BRIAN M. BOYNTON
Principal Deputy Assistant Attorney General

STEPHANIE M. HINDS (CABN 154284)
United States Attorney

MICHELLE LO (NYBN 4325163)
Chief, Civil Division

SHIWON CHOE (CABN 320041)
DAVID M. DEVITO (CABN 243695)
Assistant United States Attorneys

450 Golden Gate Avenue, Box 36055
San Francisco, California 94102-3495
Telephone: (415) 436-7200
Facsimile: (415) 436-6748
shiwon.choe@usdoj.gov
david.devito@usdoj.gov

JAMIE ANN YAVELBERG
PATRICIA L. HANOWER
ARTHUR S. DI DIO
GARY R. DYAL
LAURIE A. OBEREMBT
JONATHAN T. THROPE
United States Department of Justice
Civil Division
Commercial Litigation Branch

DAVID MOSKOWITZ
Special Attorney to the U.S. Attorney General

Attorneys for the United States of America

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 **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION** Hearing: May 4, 2023 at 1:30 p.m. Location: Zoom videoconference

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UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION** Hearing: May 4, 2023 at 1:30 p.m. Location: Zoom videoconference

UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION** Hearing: May 4, 2023 at 1:30 p.m. Location: Zoom videoconference

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:18-cv-01347-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION** Hearing: May 4, 2023 at 1:30 p.m. Location: Zoom videoconference

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UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiff, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION** Hearing: May 4, 2023 at 1:30 p.m. Location: Zoom videoconference

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:21-cv-03894-EMC **UNITED STATES' OPPOSITION TO DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION** Hearing: May 4, 2023 at 1:30 p.m. Location: Zoom videoconference

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INTRODUCTION

In its prior Order, the Court found that the United States properly alleged a scheme by Defendants ("Kaiser") to submit diagnosis codes to the Centers for Medicare and Medicaid Services ("CMS") for conditions that were unrelated to patient visits. The Court also found that the United States had properly alleged representative examples of false claims where Kaiser submitted diagnosis codes for conditions that did not exist at the time of the visit. The Court did so over Kaiser's objection that the allegations were insufficient because they were based merely on "inconsistencies in medical records." Dkt. 201, Reply at 6. The Court rejected that argument, explaining, for example, that if documentation contradicts a condition such as cachexia, "then it can reasonably be inferred" that the diagnosis was "not justified." Dkt. 223, Order of November 14, 2022 ("Order") at 14. The Court concluded that the complaint alleged facts showing a pattern of such nonexistent diagnoses with respect to cachexia. For other conditions, however, the Court found that the complaint lacked allegations sufficient to show that the representative examples of Kaiser submitting nonexistent diagnoses were "emblematic of a wider pattern of similar practices." *Id.* at 13. The Amended Complaint addresses this narrow issue.

The Amended Complaint alleges that Kaiser engaged in a single, coordinated scheme and that its false claims for nonexistent conditions derived from the same scheme already upheld by the Court. Kaiser's scheme centered on its risk-adjustment programs, through which Kaiser mined patient files to find additional lucrative diagnoses. Kaiser then queried doctors requesting that they add the diagnoses—which Kaiser termed "missed opportunities" for revenue—to the records of past patient visits. Kaiser pressed physicians to add these mined diagnoses retrospectively via addenda even where the medical record showed that the condition was unrelated to the visit and even where the medical record showed the patient did not have the condition. Even worse, Kaiser did not alert the physicians to contradictory information in the medical record.

All of the false claims alleged stem from the same basic defect in these programs: when Kaiser pressured and incentivized physicians to add diagnoses to medical records, Kaiser routinely ignored what actually occurred at the patient visit. This had two inevitable, overlapping results. First, Kaiser queried physicians to add diagnoses that did not require or affect patient care, treatment, or management at patient visits, in violation of the International Classification of Diseases ("ICD") Official Guidelines

for Coding and Reporting (the "ICD Guidelines"). Second, for a subset of those visits, Kaiser queried physicians to add diagnoses even though the patient's medical record showed that the condition did not exist at the time of the visit. Kaiser was aware of the flaw in its programs and knew that, as a result, it was repeatedly querying physicians to add conditions that did not exist. Kaiser knew, for example, that some physicians were not reviewing the medical records thoroughly in response to queries and were just adding all the requested diagnoses. Numerous physicians complained of this problem and that Kaiser was engaging in fraud. Internal audits confirmed the problem. Most importantly, Kaiser knew this resulted in the widespread submission of false claims.

In denying the bulk of Kaiser's original motion to dismiss, the Court determined that the United States' allegations regarding most aspects of this scheme were sufficient. It granted Kaiser's motion only with respect to whether, for conditions other than cachexia, individual examples of nonexistent diagnoses represented "a wider pattern of similar practices" with respect to those conditions. Order at 13. The Amended Complaint cures that deficiency: it not only describes additional instances in which Kaiser submitted nonexistent diagnoses for payment, but also alleges in detail how such representative examples related to Kaiser's wider pattern of similar practices.

