemaker complication." *Id.* ¶ 150. But they cite no authority—binding or otherwise—in support of their contention that both diagnoses should not be recorded at the same time. Nor do they assert that these members did not have arrhythmia. They instead concede that arrhythmia was the reason for the pacemaker. *Id.* They also explain that they raised the issue with a group of healthcare providers, who stated that "the record should have both the pacemaker status and the arrhythmia code assigned." *Id.* ¶ 151. In short, Relators ask the Court to accept their wholly unsupported assertion that these diagnoses were false—despite their allegations that multiple healthcare providers stated otherwise. Rules 8

and 9(b) do not require such unreasonable inferences. *See Fayer*, 649 F.3d at 1064.

This theory of fraud also belies common sense. Relators assert that TPMG and CPMG submitted diagnosis codes for ***both*** arrhythmia and the existence of a pacemaker. So HHS and the independent validator could readily observe that both diagnoses were submitted for a particular member and reject them if HHS believed the dual diagnosis was improper—nothing was hidden or undisclosed.

Major Depression. Relators' new allegations about major depression similarly fail to allege falsity. In a single paragraph, Relators allege that "Kaiser and its various regional subsidiaries aggressively pursue the diagnosis and coding of major depression." SAC ¶ 152. Again, the pursuit of valid diagnoses is not fraud. *See Integra*, 854 F. App'x at 844–45. Efforts to strive for complete documentation of all medical conditions—particularly ones such as depression that are often overlooked and undertreated—promote member health and well-being. Relators do not allege that a single healthcare provider diagnosed major depression in a member who did not have major depression. Nor do they allege that any such inaccurate diagnoses were submitted to HHS or falsely confirmed as accurate in any attestation.

ii. Relators Do Not Allege a Plausible Scheme to Defraud the ACA Program

The SAC's new allegations still do not support the inference that Defendants perpetrated a wide-ranging scheme to defraud the ACA program. The Court previously stated that the FAC's allegations were not sufficient to plead a false scheme that extended beyond the specific medical conditions described in the complaint. Order at 8. The Court required "greater specificity in alleging a systemic scheme." *Id.* Instead of curing the previous deficiencies, the SAC raises more questions about Relators' theory of fraud.

In attempting to allege a widespread fraud on the ACA program, Relators now contend that Defendants generally have "reported a healthier patient base than other insurers." SAC ¶ 208. They allege that, as a result, Defendants have paid approximately $6.13 billion into the ACA program, but that in some unspecified markets in some unspecified years, Defendants were actually "net recipient[s]" of funds under the program. *Id.* ¶¶ 208–10. And although Relators

contend that Defendants had a relatively healthy patient base, they assert that the $6.13 billion figure that Defendants ***paid*** "is based on Kaiser's systemic practice of over-documenting and upcoding its patient encounters." *Id.* ¶ 209. These allegations fatally undermine the plausibility of Relators' fraud theory.[7]

These allegations also fail to allege the "who, what, when, where, and how" of the purported scheme. *See Ebeid*, 616 F.3d at 998 (quotations omitted). They do not state ***what*** the scope of the alleged fraud was, either in monetary or diagnostic terms. They do not state ***who*** among the fifteen Defendants paid anything into the ACA program and in ***what*** years. They do not state ***who*** among the fifteen Defendants received funds through the ACA program and in ***what*** years. And they do not state whether and ***when*** Defendants were net recipients or net payors from the risk-transfer payment pool. The SAC also does nothing to connect the allegedly improper diagnosing of vent dependence, malnutrition, arrhythmia, and major depression to this wider market manipulation that they allege occurred.

Relators' vague allegations of a systemic fraud also do not rebut the plausible alternative explanation that no fraud occurred. "When faced with two possible explanations, only one of which can be true and only one of which results in liability, plaintiffs cannot offer allegations that are merely consistent with their favored explanation but are also consistent with the alternative explanation. ***Something more is needed***, such as facts tending to exclude the possibility that the alternative explanation is true, in order to render plaintiffs' allegations plausible." *In re Century Aluminum Co. Secs. Litig.*, 729 F.3d 1104, 1108 (9th Cir. 2013) (quotations omitted) (emphasis added). In the FCA context, the Ninth Circuit has held that no falsity can be inferred where the plaintiff failed to rule out the "'obvious alternative explanation' that no false claims occurred." *Cafasso, United States ex rel. v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1057 (9th Cir. 2011) ("In light of [relator's] failure to identify any particular false claims or their attendant

[7] It bears noting that the entire premise of the FCA claims asserted by the United States and various relators with regard to the Medicare Advantage program is that Defendants allegedly embarked on a fraudulent scheme to falsely report diagnostic information for Medicare Advantage members in order to make those members appear less healthy than they actually were. *See generally* Dkt. Nos. 65, 171, 240. According to the FAC, Defendants' members in the ACA program were, on a relative basis, much healthier than other health insurers' membership.

circumstances, as well as the 'obvious alternative explanation' that no false claims occurred, we will not draw the unwarranted and implausible inference that discovery will reveal evidence of such false claims.").

Here, according to the SAC, Defendants have reported that they have a healthier membership than other health plans, causing Defendants to ***pay billions of dollars in risk-adjustment payments into*** the ACA program. SAC ¶¶ 205–10. The most reasonable inference from these facts is that Defendants accurately reported patient medical conditions to HHS because Defendants are gaining nothing from the program; to the contrary, Defendants are net payors. Relators' allegation that Defendants' ACA members were actually ***even healthier*** than reported and that Defendants must have engaged in widespread fraud is simply not plausible without more specific factual allegations.

c. ACA Tax-Credit Theory

Relators' tax-credit allegations also fail to plead any plausible FCA claims. Relators base their tax-credit theory on allegations that Defendants knowingly set the premiums they charged to ACA members ***lower*** than what the premiums otherwise should have been, which somehow resulted in the United States paying ***more*** in tax credits to private citizens. *Id.* ¶¶ 211–16. This convoluted theory relies on the unsupported assertion that other health plans set their premium rates higher than what they otherwise would have ***solely because*** Defendants set their rates too low. Relators allege that these outcomes are all the result of Defendants' manipulation of risk-adjustment transfer payments through improper "upcoding," even though Relators simultaneously allege that "Kaiser generally has reported a healthier patient base than other insurers." *Compare id.* ¶ 208 ("Kaiser generally has reported a healthier patient base than other insurers"), *with id.* ¶ 212 ("Kaiser's systemic over-documentation and upcoding [make] its patient base appear more risky than it actually is"). This new theory fails to satisfy Rules 8 and 9(b) for multiple reasons.

First, like the ACA risk-adjustment theory discussed *supra* at 10–12, Relators' new tax-credit theory founders because it is premised on submissions of attestations to HHS that Relators fail to plead are false "claims" within the meaning of the FCA. And because this theory depends on Defendants' alleged scheme to defraud the ACA risk-adjustment program, it fails for all the

additional reasons addressed *supra* at 12–18.

Second, this theory of fraud is implausible because it is untethered to any specific factual allegations; it is based entirely on Relators' conjecture. While they accuse Defendants of what is essentially a price-fixing or market-manipulation scheme, Relators allege no specific facts about what Defendants specifically did or how they did it. Beyond generally discussing how tax credits work under the ACA program, the SAC does not allege with any specificity how Defendants calculate their ACA premiums, how any other health plan calculates its ACA premiums, or how either premiums or risk-adjustment transfer payments affect health plans' revenue or profit. The SAC does not even allege the size of the transfers or the total amount received from the premiums by Defendants or anyone else. So it is not possible to infer what impact—if any—risk-adjustment transfer payments had on the premiums set by Defendants or by any other health plans, including whether transfers resulted in inflated or deflated premiums. The only specific allegation about Defendants' conduct is that "Kaiser plans have served as the benchmark plan in California's 19 ratings areas (marketplaces) ***less than 30 percent of the time*** since 2014." SAC ¶ 217 (emphasis added). But this allegation cuts directly against Relators' theory that Defendants' alleged fraud affects the entire market's tax credits. Because the tax credit is determined by the benchmark plan, Defendants' premiums had a direct impact on the tax-credit amount only when they were the benchmark (*i.e.*, the second-cheapest silver plan available in the market).

Third, this new theory fails to rule out far more plausible alternative explanations for Defendants' conduct. Relators essentially allege that Defendants submit inaccurate diagnosis codes to HHS so that they can charge ***less*** than they otherwise would have charged for providing healthcare to ACA members. In other words, this purported fraudulent scheme is a financial wash for Defendants at best. If a fraudulent scheme does not benefit Defendants in any way, then there is no reason to infer that Defendants are committing fraud. The nonfraudulent explanation—that Defendants were setting their premiums at the appropriate level rather than artificially low—is far more reasonable, particularly where Relators fail to explain any motive to support the inference of fraud.

Fourth, though Relators assert that this scheme results in the United States overpaying for

premiums through tax credits, *id.* ¶ 211, they fail to allege any facts that show how that would be the case. They plead a reciprocal relationship between Defendants and other plans: Defendants charge less, so other plans must charge more. *Id.* ¶ 213.[8] On their face, those allegations merely suggest that this alleged market manipulation is a wash for the United States. And this theory relies completely on the assumption that other health plans accurately report medical conditions and tie their premium rates to that reporting—assumptions that lack any supporting factual allegations. Under Rule 9(b), Relators must plead specific facts that would support the inference that the outcome they suggest is plausible. All they offer is a single "hypothetical and simplified example" that uses random numbers, cherrypicked to show a specific outcome. *Id.* ¶ 216.

Indeed, their fictional example—in which Insurer A charges a premium of $140, Insurer B charges $130, and Defendants charge $80—does nothing to support allegations of fraud. *Id.* Relators give no explanation for these numbers or the ratios between them. They never explain, for example, why the difference between Insurer A and B is only $10 but the difference between Defendants and Insurer B is $50. Relators then assert that if the purported fraud in this hypothetical were corrected, Insurer A and Insurer B would charge $15 less and Defendants would charge $30 more. *Id.* Again there is no explanation for these numbers. Relators never explain why, but for the purported upcoding of only four medical conditions, Defendants would need to charge premiums that are nearly 50 percent more for their ACA plans. This example again reiterates that this purported scheme would result in no financial upside to Defendants: every dollar pocketed through the alleged risk-adjustment transfer scheme would be spent on keeping their premiums artificially low through the tax-credit scheme.

2. Relators Again Fail to Allege Materiality

Relators still have not alleged materiality as required to proceed on their FCA fraud claims, providing an independent basis for dismissal. They attempt to establish materiality

[8] Relators are not always consistent about whether the allegedly fraudulent scheme permits Defendants to charge higher or lower premiums, further demonstrating the flaws in their fraud theory. *Compare* SAC ¶ 213 (Defendants "use[] those 'savings' to charge ***lower*** premiums"), *with id.* ¶ 234 ("Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program and ***higher*** premiums and premium tax credits.") (emphases added).

primarily with reference to a statute and a regulation that do not address materiality in the FCA context. As this Court previously recognized, a statute or regulation alone cannot establish FCA materiality—even where the regulation articulates a condition of payment. Order at 9; *see also Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 191 (2016) ("statutory, regulatory, and contractual requirements are not automatically material [for purposes of FCA liability], even if they are labeled conditions of payment"). "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).

The statute and regulation that Relators cite do not establish materiality here. First, as they did in opposing Defendants' initial Rule 12(b)(6) motion, Relators contend that 42 U.S.C. § 18033(a)(6)(A) establishes materiality. SAC ¶¶ 85, 218, 227; Dkt. No. 195 at 14. The Court previously rejected Relators' attempt to plead materiality through this provision, and should do the same here. *See* Order at 8 ("To the extent Relators claim that there is materiality based on 42 U.S.C. § 18033(a)(6)(A) of the ACA, the Court does not agree."). This section of the ACA states, "Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments[.]" 42 U.S.C. § 18033(a)(6)(A). As Defendants previously explained, this case is not about eligibility to participate in an ACA exchange; it is about allegedly fraudulent risk-adjustment data. There is nothing in the statute to suggest that the words "material condition" has the same meaning as materiality under the FCA. Dkt. No. 204 at 6–7. Simply pointing to this statutory provision does not satisfy Relators' pleading burden. John T. Boese & Douglas W. Baruch, *Civil False Claims & Qui Tam Actions* § 2.04(B)(4) (5th ed. 2023-1 Supp.) (the ACA's "material condition" language is "not dispositive" of the FCA's materiality requirement).

Second, Relators' reliance on 45 C.F.R. § 153.710(e) also fails. That regulation concerns requirements for data submitted to HHS under the ACA program, including claims and encounter data. *See* 45 C.F.R. § 153.710 (entitled "Data requirements"). Section 153.170(d)(2) describes

an insurer's obligation to report to HHS any discrepancies between the report generated by HHS and the underlying data it has made available in the database. Section 153.170(e) in turn sets the "materiality threshold"—in essence, an acceptable error rate—for the discrepancies between the two. It states in full: "Materiality threshold. HHS will consider a discrepancy reported under paragraph (d)(2) of this section to be material if the amount in dispute is equal to or exceeds 1 percent of the applicable payment or charge payable to or due from the issuer for the benefit year, or $100,000, whichever is less." 45 C.F.R. § 153.710(e). On its face, this regulation has nothing to do with whether false risk adjustment data would be material to payment under the ACA.

An FCA materiality standard based on a "threshold" amount also lacks support in law or logic. In *Escobar*, the Supreme Court rejected the United States' position that if "the Government contracts for health services and adds a requirement that contractors buy American-made staplers, anyone who submits a claim for those services but fails to disclose its use of foreign staplers violates the False Claims Act." 579 U.S. at 195–96. Because the stapler requirement is minor and insubstantial, violating the requirement cannot be the basis for an FCA claim—regardless of whether the underlying claims totaled $10 or $1,000,000. *Id.* Similarly if HHS knows that healthcare providers routinely rely on a time-based standard when diagnosing vent dependence and does not change its payment decisions, the use of a time-based standard is not material to HHS, regardless of the total dollar value of the codes at issue. If materiality were based on the dollar amount of the underlying claims, then every minor requirement would be material when the underlying claims were large enough—that is not the law.

Relators' other stray materiality allegations are similarly deficient. Their allegations focus on the materiality of diagnosis coding generally and say nothing about whether the specific falsity alleged here—falsity of risk-adjustment ***attestations***—would have affected HHS's payment decisions had it known of the alleged falsity. SAC ¶ 228 ("Given that diagnostic data and coding is the principal determinant in the risk profile of a given insurance plan . . . the Government's payment decisions necessarily would have been different had the Government known that the data was false."). Defendants do not dispute that diagnosis codes are important in the abstract. But that alone does not establish materiality—far from it. *See Knudsen v. Sprint Commc'ns Co.*,

2016 WL 4548924, at *12–13 (N.D. Cal. Sept. 1, 2016) (dismissing complaint given relator's "conclusory statement" about compliance with a specific contract provision being material). Courts are clear that "[f]alsity and materiality are distinct elements." *United States v. Vora*, 2022 WL 89177, at *7 (W.D. Ky. Jan. 7, 2022). So Relators must do more than show falsity. They must allege that if HHS had known that risk-adjustment attestations were false in the way they contend, then HHS would have denied payment to Defendants. *Escobar*, 579 U.S. at 193 ("[M]ateriality looks to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation." (quotations omitted)); *see United States v. Scan Health Plan*, 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017) (United States failed to plead materiality where it did not plead "that [CMS] would not have paid these claims had it known of these violations").

Relators' assertion that the allegedly false diagnosis data certified in the attestations "constituted a substantial portion of all the diagnostic data," SAC ¶ 228, is implausible on its face. Relators describe only five medical conditions, one of which does not even risk adjust in the ACA program. Even accepting that Defendants improperly coded some of these medical conditions, Relators have not alleged any specific facts to conclude that this conduct constituted a "substantial portion of all the diagnostic data" submitted to HHS.

Similarly, Relators' allegation that "[t]he materiality of the Defendants' fraud is further amplified by the magnitude of Defendants' false risk adjustment data," *id.* ¶ 232, misses the mark. As explained, the size of the underlying claims has no bearing on whether HHS would consider the described violation to be material. And Relators concede that Defendants paid money into the risk-adjustment pool, *id.* ¶ 208, raising serious questions about what effect—if any—the purported fraud had on the payment transfers.

Finally, Relators' allegations about what HHS ***could*** have done do not sufficiently plead materiality. *Escobar*, 579 U.S. at 194 (it is ***not*** "sufficient for a finding of materiality that the Government ***would have the option*** to decline to pay if it knew of the defendant's noncompliance" (emphasis added)). Relators contend that "HHS is empowered to commence enforcement actions and impose monetary penalties against those entities that fail to comply with risk adjustment data requirements." SAC ¶ 230. And they assert that HHS could have kicked

Defendants out of the ACA program altogether. *See id.* ¶ 218. These allegations do not say anything about what HHS would have done had it known of the alleged conduct. The SAC is notably lacking any factual allegations that HHS has in fact imposed monetary penalties or pursued administrative enforcement actions for the same type of conduct alleged by Relators. The absence of such factual allegations strongly supports an inference that the alleged conduct is not material to HHS. *Escobar*, 579 U.S. at 194.

C. Relators Fail to Allege a Conspiracy to Violate the FCA

Relators' FCA conspiracy claim fails for all the same reasons their other fraud claims fail, but it should be dismissed for the additional reason that Relators do not allege that Defendants had any agreement to defraud the United States. A conclusory allegation that defendants "conspired" with one another does not support an FCA conspiracy claim if it is "unsupported by specific allegations of any agreement or overt act." *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1014 (11th Cir. 2005); *United States v. Toyobo Co.*, 811 F. Supp. 2d 37, 50–51 (D.D.C. 2011).

As with the FAC, Relators again cursorily allege that Defendants "conspired" with one another. SAC ¶¶ 244–45. While the Court declined to rule on Defendants' argument in the initial Rule 12(b)(6) motion that Relators did not allege a conspiracy claim, the Court directed Relators to "clarify in their amended pleading whether they are claiming one overarching conspiracy involving all Kaiser entities or rather multiple bilateral conspiracies (*i.e.*, between a health plan and its affiliated medical group)." Order at 10. But the SAC's only new conspiracy allegation is boilerplate and fails to identify any specific facts: "Defendants conspired with one another in one overarching conspiracy involving all Kaiser entities, who all share common management and control and are financially intertwined with one another. Defendants also conspired bilaterally, with each health plan and affiliated medical group conspiring to defraud the United States on a regional basis, with the various Kaiser regions essentially competing with one another on which could do so most successfully." SAC ¶ 245. This allegation is utterly useless. It is conclusory and unsupported by any factual allegations that would permit the plausible inference that these Defendants entered an agreement to perpetrate a fraud on the ACA.

D. Relators Again Rely on Impermissible Group Pleading

Relators' claims against all Defendants except for TPMG also fail because the SAC continues to rely on impermissible group pleading. The Court previously faulted the FAC for relying on group pleading. Order at 9 ("[S]ome allegations are conclusory in nature – *e.g.*, just because presentations were made or practices promoted by one region to other regions does not thereby mean that the latter regions adopted the recommendations."). But the SAC repeats the same mistakes, continuing to use "Kaiser" and "Kaiser Defendants" in the vast majority of allegations without meaningful facts that would allow the Court to conclude that other Defendants—spread across multiple geographic regions throughout the country—engaged in the same conduct. SAC ¶ 90 ("***Kaiser*** submitted Risk Adjustment Attestations to HHS under the ACA program each year"), ¶ 94 ("***Kaiser*** implemented an HCC initiative in 2011 to review and capture AA diagnoses in all clinic, emergency, outpatient surgery, and inpatient encounters"), ¶ 123 ("***Kaiser*** ignored its own improper directives by coding for vent dependence"), ¶ 150 ("***Kaiser*** routinely and improperly reported both the pacemaker status code and the cardiac arrhythmia code") (emphases added). These undifferentiated allegations are improper.

E. The Court Should Not Permit Further Leave to Amend

Relators have filed three complaints in this matter. They have had three attempts to adequately allege their FCA claims. And they have received specific instructions from the Court about how to cure the pleading defects. Their failure to do so "is a strong indication that [they have] no additional facts to plead." *Zucco Partners, LLC v. Digimarc Corp.*, 552 F.3d 981, 1007 (9th Cir. 2009) (quotations omitted). The Court should therefore dismiss their FCA fraud claims with prejudice. *See Carvalho v. Equifax Info. Servs., LLC*, 629 F.3d 876, 892 (9th Cir. 2010) ("[A] district court may exercise its discretion to deny leave to amend due to . . . repeated failure to cure deficiencies by amendments previously allowed[.]").

V. CONCLUSION

For the foregoing reasons, the Court should grant the Motion and dismiss all of Relators' FCA fraud causes of action.

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Respectfully submitted,

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

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

DECLARATION OF KYLE M. GROSSMAN IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

Hearing Date: May 4, 2023
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

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

DECLARATION OF KYLE M. GROSSMAN IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

Hearing Date: May 4, 2023
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

DECLARATION OF KYLE M. GROSSMAN IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

Hearing Date: May 4, 2023
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

I, Kyle M. Grossman, hereby declare and state as follows:

I am an active member in good standing of the State Bar of California. I am a counsel at O'Melveny & Myers LLP, counsel of record for Kaiser Foundation Health Plan; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group; Southern California Permanente Medical Group; Colorado Permanente Medical Group; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Washington Permanente Medical Group; and Northwest Permanente (collectively, "Defendants"). I submit this declaration in support of Defendants' Motion to Dismiss Relators Bryant and Hernandez's Second Amended Complaint. This declaration is based upon my personal knowledge and, if called as a witness, I could and would testify to the matters set forth below.

1. Attached hereto as **Exhibit A** is a true and correct copy of the redline created by comparing the text of Relators Bryant and Hernandez's First Amended Complaint (Dkt. No. 117) with the text of Relators Bryant and Hernandez's Second Amended Complaint (Dkt. No. 238) using the Change-Pro software program.

2. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

EXECUTED this 2nd day of February, 2023.

Kyle M. Grossman
Kyle M. Grossman

Exhibit A

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

UNITED STATES OF AMERICA, ex rel. RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:13-cv-03891-EMC (Consolidated)
UNITED STATES OF AMERICA, ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ,	Case No. 3:18-cv-01347-EMC _____

Plaintiffs-Relators, v. KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HOSPITALS, THE PERMANENTE MEDICAL GROUP, INC., SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, COLORADO PERMANENTE MEDICAL GROUP, P.C., THE SOUTHEAST PERMANENTE MEDICAL GROUP, INC., HAWAII PERMANENTE MEDICAL GROUP, INC., MID-ATLANTIC PERMANENTE MEDICAL GROUP, P.C,, NORTHWEST PERMANENTE, P.C., WASHINGTON PERMANENTE MEDICAL GROUP, P.C., KAISER FOUNDATION HEALTH PLAN OF COLORADO, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC., KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, and KAISER FOUNDATION HEALTH PLAN OF WASHINGTON, Defendants.	SECOND AMENDED COMPLAINT BY RELATORS GLORYANNE BRYANT AND VICTORIA M. HERNANDEZ FOR VIOLATIONS OF FEDERAL FALSE CLAIMS ACT DEMAND FOR JURY TRIAL

COMES NOW, Plaintiffs and Qui Tam Relators Gloryanne Bryant ("Ms. Bryant") and Victoria M. Hernandez ("Ms. Hernandez," and together with Ms. Bryant, "Relators"), individually and on behalf of the United States of America, to recover treble damages and civil penalties under the federal False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, for monies unlawfully obtained and/or retained from the federal Medicare Program by Defendant Kaiser Foundation Health Plan, Inc. and various of its direct and indirect subsidiaries and affiliates (together, "Kaiser" or the "Kaiser Defendants"), and allege as follows:

INTRODUCTION

The Kaiser Defendants are now and have been, in some cases since at least 2009, engaged in a widespread scheme to knowingly submit, or cause to be submitted, false claims for payment to the United States by submitting false "risk adjustment" information to the Centers for Medicare & Medicaid Services ("CMS") and the Department of Health and Human Services ("HHS") in order to improperly increase the amounts CMS and HHS pays them. Likewise, the Kaiser Defendants have knowingly retained overpayments received from CMS and HHS and underpaid into HHS' insurance pools as a result of their false risk adjustment submissions.

1. Millions of elderly and disabled individuals throughout the United States receive their Medicare benefits through the Medicare Advantage Program (also referred to as "Medicare Part C"). A central, distinguishing feature of the Medicare Advantage Program is the provision of Medicare benefits by private healthcare insurance organizations. Medicare beneficiaries enroll in managed healthcare insurance plans called Medicare Advantage Plans ("MA Plans") that are owned and operated by these private organizations, called Medicare Advantage Organizations ("MA Organizations"). This case involves, in ~~large~~ part, conduct by Kaiser — which operates one of the nation's largest MA Organizations — to improperly obtain or avoid returning payments under the Medicare Advantage Program that it was not entitled to receive.[1]

2. The Government pays each MA Organization a fixed monthly payment for each Medicare beneficiary enrolled in its plans. The Government adjusts these payments for various risk factors that affect expected healthcare expenditures, including the health status of each enrollee. The adjustments are intended to ensure that MA Organizations are paid more for those enrollees expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs.

3. To obtain payments based on adjustments for health status, MA Organizations submit diagnosis codes to the Government for the beneficiaries in their MA Plans. These diagnosis codes are from the beneficiaries' medical encounters (e.g., office and hospital visits). Using these diagnosis codes, the Government calculates a risk score for each beneficiary. The beneficiary's risk score is then used to calculate monthly payments to the MA Organization for that beneficiary for the following year. In general, the more numerous the conditions diagnosed, and the more severe the conditions, the higher the risk score for a beneficiary and, thus, the greater the risk-adjusted payments made to the MA Organization for that beneficiary.

4. This payment model creates powerful incentives for MA Organizations to over-report diagnosis codes in order to exaggerate the expected healthcare costs for their enrollees. In order to combat these incentives and protect the Government from making erroneous payments to MA Organizations, the Government requires that submitted diagnoses be supported and validated by the beneficiaries' medical records. It is a well-established requirement that all diagnosis codes submitted to the Medicare Program for risk adjustment payments must be unambiguously supported by clinical documentation included in the beneficiaries' medical records. Kaiser knew that these medical records are the "source of truth" for the purpose of receiving and retaining risk adjustment payments, and for each individual member's medical history and clinical profile.

5. In addition, each MA Organization must expressly certify in "Risk Adjustment Attestations" submitted to CMS that the diagnosis codes it has provided are accurate and

[1] On May 5, 2022, on motion by the Kaiser Defendants, the Court dismissed those aspects of Relators' Amended Complaint relating to allegations of the Kaiser Defendants' Medicare Advantage fraud under the False Claims Act's "first-to-file" rule, but left Relators' claims relating to allegations of the Kaiser Defendants' ACA fraud intact. Dkt. No. 171. On November 14, 2022, on subsequent motion by the Kaiser Defendants, the Court dismissed the Relators' ACA-related claims without prejudice and with leave to replead to address issues identified by the Court. Dkt. No. 226. This Second Amended Complaint amends the Relators' ACA-related allegations and claims, and preserves the Relators' MA-related allegations and claims both for purposes of appeal, and because the MA-related allegations and claims remain relevant to the ACA-related allegations and claims, as they overlap with and relate to one another.

truthful. 42 C.F.R. § 422.504(1)(2). Each MA Organization must also "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with [the Government's] program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi).

6. In excess of one million elderly and disabled Medicare beneficiaries are currently enrolled in MA Plans that are owned and operated by Kaiser throughout the United States, and that number is growing. In 2011, approximately one million Medicare beneficiaries in the United States were enrolled in Kaiser's MA Plans. In 2015, Kaiser's MA Plans had grown to 1.3 million beneficiaries, in 2016 to 1.4 million, and in 2021 to 1.7 million.

7. The United States also contributes to premiums paid by individuals to private health insurance companies, including Kaiser, under the Affordable Care Act (sometimes referred to as the "ACA"). The Affordable Care Act authorizes ~~the Department of Health and Human Services (~~HHS~~)~~ to utilize criteria and methods similar to those utilized under the Medicare Advantage program to implement risk adjustment, and requires similar attestations/certifications from health insurance companies as to the accuracy and documentation of their risk adjustment data. The HHS risk adjustment methodology developed by and on behalf of ~~the Centers for Medicare & Medicaid Services ("CMS")~~CMS is based on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency, and not the health status of the enrolled population. Accordingly, as under the Medicare Advantage program, the ACA risk adjustment model creates powerful incentives for private health insurance companies like Kaiser to over-report diagnosis codes in order to exaggerate the expected healthcare costs for their enrollees~~; the more codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States~~, which lessens their contributions to the risk adjustment pool. This over-reporting also results in honest insurers receiving less from the risk adjustment pool than they otherwise would have, causing them to raise their premiums, which in turn results in higher contributions made to premiums to all insurers by the United States when those higher premiums impact benchmark rates, which they regularly do.

~~8~~8. The ACA's risk adjustment program ("Risk Adjustment Program") depends on insurers providing accurate information to the Government, so that the Government has full transparency into the risk profile of each insurer, and the insurers into one another's risk profiles. The accuracy of risk adjustment information is so important to the Government that the ACA requires that insurers participating in the Exchanges certify that the risk adjustment data submitted to HHS is accurate, and provides for substantial penalties for noncompliance. Virtually every aspect of the ACA's Exchanges depends on accurate risk data – the premiums charged depend on it, the premium tax credits depend on it, and the risk adjustment payments to or from participating insurers depend on it. Thus, this case also involves, in part, conduct by the Kaiser Defendants — which operate ACA plans in many states, including California, Colorado, Oregon, Washington, Maryland, Georgia, Washington, D.C., Virginia and Hawaii — to improperly underpay into the ACA risk pool, and to receive inflated payments from the ACA risk pool, and to cause premiums, including the federal share of those premiums, to be elevated under the ACA program due to its false submission of risk adjustment information to the ACA's Risk Adjustment Program.

9. The United States pays billions of taxpayer dollars each year to Kaiser for the Medicare beneficiaries enrolled in its MA Plans and beneficiaries in its ACA Plans. Risk adjustment payments account for a substantial amount of these dollars. The diagnoses submitted by Kaiser drive a large percentage of the payments it receives from the Medicare Program~~.~~, and directly impact the amount of premiums it receives from the ACA program and the amount that it receives or pays into the ACA risk pool. It is not surprising then that Kaiser is not a passive conduit of diagnoses from healthcare providers to the Medicare Program~~.~~ and to HHS under the ACA. Rather, for many years, Kaiser ~~has~~ conducted programs and engaged in other activities to increase the amount of risk adjustment payments from Medicare~~.~~ and to falsely inflate the health risks of its members submitted to the ACA's Risk Adjustment Program. This includes programs and other efforts to directly influence and capture both the number of diagnoses and the severity of the medical conditions reported by providers and coded by Kaiser staff.

~~9~~10. Ms. Bryant, until her retirement on October 3, 2017, was National Director for Kaiser's national coding quality group, and, prior to that, was Managing Director of Kaiser's Health Information Management program ("HIM") for the Kaiser Foundation Health Plan in Kaiser's Northern California ("NCAL") region. Ms. Hernandez was employed by the Kaiser Defendants in various positions from June 1995 through October 2015, and as a Kaiser contract employee through May 2016, in functions that included Regional Director of auditing and coding services for The Permanente Medical Group in Kaiser's NCAL region.

~~10~~11. In these positions, Relators discovered that the Kaiser Defendants were and are engaged in fraudulent schemes pursuant to which they routinely and systematically overcharge the following government programs in the following ways:

a. Medicare Advantage

(i) Defendants "~~upcode~~upcoded" risk adjustment claims by manipulating the documentation and submitting claims and codes to the Medicare Advantage program for diagnoses that the member does not have or for which the member was not treated in the relevant year, or by claiming that a member was treated for a more serious condition than the member actually has, or by documenting and submitting a diagnosis that was labeled significant when it was not, or by training, educating, and programming its personnel and systems to support these fraudulent activities; and

(ii) Defendants ~~refuse~~refused to implement and ignore processes to correct (and ~~refuse~~refused to reimburse Medicare for) previously submitted risk adjustment claims when the Defendants ~~discover~~discovered, or in the exercise of reasonable care should ~~discover~~have discovered, that those previously submitted claims were false, and ~~subvert~~subverted and ~~ignore~~ignored Kaiser's internal compliance function and ~~pressure~~pressured it to cooperate; and

(iii) Defendants ~~manipulate~~manipulated and ~~falsify~~falsified risk-adjustment data in a deliberate scheme to over-charge the Medicare Advantage program.

b. Affordable Care Act

Similarly, Defendants ~~overdocument~~overdocumented and ~~upcode~~upcoded 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, and similarly ~~refuse~~refused to correct or reimburse ~~Medicare~~HHS for overpayments caused by this conduct, in a deliberate scheme to over-charge the ~~Medicare~~ACA program, receive more in insurance premiums funded through government tax credits, and receive more of, or contribute less into, the ACA insurance pool.

c. Through this fraudulent scheme, the Kaiser Defendants ~~have~~ defrauded the United States of hundreds of millions—and likely billions—of dollars for more than nine years.

~~11~~12. Defendants' conduct alleged herein violates the federal False Claims Act. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. Congress substantially amended the Act in 1986—and, again, in 2009 and 2010—to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

~~12~~13. The FCA prohibits, inter alia: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government; and (d) conspiring to violate any of these three sections of the FCA. 31 U.S.C. §§ 3729(a)(1)(A)-(C), and (G). Any person who violates the FCA is liable for a civil penalty of up to $21,916 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

~~13~~14. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. Id. Unless otherwise indicated, whenever the words "know," "learn," discover" or similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

~~14~~15. Each claim for risk adjustment payments that defendants have submitted or caused to be submitted to CMS under the Medicare Advantage program, where the patient was not treated by a qualified provider for that condition in the year in question, and/or the treatment and condition are not properly documented in the medical record is a false and/or fraudulent claim within the meaning of the FCA, so long as defendant knew that the claim was false when it was submitted, or the defendant later discovered its falsity and refused to correct the claim.

~~15~~16. Similarly, under the ACA program, Kaiser submits false claims when it certifies its risk adjustment data as being accurate when it is not, as that false data is used to determine risk

adjustment payments made from or to the Government. Kaiser also causes false claims to be submitted via premium tax credits, due to Kaiser's manipulation of the data it presents to the Government with its risk adjustment submissions. And, every payment made to, from, or through the Government in connection with the ACA is a false claim, because Kaiser should be ineligible to participate in the ACA exchanges due to its manipulation of risk adjustment data.

17. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

~~16~~18. Based on the foregoing laws, Relators Gloryanne Bryant and Victoria M. Hernandez seek, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for Medicare Advantage risk adjustment payments, and in connection with false and/or fraudulent claims relating to Affordable Care Act insurance pool distributions and ACA insurance premiums and credits.

JURISDICTION

~~17~~19. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

~~18~~20. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, transacts business in, or has committed the alleged acts in the Northern District of California.

VENUE AND INTRADISTRICT ASSIGNMENT

~~19~~21. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims occurred in San Francisco County and Alameda County, and within the Division and Courthouse in which this action has been commenced.

PARTIES

I. PLAINTIFFS

~~20~~22. Plaintiff-Relator Gloryanne Bryant is an individual who, currently and during all times relevant to this action, resides in this judicial district. After her distinguished career in senior coding compliance positions with other California-based health care companies, Kaiser hired Ms. Bryant in May 2009 into a senior leadership position as Managing Director HIM for the Kaiser Foundation Health Plan, Northern California Revenue Cycle. Ms. Bryant remained at Kaiser until her retirement, effective as of October 3, 2017. In September 2013, Ms. Bryant was promoted to National Director Coding Quality, Education, Systems and Support for Kaiser's National Revenue Cycle Program Office, a position which she held until her retirement. Ms.

Bryant is a nationally recognized expert and educator in coding, clinical documentation improvement, and physician querying, and speaks and teaches regularly to state, regional, and national audiences. She holds professional designations of RHIA, RHIT, CCS, CDIP, and CCDS, and is an AHIMA-Approved ICD-10-CM/PCS Trainer.

~~21~~23. Plaintiff-Relator Victoria M. Hernandez is an individual who, currently and during all times relevant to this action, resides in this judicial district. Ms. Hernandez is a coding professional with over 25 years of experience in the healthcare field. She was employed by the Kaiser Defendants in various coding leadership positions from January 2000 through October 2015, including: (i) Regional Director of Auditing & Coding Services for TPMG from October 2014 through October 2015; (ii) Regional Director of Hospital Coding Audit & Education for Kaiser Foundation Health Plan from April 2012 through October 2014; and (iii) Regional Coding Review Manager for Kaiser Foundation Health Plan's Revenue Cycle HIM from February 2010 through April 2012. She holds professional designations of RHIA, CDIP, CCS, CCS-P and is an AHIMA-Approved ICD-10-CM/PCS Trainer.

~~22~~24. The United States, on whose behalf ~~Relator brings~~Relators bring this suit, is the real party in interest. The United States has ongoing contracts with Defendants through CMS, in accordance with Defendants' participation in the Medicare and Medicaid programs, and through HHS, in accordance with Defendants' participation in the ACA program.

II. THE DEFENDANTS

~~23~~25. Kaiser Foundation Health Plan, Inc. is part of Kaiser Permanente, an integrated healthcare consortium, that operates one of the nation's largest health plans, serving over 12 million members. Kaiser employs doctors and other medical professionals and provides medical services through its Permanente Medical Groups, a for-profit set of regional affiliates that includes The Permanente Medical Group ("TPMG") in Northern California, Southern California Permanente Medical Group ("SCPMG") in Southern California, and five other regional areas including Hawaii, the Pacific Northwest, Colorado, Georgia and the Mid-Atlantic States. Kaiser owns and operates acute care hospitals in four regions (Northern California, Southern California, Northwest and Hawaii), and provides care in other settings through its non-profit Kaiser Foundation Hospitals ("KFH").

~~24~~26. Kaiser's private health insurance plan covers the majority of its patient population. Kaiser Foundation Health Plan, Inc. and its subsidiary health plans also operate, however, various MA Plans, including Medicare Advantage HMO plans called "Senior Advantage," serving approximately 1.7 million members in 2021, and 1.4 million members in 2016, in approximately seven states and one district. As of 2016, Kaiser's Medicare Advantage Program served approximately 10% of Kaiser's overall patient population (10.7 million total as of 2016), but generated approximately 30% of Kaiser's overall profits. As of 2014, Kaiser's various ACA plans served approximately 1 million customers, and generated billions in revenue for Kaiser.

~~25~~27. Kaiser reported overall operating revenue of $~~88.7~~93.1 billion in ~~2020~~2021, compared to $64.6 billion in 2016 and $60.7 billion in 2015. Kaiser reported net income of $~~6.4~~8.1 billion in ~~2020~~2021, compared to $3.1 billion in 2016 and $1.9 billion in 2015.

Kaiser Permanente Total Health Plan Membership, by Region (as of ~~early 2017~~September 2022)

Northern California:	4,~~134,194~~600,000
Southern California:	4,~~390,653~~800,000
Colorado:	~~671,500~~509,773
Georgia:	~~306,806~~318,173
Hawaii:	~~250,221~~266,531
Mid-Atlantic States (Va., Md., D.C.):	~~702,516~~825,652
Northwest (Ore./Wash.):	~~575,688~~637,987
Washington:	~~677,050~~661,081

Source: https://~~share~~about.kaiserpermanente.org/~~article~~who-we-are/fast-facts~~-about-kaiser-permanente~~/

~~26~~28. Pursuant to inter-company agreements, the Kaiser Foundation Health Plan, Inc. and its subsidiaries share moneys received from federal and state governments with Kaiser's various Permanente Medical Groups and Kaiser Foundation Hospitals. Accordingly, all of the named Kaiser Defendants possess financial interests in maximizing the amounts claimed to and paid by the governments, and each Kaiser Defendant has participated in various aspects of the fraudulent practices, as described further herein.

~~27~~29. Defendant Kaiser Foundation Health Plan, Inc. is a California corporation with its principal place of business in Oakland, California within this judicial district.