The Court should deny Kaiser's motion to dismiss in its entirety. The Amended Complaint more than satisfies pleading standards for all of the elements under the False Claims Act ("FCA"). None of Kaiser's arguments with respect to falsity, knowledge, materiality, or conspiracy have merit.

First, the Amended Complaint plausibly alleges falsity. The Amended Complaint details both representative examples of false claims that Kaiser submitted where the patient did not have the condition *and* extensive allegations plausibly showing those claims were emblematic of a wider pattern.

Second, the Amended Complaint plausibly alleges Kaiser's "knowledge" under the FCA. Kaiser concedes the allegations show it knew that its risk-adjustment programs were querying physicians to add diagnoses for conditions that did not exist. But contrary to Kaiser's argument, the allegations also show Kaiser knew that these programs resulted in the submission of false claims. The allegations show, at a minimum, that Kaiser acted with reckless disregard or deliberate indifference to the truth or falsity of the claims it submitted. Nor was the United States required to allege every Kaiser physician acted knowingly. To the contrary, the Ninth Circuit has held that FCA claims may proceed based on the

organization's knowledge: "where [an] organization turns a blind eye to [diagnostic-code] over-reporting errors, it exhibits reckless disregard and deliberate ignorance toward the truth or falsity of the data submitted to CMS." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1175-76 (9th Cir. 2016) (*Swoben*). That is exactly what is plausibly alleged to have occurred here.

Third, the Amended Complaint alleges materiality. Indeed, Kaiser concedes in a footnote that CMS would not pay for claims where the condition did not exist. Dkt. 249 ("MTD") at 20 n.10.

Fourth, the Amended Complaint plausibly alleges that all of the Defendants participated in this scheme. It alleges that each Kaiser Defendant jointly operated the risk-adjustment programs at issue and did so "knowing" that these programs were querying physicians to add diagnoses that did not exist and "knowing" that this conduct resulted in false claims. Kaiser's argument ignores nearly all of the allegations in the Amended Complaint, including the allegations of the joint planning and operation of these programs and the specific representative false claims covering each region and Defendant. These allegations plausibly allege the participation of each Defendant in the scheme and give rise, at a minimum, to an inference of an agreement. Indeed, these programs could not have functioned, and Kaiser would not have been able to submit the false claims at issue, without the joint agreement and participation by all of the Kaiser Defendants.

Fifth, Kaiser presents no arguments regarding the payment by mistake and unjust enrichment claims, which should proceed regardless.

BACKGROUND

I. The Court's Order

In its Order, the Court largely rejected Kaiser's arguments for dismissal of the United States' Complaint. The Court concluded that the United States adequately pled that Kaiser engaged in a scheme to add diagnoses via addenda to patient medical records where the condition did not require or affect patient care, treatment, or management, in violation of the ICD Guidelines. Order at 16-24. The Court concluded that no claims are time barred. *Id.* at 24-28. The Court also concluded that the United States' common law claims could proceed. *Id.* at 28-31.

The Court further found that the United States sufficiently pled instances where Kaiser falsely submitted diagnosis codes for conditions that did not exist at the time of the visit. *Id.* at 11-14. Kaiser

had argued that the United States' allegations were insufficient to allege these "diagnoses were actually inaccurate" because the allegations were based on "purported inconsistencies in the medical record" and had failed to rule out other plausible alternatives, such that these were "either a mistake corrected by the healthcare provider with the addenda" or an indication of a health status change. Dkt. 201, Reply at 6-8. The Court rejected Kaiser's argument, finding that allegations of such inconsistencies properly pled falsity and that Kaiser failed to give all reasonable inferences in favor of the government. Order at 11-14. The Court explained, for example, that "if documentation contradicted the definition of cachexia, then it can reasonably be inferred that a diagnosis of cachexia was not justified." *Id.* at 14. The Court similarly found that the other examples, also based on allegations that the diagnoses were contradicted by the medical record, were properly pled. *Id.* at 11-13.

The Court concluded, however, that, except for cachexia, the complaint did not contain sufficient allegations plausibly establishing that these examples "were emblematic of a wider pattern of similar practices." *Id.* at 13. The Court granted the United States leave to replead.

II. The Amended Complaint

The Amended Complaint is directed at this narrow issue: to establish that the representative examples of nonexistent diagnoses were part of a pattern of similar practices by Kaiser involving other diagnoses. The Amended Complaint first clarifies that Kaiser engaged in a single, coordinated scheme, not multiple schemes. Dkt. 240, Amended Complaint ("FAC") ¶¶ 1-2, 101-03. That is, Kaiser's submission of diagnosis codes for conditions that did not exist at the time of the patient visit was part of the same scheme through which Kaiser submitted diagnosis codes for conditions that had no relevance to the visit. *Id.* At a basic level, Kaiser's risk-adjustment programs mined patient files for potential diagnoses and then pressed Kaiser's physicians to retrospectively add those diagnoses to make it appear as if they were part of the visit. *Id.* ¶¶ 1, 102. The fraud stems from Kaiser's "knowing" failure, through these programs, to account for what actually occurred during the patient visit. *Id.* ¶¶ 101-03. Kaiser knew that it could submit only diagnosis codes to CMS for payment where the conditions both existed at the time of the patient visit and required or affected care, treatment, or management. *Id.* ¶¶ 1, 90-100, 102. But Kaiser nevertheless pressed physicians to add diagnoses via addenda even where the condition was completely unrelated to the visit and even where the medical record also showed that the patient did

not have the condition. *Id.* ¶¶ 1, 102, 134, 137.

Kaiser's scheme led directly to the widespread submission of inaccurate diagnosis codes that were false in two related and overlapping ways—both of which resulted from its failure to account for what actually occurred at the patient visit. *Id.* ¶¶ 2, 9. First, Kaiser falsely submitted diagnosis codes for conditions that did not require or affect patient care, treatment, or management at the visit, as required by the ICD Guidelines. *Id.* Second, for a subset of those false claims, the diagnosis codes were also false because the patient did not actually have the condition at the time of the visit, as the existence of the condition was contradicted by the medical record. *Id.*

Because the Court already concluded that the allegations were sufficient regarding the first issue, the Amended Complaint's new allegations focus on the second issue and specifically on Kaiser's practice of submitting diagnosis codes for conditions that were contradicted by the medical record and therefore did not exist at the visit. The Amended Complaint demonstrates how this fraud arose directly from the design of Kaiser's risk-adjustment programs, which were national in scope and covered Kaiser's California and Colorado regions. *Id.* ¶¶ 103-04, 126-39, 164-65. By design, Kaiser's risk-adjustment programs generated voluminous queries to physicians after visits, pressuring them to add diagnoses to medical records without properly accounting for information that contradicted the conditions Kaiser sought to add. *Id.* ¶¶ 10-11, 134, 137, 141-42, 161. To make matters worse, Kaiser did not even alert its physicians to the contradictory information in the medical record. *Id.* ¶¶ 10, 137, 142, 174-76, 375.

For example, a data-mining algorithm may be run at the beginning of the year and identify a potential diagnosis based on outdated information from the prior year. *Id.* ¶ 142. If a patient visit occurred after the algorithm was run, Kaiser would routinely generate queries related to the data-mined diagnosis without regard to what actually occurred at the visit. *Id.* As a result, even if the clinical indicators at the time of the visit showed the condition did not exist, Kaiser would still query the physician for the data-mined condition and would not alert the physician to the contradictory information. *Id.* ¶¶ 102, 142, 174. Similarly, even if a medical record was inconsistent with the condition—for example, if the medical note stated the condition was historical (as opposed to active)—Kaiser often did not remove the diagnosis from its program and instead continued to query physicians to

add the diagnosis. *Id.* ¶ 161.

Kaiser knew about the serious defects in its programs and knew it was repeatedly querying physicians to add diagnoses for conditions that did not exist. Internally, Kaiser called these data-lag issues a threat and weakness of its risk-adjustment programs. *Id.* ¶ 142. Numerous physicians warned Kaiser that it was repeatedly querying for conditions the patient did not have, putting Kaiser on further notice of the problem. *Id.* ¶¶ 12, 274, 309-11. Some physicians who were pressured to add diagnoses for conditions that did not exist complained that Kaiser was asking them to participate in fraud. *Id.* ¶ 311. Kaiser's own analyses likewise confirmed that its programs were prompting physicians to add diagnoses for conditions that patients never had or did not have at the time of the visit. *E.g.*, *id.* ¶¶ 346-47.

Kaiser not only routinely queried providers to add diagnoses for conditions that did not exist, but also pressured and incentivized physicians to add these diagnoses. *Id.* ¶¶ 11, 243-60. These queries were often called "missed opportunities"—as in missed opportunities to make money. *Id.* ¶ 8. As part of its efforts to increase revenue, Kaiser required its physicians to meet certain metrics related to its risk-adjustment program, such as "refreshing" 99% of diagnoses identified by Kaiser. *Id.* ¶¶ 11, 251-60. Kaiser meticulously tracked and monitored these metrics across physicians, facilities, and regions. *Id.* Physicians who scored high were praised and rewarded. *Id.* Those who did not were often required to meet with supervisors about their performance and could face financial consequences. *Id.* Kaiser further made it time-consuming and administratively burdensome for physicians to reject queries, requiring physicians to justify refusals through multiple levels of review. *Id.* ¶¶ 243-50. If the physician just followed Kaiser's request to add the diagnoses, that generally led to no further review, *id.*, even though Kaiser knew its queries contained many conditions that did not exist, *id.* ¶¶ 12, 142, 274, 309-11, 347. Kaiser set increasingly higher risk-score targets every year, despite concerns from physicians that it created "a culture of 'meet the target at any cost.'" *Id.* ¶ 123. Because of this pressure to meet targets and add diagnoses, some Kaiser physicians complied with Kaiser's queries by adding an addendum that documented the patient had a *history* of the condition, which typically does not receive a risk-adjustment payment. But Kaiser would nevertheless falsely submit the diagnosis code reflecting an *active* condition at the time of the visit to receive a payment. *Id.* ¶¶ 177-79.