~~28~~30. Defendant Kaiser Foundation Hospitals is a California corporation with its principal place of business in Oakland, California within this judicial district.

~~29~~31. Defendant The Permanente Medical Group, Inc. ("TPMG") is a California corporation with its principal place of business in Oakland, California within this judicial district. TPMG operates all Kaiser medical group operations in the Northern California region ("NCAL region").

~~30~~32. Defendant Southern California Permanente Medical Group ("Southern California PMG" or "SCPMG") is a California corporation with its principal place of business in Pasadena, California. SCPMG operates all Kaiser medical group operations in the Southern California region ("SCAL region").

~~31~~33. Defendant Colorado Permanente Medical Group, P.C. ("Colorado PMG") is a Colorado corporation with its principal place of business in Denver, Colorado. The Colorado PMG operates all Kaiser medical group operations in the Colorado region.

~~32~~34. Defendant The Southeast Permanente Medical Group, Inc. ("Southeast PMG") is a Georgia corporation with its principal place of business in Atlanta, Georgia. The Southeast PMG operates all Kaiser medical group operations in the Southeast region.

~~33~~35. Defendant Hawaii Permanente Medical Group, Inc. ("Hawaii PMG") is a Hawaii corporation with its principal place of business in Honolulu, Hawaii. The Hawaii PMG operates all Kaiser medical group operations in the Hawaii region.

~~34~~36. Defendant Mid-Atlantic Permanente Medical Group, PC ("Mid-Atlantic PMG") is a Maryland corporation with its principal place of business in Rockville, Maryland. The Mid-Atlantic PMG operates all Kaiser medical group operations in the Mid-Atlantic region, including Georgia.

~~35~~37. Defendant Northwest Permanente, P.C. ("Northwest PMG") is an Oregon corporation with its principal place of business in Portland, Oregon. The Northwest PMG operates all Kaiser medical group operations in the Northwest region, including Oregon.

~~36~~38. Defendant Washington Permanente Medical Group, P.C. ("Washington PMG") is a Washington corporation with its principal place of business in Seattle, Washington. The Washington PMG operates all Kaiser medical group operations in the Washington region.

~~37~~39. TPMG, Southern California PMG, Colorado PMG, Southeast PMG, Hawaii PMG, Mid-Atlantic PMG, Northwest PMG, and Washington PMG are referred to collectively herein as "The Permanente Medical Groups" or "PMGs". The PMGs have a national leadership and consulting organization, the Permanente Federation, which is run by the leadership of the PMGs. Unless stated otherwise, references to Kaiser actions or conduct taking place in a particular Kaiser region refers to the actions or conduct of the specific Permanente Medical Group that operates in that region.

~~38~~40. Defendants Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Health Plan of the Northwest, and Kaiser Foundation Health Plan of Washington (the "Kaiser Health Plans") are corporations organized under the laws of, and with their principle places of businesses in, Colorado, Georgia, Maryland, Oregon and Washington, respectively, and are subsidiaries of Kaiser Foundation Health Plan, Inc. Unless stated otherwise, references to the actions or conduct of a Kaiser health plan taking place in a particular Kaiser region refers to the actions or conduct of the specific Kaiser Health Plan that operates in that region.

THE LAW

~~A. Medicare Advantage (Medicare Part C)~~

~~39~~I. MEDICARE ADVANTAGE (MEDICARE PART C)

41. Under Medicare Part C, the Medicare Program pays each MA Organization a predetermined monthly amount for each Medicare beneficiary in the plan. This monthly payment is known as a "per-member, per-month" payment (or "PMPM"). This capitated payment for each plan varies depending on various factors, including amounts set forth in the plan's bid submitted

to CMS. Since 2000, Congress has also required that the payments be risk adjusted for each beneficiary based on demographic factors (e.g., gender, age) and health status. By risk adjusting for health status, Congress required that more be paid for beneficiaries with higher risk scores than be paid for beneficiaries with lower risk scores. CMS currently employs a health-based risk adjustment model — known as the Hierarchical Conditions Category ("HCC") model — that takes into account diagnoses from inpatient hospital stays, emergency and outpatient surgery encounters, and physician office visits.

~~40~~42. The HCC model is prospective, meaning that it relies on diagnoses for certain medical conditions assigned to beneficiaries by their physicians in a one calendar year timeframe (referred to by CMS as the "data collection" year but also generally known as the "date of service" or "DOS" year) to set the payment for each beneficiary for the following year (often referred to as the "payment year" or "PY"). The medical conditions included in the model are grouped into HCCs, which are categories of clinically-related medical diagnoses. See 42 C.F.R. § 422.2. The diagnoses grouped into HCCs include major, severe/acute, and/or chronic illnesses. Related groups of diagnoses are ranked on the basis of disease severity and the cost associated with their treatment. Between 2004 and 2013, the CMS-HCC model included 70 HCCs. Starting in 2014, the CMS-HCC model included 79 HCCs.

~~41~~43. The Government assigns a relative numerical value/weight to each HCC group that correlates to the predicted incremental costs of care associated with treating the medical conditions in each category. It determines the relative values based on the amounts that it paid to fee-for-service providers to treat these major, severe, and chronic medical conditions under Parts A and B of the Medicare Program. Higher relative values/weights are assigned to HCCs that include diagnoses with greater disease severity and greater costs associated with their treatment.

~~42~~44. As previously stated, the HCC risk adjustment model is prospective and a beneficiary's risk score for a particular payment year is determined by his or her medical conditions during the previous year (i.e., the date of service year). These medical conditions must be documented by a qualified healthcare provider (e.g., a doctor, physician's assistant, etc. as defined by the CMS MA program) in the beneficiary's medical record during the previous year.

~~43~~45. Each beneficiary's risk score is calculated anew for each payment year. For example, a beneficiary's risk score for payment year 2012 is determined by the diagnoses that his or her qualified healthcare providers documented in his or her medical records during face-to-face medical encounters during date of service year 2011.

~~44~~46. MA Organizations obtain diagnosis data from the healthcare providers that treat the beneficiaries in their plans. Healthcare providers can transmit diagnosis codes to MA Organizations with claims for payment for services rendered, in encounter records reporting the services rendered, or by alternative means.

~~45~~47. MA Organizations submit risk adjustment data, including diagnoses, to CMS using CMS' Risk Adjustment Processing System ("RAPS"). Each RAPS submission must include the following information: the Medicare beneficiary's identification number (called a "HIC number" or "HICN"); the date(s) of the medical encounter; the type of provider (physician or hospital); and the diagnosis code(s) reported by the provider for the encounter. Medical encounters include

physician office visits, hospital outpatient visits, and hospital inpatient stays.

~~46~~48. MA Organizations are entitled to risk adjustment payments based on the diagnosis codes that they submit to CMS only if the codes are from face-to-face medical encounters between the Medicare beneficiary and provider, the encounter occurred during the relevant date of service year, the provider was of a type and specialty acceptable for risk adjustment purposes, and at the time of the encounter, the provider documented the medical conditions identified by the diagnosis codes in the medical record based on acceptable documentation. In addition, codes should be based on documented conditions that require or affect patient care treatment or management. See 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide ("2008 RA Participation Guide") at § 6.4.1.

~~47~~49. Risk adjustment claims are true, and the resulting risk adjustment payments are valid, only to the extent that the diagnosis codes submitted by the MA Organizations are valid. The diagnoses must be coded according to the International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting ("ICD-9- CM" & "ICD-10-CM") and documented with sufficient clinical specificity. All diagnosis codes submitted by MA Organizations must be supported by medical record documentation. If the medical record is ambiguous, it cannot be relied on for diagnosis information for risk adjustment payments. See 2008 RA Participation Guide at § 7.2.4.1 (stating that risk adjustment claims and payments cannot be based on questionable diagnoses).

~~48~~50. MAOs have a statutory obligation to report and return any overpayment received from the Government, 42 U.S.C. § 1320a-7k(d). Further, federal regulations are clear that MAOs like Kaiser are required to report and return both overpayments that they have identified and overpayments that they "should have determined through the exercise of reasonable diligence" were made by CMS. 42 C.F.R. § 422.326(c). The law is clear that any overpayment retained after the statutory deadline of 60 days is an "obligation" for purposes of 31 U.S.C. § 3729. 42 U.S.C. § 1320a-7k(d)(4)(B) (defining overpayments); 42 C.F.R. § 422.326(e).

II. ~~B. Affordable Care Act ("ACA")~~

~~49. The Affordable Care Act sets up a program of risk adjustment in individual and group markets to lessen or eliminate the influence of risk selection on the premiums that plans charge. In the risk adjustment model utilized under the ACA, which is named the HHS-Hierarchical Condition Categories ("HHS-HCC") risk adjustment model, HHS utilizes criteria and methods similar to those utilized under the Medicare Advantage program, and adapts Medicare Advantage HCCs for use in the HHS-HCC model. The chief goal in the design of the HHS-HCC model is to assure that premiums reflect differences in benefits and plan efficiency. The HHS-HCC model uses current year diagnoses and demographics to predict the current year's spending, as distinguished from the Medicare Advantage program, which uses the risk adjustment model to predict next year's spending. But in the end, the effect of risk adjustment on ACA premiums is similar to the impact of risk adjustment on capitated payments made under the Medicare Advantage program. Insurers like Kaiser receive more ACA premiums the more documented and coded conditions are submitted for their insureds.~~

~~50. Pursuant to the ACA, the United States contributes, through tax credits, to premiums paid~~

~~by low-income individuals to private health insurance companies, including Kaiser, based upon a sliding scale calibrated to the poverty line. Accordingly, when premiums are artificially high due to documentation and coding fraud, both enrollees and the United States are harmed by the overcharges.~~

AFFORDABLE CARE ACT

51. Through passage of the landmark ACA, Congress greatly expanded the availability of health insurance to previously uninsured Americans by making insurance more accessible and less expensive. To do this, it prohibited insurers from setting premiums based on the health status of prospective enrollees, and provided tax credits to qualifying individuals to cover premium costs. This allowed millions of previously uninsured Americans, who may not have had health insurance prior to the ACA due to preexisting health conditions or financial inability to pay premiums, to become insured.

52. One of the principal features of the ACA is the creation of "Exchanges" consisting of private insurers offering health insurance plans to individuals and small groups in a particular State. The Kaiser Health Plans each sell health care plans through the ACA Exchanges in their respective States and regions.

53. Under the ACA, private insurers offer different tiers of plans: Bronze, Silver, Gold, or Platinum. Consumers select the tier of coverage they want from among the insurers offering plans in their area, and pay the corresponding monthly premium, with the Government providing tax credits to fully or partially offset the monthly premiums for those consumers that qualify. The insurer has to justify the premium charged by providing the Government with a comprehensive set of data that explains the rates charged.

54. Opening up insurance to those without existing coverage, like the ACA did, could also make insurers flee the market due to fears of unhealthy individuals rushing to sign-up, coupled with the general uncertainty of what kind of risk pool would develop when prices did not depend on existing health conditions. At the same time, the success of the ACA Exchanges depends on enticing insurers to offer coverage and compete against one another to keep premiums low.

55. To meet both goals – keeping insurers in the market, and keeping prices low – as part of the ACA, Congress set up the Risk Adjustment Program. The ACA's Risk Adjustment Program, explained in greater detail below, "is intended to provide increased payments to health insurance issuers that attract higher-risk populations (such as those with chronic conditions) and reduce the incentives for issuers to avoid higher-risk enrollees. Under this program, funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees." Final Rule, 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012).

56. The ACA's Risk Adjustment Program takes patient data provided by insurers, evaluates each insurer's risk in a given market, and shifts money from insurers who ended up with healthier populations to insurers who ended up with sicker populations. After completion of the risk adjustment process for a given benefit year, the Government shifts funds by issuing invoices to those insurers who owe risk adjustment payments (and those insurers then submit the due funds directly to the Government), and issues payments from the Treasury to those insurers who

are due risk adjustment payments.

57. The ACA's Risk Adjustment Program depends on insurers providing accurate information to the Government, so that the Government has full transparency into the risk profile of each insurer, and the insurers have transparency into the risk profiles of one another. The accuracy of risk adjustment data is so important to the Government that the ACA requires that insurers participating in the Exchanges certify that the risk adjustment data submitted to HHS is accurate, and provides for substantial penalties for noncompliance. Virtually every aspect of the ACA's Exchanges depends on accurate risk data – the premiums charged depend on it, the premium tax credits depend on it, and the risk adjustment payments to or from participating insurers depend on it.

58. This balancing of risk is of critical importance to the ACA. If there were no risk sharing among insurers, fewer (if any) insurers would participate in the program, leaving uninsured Americans with more expensive health care coverage, and resulting in fewer people having health insurance.

59. Through the Risk Adjustment Program, the Government thus balances out the overall risks taken on by insurers in a given market, by shifting funds from insurers with less risky (less expensive, more healthy) patients to insurers with more risky (more expensive, less healthy) patients. See 42 U.S.C. § 18063(a).

60. Through the ACA, Congress authorized the Secretary of HHS to "issue regulations setting standards for meeting the requirements" of, inter alia, the establishment of Risk Adjustment Programs. 42 U.S.C. § 18041(a)(1)(C).

61. On March 23, 2012, HHS issued a Final Rule setting forth 45 CFR Part 153, the regulations implementing standards including standards for the Risk Adjustment Program. 77 Fed. Reg. 17220 (Mar. 23, 2012). HHS modified and expanded Part 153 as its experience with the Risk Adjustment Program dictated. For instance, on March 11, 2013, HHS issued a Final Rule making certain changes to 45 CFR Part 153, including adding Subpart H, "Distributed Data Collection for HHS-Operated Programs." 78 Fed. Reg. 15410 (Mar. 11, 2013).

A. HHS Operates the ACA Risk Adjustment Program

62. Each State has the option of establishing and running its own Risk Adjustment Program, or letting HHS "carry out all of the provisions" of the Risk Adjustment Program "on behalf of the State." 42 C.F.R. §§ 153.310(a)(2) and (a)(3).

63. Since 2017, all States have opted to let HHS run and administer their Risk Adjustment Programs. Prior to 2017, the only exception was Massachusetts. Kaiser does not offer health care plans in Massachusetts. In other words, in all States in which Kaiser offers health care plans through the ACA—California, Colorado, the District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington—and since 2014 when the ACA's Risk Adjustment Program became operative, HHS has operated and continues to operate the Risk Adjustment Programs.

64. Accordingly, only HHS-operated Risk Adjustment Programs are relevant to this lawsuit; how Massachusetts (the sole other entity to operate a Risk Adjustment Program under the ACA)

operated its Risk Adjustment Program prior to 2017 has no bearing on this lawsuit, Relators' claims, or Kaiser's fraud.

B. Requirements and Operation of HHS' Risk Adjustment Program

65. The ACA utilizes a hierarchical condition category ("HCC") model (the "HHS-HCC" model) modeled after the Medicare risk adjustment model. See, e.g., 2013 Final Rule, 78 Fed. Reg. 15410, 15420 ("The ten principles that were used to develop the HCC classification system for the Medicare risk adjustment model also guided the creation of the HHS risk adjustment model[.]"). The medical conditions in the model are grouped into HCCs, or categories of clinically-related medical diagnoses. Initially, 127 HHS-HCCs were included in the HHS risk adjustment model. Id. The HHS-HCC model also takes into account prescription drug data.

66. The HHS risk adjustment model determines an individual's "individual risk score," defined as "a relative measure of predicted health care costs for a particular enrollee that is the result of a risk adjustment model." 45 C.F.R. § 153.20. Under the HHS Risk Adjustment Model, the "individual risk score" is determined by an individual's age, sex, and medical diagnoses. See, e.g., 2013 Final Rule, 78 Fed. Reg. 15410, 15422 ("For clarity, we describe here the HHS risk adjustment models that we are finalizing. An individual's risk score will be calculated for adults and children as the sum of the factors in the applicable model for the relevant age and sex categories, HHS HCCs, and, where applicable, disease interactions."); 2016 Final Rule, 81 Fed. Reg. 94058, 94071 ("In each of the adult and child models, the relative costs assigned to an enrollee's age, sex and diagnoses are added together to produce a risk score.").

67. With respect to documenting medical data related to diseases, injuries, impairments, other health problems, as well as the diagnosis, treatment, and management of hospital inpatients, the ACA requires the use of the International Classification for Diseases ("ICD") standards. Before October 1, 2015, the ACA's standard was ICD-9-CM. See 45 C.F.R. § 162.1002(a) and (b). After that date, the ACA has required the use of ICD-10-CM. See 45 C.F.R. § 162.1002(c). See also 45 C.F.R. § 153.610 (requiring that all "risk adjustment data" be submitted in accordance with the procedures established by HHS). At all times, the ACA has further required that insurers in its Exchanges adhere to "The Official [ICD-9-CM or ICD-10-CM] Guidelines for Coding and Reporting." 45 C.F.R. § 162.1002(a), (b), and (c). Thus, in addition to the ICD-9-CM and ICD-10-CM classifications, adherence to the corresponding Official Guidelines for Coding and Reporting is mandatory under the ACA.

68. To facilitate the Risk Adjustment Program, HHS requires insurers to use a "dedicated distributed data environment" to provide required data to HHS. See 45 C.F.R. § 153.700(a) ("Dedicated distributed data environments. For each benefit year in which HHS operates the risk adjustment or reinsurance program on behalf of a State, an issuer of a risk adjustment covered plan or reinsurance-eligible plan in the State, as applicable, must establish a dedicated data environment and provide data access to HHS, in a manner and timeframe specified by HHS, for any HHS-operated risk adjustment and reinsurance program.").

69. Binding ACA regulations require entities participating in the Exchanges to validate the data that they submit to the Government as part of the risk adjustment process, including ensuring that the documentation "align[s] with dates of service for the medical diagnoses, and

reflect[s] permitted providers and services," and "[v]alidating medical records according to industry standards for coding and reporting." 45 C.F.R. § 153.630(b)(7).

70. The "dedicated distributed data collection environment" that HHS requires insurers to use is called the External Data Gathering Environment, or EDGE. Using EDGE, insurers must provide HHS with "access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS." 45 C.F.R. § 153.710(a). As set forth above, that data includes HHS-HCC diagnoses.

71. The insurer confirms that the data contained in EDGE is accurate by way of an attestation that legally and financially binds the insurer.

72. Specifically, at the end of the EDGE data submission process, HHS issues final EDGE server reports to an insurer, reflecting the data that the insurer has submitted for a benefit year. The insurer then has 15 days to either confirm that the information contained in the final EDGE server report for a benefit year is accurate, or describe any discrepancy that it identifies. 45 C.F.R. § 153.710(d). HHS considers a discrepancy to be "material" if it exceeds the lesser of $100,000 or 1% of the payment due to or from the insurer under the Risk Adjustment Program. 45 C.F.R. § 153.710(e).[2]

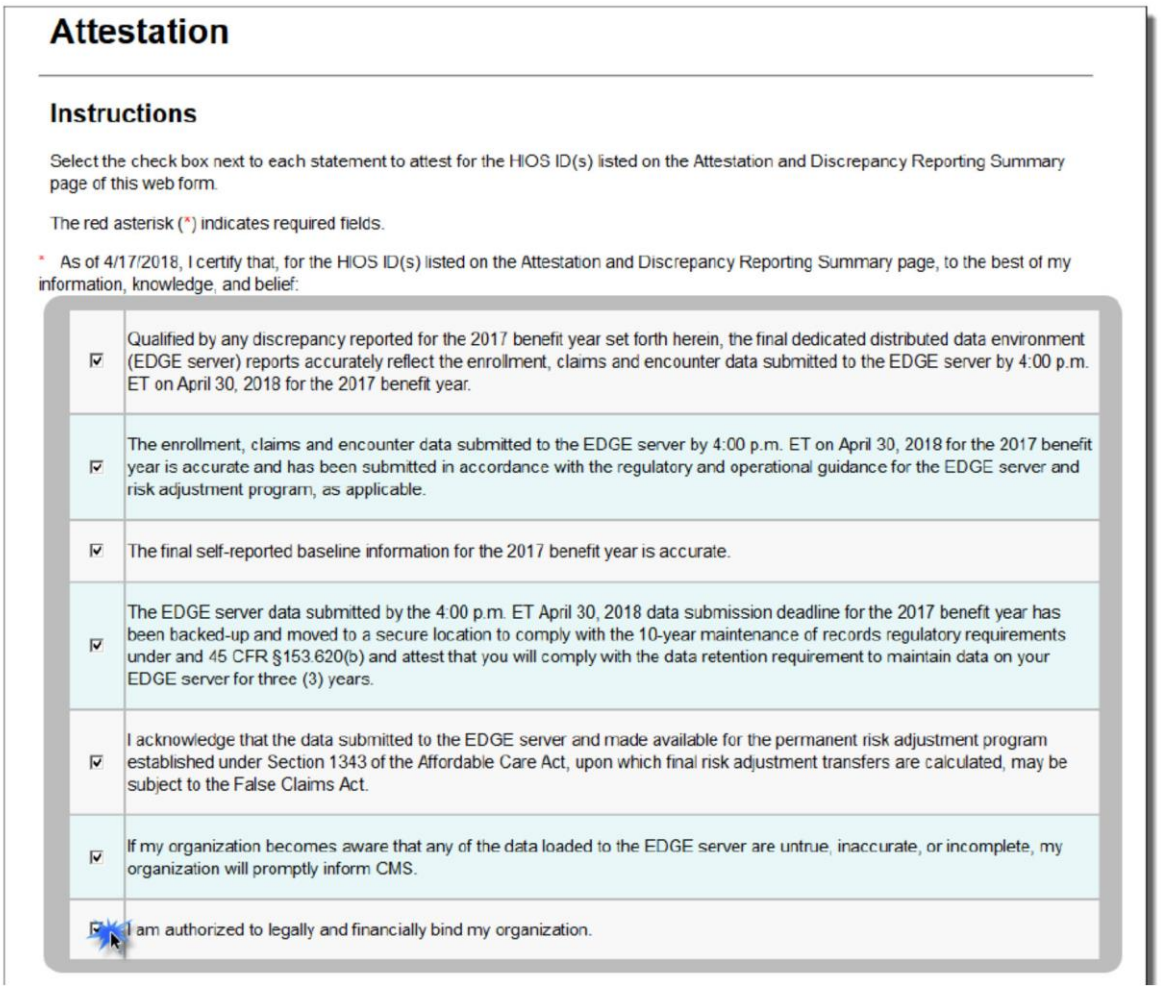
73. In providing the EDGE attestations, insurers certify that the information provided via EDGE accurately reflects the enrollment and claims data for the insurer; that the insurer has complied with all regulatory and operational guidance for the EDGE system; and that data submitted and used for the Risk Adjustment Program may be subject to the False Claims Act. For example, below is a screenshot of the 2017 benefit year attestation:

[2] The materiality threshold was changed from $10,000 to $100,000 in 2021. See 2021 Final Rule, 86 Fed. Reg. 24140, 24195-95.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

EDGE Attestation & Discrepancy Reporting

Figure 35: Attestation Statement



Attestation

Instructions

Select the check box next to each statement to attest for the HIOS ID(s) listed on the Attestation and Discrepancy Reporting Summary page of this web form.

The red asterisk (*) indicates required fields.

* As of 4/17/2018, I certify that, for the HIOS ID(s) listed on the Attestation and Discrepancy Reporting Summary page, to the best of my information, knowledge, and belief:

☑	Qualified by any discrepancy reported for the 2017 benefit year set forth herein, the final dedicated distributed data environment (EDGE server) reports accurately reflect the enrollment, claims and encounter data submitted to the EDGE server by 4:00 p.m. ET on April 30, 2018 for the 2017 benefit year.
☑	The enrollment, claims and encounter data submitted to the EDGE server by 4:00 p.m. ET on April 30, 2018 for the 2017 benefit year is accurate and has been submitted in accordance with the regulatory and operational guidance for the EDGE server and risk adjustment program, as applicable.
☑	The final self-reported baseline information for the 2017 benefit year is accurate.
☑	The EDGE server data submitted by the 4:00 p.m. ET April 30, 2018 data submission deadline for the 2017 benefit year has been backed-up and moved to a secure location to comply with the 10-year maintenance of records regulatory requirements under and 45 CFR §153.620(b) and attest that you will comply with the data retention requirement to maintain data on your EDGE server for three (3) years.
☑	I acknowledge that the data submitted to the EDGE server and made available for the permanent risk adjustment program established under Section 1343 of the Affordable Care Act, upon which final risk adjustment transfers are calculated, may be subject to the False Claims Act.
☑	If my organization becomes aware that any of the data loaded to the EDGE server are untrue, inaccurate, or incomplete, my organization will promptly inform CMS.
☑	I am authorized to legally and financially bind my organization.

Source: EDGE Attestation & Discrepancy Reporting, Web Form Guide, May 2018.

C. How Premiums Are Calculated Under the ACA

74. Every insurer offering health insurance in either the individual market or small group market through the ACA must submit a "rate filing justification" with CMS in support of the premiums that it charges. 45 C.F.R. § 154.103; 45 C.F.R. § 154.215.

75. The "rate filing justification" that insurers submit includes a completed "Unified Rate Review Template" ("URRT") which includes historical and projected claims data. 45 C.F.R. § 154.215(a)(1); 45 C.F.R. § 154.215(d)(1). As HHS explains, "[t]he URRT is required for all single risk pool plans in the individual, small group, and combined markets. This includes single risk pool plans that experience no rate changes, rate decreases, as well as new single risk pool plans. It is intended to capture information needed to monitor premium increases of health

insurance coverage offered through and outside an Exchange and ensure compliance with the single risk pool methodology, including allowable market level Index Rate adjustments to reflect risk adjustment payments and charges, and other federal rating requirements." 2023 Unified Rate Review Instructions, OMB Control No. 0938-1141, at 4. The use of a single risk pool is a critical component of the ACA and the URRT process. All participating insurers are required to set their plans to the market average by estimating risk adjustments. Though insurers do not have to use the URRT methodology to construct their premiums, they do have to input their data according to URRT guidelines.

76. HHS provides step-by-step instructions for insurers to complete the URRT. See 2023 Unified Rate Review Instructions, OMB Control No. 0938-1141. Through the URRT process, the insurer derives the ultimate Consumer Adjusted Premium Rates, as shown in this diagram from the instructions:

The following graphic depicts the flow of the Index Rate development process:

Figure 1 Flow of the Index Rate development process

Source: 2023 Unified Rate Review Instructions, OMB Control No. 0938-1141, at 10.

77. The insurer's premiums factor in payments that the insurer expects to either make or receive through the Risk Adjustment Program. See, e.g., 45 C.F.R. § 156.80(d)(1)(ii). In completing the URRT, when making adjustments to the Projected Index Rate (the second blue box in the diagram above), the insurer includes the amount of risk adjustment payments that the insurer expects to receive or make under the ACA's Risk Adjustment Program. 2023 Unified Rate Review Instructions, OMB Control No. 0938-1141, at 18.

78. In addition, if the insurer is increasing its rates at all from the previous year, it must also include "an actuarial memorandum that contains the reasoning and assumptions" supporting the proposed rate. 45 C.F.R. § 154.215(a)(2); 45 C.F.R. § 154.215(f). If the proposed increase is more than 15%, the insurer also has to provide a written description justifying the rate increase. 45 C.F.R. § 154.215(a)(3); 45 C.F.R. § 154.215(e). In many years since the ACA's inception, Kaiser has submitted such actuarial memoranda and written descriptions as part of the URRT process to justify increasing its rates.

D. Premium Tax Credits Under the ACA

79. Through the ACA, the Government pays a portion of premiums to insurers offering ACA plans. It does so through the use of tax credits, using federal funds to pay private insurers for all or part of the premiums charged to qualifying individuals under the ACA.

80. The amount of the tax credit depends on two things: the cost of the "benchmark plan" for an individual, and the individual's expected contribution (based on a percentage of the individual's income). Essentially, the Government, using federal funds, pays those portions of

the ACA premiums that exceed an individual's expected contributions to the cost of the benchmark plan in the individual's area.

81. The "benchmark plan" is the "second lowest cost silver plan... offered through the Exchange for the rating area where the taxpayer resides[.]" 26 C.F.R. § 1.36B-3(f).

82. An individual's expected contribution is determined on a sliding scale, based on family size and income.

83. Thus, the amount of the premium tax credit is the cost of the benchmark plan minus the expected contribution.[3]

84. Individuals then take that tax credit and apply it to whatever type of plan - Platinum, Gold, Silver, Bronze - they choose, from whichever insurer. The amount of the credit does not change based on the plan chosen, and the credit can be applied to any plan, not just the benchmark plan. Individuals can elect to have the premium tax credit paid directly from the Government to their insurer, or can claim it on their tax returns. In either scenario, Government funds are used to pay the credit. If the premium of the plan selected by the individual is less than the tax credit to which the individual is entitled, the maximum credit applied is the amount of the premium.

E. Conditions of Insurer Participation in the ACA

85. The ACA explicitly addresses materiality as follows: "Compliance with the requirements of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall be a material condition of an issuer's entitlement to receive payments, including payments of premium tax credits and cost-sharing reductions, through the Exchange." 42 U.S.C. § 18033(a)(6)(A).

86. The Secretary has issued "issuer participation standards" establishing criteria that must be met for insurers to be eligible to participate in the ACA. 45 C.F.R. § 156.200. See also 77 Final Rule 18309 at 18415 ("In § 156.200, we outline the proposed standards on QHP issuers as a condition of participation in the Exchange."). The "participation standards" outlined by the Secretary include the requirement that insurers comply with the Risk Adjustment standards contained in 45 C.F.R. part 153. 45 C.F.R. § 156.200(b)(7).

87. Thus, in order for an insurer to be able to participate in the ACA Exchange, and to receive premium tax credits and risk-adjustment payments, it must comply with the Risk Adjustment standards discussed above and set forth in 45 C.F.R. part 153.

THE FACTS

I. KAISER AND ITS RELATED COMPANIES OVERDOCUMENT AND OVERCODE/UPCODE "HIGH-VALUE" HIERARCHICAL CONDITION CODES ("HCCS")

[3] Due to the American Rescue Plan and the Inflation Reduction Act, from 2021 through 2025, the expected contribution is capped at 8.5% of a household's income.

~~51~~88. Ms. Bryant and Ms. Hernandez have witnessed Kaiser and its related companies engage in systematic fraud on the Medicare Advantage program~~,~~ and ~~other government programs including~~ the ACA~~,~~ program for many years through teaching and implementing "HCC maximization techniques" to physicians and coding staff, resulting in systematic over-documenting, over-coding and upcoding of certain high value HCCs, as detailed below. The HCCs directly impact risk adjustment scores, meaning that the Government overpays Kaiser for its patient population which is not as sick as Kaiser reports.

~~52~~89. Kaiser submitted a Risk Adjustment Attestation to the Medicare Program each year after the final risk adjustment submission deadline and knew that it was required to submit a truthful Risk Adjustment Attestation. Despite its obligations under Medicare law, Kaiser's documentation, coding and Risk Adjustment Attestations have been false.

90. Similarly, Kaiser submitted Risk Adjustment Attestations to HHS under the ACA program each year after the final risk adjustment submission deadline and knew that it was required to submit truthful Risk Adjustment Attestations. Despite its obligations under the ACA, Kaiser's documentation, coding and Risk Adjustment Attestations have been false.

A. Aortic Atherosclerosis ("AA")

~~(i)~~1. Clinical significance, documentation and coding convention

~~53~~91. AA is sometimes referred to as "hardening of the arteries." It describes a thickening and loss of elasticity in the arterial wall. This condition is often an incidental finding in radiology and imaging reports and neither treated nor managed after being identified. It often has no impact on patient care or outcomes. Unless AA is related to signs, symptoms or conditions/diagnoses that necessitated the performance of the radiology and imaging test, treatment and management is actually directed toward the AA, or a follow-up office visit is ordered for treatment, it should not be reported/coded to Medicare.

~~54~~92. For example, the American Hospital Association's ("AHA") Coding Clinic, the official clearing house for ICD-9-CM and ICD-10-CM/PCS coding guidance, publishes the following guidance for outpatient encounters, including emergency room visits: "It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a patient being seen in the emergency department (ED). The ED physician would need to clarify that the finding was clinically significant and related to the visit in order for it be coded." See Exhibit 1.

~~55~~93. Official Coding and Reporting Guidelines applicable to inpatient encounters further confirm ~~the standard:~~

> encounters for diagnostic tests that have been interpreted by a provider.

that coding is only appropriate for "encounters for diagnostic tests that [actually] have been interpreted by a provider," and "abnormal findings ... are not coded and reported unless the provider indicates their clinical significance." When it is coded, AA is currently assigned ICD-10-CM code 170.0 (Atherosclerosis of Aorta). Under ICD-9-CM, AA was assigned ICD-9-CM

code 440.0 (Atherosclerosis of Aorta). The AA diagnosis is assigned to HCC 108; in 2016, Kaiser received approximately $2,260 for each HCC 108 code under Medicare Advantage. There is no corresponding HHS-HCC for AA in the ACA program.

~~(ii)~~2. Kaiser's scheme

~~56~~94. Labeled an "area of significant missed opportunity" by Kaiser's Medicare Finance Group and Kaiser's Permanente Medical Groups, Kaiser implemented an HCC initiative in 2011 to review and capture AA diagnoses in all clinic, emergency, outpatient surgery, and inpatient encounters, even when incidental to the encounter. In Kaiser's NCAL region, Kaiser subsidiary TPMG trained its physicians to choose a diagnosis from Kaiser's proprietary, electronic diagnosis "pick list" to capture AA, even when it was merely an incidental finding.

~~57~~95. Kaiser's TPMG senior clinician leaders took the position that AA is a "chronic, systemic condition" that is a permanent risk factor once diagnosed, and thus is properly codeable regardless of its actual significance or treatment. This interpretation, if accurate, would result in the AA diagnosis meeting the Official Coding and Reporting Guideline for the coding of a systemic condition without coding staff questioning it. Kaiser's NCAL TPMG region directed Regional Health Information Management ("Regional HIM") coding leaders to instruct and train to "always code" AA on the basis that it was supposedly a systemic condition and should always be coded. This direction and instruction ignored coding conventions and guidance, and internal feedback from Kaiser NCAL's Regional HIM, including Ms. Bryant and Ms. Hernandez who questioned whether this condition was truly systemic. This improper TPMG direction was eventually migrated to Kaiser's other regions as a "best practice~~."~~," and implemented in each of those regions by the other Kaiser Permanente Medical Groups.

~~58~~96. Kaiser's NCAL Regional HIM, led by Ms. Bryant, remained uncomfortable with the TPMG instruction on AA. Ms. Bryant had numerous conversations with individuals within TPMG and others within Kaiser regarding her and her colleagues' concerns, and submitted a written inquiry to AHA Coding Clinic as to whether the diagnosis of AA is properly considered a chronic, systemic condition (similar to hypertension and diabetes mellitus) that is codeable on a routine basis even in the absence of treatment, management, and/or monitoring. The guidance received from AHA Coding Clinic subsequently rejected NCAL TPMG's clinical determination. But TPMG management exerted intimidation, pressure and other undermining techniques to silence Ms. Bryant and her Regional HIM staff.

~~59~~97. To provide "documentation" that would constitute evidence of the clinical significance of AA and meet the Official Coding and Reporting Guidelines, Kaiser's NCAL TPMG region developed a "SMARTPHRASE" to automatically populate the medical record when AA was observed and/or diagnosed in radiology and imaging reports that would routinely, automatically, and falsely state that the diagnosis was significant, not incidental, and would require clinical follow-up, often through the use of "addenda" added to the medical record long after the medical visit. This process was implemented so that the hospital coding staff would assign the ICD-9-CM code for AA, and the HCC for AA would be captured.

~~60~~98. Ms. Bryant continued to bring her concerns to Kaiser's National Compliance Ethics & Integrity Office ("National Compliance Office" or "NCO") and finally, in August 2015, Kaiser

NCO announced that a Kaiser Permanente ("KP") clinical review overruled NCAL TPMG's clinical determination that AA is a chronic, systemic condition that should always be coded. But three years had passed and hundreds of thousands of inaccurate, false codes entered before that belated direction was issued. There was no discussion of or action plan developed to address the inaccuracies of the past with the AA diagnosis and HCC capture.

~~61~~99. Kaiser coded data reports from 2010-2016 shows that the increased AA diagnosis-capture scheme worked – AA diagnoses and coding increased four- and five-fold across all Kaiser regions over that period ~~and spread to all patient populations and payers~~.

~~(iii)~~3. Chronology and evidence

~~62~~100. In late 2011, members of Kaiser's National Compliance Office and NCAL Revenue Cycle teams for The Kaiser Foundation Health Plan and Hospitals ("NCAL KFHP") focused attention on the accurate coding of AA as a result of internal inquiries and requests for guidance. After an exchange of emails, members of these teams, including Ms. Bryant and Ms. Hernandez, drafted and published a memo to all Regional HIM Directors and hospital Coding Staff in March 2012 outlining the correct coding convention for AA. See Exhibit 2. The memo correctly stated that AA should not be coded except under certain limited conditions (see above).

~~63~~101. TPMG Director Anne Cadwell, NCAL Revenue Cycle VP David Nyburg, and TPMG Physician Liaison Dr. David Bliss reacted unfavorably to this memo immediately. In calls with Ms. Bryant, they took the position that AA "is always significant and a risk factor so thus they will teach the MDs to document that so it will be coded." See Exhibit 3. Ms. Bryant noted that she was "troubled" by this approach in an email to Janet Franklin, Kaiser's Senior Compliance Practice Leader in its National Compliance Office. Id. Ms. Hernandez and other HIM coding leaders shared Ms. Bryant's concern. No definitive guidance was provided nor action taken by Kaiser's National Compliance Office.

~~64~~102. In 2012, TPMG trained its doctors to document AA as if it were always significant, and KFH hospital coding staff to always code AA, as directed by Dr. Bliss and other TPMG Directors (e.g., Anne Cadwell, Karen Graham, and Erica Eastham). In a December 3, 2012 email, TPMG's Ms. Cadwell wrote to Ms. Bryant and Ms. Hernandez that she was concerned that Kaiser Hospital coding staff was not getting the communication about AA: "We need to get everyone on the same page that AA is not an incidental finding from a clinical perspective." See Exhibit 4 (emphasis in original). Ms. Bryant and Ms. Hernandez felt that they were being strongly pressured to violate coding guidelines and to participate in manipulating documentation and codes.

~~65~~103. During a December 12, 2012 WebEx/call with TPMG, TPMG Director Ms. Cadwell told NCAL HIM Leadership that the NCAL region would develop and implement a "SMARTPHRASE" for its doctors to add to, or "addend," the patients' electronic files (e.g., in their EPIC electronic health records, called "KP Health Connect") whenever AA was found on a radiology report in order to indicate its significance, even months after the encounter. It was requested that NCAL HIM leadership approve this documentation so that AA would be "always coded~~."~~"" for all risk-based payers, including both the MA program and the ACA program See Exhibit 5 (WebEx meeting invitation).

~~66~~104. The "SMARTPHRASE" developed by TPMG in Kaiser's NCAL region stated as follows: "Aortic Atherosclerosis noted on review of the radiology exam associated with chart review and this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time by PCP or appropriate specialist." See Exhibit 6 at REL0000061. This phrasing was developed in an attempt to satisfy the numerous concerns raised by NCAL HIM Leadership (i.e., Ms. Bryant and Ms. Hernandez) that documentation of AA was required, including language of clinical significance, to pass audit and/or coding compliance testing. But it was clinically false and misleading. AA can be clinically insignificant and incidental and should not always be coded, but Kaiser was training its physicians to always document the clinical significance of the findings so as to cause coders to always code it without question. In December 2012, NCAL HIM was still waiting for Kaiser's National Compliance Office to provide definitive guidance. In the meantime, Ms. Bryant and Ms. Hernandez made repeated but futile attempts to help TPMG leadership understand the compliant and appropriate documentation for the coding of AA.