Kaiser knew that the flaws in its programs were causing it to submit false claims for conditions

that did not exist. *E.g.*, *id.* ¶¶ 178, 323, 337-38, 345. Internally, Kaiser recognized that many times physicians were not properly reviewing diagnoses for which Kaiser queried and knew that this practice was leading to the repeated submission of incorrect diagnoses. *Id.* ¶ 323. For example, one internal document identified as a weakness of the program that "[s]ome clinicians refresh the diagnoses without proper and detailed review of the medical record, and as a result *incorrect diagnoses keep being reported*." *Id.* (emphasis added). Knowing that its query lists often contained inaccuracies, Kaiser knew that physicians who simply agreed to add all listed diagnoses represented a red flag. *Id.* In audits that reviewed this issue, Kaiser found hundreds of erroneous diagnoses that matched the pattern alleged in the Amended Complaint, where diagnoses were added via addenda even though their existence was contradicted by the original visit record. *Id.* ¶¶ 337-38. Contrary to the benign explanation proffered in its motion, Kaiser categorized these diagnoses as *errors*, not physicians correcting clerical mistakes. *Id.* Similarly, Kaiser's documents and audits show that it was aware that it was repeatedly improperly submitting for payment diagnosis codes for active conditions when the conditions were documented to be historical. *Id.* ¶¶ 178-79, 345.

The Amended Complaint contains various examples across each of the three regions that are representative of the types of false claims that resulted from this scheme. These include the examples from the original complaint, which the Court already found were sufficiently pled, plus additional examples that illustrate the practices alleged in the Amended Complaint:

- A patient was seen for a blood pressure check and lab results. The physician documented that the patient had a *history of* prostate cancer. Six months later, he was queried for several uncoded diagnoses "the region thinks should be picked up'"—including prostate cancer. The doctor responded to the query by adding all the requested diagnoses, including active prostate cancer, even though the original note showed the visit had nothing to do with cancer and contradicted the existence of active prostate cancer at the time of the visit. *Id.* ¶ 365.

- A patient was seen for shortness of breath and was diagnosed with exacerbation of chronic obstructive pulmonary disease. The physician ordered a chest x-ray to rule out pneumonia. The results of the x-ray showed the patient did not have pneumonia. The physician later added thirteen additional diagnoses via addenda over the course of ten months, a tell-tale sign of data mining and refresh queries. One of these added diagnoses was severe obesity equivalent; however, this diagnosis was contradicted by the medical record because the patient's BMI at the time of the visit was below the threshold for that diagnosis. *Id.* ¶ 366.

- A physician added an addendum for obesity hypoventilation syndrome, a breathing disorder found in some obese patients, where the medical record showed the patient was clearly not obese. This resulted from Kaiser querying this and other physicians to add acute and/or chronic respiratory failure and obesity hypoventilation syndrome for all patients on oxygen,

regardless of whether they were obese. Kaiser did not alert physicians to contradictory information showing these patients could not have the condition. *Id.* ¶¶ 155, 157, 227-28.

- A patient was seen by an orthopedic physician assistant ("PA") for left knee pain and was documented to be obese at the visit. As a result of Kaiser's flawed refresh program, the PA added malnutrition to the visit record, despite contradictory evidence in the medical record. Kaiser further failed to alert the PA that it had also prompted the patient's primary care physician to refresh malnutrition around the same time, but that the physician documented that the patient did not have malnutrition. *Id.* ¶ 175.

- A patient was seen for a throat issue and documented to be "well nourished" at the visit. Kaiser failed to alert the physician that the patient's medical record was inconsistent with malnutrition, both because she was documented to be "well nourished" at the visit and her most immediate prior test results were inconsistent with malnutrition. As a result of Kaiser's flawed refresh program, the physician added malnutrition to the visit record. *Id.* ¶ 176.

As the Amended Complaint alleges, these examples are representative of many more diagnoses that, in addition to being unrelated to the patient visit, were in fact contradicted by the patient's medical record (i.e., the patient did not have the condition at the time of the visit). *Id.* ¶ 375. For each such diagnosis: (1) the physician did not document the condition or its relevance during the original visit record; (2) Kaiser's refresh or data-mining programs pressed the physicians to add these diagnoses despite contradictory information in the medical record showing that the condition did not exist at the time of the visit and despite the condition not being relevant to the visit; (3) Kaiser failed to alert the physician to the contradictory information in the medical record; and (4) the physician followed Kaiser's direction to add the diagnosis to the patient's medical record. *Id.* Nor is there any evidence in these circumstances that the physician was correcting any mistaken information in the medical record. *Id.*

The Amended Complaint contains a further example of the many instances where physicians responded to Kaiser's query requests by documenting that the patient had a history of the condition, but Kaiser falsely submitted for payment the diagnosis code for the active condition. *Id.* ¶ 220. In this example, a patient was seen for leg pain and cramping, and Kaiser requested that the physician add a wholly unrelated mined condition—thrombocytopenia (low blood platelet count). The physician created an addendum stating that the patient had a history of thrombocytopenia (for which Kaiser would not receive a risk adjustment payment), but Kaiser submitted the condition as active thrombocytopenia and thus received payment for it. *Id.* This example is representative of Kaiser's widespread pattern of submitting as *active* conditions that were actually *historical*. *Id.* ¶¶ 177-79.