~~67~~105. By January 2013, Dr. Bliss, TPMG Director Ms. Cadwell and other senior management had fully overridden the coding memo issued in March 2012 by NCAL HIM Leadership. Summarizing Kaiser NCAL's new directive for coding AA in the hospital setting, Ms. Bryant emailed Kaiser's National Compliance personnel, including Ms. Franklin, as follows (copying Ms. Hernandez) to alert NCO as to the new direction in the NCAL region: "TPMG takes the position that once AA is present it never goes away and is then a lifelong risk factor ~~....~~.... We (NCAL) do believe that AA meets the criteria to be reportable and does impact care and decision making. To go further with this discussion I believe needs individual with greater clinical knowledge like physicians and would invite TPMG i.e. Dr. David Bliss) [sic] to discuss this further." See Exhibit 7. Kaiser's National Compliance Office did nothing to stop this new direction.

~~68~~106. In fact, Ms. Bryant was required to be "supportive," "collaborative," and a "partner" with TPMG's direction for capturing the AA HCC by putting together an educational power point presentation with Dr. Bliss titled "Documentation and Coding Aortic Atherosclerosis Clarification," which they presented during a January 2013 WebEx conference call for NCAL Regional hospital coding staff and Clinical Documentation Integrity Staff (CDI). See Exhibit 8. The presentation identified AA as an "Area of significant missed opportunity."[4] Id. at REL0000069. The presentation adopted TPMG's and Dr. Bliss' position that AA is a "systemic disease" that should always be diagnosed, documented, and coded when identified in a radiology report, and should be added to Kaiser's "Always Code" List (which is a Kaiser National Compliance Office document).

~~69~~107. Similar presentations were made throughout 2013, 2014 and 2015 to various Kaiser regional leadership audiences. TPMG's AA directive and ~~smartphrase~~Smartphrase were migrated to Kaiser's other regions and adopted by Kaiser's other Permanente Medical Groups. For example, at Kaiser's Regional Reporting Group ("RRG") meetings, Kaiser regional leaders overseeing its Medicare Advantage programs presented on opportunities and techniques to

[4] Two years earlier, in a September 2011 power point presentation entitled "Documentation and Coding Leads Meeting," TPMG used the same phrase for capturing AA – "Area of significant missed opportunity" – establishing that capturing the diagnosis had been a long-term focus in the Kaiser NCAL region. See Exhibit 9 at REL0000107.

capture high-yield HCCs, including AA, emulating NCAL TPMG. See Exhibit 10 at REL0000137. Similarly, Kaiser NCAL's Revenue Cycle Clinical Documentation Integrity/Improvement ("CDI") included vascular disease (including AA) as an HCC target, and an opportunity to query physicians based on radiology and imaging findings. See Exhibit 11 at REL0000179-80.

~~70~~108. On behalf of NCAL HIM Regional Leadership, Ms. Bryant remained deeply concerned and continued to pursue direction and guidance from Janet Franklin of Kaiser's National Compliance Office, but received none. Moreover, Ms. Bryant and NCAL HIM Regional Leadership, including Ms. Hernandez, continued to question the new direction taken by TPMG leadership regarding AA diagnosis and coding. Due to her continued concern, Ms. Bryant went so far as to submit a question to AHA Coding Clinic, the recognized authority on ICD-9 and ICD-10 coding, on the issue in December 2012. See Exhibit 12.

~~71~~109. Kaiser drafted queries to Coding Clinic at least two other times regarding the proper coding of AA (see Exhibit 13): In May 2013, Kaiser queried Coding Clinic regarding the status of AA as "a chronic systemic condition." Id. at REL0000189. In its May 16, 2013 response, Coding Clinic stated that if the impact of AA were unclear, the physician should be queried. Id. Over a year later, in approximately November 2014, Kaiser NCO's Janet D. Franklin, with the assistance of Ms. Bryant, drafted a detailed follow-up question to AHA Coding Clinic: Would AA "be considered a systemic condition that can be coded even in the absence of active intervention in the same way that other systemic diagnoses noted in Coding Clinic (e.g. COPD, CHF, Diabetes, Parkinson's Disease, hypertension) may be coded without additional documentation of evaluation, treatment, consideration, etc."? Id. at REL0000186-87. Ms. Franklin noted in the attached exhibit that her draft was subject to review by Dr. Simon Cohn, Kaiser's physician lead for The Medical Group Federation and RRG, and other Kaiser staff. Ms. Bryant was later told by Nancy Anderson of Kaiser's NCO group that the question was never submitted to AHA Coding Clinic based upon a decision by Kaiser leadership, yet another Kaiser decision that caused Ms. Bryant and Ms. Hernandez significant concern.

~~72~~110. In the meantime, while the Permanente Medical Groups in Kaiser's other regions were following TPMG's practice to always document and code AA, Kaiser's National Compliance Office was taking its time deciding whether that direction was proper. On July 23, 2014, TPMG approached Ms. Bryant and Ms. Hernandez to meet to discuss viewpoints regarding AA capture for Kaiser's National Compliance office. See Exhibit 14 (calling the long-delayed meeting "a high priority and time critical").

~~73~~111. On July 31, 2014, a presentation was given to Kaiser's Coding Governance Group (CGG), which represents all Kaiser Regions, on the topic of AA capture for coding, taking the position that AA should be added to Kaiser's "Always Code List" as a chronic, systemic condition. See Exhibit 15 at REL0000220.

~~74~~112. In 2015, Dr. Simon Cohn, the physician lead for Kaiser's Medical Group Foundation and RRG, requested that Ms. Bryant meet with him face-to-face, but did not provide the topic of the discussion in advance. During the meeting in Dr. Cohn's office, Dr. Cohn asked Ms. Bryant to summarize the events surrounding AA HCC capture at Kaiser, including the TPMG guidance and direction of Dr. Bliss and others, which she did. Dr. Cohn told Ms. Bryant that this issue was

being further reviewed by the medical groups. Ms. Bryant told Dr. Cohn that it was not her place to question the clinical and medical interpretations of Dr. Bliss, so she accepted his direction but felt compelled to go to NCO for further and final advice. In the meantime, the improper coding of AA continued throughout Kaiser, with Kaiser physicians being instructed, trained, and prompted to add the HCC diagnosis during or even months after patient encounters through addenda to the medical records.

~~75~~113. Finally, on August 4, 2015, Kaiser's National Compliance Office and Medical Group Federation completed its "clinical review" of TPMG's AA directive, requiring that it be changed back to the way that Ms. Bryant, Ms. Hernandez and their colleagues in NCAL HIM stated it in 2011 and early 2012: "After having gone through clinical review, AA is not considered a systemic condition and will not appear on the final list of examples of systemic conditions. The clinician must do more than just list this condition. There must be documentation to show how it impacted the current encounter. It will be up to the region to decide if they want to query the provider about this condition when it is only listed. Without a query and additional documentation from the provider to show how it impacted the encounter, it cannot be coded." See Exhibit 16 at REL0000224. This information from NCO was shared with Kaiser Coding Leaders as well so that they would be informed and comply with the directive.

~~(iv)~~4. Impact of Kaiser's HCC AA "missed opportunity" directive

~~76~~114. Kaiser's internal data establishes that its efforts to mine for AA succeeded in capturing and submitting an enormous increase of AA codes to Medicare ~~and other payers~~, beginning with fewer than 600,000 AA codes captured and submitted in 2010 and culminating in over three million submitted in 2015~~.~~ to the MA program. AA Dx ("Diagnosis") Frequency Report 2010-2016 (Source: Kaiser internal data aggregated by Ms. Bryant) see Exhibit 17 at REL0000226. Medicare claims for HCC 108 (Vascular Disease), the classification that includes AA diagnoses, were among the highest in number and revenue for Kaiser during 2014-2016. See Exhibit 18 at REL0000254. (Over 350,000 HCC 108 cases in 2014 submitted for almost $800 million in revenue).

~~77~~115. In early 2016, Ms. Bryant discovered in the course of ICD-10-CM/PCS national coding quality monitoring and coding validation that Kaiser was still coding AA based upon it being a systemic condition, notwithstanding the August 2015 conclusion of Kaiser NCO rejecting AA as a "chronic, systemic condition." Ms. Bryant, who was at that time working in Kaiser's National Revenue Cycle group, shared this finding with Ms. Hernandez, who was also working for this group at the time. Both Ms. Bryant and Ms. Hernandez were disturbed and troubled. Ms. Bryant brought the AA findings to the attention of Janet D. Franklin and Nancy Anderson of Kaiser NCO. Ms. Bryant requested that the appropriate coding guidance be posted in the National Coding Bulletin Board for all Kaiser Regions to see. She also provided the appropriate coding advice on AA to regional HIM leaders during leadership forum meetings and requested that each region disseminate the guidance to all appropriate staff and stakeholders, including Kaiser's medical groups.

~~78~~116. In 2016, after Kaiser had started to pull back the directive, there were still almost two million AA codes submitted ~~across payers.~~to the MA program. Exhibit 17. In just the first four months of 2016, Kaiser reported to Medicare Advantage over 300,000 cases of vascular disease

(HCC 108), which includes the AA diagnosis codes, accounting for almost $700 million. Exhibit 18. Many Kaiser members now have the diagnosis of AA assigned to their clinical profiles incorrectly, potentially impacting patients' future insurance coverage and profile.

~~79~~117. Ms. Bryant's and Ms. Hernandez believe and therefore allege that Kaiser has never gone back to validate the accuracy of AA documentation and coding for years prior to 2016, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding AA. Moreover, they believe and therefore allege that there ~~has been~~was no specific AA validation of documentation and coding or discussion regarding rebilling or resubmission of corrected claims or data. Indeed, shortly before her retirement from Kaiser in October 2017, Ms. Bryant was asked by NCO's Nancy Andersen to join a coding workgroup to look at AA, as the Kaiser Medical Groups wanted to revisit the issue, yet again, of whether the condition is "systemic." Thus, Kaiser ~~continues~~continued its efforts to avoid "missed opportunities" with this false documentation and coding.

B. Mechanical Ventilation Dependence Status ("Vent Dependence")

~~(i)~~1. Clinical significance, documentation and coding convention

~~80~~118. The HCC for "dependence on respirator status" is HCC 82 and HHS-HCC 125 (linked with ICD-9-CM code V46.11 (Dependence on respirator, status) and ICD-10-CM code Z99.11 (Dependence on respiratory ventilator status)). Dependence on respirator (or ventilator) status is a "status code" that is used when a patient requires long-term, continued ventilator support to breathe beyond the acute care phase. The status code is/was reported for both Medicare Advantage HCCs and HHS-HCCs (e.g., ~~Medicaid~~ under the Affordable Care Act). In 2016, Kaiser received approximately $11,497 for each HCC 82 under the MA program.

~~81~~119. On February 7, 2014, Coding Clinic stated in a specific response to Kaiser's inquiry – an inquiry initiated by Ms. Bryant with Ms. Hernandez's input – that "this code should be reported when the patient requires continued ventilator support for an unexpected period of time and not for the short-term acute phase of a condition." Coding Clinic further stated that "there is no time frame set on what constitutes ventilator dependency." See Exhibit 19.

~~82~~120. In short, the HCC for vent dependence status should never be coded, and "respirator dependence," "ventilator dependence," "vent status," or similar terminology should never be documented in the medical record, if a patient is weaned from a ventilator during or at the end of an acute short-term stay in the hospital (of whatever length) and discharged home or to a post-acute-care facility without clinically requiring vent support. That does not constitute "vent dependence status." Rather, a patient is vent dependent only if the patient relies on the ventilation to live on a long-term basis and not for the short-term acute phase of a condition.

~~(ii)~~2. Kaiser's scheme originated with ACA newborns

~~83~~121. Kaiser's directives on vent dependence documentation and coding differ region by region, but were all similarly invalid, with regions establishing a "time frame"-based criteria for documenting vent dependence status after which the specific code assignment is permitted. For example, TPMG, the medical group in Kaiser's NCAL region, initially defined the time period as 12 hours or more but later changed it to 30 days or more on a ventilator before the status

condition should be documented and then coded irrespective of discharge status or disposition. Kaiser's Southern California PMG only required 21 days as its time-frame criteria for documenting and coding this status.

~~84~~122. These directives contravened AHA Coding Clinic's caution that there is no "set time frame" and that vent dependence should not be reported for the short-term acute phase of a condition. Kaiser, especially its Permanente Medical Groups, consciously ~~ignores~~ignored Coding Clinic's response, instead criticizing and rejecting Ms. Bryant's professional coding decision to seek input from Coding Clinic in the first place, which led to Ms. Bryant being excluded from further coding discussions on this topic and others. By elevating set time periods over actual long-term dependence, Kaiser manipulated the system to over-document and over-code for vent dependence status. Any patient that is on a ventilator for a set period of time ~~is~~was assigned the status code by Kaiser, even if the patient's reliance is neither long-term nor continuous but instead arises from the acute phase of a condition or following a procedure.

~~85~~123. Moreover, Kaiser ignored its own improper directives by coding for vent dependence status even when patients ~~are~~were on vents for just a few days, then discharged without the vent. Kaiser data shows high volumes of patients being coded for vent dependence status even after being discharged from the acute care hospital without a ventilator, and even for lengths of stay as short as one or two days across four of Kaiser's hospital regions, and in the outpatient physician office/clinic setting after discharge. As demonstrated below, Kaiser's over-documentation and over- coding of vent dependence began in the newborn population receiving care under Kaiser's ACA plans.

~~(iii)~~3. Chronology and evidence

(~~A~~a) October/November 2013

~~86~~124. Ms. Hernandez and Ms. Bryant were first made aware of Kaiser's vent dependence status documentation and coding practices in the context of newborns that are placed on ventilators temporarily in ~~the hospital~~Kaiser Foundation Hospitals before being discharged home. This came about due to the patient population impacting the Affordable Care Act, and questions were raised internally by Regional NCAL HIM leadership (Ms. Bryant, Ms. Hernandez and Dawna Toews) about whether V46.11 (vent dependence status) was appropriate in this circumstance. Ms. Bryant, Ms. Hernandez and Ms. Toews were extremely concerned with the direction that TPMG wanted to take with the V46.11 status code. The three of them discussed the situation and agreed that the status code should be infrequently assigned and coded; given the high number of such codes at Kaiser, it thus appeared that TPMG was focusing on capturing this status code inappropriately.

~~87~~125. In a series of meetings and emails, chronicled contemporaneously by Ms. Hernandez (see Exhibit 20), Ms. Hernandez and Ms. Bryant investigated Kaiser's existing documentation and coding practices, researched the proper coding convention, reached out to external clinical and coding experts and, on November 21, 2013, submitted email queries to AHA's Nelly Leon-Chisen, Director and Editor of Coding Clinic, and a separate email to Sue Bowman, American Health Information Management Association ("AHIMA") Senior Director of Coding Policy and Compliance. ("AHIMA," like AHA's Coding Clinic, is a neutral organization that can be queried

for guidance by coding professionals.)

~~88~~126. On November 22, 2013, AHIMA's Ms. Bowman responded by email as follows: "V46.11 is intended for 'dependence' on a ventilator – meaning long-term dependence (such as patients with spinal cord injuries or progressive neuromuscular diseases such as multiple sclerosis) – not for short-term use of a ventilator during an acute illness, following surgery, etc. So it seems unlikely that a newborn would be declared ventilator-dependent". Id. at REL0000262.

~~89~~127. On November 25, 2013, Kaiser's NCAL HIM's Regional Coding Review Managers met onsite. All agreed that the vent dependence status code would not be appropriate for newborn initial clinic visits, follow-up clinic visits, or hospital short-term acute care visits, nor if the newborn was weaned and discharged home without ventilation. They concluded and insisted that Kaiser's hospital coding staff should follow and be compliant with official coding guidelines for the assignment of a respiratory/vent status code.

(~~B~~b) December 2013

~~90~~128. During a follow-up phone conference on December 3, 2013 attended by Ms. Hernandez and members of TPMG's Encounter Information Operations group ("EIO," a TPMG group that specifically ~~focuses~~focused on the Medicare Advantage ~~program~~and ACA programs and was led at the time by Director Anne Cadwell), the above coding guidance conclusion was rejected over Ms. Hernandez's objection and notwithstanding the references provided, including that Ms. Bryant had submitted an inquiry to AHA Coding Clinic. TPMG stated that it would move forward with capturing vent dependence status if a hospital newborn was placed on ventilation for at least 12 continuous hours, even if the newborn was successfully weaned from the respirator/ventilator and discharged without a respirator/ventilator.

~~91~~129. The December 3 directive was followed by a call to Ms. Hernandez on December 4, 2013 from TPMG Director Ms. Cadwell and Dr. Bliss, who focused not on Kaiser's invalid coding of vent dependence or references provided, but on why Coding Clinic was queried by Ms. Bryant in the first place. Ms. Hernandez was required to provide Ms. Bryant's cell phone number so that the TPMG EIO Directors could immediately contact Ms. Bryant once they learned that she was the one who submitted the Coding Clinic query. Dr. Bliss and Ms. Cadwell called Ms. Bryant to rebuke and chastise her for submitting a query to Coding Clinic without notifying TPMG. Both Ms. Hernandez and Ms. Bryant were in Dr. Bliss' "line of fire," and were very distressed. See Exhibit 21.

~~92~~130. Ms. Hernandez and Ms. Bryant were told not to inquire outside Kaiser anymore on such issues without input and approval from Kaiser's Coding Governance Group (CGG). They were warned that outside inquiry would create risk for Kaiser. Once again, pressure and criticism were directed at Ms. Bryant and Ms. Hernandez for not agreeing to TPMG's approach to capturing this diagnosis.

~~93~~131. On December 8, 2013, Ms. Hernandez was further instructed by TPMG Clinical Documentation Improvement ("CDI") Physician Director Dr. Shirley Cachola, to "use 'respirator dependence' for patients with tracheal intubation until the specifics are clarified by the coding

clinic ~~....~~.... Not sure this meets compliance since it is not defined but this is how med. group wishes to proceed for now." Exhibit 22 at REL0000273. Ms. Bryant and Ms. Hernandez believed this instruction to be clear error and unethical, a sentiment echoed by their colleague in the Regional HIM group, Dawna Toews, who questioned how the company could proceed "when it is clearly out of compliance~~....~~.... I am not inclined to continue working for a company that blatantly ignores guidelines I have promised to follow, and that put me in jeopardy of losing my professional licensing." Id. at REL0000269.

~~94~~132. Ms. Bryant was directed by TPMG to quickly follow-up on the pending response from Coding Clinic on the newborn-specific issue of vent dependence coding. On December 6, 2013, Coding Clinic's Senior Coding Consultant Anita Rapier wrote via email to Ms. Bryant that "code V46.11 (respirator dependence status) is used to describe patients who have been dependent on mechanical ventilation over a period of time. It is not used for newborns who are placed on a vent for a short period." Exhibit 20 at REL0000267.

~~95~~133. Ms. Bryant sent a follow-up email to Anita Rapier as follows: "Thus if a newborn was placed on a vent for 12 or even 20 hours and then at discharge is NO longer on the vent, we would not assign the V46.11 status code to that discharge/stay." AHA Coding Clinic's Senior Coding Consultant Ms. Rapier responded immediately: "Yes, that is my interpretation." Id. at REL0000266. Thus, Coding Clinic corroborated AHIMA's response and Ms. Bryant's and Ms. Hernandez's original conclusion. Coding Clinic's more formal February 7, 2014 response letter to Ms. Bryant, quoted above, confirmed its guidance. See Exhibit 19.

~~96~~134. Contemporaneously, Ms. Bryant and Ms. Hernandez continued to have deep concern and investigated Kaiser's coding practices for vent dependence status both inside and outside of the newborn care context, including for patients in the Medicare Advantage program~~-~~ and the ACA program. They quickly confirmed that they were similar. TPMG in Kaiser's NCAL region required its CDI Physician Director Dr. Cachola, CDI Managers, Susan Ingerbretsen and Donna McIvor (under Dr. Bliss' leadership) to create an acceptable timeline for the capture of vent status code. In Diagnostic Guidelines published in November 2013, TPMG CDI established a "greater than 30 day" rule for vent dependence status: that is, if a patient is receiving respiratory support through intubation for more than 30 days, then vent dependence status should be documented and the code should be assigned, even if the patient is successfully weaned and discharged without a ventilator. Exhibit 23 (TPMG Neonatal Intensive Care Unit Diagnostic Guidelines), at REL0001005.