The fraudulent diagnoses at issue were not accidents—they were the inevitable result of Kaiser's

flawed programs to increase risk-adjustment revenue by trolling for diagnoses without regard to what actually occurred at the visit, including whether the condition was unrelated to the visit or whether the existence of the condition was contradicted by the medical record. *Id.* ¶ 376. Kaiser routinely queried physicians to add diagnoses unrelated to the visit and failed to ensure that it did not query physicians for conditions whose existence was contradicted by the medical record. *Id.* Kaiser failed to inform physicians of relevant, contradictory information regarding the conditions it sought to add. *Id.* These failures were further compounded by Kaiser's failure to review the addenda to ensure that it was not submitting inaccurate ICD diagnosis codes, including when physicians documented conditions as historical. *Id.* These failings directly led to the pattern of false claims at issue here. *Id.* None of these inaccurate diagnoses existed in the original patient visit record. *Id.* All were generated at Kaiser's request. *Id.*

LEGAL STANDARD

In considering a motion to dismiss, a court must accept as true all well-pleaded allegations in the complaint, construing them in the light most favorable to the plaintiff. *United States v. Corinthian Colleges*, 655 F.3d 984, 991 (9th Cir. 2011). The court determines whether the complaint contains "sufficient factual matter that, taken as true, state a claim for relief [that] is plausible on its face." *Id.* (cleaned up). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.*

Rule 9(b) requires a party to "state with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). "Rule 9(b) requires only that the *circumstances of fraud* be stated with particularity; other facts may be plead[ed] generally, or in accordance with Rule 8." *Corinthian Colleges*, 655 F.3d at 992. Rule 9(b)'s standard does not apply to knowledge, which may be pleaded generally. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 679 (9th Cir. 2018). Rule 9(b) ensures that the allegations are "specific enough to give defendants notice of the particular misconduct that is alleged to constitute the fraud charged so that they can defend against the charge," but the Ninth Circuit has emphasized that "this standard does not require absolute particularity or a recital of the evidence" and consequently "a complaint need not allege a precise time frame, describe in detail a single specific transaction or identify the precise method used to carry out the fraud." *Swoben*, 848 F.3d at

1180 (cleaned up). Representative examples are not required. *Id.* However, "use of representative examples" is "one means of meeting the pleading obligation." *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010). The Ninth Circuit has emphasized that a plaintiff need not allege each and every instance of a false claim and instead need only provide enough detail to put the defendant on notice of the alleged misconduct. *See, e.g.*, *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1121 n.9 (9th Cir. 2020).

ARGUMENT

I. The Amended Complaint Plausibly Alleges Falsity.

A. The United States plausibly alleges that the representative examples, which the Court already found were properly pleaded, are emblematic of a wider pattern.

The United States plausibly alleges that Kaiser submitted false claims for conditions that the patient did not actually have at the visit. The Amended Complaint alleges a single, coordinated scheme where Kaiser, through its risk-adjustment programs, improperly pressed physicians to retrospectively add diagnoses via addenda and then submitted false claims for inaccurate ICD diagnosis codes based on those addenda. FAC ¶¶ 1-2, 101-03. The false claims arose from the design of Kaiser's risk-adjustment programs, which were national in scope and covered Kaiser's California and Colorado regions. *Id.* ¶¶ 126-39. These issues were not specific to any particular condition but were programmatic. By design, Kaiser's risk-adjustment programs generated voluminous queries to physicians after visits, but the programs would often fail to account for what actually occurred at the visit, ignoring both whether the condition had any relevance to the visit and contradictory information in a patient's medical record showing the patient did not have the condition. *Id.* ¶¶ 1-2, 101-03, 134, 137, 141-42, 161. Consequently, even if the medical record for the visit contradicted the existence of the condition, Kaiser would still regularly query the physician after a visit to create an addendum to add the diagnosis. *Id.*

Kaiser knew that it was repeatedly querying physicians to add diagnoses for conditions that did not exist and knew that this was a threat and a weakness of its risk-adjustment programs. *E.g.*, *id.* ¶ 142. Physicians warned Kaiser that it was repeatedly querying for conditions the patient did not have at the time of the visit, putting it on further notice of the problem. *Id.* ¶¶ 12, 274, 309-11. Moreover, Kaiser also pressured and incentivized physicians to add these diagnoses, even where the medical record

showed the condition did not exist. *Id.* ¶¶ 11, 243-60. Physicians complained that Kaiser managers returned stop prompts (i.e., a request for the organization to stop prompting the diagnosis) and continued to pressure physicians to make diagnoses that were clearly wrong. *Id.* ¶ 311. Kaiser's own analyses likewise confirmed that its programs were prompting physicians to add diagnoses for nonexistent conditions. *E.g.*, *id.* ¶ 347. Kaiser made it difficult for physicians to reject queries, requiring physicians to justify their refusals through multiple levels of review. *Id.* ¶¶ 243-50. If the physician just followed Kaiser's request, that generally led to no further review, *id.*, even though Kaiser knew its lists contained many nonexistent conditions. *Id.* ¶¶ 12, 142, 274, 309-11, 347. Some physicians responded to this pressure by documenting that the patient had a history of the condition, which does not receive a risk-adjustment payment—but Kaiser would nevertheless submit an ICD diagnosis code for the active condition to receive payment. *Id.* ¶¶ 177-79. The result was Kaiser's widespread submission of false claims for conditions whose existence was contradicted by the medical record. *Id.* ¶¶ 363, 375-76. In none of these circumstances is there any evidence that the physicians were correcting erroneous information in the original record. *Id.* ¶ 375.

Kaiser knew that these flaws in its risk-adjustment programs were causing it to submit false claims for conditions that did not exist at the time of the visit. *E.g.*, *id.* ¶¶ 178, 323, 337, 338, 345. Internally, Kaiser recognized that many times physicians were not properly reviewing diagnoses for which Kaiser queried and knew that this practice was leading to the repeated submission of incorrect diagnoses. *Id.* ¶ 323. For example, one internal document identified as a weakness of the program that "[s]ome clinicians refresh the diagnoses without proper and detailed review of the medical record, and as a result *incorrect diagnoses keep being reported*." *Id.* (emphasis added). Aware that its query lists often contained inaccuracies, Kaiser knew that physicians who simply agreed to add all listed diagnoses represented a red flag. *Id.*

The Amended Complaint further alleges representative examples typical of the pattern described above. The Court already concluded that the original examples properly alleged false claims, which Kaiser wholly ignores. Order at 11-13. Moreover, Kaiser does not meaningfully challenge any of the additional representative examples, all of which plausibly allege specific instances where Kaiser submitted false claims for conditions that did not exist at the visit and were contradicted by the medical

record. Instead, Kaiser argues that the United States should have added more examples or for different conditions.[1] But that simply misunderstands the law and the Court's Order. The United States was not required to allege any representative examples to meet its pleading obligation. *Swoben*, 848 F.3d at 1180. Moreover, the Order explained that the United States had properly alleged representative examples but requested that the United States add allegations plausibly showing that the examples "were emblematic of a wider pattern of similar practices." Order at 13. That is exactly what the United States did, as detailed above. *See also, e.g.*, FAC ¶¶ 376-77 (alleging how the representative examples were typical of the conduct alleged in the Amended Complaint).

Lest there be any doubt, Kaiser's own audits found hundreds of erroneous diagnoses that matched the pattern alleged in the Amended Complaint, where diagnoses were added via addenda even though their existence was contradicted by the original visit record. *Id.* ¶¶ 337-38. Kaiser categorized these diagnoses as *errors*, not physicians accurately amending medical records. *Id.* Similarly, Kaiser's audits show that it repeatedly improperly submitted diagnosis codes for active conditions when the patients had only a history of the condition at the visits. *Id.* ¶¶ 178-79, 345.

Taken together and accepted as true, these allegations plausibly show that Kaiser submitted false claims for conditions that did not exist. The Amended Complaint alleges that the representative examples, which the Court found properly alleged false claims, are emblematic of a wider pattern. Therefore, the Amended Complaint plausibly alleges falsity.

B. Kaiser's arguments to the contrary fail.

Rather than address the narrow issue identified in the Court's Order (and rectified in the Amended Complaint), Kaiser raises various scattered arguments, none of which has merit. At the outset, Kaiser's straw man argument (which pervades its motion)—that the United States has presented a new

[1] Kaiser's only other argument is that two examples in the Amended Complaint did not specifically identify that the two medical providers—who are identified by name—worked for SCPMG. MTD at 15; FAC ¶¶ 175-76. Kaiser, of course, knows where both providers worked. As this Court recognized, Rule 9(b) is intended to provide adequate notice to allow Defendants to defend themselves. Dkt. 225, Order at 12 (Taylor provided sufficient information for Defendants to "defend themselves at this juncture"); *see also* 5A Charles Alan Wright & Arthur R. Miller, Fed. Prac. & Proc. Civ. § 1298 (4th ed. 2023) (Rule 9(b) requires only detail "necessary to give adequate notice to an adverse party and to enable that party to prepare a responsive pleading"). These detailed examples give Kaiser the necessary information to pinpoint the exact transactions at issue (from a list that Kaiser itself created). Should the Court deem necessary, the United States can submit an erratum to the Amended Complaint (or amend the complaint again) to add the affiliations and dates of these visits. But Kaiser's argument does not meaningfully contest that these representative examples plausibly show that Kaiser submitted false claims.

theory and no longer alleges that Kaiser submitted false claims for "medical conditions that members ***did not actually have***," MTD at 8—is flatly wrong. The Amended Complaint specifically alleges that Kaiser "falsely submitted diagnosis codes for conditions that the patient did not actually have at the time of the visit." FAC ¶ 2; *id.* ¶ 9 (alleging the "widespread submission of invalid diagnosis codes . . . where the very existence of the condition at the time of the visit was contradicted by the medical record"); *id.* ¶ 101 ("patient did not even have the condition"); *id.* ¶ 103 ("patient did not even have the condition at the time of the visit").[2] The allegations here are consistent with the original complaint, which alleged that Kaiser falsely submitted diagnosis codes for conditions that did not exist, as evidenced by contradictory information in patient medical records.[3]