~~97~~135. Similarly, in Kaiser's SCAL region, SCPMG's regional CDI program established a 21-day duration of care to constitute vent dependence. Exhibit 24 (HIX Neonatology Documentation and Coding 2014), at REL0001040.

~~98~~136. The RRG meetings that Ms. Bryant attended often included the capture of specific HCCs in both the Medicare Advantage and ACA programs, and ventilation status was included on numerous occasions. Kaiser promoted the documentation and capture of the respirator/ventilator dependence code ~~(HCC 82)~~ in education sessions and materials to Kaiser physicians throughout the Kaiser regions. In this way, Kaiser's improper practice for coding the ventilation status code was migrated systemically throughout the Kaiser regions and adopted by all of Kaiser's Permanente Medical Groups and Kaiser Foundation Hospitals and reported to the Medicare

Advantage and ACA programs by all of the Kaiser Health Plans, notwithstanding the coding guidance from Coding Clinic and AHIMA.

~~(iv)~~4. Impact of Kaiser's vent dependence practices

~~99~~137. Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that the Vent Dependence status code is or was being captured frequently by Kaiser. Medicare Advantage and HHS-HCC payer data specifically indicated a high volume of these codes, particularly in Kaiser's NCAL and SCAL regions. See Exhibit 25 and Exhibit 18.

~~100~~138. The coding data includes a high volume of cases in which patients were successfully weaned from ventilation and routinely discharged home or to self-care, including after just a day or two in the hospital. See id.; Exhibit 26 (showing NCAL vent dependence cases). In a December 2013 validation audit, Ms. Hernandez and her NCAL audit team concluded that 100% of a sample of TPMG vent dependence cases were invalid. See Exhibit 27.

~~101~~139. Data from all Kaiser Regions confirms that the vent dependence coding volume skyrocketed across Kaiser. See Exhibit 28 (Kaiser data gathered by Ms. Bryant~~).~~ for all payors, including Medicare Advantage and ACA programs). See also Exhibit 18 (includes vent dependence (HCC 82) data submitted by Kaiser to the Medicare Advantage program from January, 2014 through April, 2016).

~~102~~140. Kaiser cannot articulate or produce any clinical research, standards or evidence-based medical justification for coding vent dependence status once a patient has been ventilated and removed after a set number of days; for coding vent dependence status even when ventilation is used for far fewer days than the purported thresholds; or for setting different policies for determining ventilation dependence status within the various Kaiser regions.

~~103~~141. Ms. Bryant and Ms. Hernandez further believe and therefore allege that Kaiser's proprietary, diagnoses electronic "pick list" was being utilized by Kaiser in all of its regions to easily and falsely capture this inaccurate status code in all clinical settings~~.~~, across all Kaiser regions. Moreover, they believe and therefore allege that no Kaiser ~~has never gone~~Health Plan went back to validate the coding to identify incorrect codes, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding vent dependence status. To their knowledge, there has been no validation or discussion for rebilling or resubmission of corrected claims or data.

C. Malnutrition

142. Ms. Bryant and Ms. Hernandez also believe and therefore allege that Kaiser systematically over-documented and coded protein-calorie malnutrition (ICD-9-CM codes 260-263.9 and ICD-10-CM codes E43 – E46), which also falls within an HCC category under both the MA and ACA programs (MA HCC 21 and HHS-HCC 23). There are specific codes to identify mild, moderate and severe Protein Calorie Malnutrition ("PCM").

143. Kaiser's CDI querying activities improperly led physicians to diagnose protein-calorie malnutrition, including the use of "SMARTPHRASE" acknowledgments of dietician diagnoses of PCM with a co-signature of dietary notes for all risk-based payers, including both the MA

program and the ACA program. TPMG CDI targeted protein-calorie malnutrition HCC as one of the top risk-adjustment opportunities. Ms. Hernandez witnessed several instances of this in October and November 2012, which she discussed with Ms. Bryant, Kaiser's Coding Review Manager, and Kaiser's NCO coding group, including Janet D. Franklin and Nancy Andersen. There was general agreement among this group that leading queries are not appropriate, and that the co-signature of a physician on dietary notes is not sufficient documentation for a PCM diagnosis. Ms. Hernandez also addressed the issue with TPMG CDI's Quality Assurance manager in the hope that it would be communicated to the CDI management team. Nevertheless, to Ms. Hernandez's knowledge, the leading queries were not discontinued nor were the documentation requirements changed.

144. Ms. Bryant is aware of another concern regarding protein-calorie malnutrition documentation and coding in Kaiser's Northwest Region relating specifically to the Kaiser's ACA program in that region. The Northwest Permanente Medical Groups' HIM Coding Manager, Sharon Beausoleil, emailed Ms. Bryant in late 2014 regarding concerns about documentation and coding of protein-calorie malnutrition on HHS-HCC's for newborns. In particular, she was concerned with the query language being utilized by the CDI staff in the NW Region, which appeared to not be supported by clinical indicators and to be leading.

145. Ms. Beausoleil provided Ms. Bryant with a short list of inpatient medical record accounts which Ms. Bryant asked one of her staff, Ms. Sherry Davis, to review to validate the protein-calorie malnutrition documentation and coding. Ms. Davis identified in her review that there was no supporting documentation or clinical indicators for a newborn malnutrition diagnosis for these records. Ms. Bryant reviewed the findings with Ms. Davis and concurred. Ms. Bryant and Ms. Davis prepared a written summary of their findings which they shared with Ms. Beausoleil via webex in March 2015. See Exhibit 34.

146. Shortly thereafter, Ms. Beausoleil spoke with Ms. Bryant and cautioned her that Dr. Annette Guido, Northwest Permanente Medical Group's Medical Director, was questioning Ms. Bryant's authority to audit the region's medical records, notwithstanding Ms. Bryant's position with Kaiser's National Revenue Cycle group. In addition, Ms. Beausoleil called after work hours and told Ms. Bryant that she (Ms. Beausoleil) was told "not to contact" her (Ms. Bryant) regarding documentation issues, and Ms. Beausoleil stated that Ms. Bryant should be very careful and "should watch her back." Ms. Bryant was gravely concerned with and deeply troubled by these warnings and with the barrier placed on her pursuing the issue further.

147. These issues continued at Kaiser long after these interactions. In late 2016, Kaiser's TPMG CDI Director Emily Emmons contacted Ms. Bryant about a possible compliance issue regarding PCM diagnosis, documentation, and coding. See Exhibit 35. Ms. Emmons was concerned with dietary documentation of PCM wherein physicians appeared to be queried in a leading manner. After discussing and reviewing the documentation examples, Ms. Bryant agreed that they appeared to be leading in order to obtain a diagnosis of severe or moderate malnutrition. Ms. Bryant requested that Ms. Emmons set up a conference call with the Regional Dietary Lead and Regional Compliance. There were several emails and conference calls held on the topic which included Dietary, Regional Compliance, Regional CDI and Ms. Bryant which continued into mid-2017. Id.

148. Moderate and Severe PCM in hospital inpatient records at Kaiser Foundation Hospitals were a focus of Kaiser's dietary staff once the patient met some specific clinical criteria. The query language being used was directing the physicians to choose either moderate or severe PCM, the high-paying diagnoses, and no other. Ms. Bryant and Ms. Emmons advised that to be compliant, the query language should be revised to include other options such as mild, other, unspecified, clinically undetermined, etc. It was agreed by Ms. Emmons, the Dietary Lead (Jan Villarente, Regional Director), Regional Compliance (Svitlana Ozhyndovsky) and Ms. Bryant that Kaiser's dietary leadership across all Kaiser regions should make changes to the query language to address the compliance concerns. Ms. Bryant believes and therefore alleges, however, that use of the leading query language had been ongoing for a year or more before it was identified and changed, and has no knowledge of corrective actions taken by the NCAL Region or any other Kaiser region on prior medical records for all risk-based payers, including both the MA program and the ACA program.

149. Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that malnutrition continued to have a high frequency of being coded in Kaiser's MA and ACA populations. Ms. Bryant and Ms. Hernandez believe and therefore allege that no Kaiser Health Plan conducted a validation of the diagnosis of protein-calorie malnutrition, and never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding protein-calorie malnutrition. Moreover, they believe and therefore allege that there was no documentation and coding validation or discussion regarding rebilling or resubmission of corrected claims or data.

D. Other Over-Coded and Up-Coded Diagnoses

150. Arrhythmia for members with pacemakers. Near the end of her employment with Kaiser, Ms. Bryant was informed and believes, and therefore alleges, that at least Kaiser's NCAL and Colorado regions (TPMG and the Colorado PMG), and perhaps other Kaiser regions, were instructing doctors to diagnose and document so that Kaiser's coders would code heart arrhythmia for members even after the members receive pacemakers to correct their arrhythmia for all risk-based payers, including both the MA program and the ACA program. It would be atypical for a patient to have a pacemaker but to continue to suffer from arrhythmia, unless there is a rare pacemaker complication. Yet Kaiser routinely and improperly reported both the pacemaker status code and the cardiac arrhythmia code (HCC 96 and HHS-HCC 142), adding thousands of dollars to the risk profile of each such member. In addition to cardiac arrhythmia, diagnoses for ventricular fibrillation and ventricular flutter (HCC 84 and HHS-HCC 142) were also overdocumented. In 2016, Kaiser received approximately $2,231 for each HCC 96 and approximately $2,489 for HCC 84 under the MA program.

151. Ms. Bryant was first made aware of the issue in 2014 with respect to Kaiser's Colorado PMG, but later (in the fall of 2017) was informed by Ms. Andersen of Kaiser NCO that it was also evident in Kaiser's NCAL region operated by TPMG. Ms. Bryant expressed her disagreement to physicians from the Washington and Northwest Medical Groups, who nevertheless insisted that the record should have both the pacemaker status and the arrhythmia code assigned.

152. Major depression. Ms. Bryant and Ms. Hernandez also witnessed Kaiser and its various

regional subsidiaries aggressively pursue the diagnosis and coding of major depression (HCC 58 and HHS-HCC 88) for both the MA program and the ACA program. See, e.g., Exhibit 10 at REL0000139 (June 16, 2015 RRG WebEx presentation highlighting major depressive disorder capture). Kaiser's laser focus on this valuable code (worth approximately $2,482 per code in 2016) led to over-coding and up-coding. In 2016, Kaiser received approximately $2,496 for each HCC 58 under the MA program. Moreover, Ms. Bryant is informed and believes that, in 2015, in at least Kaiser's SCAL region (SCPMG) and likely other Kaiser regions, Kaiser manipulated its electronic system for picking diagnoses to "gray out" the diagnosis of "major depression unspecified," which is not linked to an HCC, so that Kaiser doctors would not pick that diagnosis but would instead select a major depression diagnosis category that is linked to a high-paying HCC. Ms. Hernandez believes that this practice also took place within TPMG.

III. ~~II.~~ "THE KAISER WAY" IGNORES ESTABLISHED PROCEDURE, INCENTIVIZES GREED, AND CULTIVATES FRAUD

~~104~~153. At every level and across regions, Kaiser is driven by a corporate culture that demands and rewards financial success from its employees. Kaiser's senior management pushes relentlessly to increase Kaiser's revenue from risk adjustment. The risk adjustment practices described in this Complaint are attributable in large part to these demands and rewards. Ms. Bryant and Ms. Hernandez ~~have~~ witnessed Kaiser's profit-seeking and financial-gaming culture corrode its compliance function over many years, leading to the frauds described herein on the government and its Medicare and ~~Medicaid~~ACA programs.

154. Kaiser knows that it faces less actual risk than the data it submits to the Government under the ACA program via EDGE suggests. Because Kaiser has inflated its supposed risk, it pays less into the Risk Adjustment Program than it should, or receives more than it should in years when it is a net recipient. Thus, other insurers (Kaiser's competitors) receive less than they should from the Risk Adjustment Program, or pay more than they should. When those other insurers are pricing their own plans, in turn, they have to charge higher premiums to account for their lower risk adjustment payments or receipts to or from the pool. These higher premiums are due to Kaiser's upcoding and manipulation, and have a direct impact on the public fisc when, as illustrated below, they cause an area's benchmark – and corresponding premium tax credit – to increase.

A. Kaiser's policies and procedures

~~105~~155. Kaiser consistently publishes and enforces internal company policies and procedures that contravene coding and diagnostic principles that are widely accepted and enforced within the broader coding community. To avoid detection, Kaiser sometimes labels its instructional documents as "Program Advisories" rather than "policies" in order to circumvent the implications of imposing an improper requirement. But these Advisories are not optional and are enforced like any other policy and procedure within Kaiser.

~~106~~156. Many of Kaiser's proprietary policies regarding diagnosing and coding are intentionally constructed to be less restrictive than the norm in furtherance of the company's emphasis on profit over compliance. These departures from accepted policy and procedure lead directly to improper documentation, coding and overbilling. Kaiser's Permanente Medical

Groups and Kaiser's Medicare Finance Department initiate and lead this corporate culture, focusing on capturing higher reimbursement without any contravening focus on the avoidance of overbilling.

~~107~~157. Kaiser's National Compliance Office is ineffective, apprehensive, and slow in investigating and responding to documentation and coding compliance issues. In addition, NCO coding leadership ~~has~~ openly admitted to Ms. Hernandez that the Permanente Medical Groups have significant control over chart audit selection, accuracy rates, documentation guidance, coding policy and practices, all to manipulate the capture of more HCC codes and to increase government payer reimbursement. Instead of turning to NCO, the Permanente Medical Groups asked "Medical Group Regional Compliance" staff for advice about who can be manipulated easily within the region to get the desired result (e.g., more HCC target capture). When NCO completes an internal audit that shows inaccurate or misleading documentation or coding, NCO is pressured and intimidated by the relevant Regional PMG to change the audit's accuracy results.

~~108~~158. On a system-wide basis, Kaiser has been reluctant to perform historical code correction and billing submission when a problem or issue has been identified that should be rebilled. The culture at Kaiser perpetuates a superiority, manipulation, and intimidation by physician medical group leaders and medical group management, resulting in an inability to challenge or present a different perspective, even when backed by express, unambiguous coding guidelines, standards or HIM coding expertise, without being chastised, threatened and ridiculed.

~~(i)~~1. Query templates

~~109~~159. Coding professionals are permitted under AHIMA's Standards of Ethical Coding to query physicians/providers for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation. Querying physicians/providers is also permitted after billing (e.g., retrospectively) if performed in a timely manner.

~~110~~160. But these Standards, as well as AHIMA's Guidelines for Achieving a Compliant Query Practice and AHIMA's Managing an Effective Query Process Practice Brief, forbid coding professionals and others (e.g., clinical staff, physicians, nursing staff, etc.) who query from "leading" providers to select a particular diagnosis. See Exhibit 29.

~~111~~161. According to AHIMA's Managing an Effective Query Practice Brief, "Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption." Exhibit 30 at REL0000511.

~~112~~162. In Health Information Management Compliance: A Model Program for Healthcare Organizations, AHIMA's Sue Bowman writes that "Communication tools between coding personnel and physicians, such as coding summary sheets, attestation forms, or coding clarification forms (e.g., physician query forms), should never be used as a substitute for

appropriate physician documentation in the health record."

~~113~~163. Nevertheless, some of the Kaiser regions developed sets of query "templates" for clinical documentation improvement (CDI) staff for specific HCC diagnoses to use in concurrent querying of providers that do just that. These improper query templates were used in at least Kaiser's NCAL hospital CDI and Northwest CDI, and perhaps others. There is a cultural reluctance within NCO to give direction and/or require the Kaiser Regions to utilize the Kaiser standard query form language for coding and CDI.

~~114~~164. The hospital coding staff also utilizes templated physician queries, but these query templates are reviewed and constructed to ensure non-leading language for a variety of diagnoses, regardless of payer type or reimbursement impact. Most of the query reviews of language utilized were under the oversight of Ms. Bryant and guidance of Ms. Hernandez, always utilizing, communicating, and applying the AHIMA direction, guidance and practice briefs.

~~115~~165. KP NCAL and Northwest CDI query templates developed by TPMG and the Northwest PMG, respectively, many of which involve diagnoses directly linked to HCCs under the Medicare Advantage program and HHS-HCCs under the Affordable Care Act, ~~are~~were designed to be, and are in fact, leading. Through the queries, CDI staff introduce clinical indicators for specific HCC diagnoses to the providers, who in turn routinely ~~follow~~followed the suggestion to add a reimbursable diagnosis where none existed and should not have been added. In Kaiser's NCAL Region, the CDI queries ~~are~~were not made an official permanent part of the record while HIM coding queries ~~are~~were, thus obscuring the role of CDI and improper querying from review.

~~116~~166. Although the role of CDI staff is to seek clarification from providers for documentation for specific clinical indicators, there ~~has been~~was inconsistent application of the Practice Brief Guidance at Kaiser. These queries ~~are~~were always, or almost always, directed toward an HCC diagnosis for maximizing reimbursement capture and not for overall quality documentation for all clinical situations, all payers, and all patients. In fact, Ms. Bryant recalls on several occasions a stated reluctance from Kaiser's Revenue Cycle leaders to look at documentation and coding both ways – e.g., for both over- and under coding – on the basis that it is too costly and time consuming. Moreover, Kaiser's CDI program is not a "payer agnostic" approach. TPMG in Kaiser's NCAL Region, for example, limits its CDI focus to HCCs only under the MA and ACA programs and never expanded to examine severity of illness (SOI) and risk of mortality (ROM) to all patients and to all payers, notwithstanding Ms. Bryant's strong recommendations,

~~117~~167. Examples of the leading query templates include Kaiser's templates for: obesity/extreme or morbid obesity; protein calorie malnutrition (mild/moderate/severe); pressure ulcer; neoplasm (history versus current); emphysema; depression; adrenal mass; aortic atherosclerosis; diabetes manifestations; neutropenia; sepsis/SIRS with organ dysfunction, and others. See Exhibit 31 (improper query templates from Kaiser's Northwest region, operated by the Northwest PMG); Exhibit 32 (TPMG CDI Tip Sheet).

~~118~~168. Moreover, certain query templates in Kaiser's Northwest Region developed by

the Northwest PMG include leading language introducing a diagnosis to the physician, and not including options of "unknown," "other," "clinically undetermined" or "unspecified." They contravene AHIMA's guidance on Achieving a Compliant Query Process, which states that "Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option.... ....Multiple choice query formats should also include additional options such as 'clinically undetermined' and 'other' that would allow the provider to add free text. Additional options such as 'not clinically significant' and 'integral to' may be included on the query form if appropriate."

~~(ii)~~2. Inquiries to AHA Coding Clinic

~~119~~169. As discussed above in the Vent Dependence Status section, Kaiser chastised and reprimanded Ms. Bryant, Ms. Hernandez and other HIM coding professionals for submitting coding questions directly to the American Hospital Association Central Office for Coding Clinic, a routine and standard of practice for coding professionals across the country. Ultimately, Kaiser instituted and mandated requirements for all AHA Coding Clinic questions, routing them through a rigorous review committee comprised primarily of non-coding professionals and many layers of approval process before submission.

~~120~~170. Ms. Bryant was directed that any and all coding questions must go through Kaiser's own Coding Governance Group ("CGG"), a group that was and is composed of a majority of physicians and representatives from Kaiser's Permanente Medical Groups rather than coding professionals. In December 2013, Ms. Bryant was told by Kaiser TPMG's senior physician lead Dr. Bliss that she was "putting the organization at risk" by submitting questions directly to Coding Clinic, a sentiment echoed by TPMG Director Anne Cadwell on a call that also included many regional physicians and Revenue Cycle leaders. Ms. Bryant's expertise, professional knowledge and career-long practice of submitting questions to Coding Clinic were thus called into question. Ms. Bryant commented to the group that it was her duty and responsibility as a coding professional, and a standard of practice, to submit questions for coding clarification to AHA Coding Clinic without a committee review.

~~121~~171. Ms. Bryant expressed concern on the December 2013 call that this internal group lacked coding expertise, and inserted a layer of bureaucracy in an area where Kaiser's National Coding group (led by Ms. Bryant) should have independence and the ability to send unattributed questions to Coding Clinic. Her protests and professional rationale were ignored.