In fact, Kaiser's main argument here—that medical record documentation contradicting the existence of a condition does not raise a plausible inference of falsity—is just a rehashing of an argument the Court already rejected. In its prior motion to dismiss, Kaiser argued that the United States failed to allege any false claims because falsity was premised on "purported inconsistencies in medical records." Dkt. 201, Reply at 6-8 (arguing there were "plausible alternatives" to falsity, including that these could have just been mistakes or health status changes—identical to its arguments here). But the Court correctly rejected Kaiser's argument. Order at 11-14. As the Court explained, "if documentation contradicted the definition of cachexia, then it can reasonably be inferred that a diagnosis of cachexia was not justified." *Id.* at 14. The Court similarly found the United States properly pled the other examples where the documentation contradicted the existence of the condition. *Id.* at 11-12.

Furthermore, Kaiser's motion is premised on an erroneous legal standard. Kaiser claims that to plead a plausible claim, the United States must effectively prove its case now and rule out all other possibilities. That is not the law. "If there are two alternative explanations, one advanced by defendant and the other advanced by plaintiff, both of which are plausible, plaintiff's complaint survives a motion

[2] The apparent basis for Kaiser's claim that the United States has a "new theory" is a single edit to one paragraph: replacing "did not even exist" with "were not current conditions." FAC ¶ 131.

[3] Kaiser also wrongly cites to only one prong of potential liability under the FCA. MTD at 9. In fact, Congress has identified seven different ways that a party can violate the FCA, including as relevant here, by making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim, 31 U.S.C. § 3729(a)(1)(B), or conspiring to commit a violation of the FCA, *id.* § 3729(a)(1)(C). As the Ninth Circuit has held, "We construe the [FCA] broadly, as it is 'intended to reach all types of fraud, without qualification, that might result in financial loss to the Government.'" *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 899 (9th Cir. 2017) (cleaned up).

to dismiss under Rule 12(b)(6). Plaintiff's complaint may be dismissed only when defendant's plausible alternative explanation is so convincing that plaintiff's explanation is *im*plausible. The standard at this stage of the litigation is not that plaintiff's explanation must be true or even probable. The factual allegations of the complaint need only 'plausibly suggest an entitlement to relief.'" *Starr v. Baca*, 652 F.3d 1202, 1216-17 (9th Cir. 2011); *accord, e.g.*, *United States v. Mariner Health Care, Inc.*, 552 F. Supp. 3d 938, 949 (N.D. Cal. 2021) (Chen, J.) (holding that FCA plaintiff "need not rule out obvious alternative explanations" to survive motion to dismiss).

Kaiser's alternative explanation—that *all* of these claims are just physicians accurately correcting errors in the original medical record—is not plausible, let alone so convincing that it renders the United States' allegations *im*plausible. The Amended Complaint alleges there is no evidence in the circumstances at issue that the physician was simply correcting mistaken information in the original medical record. FAC ¶ 375. Such evidence would generally be obvious because physicians who are actually correcting typographical or other errors will document in the medical record that they are making such a correction, so that future providers do not rely on erroneous information in the original record.[4] At bottom, Kaiser not only refuses to accept as true the United States' allegation that there is no evidence of any such corrections, Kaiser demands that the Court accept its counter-allegation as true. Nor is Kaiser's explanation consistent with the voluminous allegations, such as Kaiser's own audits finding hundreds of these same so-called errors, or documents detailing that Kaiser knew its flawed programs were leading to reporting erroneous diagnoses. As alleged in the Amended Complaint, the purpose of Kaiser's data-mining and refresh programs was to generate additional diagnoses codes to submit for risk-adjustment payments, not to identify typographical errors.

Kaiser's hypotheticals and discussion regarding changes in health status fare no better, as evidenced by its hypothetical regarding cancer. As Kaiser points out, cancer can return. But if a patient's cancer comes back, that change would be documented in a medical record for a visit that concerned the cancer, not in an addendum months after an unrelated patient visit at which the provider documented that the patient *did not have cancer at the time*. Moreover, if a patient's cancer returns at a date after a

[4] Kaiser's argument that medical providers will stop correcting medical records for fear of being accused of fraud is nonsensical. Again, when physicians are actually correcting medical records, they will simply document that they are making a correction, as they already do.

patient visit, the ICD Guidelines do not allow that later diagnosis to be reported in a prior visit. The condition must have existed *at the time of the visit* and required or affected patient care, treatment, or management at that visit. FAC ¶¶ 5, 85, 91, 101, 184, 288. Thus, rather than justify its conduct, the potential for changes in patient health status is a key reason Kaiser's practices were problematic: by data mining patients' medical histories, Kaiser ran the serious risk that it would query providers to add diagnoses that did not exist at the time of their visits with patients. But rather than adjust its practices to ensure accuracy, Kaiser disregarded this reality in order to maximize its risk-adjustment revenue.