~~122~~172. Ms. Bryant reported back to Kaiser's NCAL HIM leadership, including Ms. Hernandez and Dawna Toews, regarding this new directive. Her staff was appalled with the outcome of the meeting and felt that their credentials were at risk due to being prohibited from following ethical coding practices to seek and comply with official coding guidelines. See Exhibit 22. Under extreme pressure, Ms. Bryant reluctantly complied with the CGG request and worked with NCO's Nancy Andersen to develop a coding questions workflow over the coming years (started in 2014 and finalized in 2015, ~~currently~~ still under revision in 2017).

~~123~~173. The internal coding question workflow for submitting coding questions to Coding Clinic was discussed during a March/April 2015 conference call/meeting involving NCO's

Diana Medal, Nancy Andersen, Ms. Bryant and Ms. Hernandez. The group specifically discussed the restrictive and controlling nature of the CGG directive and how the physician members of the CGG were extremely apprehensive of Ms. Bryant sending questions to Coding Clinic due to their concern that Coding Clinic's response might force Kaiser to change its HCC documentation and HCC capture practices.

~~124~~174. NCO's Nancy Andersen mentioned that the CGG physician leader, Dr. Annette Guido, was behind the restriction that had been imposed and that she (Ms. Andersen) did not entirely agree with it, but that the physicians' directive had to be followed. Ms. Bryant stated her concerns with the CGG being composed mostly of physicians and not coding experts, a point with which Ms. Andersen agreed. On the same call, Ms. Hernandez discussed her concern that TPMG had been focusing on HCCs and had restricted her in the past from collaborating outside TPMG EIO (i.e., with Ms. Bryant, Ms. Anderson and NCO), much less submit a question to Coding Clinic, and felt that TPMG feared that the Coding Clinic response or guidance would derail its capture efforts of HCC diagnoses. Ms. Andersen stated that she understood but "we have no choice." She stated that it was difficult to get the medical groups and CGG to understand the need to query AHA Coding Clinic directly and freely.

~~125~~175. When Ms. Hernandez requested a copy of the recording of the conference call several days later, Ms. Medal stated via email that it had been deleted per the instructions of Ms. Andersen. Ms. Bryant and Ms. Hernandez believe that the recording was deleted due to the fact that many comments were made during the call, including by NCO leadership, that were highly critical of CGG's and TPMG's leadership and practices.

B. Kaiser's emphasis on financial outcomes

~~126~~176. At every level of the company, Kaiser emphasizes financial results over compliance and accuracy, bending the rules and utilizing gaming strategies to falsely engineer profits.

~~(i)~~1. CDI program and related activities.

~~127~~177. In late 2009, Kaiser NCAL Revenue Cycle developed its "Clinical Documentation Improvement" program, which it called "Clinical Documentation Integrity" or "CDI," to ostensibly improve its clinical documentation of hospital inpatient medical encounters. This effort was followed by the SCAL and Northwest Regions in the hospital setting. In actuality, Kaiser's CDI programs ~~strive~~strived only to improve clinical documentation insofar as it increases HCC capture and Medicare and HHS reimbursement.

~~128~~178. AHIMA's guidance on CDI programs provides that they are required to address all payers, not just Medicare~~.~~ or other government programs. In addition, CDI programs should not focus solely on reimbursement. In furtherance of this guidance, the original NCAL CDI program initially developed by Ms. Bryant in 2009 was designed to achieve a payer-agnostic focus by the end of a three-year plan. But Kaiser's CDI program, in practice, ~~has~~ diverged from Ms. Bryant's expertise and design and ~~is~~was definitively not "payer agnostic." It ~~focuses~~focused almost exclusively on risk-adjusted payers, such as HHS under the ACA program and CMS under the Medicare Advantage program, and only on documentation impacting HCCs.

~~129~~179. Ms. Bryant made several requests to expand Kaiser's CDI program to other payers and not to focus solely on HCC reimbursement, but was not successful. In approximately late 2010, Kaiser NCAL Revenue Cycle Vice President Dave Nyburg moved the CDI Program from Ms. Bryant's oversight to his direct oversight. Ms. Bryant believes that this move was made due to ongoing TPMG discomfort with the direction she wanted to move the program and the pressure and resistance to Ms. Bryant's advice and guidance.

~~130~~180. Moreover, in the past, Kaiser's CDI program conducted its concurrent documentation reviews by going into prior or old encounters and pulling diagnostic and clinical information to query physicians for the current encounter for HCC diagnosis capture. Again, this contravenes coding guidelines and AHIMA Standards of Ethical Coding under section 4.5: Coding professionals shall not "Utilize health record documentation from or in other encounters to generate a provider query." See Exhibit 29.

~~131~~181. For example, Ms. Hernandez received multiple inquiries from CDI leadership and CDI nursing staff as to whether they may use old lab values, clinical indicators and documentation from previous encounters and apply these to send a query about a different, current encounter. Ms. Hernandez has repeatedly told CDI leadership staff that this is not appropriate. But the repeated nature of the inquiries gave rise to Ms. Hernandez's belief that the CDI program was routinely looking backwards; it was highly unlikely that the CDI leadership was getting to every instance and every CDI employee to provide Ms. Hernandez's guidance.

~~132~~182. For many years, Kaiser's CDI program, especially in the NCAL region, ~~has~~ consistently expressed the value of its work in terms of additional dollars captured, not in improved quality of care, patient safety, severity of illness, improved mortality scores, compliant documentation, or outcomes.

~~133~~183. For example, in a July 2010 NCAL presentation "CDI Prioritization for Roll Out," Kaiser's NCAL CDI group analyzed the results of an internal audit of inpatient "HCC underpayment." The presentation quantified the impact of the HCC codes that had been "recaptured" in the audit in terms of how much additional revenue that meant for the company. The presentation did not mention compliance or identify any HCC overpayment. See Exhibit 33.

~~134~~184. In a Kaiser NCAL "CDI Program: Update" presentation in December 2011, the company emphasized in its Key Findings that the program had generated year-to-date 2011 revenue of "$27.80 million." See Exhibit 11. The presentation even quantified the "Top CDI Queries" by HCC in terms of the "Revenue Impact" to the company. CDI Program Updates ~~have~~ followed the same format and included these same metrics for many years.

~~(ii)~~2. Kaiser's RRG meetings and Regional Competitions for Revenue/HCC Capture.

~~135~~185. In approximately 2008-2009, Kaiser formed Regional Reporting Group ("RRG"), comprised of senior personnel from the Health Plan, Permanente Medical Groups and Revenue Cycle of each region with the focus of Medicare Advantage Finance Risk Adjustment~~.~~, and later risk adjustment under the ACA program as well. The RRG meetings were initially led by Dr. Simon Cohn until his retirement in 2015, after which the RRG was led by Dr. Annette Guido of Kaiser's Northwest Region, along with Hovannes Daniels, Kaiser's Medicare Finance VP under

Kaiser's Health Plan.

~~136~~186. The RRG ~~meets~~met regularly to share regional "best practices" on how to capture more HCC conditions, diagnoses, and codes, and thus to increase Kaiser revenue. This was ~~and is~~ the top focus of these high-level meetings. Other topics discussed ~~are~~were risk scores and Risk-Adjustment Data Validation (RADV) audits, regulatory changes, comparing regions to each other, and reviewing financial and HCC targets.

~~137~~187. "Best practices" often ~~contain~~contained improper and inaccurate querying, documentation, and coding practices. Certain HCC conditions and diagnoses ~~are~~were specifically targeted at the RRG meetings for their financial impact and discussed and compared with the other regions. Ms. Bryant recalls a RRG meeting where a regional physician leader made a presentation which contained inaccurate documentation and coding information. Ms. Bryant took her concerns about the presentation to Janet D. Franklin of Kaiser's NCO. Ms. Franklin agreed that Ms. Bryant was correct but said that that they could not say anything here at the RRG meeting in front of the Permanente Medical Groups. Ms. Bryant told Janet Franklin that she was concerned with that approach in that there was a large audience in many regions who would think that the presentation had correct information. Ms. Franklin agreed, but said that there was nothing that could be done.

~~138~~188. Kaiser's various regions, including especially its NCAL (TPMG) and Southern California regions (SCPMG), ~~compete~~competed with each other on which region ~~manages~~managed to capture the highest number of HCCs and improved risk scores. Monthly or Bi-monthly WebEx meetings and report outs ~~are~~were generated showing the results of the risk-adjustment metrics, as well as goals and targets for regional HCC capture over the next period. In addition, the regions ~~compete~~competed in the third and fourth fiscal quarters each year as to their metrics on capturing chronic conditions and HCCs, and improving scores and revenue, metrics which ~~are~~were also discussed and presented at RGG meetings.

~~(iii)~~3. Employee and management bonuses.

~~139.~~ 189. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser's NCAL region, including TPMG, ~~gives~~gave bonuses to employees and leadership near year-end that ~~are~~were tied to the overall financial goals and success of the Kaiser region. They therefore believe and allege from their experience working in TPMG that bonuses ~~are~~were related, directly or indirectly, to HCC and revenue capture.

~~(iv)~~4. Kaiser's regional medical groups dominate over Kaiser's compliance function.

~~140~~190. In June 2013, Nancy Andersen, Kaiser's National Compliance manager, told Ms. Hernandez that the regional Permanente Medical Groups choose what and how to be audited. She told Ms. Hernandez that "she knows where the bodies are buried," but that the National Compliance Office has no power over the Permanente Medical Groups. This is exactly the opposite of how the compliance function should operate in a compliant organization. In 2016, Ms. Andersen confirmed to Ms. Bryant that Kaiser's Permanente Medical Groups continue to be "rabid for HCCs" and that Kaiser's NCO group has no power to focus the organization on compliance.

C. Kaiser improperly employs technology to further its HCC and revenue capture.

~~(i)~~1. Data ~~mining~~Mining and Addenda.

~~141~~191. In 2014-2015, Kaiser's TPMG EIO's "data mining" team, comprised largely of out-of-country doctors, used "algorithms" in the NCAL region to identify and capture possible missed HCCs to create "addenda" or "add files," referred to as "missed opportunities" by TPMG. Ms. Hernandez believes and therefore alleges that this practice had been going on for many years.

~~142~~192. Also in 2014-2015, Ms. Hernandez witnessed TPMG utilizing foreign doctors, who were not licensed as physicians in the United States and may not have had current foreign licenses, to access the clinic encounters. The foreign doctors would send "Dear Doctor" notes via KP Health Connect to the primary care physician asking them to add to (addend) the medical records with HCC diagnoses based on their reviews and using their algorithms, often several months after the encounter.

~~143~~193. This process was improper and led to HCC ~~payment~~ errors both in the MA and ACA programs. For example, as part of an NCO audit in 2015, Ms. Hernandez found documentation of sepsis added onto a clinic encounter four months after the patient was seen, with no supporting documentation as to how the HCC diagnosis was determined (e.g., no lab values, signs/symptoms, treatment, clinical indicators, etc.). When Ms. Hernandez shared with her director, Anne Cadwell (TPMG EIO Director), that Ms. Hernandez agreed with NCO's finding that sepsis was improperly coded, Ms. Hernandez was told by Ms. Cadwell "never to agree" with an NCO audit, and if the topic came up, to just say "thank you." Ms. Hernandez asked what to enter in the audit response, given that she agreed with the finding. Ms. Cadwell instructed Ms. Hernandez not to talk at the audit exit call and to only speak when Ms. Cadwell asked Ms. Hernandez to say something.

~~(ii)~~194. Kaiser kept careful track of its data mining progress, regularly tabulating and presenting annual and year-to-date statistics across all Kaiser regions, and by medical center and condition. Kaiser tracked its data mining data for all risk-based payors, including both the MA program and the ACA program, and separately presented ACA data mining data on a condition-by-condition basis, including for certain of the conditions discussed above. Kaiser's policy for data mining and addenda was expressly applicable to all risk-based payors, including both the MA program and the ACA program.

195. Similarly, in approximately August 2015, Ms. Cadwell demanded that records of newborns that were part of the ACA program be "auto-populated" with the diagnosis of "infant prematurity," which would then receive an HHS-HCC code, whenever an infant's birthweight was low, even though low birthweight is not necessarily or always caused by prematurity, but regularly happens in the ordinary course of deliveries that occur close to or at term. Ms. Hernandez resisted Ms. Cadwell's demands and took the issue to Rod Madamba, Director HIM Northern California, who agreed with Ms. Hernandez given the clear error in Ms. Cadwell's medical and coding logic, and refused to implement the auto-populate directive. Ms. Cadwell did not succeed in auto-populating newborn records with the improper code at that time, but her attempt to do so was consistent with Kaiser's overall efforts to over-document and over-code

wherever and whenever possible in both the MA and ACA programs.

2. Improper Carry-Over From Prior Years.

~~144~~196. In 2014-2015, Ms. Hernandez discovered that in Kaiser's NCAL TPMG region, Kaiser's "Business Intelligence Team" ("BIT") generated questionable "block" files and "add" files for resubmission to CMS based on algorithms. The addenda process they used may have improperly carried over HCCs from previous years to the current year without physician validation or a face-to-face encounter.

~~145~~197. Ms. Hernandez was part of the TPMG EIO Director email distribution list where medical record diagnoses files were emailed to the directors asking for approval for "add" or "block" files, which Ms. Hernandez never approved. To Ms. Hernandez' knowledge, "add" (or "addenda") files were created based on algorithms run by the BIT team (e.g., diabetes with manifestations, etc.), and automatically carried from the previous year to the current year's problem list even where patients were not seen face-to-face as required under the Medicare Advantage ~~program~~and ACA programs.

~~(iii)~~3. Computer Assisted Coding

~~146~~198. Computer Assisted Coding (CAC) is a natural language processing technology utilized as a tool to assist the coding professional to confirm and select ICD and CPT codes based on words and language used in the medical record. CAC identifies wording and/or full sentences within the electronic health record which contains signs, symptoms, diagnoses and procedures for which a code may possibly be assigned once confirmed and validated by the coding professional. CAC was identified and implemented by Kaiser as a valuable tool and asset to increase coding productivity, coding accuracy, and HCC capture.

~~147~~199. In approximately 2013, during the pilot phase of CAC implementation in Kaiser's NCAL region, Ms. Hernandez conducted auditing and validation of the resulting diagnoses and codes, along with Ms. Sheryl Roy (Regional NCAL HIM employee at the time). Ms. Hernandez and Ms. Roy determined that CAC was capturing and overcoding diagnoses with an overall poor accuracy rate (60% or less). They shared their findings with Ms. Bryant, who agreed with their concerns.

~~148~~200. During a CAC quality assurance meeting, which was held via recorded webex, Ms. Bryant, Ms. Hernandez and Ms. Roy reported their audit findings and concerns to NCAL Revenue Cycle Charge Capture Manager, Gina Sandler, and Revenue Cycle Integrity Director, Diane Ott, who were members of Kaiser's CAC implementation team. Ms. Sandler typed meeting minutes during the call. Ms. Hernandez and Ms. Roy later discovered that the audit results and their concerns had been excluded from the meeting minutes. Moreover, they discovered that Ms. Sandler and Ms. Ott had manipulated the actual audit results to indicate a higher accuracy rate. Ms. Hernandez and Ms. Bryant believe and therefore allege that the audit results were manipulated and their concerns were ignored so as to avoid identification of any problems with CAC which might delay its full implementation at Kaiser. Ms. Bryant and Ms. Hernandez voiced their concerns to NCAL Revenue Cycle Leadership and to Kaiser's NCO leadership (Ms. Anderson), but were ignored.

~~149~~201. Ultimately, Kaiser's CAC implementation moved forward in 2014 on outpatient and inpatient encounters. After 18 months to two years of constant problems with CAC, the hospital coding and auditing staff expressed outrage with the continued inaccuracy and their mistrust of the CAC tool. These complaints resulted in NCAL Revenue Cycle Leadership finally discontinuing CAC in hospital outpatient encounters in 2016.

~~150~~202. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser never went back to correct the many inaccurate codes generated by the Kaiser's flawed CAC processes.

D. The Kaiser Defendants Acted With Intent.

~~151~~203. The Kaiser Defendants acted with intent in over-charging the United States and retaining and failing to return such overpayments. Kaiser's entire corporate culture is built around "mining for", "gaming" and "capturing" codes even when they are not validly supported or documented, training its physicians to over-diagnose and falsely document diagnoses, elevating its profits over its compliance function, and motivating employees through the setting of metrics and, upon information and belief, utilizing bonuses for successful code and revenue capture. The specific schemes described above engineered by Kaiser regarding aortic atherosclerosis, vent dependent status, and others evidence Kaiser's intentional, systematic efforts to circumvent proper documentation and coding practices and Medicare law and the ACA. Moreover, although Kaiser has a National Compliance Office with hundreds of staff, there are huge holes and gaps in the effectiveness of its compliance program, which is subverted to the profit goals of Kaiser's medical groups.

~~E~~E. Kaiser Submitted or Caused to be Submitted False Claims to the ACA Program

204. Through the conduct described above, Kaiser submitted, or caused others to submit, false claims for payment to the Government. Specifically, Kaiser submitted false claims when it certified its EDGE data as being accurate when it knew that it was not, as that false data is used to determine risk adjustment payments made from or to the Government, and in underpaying into the ACA risk pool, or receiving inflated payments from the ACA risk pool, as a result of its inaccurate risk adjustment data. Kaiser also caused false claims to be submitted via premium tax credits, due to Kaiser's manipulation of the data it presents to the Government with its URRT submissions. And, every payment made to, from, or through the Government by Kaiser in connection with the ACA program is a false claim, since Kaiser is ineligible to participate in the ACA exchanges due to its manipulation of risk adjustment data.

1. Risk Adjustment Payments

205. The more risky an insurer's patient base, either (1) the amount it receives through the risk adjustment payments increases if it is owed money from the pool, or (2) the amount it must pay in risk adjustment payments decreases if it owes money into the pool.

206. As set forth above, Kaiser's upcoding fraud causes its patients to appear more risky and expensive to insure than they actually are. As a result, Kaiser's risk adjustment payments are skewed. Since its patient base appears more risky, Kaiser either pays less in risk adjustments than it should have (when HHS determines that it owes money into the risk pool), or it receives

more in risk adjustment payments than it should (when HHS determines that it is owed money from the risk pool). In either scenario, on a net basis Kaiser benefits more from the Risk Adjustment Program than it should have, had it accurately submitted its risk adjustment data.

207. For every plan and every year, Kaiser falsely certified and attested to the Government that it had presented accurate claims data, reflecting actual diagnoses, when it had not.

208. From an analysis of risk adjustment payments made or received by a Kaiser entity between 2014 and 2021, Kaiser has made, in the aggregate, nearly $6.13 billion in risk adjustment payments into the pool under the ACA. This net figure reflects that, overall, Kaiser generally has reported a healthier patient base than other insurers, requiring it to pay more into the risk pool than it has received, although its status as payor or recipient has varied by individual State market and year.

209. This net $6.13 billion figure is based on Kaiser's systemic practice of over-documenting and upcoding its patient encounters. Had Kaiser accurately coded its patient encounters, HHS would have determined that Kaiser owed substantially more money to the risk pools than Kaiser actually paid.

210. By making lower payments than what Kaiser should have paid to the Government in risk adjustment payments, Kaiser has unlawfully kept Government funds; and in receiving more payments from the risk pool than it was due in those markets and years where it was a net recipient, Kaiser has unlawfully received Government funds.

2. Tax Credits

211. Kaiser's systemic practice of over-documenting and upcoding also has caused the Government to overpay via ACA premium tax credits.

212. As set forth above, the URRT's that Kaiser submits each year in each state include historical and estimated claims data. This data is skewed by Kaiser's systemic over-documentation and upcoding, making its patient base appear more risky than it actually is. Kaiser uses this riskier-appearing patient base to lower its contributions to the Risk Adjustment Program, and lessen the amounts received by other insurers. If not for the upcoding, Kaiser would pay more or receive less in risk adjustment payments, and its competitors would receive more or pay less in risk adjustment payments.

213. The URRTs that Kaiser submits each year also factor into the premiums that Kaiser and other insurers set, and the federal share of those premiums through federal tax credits. If Kaiser were accurately reporting its risk adjustment data, it would either receive less from the Risk Adjustment Program, or pay more into the Risk Adjustment Program. Since it does not, it is able to lower its premiums because it does not anticipate paying the full amount of money that it should into the Risk Adjustment Program; instead, it uses those "savings" to charge lower premiums. Kaiser's competitors, in turn, are forced to raise their premiums, because they anticipate receiving artificially low risk adjustment transfers (unbeknownst to them) from Kaiser.

214. This over-documentation and upcoding fraud has had a direct impact on the premium tax credits, which are funded directly by the Government, because it causes competitors to

unknowingly artificially raise their own premium prices, directly impacting the federal share of the premiums through tax credits.

215. When Kaiser's over-documentation and upcoding impacts an area's benchmark premium, which it does in every State and market in which it participates, the tax credits for all plans purchased by all consumers from any insurer are inflated due to Kaiser's scheme, particularly when the Kaiser plan in that marketplace is not chosen as the benchmark plan, which happens in the substantial majority of markets in any given year.

216. As a hypothetical and simplified example, assume that there are three insurers in a particular market. Insurer A charges $140 for a silver plan, Insurer B charges $130, and Kaiser charges $80. As the second-lowest priced plan, Insurer B's premium of $130 would serve as the benchmark, and all premium tax credits would be tied the $130 price. For qualifying individuals, the Government would pay up to $130 of the premium cost, using taxpayer dollars. However, due to Kaiser's upcoding fraud (and the resulting lower share of risk adjustment payments received by Insurers A and B), the premiums charged by Insurers A and B are artificially inflated. If Kaiser submitted accurate risk adjustment data, Insurers A and B would each charge $15 less (anticipating higher risk adjustment pool payments by Kaiser), and Kaiser would charge $30 more (to recover more from consumers in anticipation of the need to pay more into the pool). In other words, if Kaiser were behaving lawfully, Insurer A would charge $125, Insurer B would charge $115, and Kaiser would charge $110. With accurate data, the benchmark in the area would now be $115, instead of $130. As a result of Kaiser's fraud, the maximum premium tax credit – and amount paid by the Government towards all premium payments in the area by qualified individuals – would be up to $15 higher than it should have been. Due to Kaiser's over-documentation and upcoding, the Government is overpaying by up to $15 per month for each and every plan purchased in that area due to Kaiser's over-documentation and upcoding fraud.

217. This scenario plays out in each of the States and regions in which Kaiser Health Plans participate in ACA marketplaces, as Kaiser causes the benchmark premiums and tax credits to be elevated when it does not itself act as the benchmark plan, which is the case a substantial majority of the time. For example, Kaiser plans have served as the benchmark plan in California's 19 ratings areas (marketplaces) less than 30 percent of the time since 2014.

218. Because Kaiser should have been ineligible to participate in the ACA due to its abject failure to comply with the requirements of the Risk Adjustment Program, all "[p]ayments made by, through, or in connection with an Exchange" involving federal funds – i.e., all premium tax credits used for Kaiser plans, and all Risk Adjustment Payments made or received by Kaiser – are subject to False Claims Act liability. 42 U.S.C. § 18033(a)(6)(A).

219. Alternatively, Kaiser is responsible under the FCA, at minimum, for the amounts that it underpaid into the ACA insurance pool, or overpayments that it received from the ACA insurance pool, and for all federal funds received in the form of excess premium tax credits caused by its submission of false Risk Adjustment Data.

F. Kaiser's Fraud Was and Is Material to the Government's Payment Decision

220. Medicare Advantage: ~~152.~~ The United States, unaware of the falsity of the records,

statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, has paid money that it otherwise would not have paid~~.~~ under the Medicare Advantage program. For example, 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. The fraudulent diagnostic data and coding submitted by the Kaiser Defendants constituted a substantial portion of all of the diagnostic data and coding submitted by the Kaiser Defendants to the government. Given that diagnostic data and coding is the sole determinant in the calculation of any risk adjustment payment based on a beneficiary's health status, the government's payment decision necessarily would have been different had the government known that the data and coding were false.

~~153~~221. Moreover, CMS makes reconciliation payments to the Kaiser Defendants based on the diagnostic data submitted~~.~~ under the Medicare Advantage program. Those payments are adjusted to account for invalid diagnoses codes that providers such as Kaiser submit. 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. But when the Kaiser Defendants did not delete invalid diagnoses from RAPS, Medicare paid for the invalid diagnoses as part of its final reconciliation payment to the Kaiser Defendants. If the Kaiser Defendants had corrected their invalid diagnoses, CMS would have processed the corrected data to produce accurate risk scores for beneficiaries, which necessarily would have changed the risk adjustment payments for those beneficiaries.

~~154~~222. The risk adjustment attestations submitted to CMS by the Kaiser Defendants each year are a reminder to the Kaiser Defendants of their obligation to submit valid data and to promptly correct invalid data. They also have a direct impact on the government's risk adjustment payments. For example, if CMS knew that the Kaiser Defendants' attestations were false, CMS's risk adjustment payments would have changed in that CMS would have refused to make risk adjustment payments to the Kaiser Defendants, in whole or in part.

~~155~~223. The materiality of the Kaiser Defendants' fraud on the Medicare Advantage program is further established by the fact that the United States has filed suit against Kaiser in this case and against other managed care organizations over similar documentation and coding fraud as alleged herein.

224. Affordable Care Act: As to the ACA, the United States was unaware of the falsity of the records, statements, and claims made and submitted by Defendants, their agents, and employees. As a result, it has paid money to Defendants that it otherwise would not have paid, or refrained from recovering more money from Defendants than it otherwise would have.

225. The ACA's materiality threshold for discrepancies in risk adjustment data is, at most, $100,000. See 45 C.F.R. § 153.710(e). Kaiser's fraud far exceeds this threshold, many times over.

226. From the inception of the ACA Risk Adjustment Program, Kaiser squeezed, manipulated,

over-documented and upcoded more and more risk adjustment data such that it managed to increase its overall ACA risk score most every year by at least one percent annually, often much more than that. Given the amount of premium revenue and the size of the insurance pool, this level of risk adjustment fraud benefitted Kaiser's ACA plans by at least tens of million dollars in federal risk pool adjustments each year, a substantial portion of which was funded through federal tax credits. This fraud is well in excess of the ACA's materiality threshold of $100,000.

227. Moreover, because Defendants falsified their risk adjustment data, they violated a material condition making them eligible to participate in the ACA Exchanges, and in turn to receive any funds in connection with that program. 42 U.S.C. § 18033(a)(6)(A). The United States would have refused to fund premium tax credits for Kaiser plans, would have refused to make risk adjustment payments to Kaiser, and/or would have demanded additional risk adjustment payments from Kaiser. Further, Congress has explicitly stated that such violations of material conditions of participation in the ACA Exchanges subject Defendants to False Claims Act liability. Id.

228. Further, the inflated diagnostic data and coding submitted by Defendants constituted a substantial portion of all the diagnostic data and coding submitted by the Defendants to the Government. Given that diagnostic data and coding is the principal determinant in the risk profile of a given insurance plan, and in turn directly impacts the premiums that plan can charge, the tax credits that can be applied to the plan's premium payments, and the risk adjustment payments going to or coming from the insurer, the Government's payment decisions necessarily would have been different had the Government known that the data was false.

229. The EDGE attestations submitted by the Defendants each year are a reminder to the Defendants of their obligation to submit valid data and to promptly correct invalid data. They also have a direct impact on the Government's risk adjustment transfers. For example, if HHS knew that the Defendants' attestations were false, HHS' risk adjustment transfers would have changed, and required Defendants to pay more in risk adjustment transfers or receive less in risk adjustment transfers.

230. The materiality of the Defendants' fraud is further established by the fact that HHS is empowered to commence enforcement actions and impose monetary penalties against those entities that fail to comply with risk adjustment data requirements as Kaiser has. 45 C.F.R. § 153.740(a); 45 C.F.R. § 156.805.

231. The Government, in fact, has launched investigations into insurers manipulating risk adjustment data to alter risk adjustment payments under the ACA. For instance, in 2017, the FBI issued subpoenas and investigated an insurer for such manipulation in Oregon. See, e.g., https://www.healthcaredive.com/news/fbi-investigating-zoom-for-aca-risk-adjustment-fraud/444803/.

232. The materiality of the Defendants' fraud is further amplified by the magnitude of Defendants' false risk adjustment data. On a net basis, Defendants' insurance plans under the ACA were responsible for the movement of over $6.13 billion since 2014. Further, when Defendants' conduct impacts the benchmark rates in a given area, which it regularly does, Defendants' fraud impacts the premium tax credit for every enrollee in any insurer's plan that is

eligible for a tax credit.

FIRST CLAIM FOR RELIEF

False Claims Act: Presentation of False or Fraudulent Claims

U.S.C. § 3729(a)(1)(A) (formerly 31 U.S.C. § 3729(a)(1))

~~156~~233. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – ~~208~~232 above as though they are fully set forth herein.

~~157~~234. Defendants violated 31 U.S.C. § 3729(a)(1)(A) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. 3729(b)(1)) presented or caused to be presented a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program and higher premiums and premium tax credits and a greater share of the ACA insurance pool under the ACA program.

~~158~~235. Defendants violated former 31 U.S.C. § 3729(a)(1) as follows: Defendants knowingly presented, or caused to be presented, to the United States a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program and higher premiums and premium tax credits and a greater share of the ACA insurance pool under the ACA program.

~~159~~236. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

~~160~~237. By virtue of the said false or fraudulent claim, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

SECOND CLAIM FOR RELIEF

False Claims Act: Making or Using False Records or Statements

U.S.C. § 3729(a)(1)(B) (formerly 31 U.S.C. § 3729(a)(2))

~~161~~238. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – ~~213~~237 above as though they are fully set forth herein.

~~162~~239. Defendants violated 31 U.S.C. § 3729(a)(1)(B) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to a false or fraudulent claim for risk adjustment payments from the Medicare Program

and higher premiums and premium tax credits and a greater share of the ACA insurance pool under the ACA program.

~~163~~240. Defendants violated former 31 U.S.C. § 3729(a)(2) as follows: Defendants knowingly made, used, or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the United States. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation to get a false or fraudulent claim for risk adjustment payments paid or approved by the Medicare Program and higher premiums and premium tax credits and a greater share of the ACA insurance pool under the ACA program.

~~164~~241. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

~~165~~242. By virtue of the said false record or statement, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

THIRD CLAIM FOR RELIEF

False Claims Act: Conspiracy

U.S.C. § 3729(a)(1)(C) (formerly 31 U.S.C. § 3729(a)(3))

~~166~~243. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – ~~218~~242 above as though they are fully set forth herein.

~~167~~244. Defendants violated 31 U.S.C. § 3729(a)(1)(C) as follows: Defendants conspired with one another to commit a violation of 31 U.S.C. § 3729(a)(1)(A), (B), and/or (G), as those violations are specifically alleged in Claims I, II, and IV of this Complaint.

~~168~~245. Defendants violated former 31 U.S.C. § 3729(a)(3) as follows: Defendants conspired with one another to defraud the United States by getting a false or fraudulent claim allowed or paid. Specifically, Defendants conspired with one another to defraud the United States by getting risk adjustment payments from the Medicare Program based on a false or fraudulent claim for risk adjustment payments and/or a false or fraudulent Risk Adjustment Attestation, and higher premiums and premium tax credits and a greater share of the ACA insurance pool under the ACA program. Defendants conspired with one another in one overarching conspiracy involving all Kaiser entities, who all share common management and control and are financially intertwined with one another. Defendants also conspired bilaterally, with each health plan and affiliated medical group conspiring to defraud the United States on a regional basis, with the various Kaiser regions essentially competing with one another on which could do so most successfully.

~~169~~246. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

~~170~~247. By virtue of the said conspiracy, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FOURTH CLAIM FOR RELIEF

False Claims Act: Reverse False Claims

U.S.C. § 3729(a)(1)(G) (formerly 31 U.S.C. § 3729(a)(7))

~~171~~248. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – ~~223~~247 above as though they are fully set forth herein.

~~172~~249. Defendants violated 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program, and to repay higher premiums and premium tax credits and to receive a greater share of the ACA insurance pool to which they were not entitled under the ACA program.

~~173~~250. Defendants also violated 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) concealed or improperly avoided or decreased an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly concealed or improperly avoided or decreased an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program, and to repay higher premiums and premium tax credits and to receive a greater share of the ACA insurance pool to which they were not entitled under the ACA program.

~~174~~251. Defendants violated former 31 U.S.C. § 3729(a)(7) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly made, used, or caused to be made or used, a false Risk Adjustment Attestation to conceal, avoid or decrease an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program, and to repay higher premiums and premium tax credits and to receive a greater share of the ACA insurance pool to which they were not entitled under the ACA program.

~~175~~252. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

~~176~~253. By virtue of the said false record, statement, and other acts of concealment and improper avoidance, the United States incurred damages and therefore is entitled to multiple

damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FIFTH CLAIM FOR RELIEF

False Claims Act: Relief From Retaliatory Actions Against Defendant TPMG

U.S.C. § 3730(h)

~~177~~254. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – ~~246~~253 above as though they are fully set forth herein.

~~(a)~~255. 31 U.S.C. § 3730(h), Relief From Retaliatory Actions, provides:

(i) In general.— Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor, or agent or associated others in furtherance of other efforts to stop 1 or more violations of this subchapter.

(ii) Relief.— Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

~~178~~256. Ms. Hernandez was employed by the Kaiser Defendants from June 1995 through October 2015. From January 2000 forward, Ms. Hernandez's was employed in various coding leadership positions.

~~179~~257. Ms. Hernandez received stellar employment reviews throughout her career with Kaiser until she was hired into Kaiser's TPMG organization. In her last year of Kaiser employment (October 2014 through October 2015), the only year that she worked at Kaiser's TPMG subsidiary, Ms. Hernandez was criticized for purported lack of communication and, at the same time, also reprimanded for communicating her concerns about TPMG's coding and auditing functions.

~~180~~258. This review came after, and was the direct result of, Ms. Hernandez observing and reporting internally several of the coding errors and systemic fraud detailed herein committed at and by Kaiser and its affiliates, including TPMG.

~~181~~259. The poor review was improper retribution for Ms. Hernandez's efforts to bring to the attention of leadership the deceptive and fraudulent practices within Kaiser. She was set up to be terminated for reporting what she observed even though she had been asked by TPMG leadership to stop looking for another job. Ms. Hernandez felt harassed, disrespected, and bullied. She was subjected to threats and intimidation by TPMG leadership.

~~182~~260. In October 2015, in anticipation of being terminated, and due to Kaiser TPMG's intimidation and harassment, she resigned her position with Kaiser.

~~183~~261. Ms. Hernandez engaged in protected activity by, among other things, reporting to multiple Kaiser supervisors her concerns that Kaiser was submitting illegal, unlawful and/or false claims to the Government in an effort to stop Kaiser from presenting or causing to be presented to the Government false or fraudulent claims for payment or approval, and from making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim.

~~184~~262. Kaiser TPMG knew that Ms. Hernandez engaged in the above described protected activity.

~~185~~263. Kaiser TPMG discharged, demoted, threatened, harassed, and otherwise discriminated against Ms. Hernandez as a result of her protected activities.

~~186~~264. As a result of Kaiser's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

SIXTH CLAIM FOR RELIEF

Violation of Cal. Lab. Code § 1102.5, et seq. Against Defendant TPMG

~~187~~265. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – ~~256~~264 above as though they are fully set forth herein.

~~188~~266. In violation of Cal. Lab. Code § 1102.5, Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez for having opposed, resisted, and complained of the acts alleged herein.

~~189~~267. Defendant TPMG retaliated against Ms. Hernandez for opposing and refusing to participate in Defendant's violations of state and federal statutes and/or rules and regulations. In contesting Defendant's violations, Ms. Hernandez was engaged in protected activity. Under Cal. Lab. Code § 1102.5, Defendant TPMG is prohibited from retaliation against Ms. Hernandez for opposing any practices forbidden or made unlawful under Cal. Lab. Code § 1102.5.

~~190~~268. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

~~191~~269. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

SEVENTH CLAIM FOR RELIEF

Violation of Cal. Lab. Code § 98.6 Against Defendant TPMG

~~192~~270. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – ~~261~~269 above as though they are fully set forth herein.

~~193~~271. In violation of Cal. Lab. Code § 98.6, Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez for having opposed, resisted, and complained of the acts alleged herein.

~~194~~272. After Ms. Hernandez complained about and objected to Kaiser's practices detailed herein and in response to such complaints and objections, Defendant TPMG subjected her to ongoing retaliation, including but not limited to ostracism and the threat of termination.

~~195~~273. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. ~~Hernandez's rights, entitling her to an award of punitive damages.~~

~~196. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.~~

~~EIGHTH CLAIM FOR RELIEF~~

~~Violation of Fair Labor Standards Act Against Defendant TPMG~~

~~29 U.S.C. § 215~~

~~197. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 266 above as though they are fully set forth herein.~~

~~198. In violation of the Fair Labor and Standards Act of 1939 ("FLSA"), Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez in constructively discharging her for having opposed, resisted, and complained of the acts alleged herein, including numerous violations of federal law and rules and regulations.~~

~~199. In making the above-described internal complaints, Ms. Hernandez was engaged in a protected activity under the FLSA. Defendant TPMG willfully continued to mask its violations after Ms. Hernandez apprised Defendant of the extent of Defendant's non-compliant practices. Ms. Hernandez subsequently suffered an adverse employment action when she was constructively discharged from her employment by Defendant in retaliation for making said complaints and refusing to accede to Defendant's masking of its unlawful practices.~~

~~200. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms.~~ Hernandez's rights, entitling her to an award of

punitive damages.

~~201~~274. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

PRAYER

WHEREFORE, qui tam plaintiffs Gloryanne Bryant and Victoria M. Hernandez pray for judgment against Defendants as follows:

On Claims I, II, III, and IV (False Claims Act), against all Defendants jointly and severally:

- for the amount of the United States' damages, trebled as required by law, together with the
- maximum civil penalties allowed by law, costs, post-judgment interest, and such other and further relief as the Court may deem appropriate;
- for Relators to be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act;
- for Relators to be awarded all costs of this action, including attorneys' fees and expenses;
- and for the United States and Relators to receive all such other relief as the Court deems just and proper.

Further, on Claims V, VI, and VII, ~~and VIII,~~ Plaintiff-Relator Ms. Hernandez, on her own behalf, demands that judgment be entered in her favor and against Defendant The Permanente Medical Group, Inc. granting the following relief:

- An award of back pay with prejudgment interest;
- An award of front pay in lieu of reinstatement;
- An award of general damages to compensate Ms. Hernandez for the mental and emotional distress caused by Defendant TPMG's misconduct;
- An award of punitive damages to deter and punish Defendant TPMG;
- An award of double, treble, exemplary, and/or punitive damages pursuant to 31 U.S.C. § 3730(h)(2~~),~~) and the California Labor Code~~, and the FLSA~~;
- An award of attorneys' fees and costs pursuant to 31 U.S.C. § 3730(h)(2~~),~~) and the California Labor Code~~, and the FLSA~~; and

- An award of such other and further relief as this Court deems just and proper.

DEMAND FOR JURY TRIAL

Relators hereby demand a trial by jury as to all issues.

Dated: ~~November 15, 2021~~December 12, 2022

Respectfully submitted,

GLORYANNE BRYANT and

VICTORIA M. HERNANDEZ

By /s/ Roger A. Lewis

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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

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

Hearing Date: May 4, 2023
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

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

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

Hearing Date: May 4, 2023
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

[PROPOSED] ORDER GRANTING MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

Hearing Date: May 4, 2023
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

[PROPOSED] ORDER

With good cause shown, Defendants' Motion to Dismiss Relators Bryant and Hernandez's Second Amended Complaint is GRANTED. The Court dismisses all FCA fraud causes of action from the Second Amended Complaint with prejudice as to Relators Bryant and Hernandez.

IT IS SO ORDERED.

DATED:

_____
HONORABLE EDWARD M. CHEN
UNITED STATES DISTRICT JUDGE