Examples provided in the Amended Complaint are representative of the type of claim at issue and show the fallacy of Kaiser's argument. For example, the visit for Patient #2 was short and unrelated to cancer, and the provider documented that the patient had only a *history* of cancer. *Id.* ¶ 365. Nevertheless, Kaiser queried the physician six months after the visit to code several diagnoses completely unrelated to the visit that the region wanted to submit for risk-adjustment payment, including prostate cancer. *Id.* The query did not alert the physician that the medical record showed that the patient's cancer was historical. *Id.* As this Court already found, this example plausibly alleges a false claim for a cancer condition that did not exist at the time of the visit. Order at 11-12. In rebuttal, Kaiser merely makes the *ipse dixit* assertion that a notation regarding a "history of" cancer "does not plausibly suggest that the patient in question does not have cancer." *See* MTD at 9. But that is *exactly* what a "history of" (vs. "active") designation means. Kaiser's argument thus appears to rest on the unsupported assumption that the physician in this scenario determined the patient had active cancer at the time of the visit but nevertheless erroneously documented historical cancer, and that he recalled this error only when, six months later, Kaiser sent him a query asking him to add an active cancer diagnosis to the visit record. This is not plausible, let alone so convincing to make the United States' allegations *im*plausible.

Kaiser's other hypotheticals also do not support its case. The COVID-19 example is completely irrelevant. Not only is COVID-19 not part of the HCC model, but under Kaiser's hypothetical the medical record did not contradict the existence of the condition. The Amended Complaint is focused on circumstances "where the very existence of the condition at the time of the visit was contradicted by the medical record," FAC ¶ 9. These do not include circumstances where a patient had COVID-19 in the past and returns to test for COVID-19 again. Likewise, Kaiser's typographical-error hypothetical

involves evidence in the medical record of the mistake. But none of the United States' examples contain such evidence, and the Amended Complaint alleges that none of the circumstances at issue involve correcting such mistakes in the original medical record. *Id.* ¶ 375.

Finally, the case law that Kaiser relies upon does not support its argument. When the Supreme Court announced the plausibility standard, it cautioned that this standard "does not impose a probability requirement at the pleading stage." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007). "[A] well-pleaded complaint may proceed even if it strikes a savvy judge that actual proof of those facts is improbable, and that a recovery is very remote and unlikely." *Id.* The allegations here more than satisfy the standard outlined in *Twombly*. To begin with, as this Court ruled in its Order, when documentation for a visit contradicts the existence of a medical condition, that contradiction plausibly suggests the diagnosis was not justified. Order at 14. Further, the Amended Complaint does not rely on such contradictions alone—it offers substantial detail regarding the context in which these contradictions occurred that clearly raises a plausible inference that Kaiser submitted false claims for conditions that did not exist, including specific examples that Kaiser does not contest. That context covers the details of the scheme, including:

- Kaiser created risk-adjustment programs that repeatedly generated queries for conditions that were contradicted by the medical record, FAC ¶¶ 10-11, 134, 137, 141-42, 161;
- Kaiser knew about this flaw, including through warnings from physicians that it was repeatedly querying for conditions that did not exist, *id.* ¶¶ 12, 274, 309-11;
- Kaiser failed to alert physicians to the contradictory information in the medical record, *id.* ¶¶ 10, 137, 142, 174-76, 375;
- Kaiser knew many physicians receiving these queries were not thoroughly reviewing the medical record and that some physicians were merely adding all the requested diagnoses, *id.* ¶ 323;
- Kaiser's own documents and audits reflected that its risk-adjustment programs reported erroneous diagnoses, *id.* ¶¶ 178-79, 337-38, 345;
- None of these erroneous diagnoses existed in the original medical record but were added often months later at Kaiser's request to increase risk-adjustment payments, *id.* ¶¶ 126-39, 146-49, 153-54, 164-65, 170-71, 376; and
- Kaiser pressured and incentivized physicians to add these diagnoses and the representative examples show particular instances of false claims, *id.* ¶¶ 11, 243-60.

Thus, Kaiser's reliance, for example, on *Integra Med Analytics LLC v. Providence Health &*

Servs., 854 F. App'x 840, 844-45 (9th Cir. 2021), is wholly inapposite. *Integra* concluded that, based on the particular facts alleged there, statistical evidence alone was not sufficient to show a false claim. But as this Court later recognized, *Integra* made clear that this did not mean that parties cannot rely on statistical evidence; rather, it merely needed to be accompanied by some other allegations of fraud. *Mariner Health Care*, 552 F. Supp. 3d at 947-49; *see also Integra*, 854 F. App'x at 845 n.5 (statistical evidence can be used to meet Rule 8 and "when paired with particular details of a false scheme, Rule 9(b)"); *United States ex rel. Cafasso v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1057 (9th Cir. 2011) (dismissing case based on relator's "failure to identify any particular false claims or their attendant circumstances"). None of these cases suggest that the allegations here are insufficient.

Moreover, all of the cases that Kaiser relies upon involve scenarios where courts addressed whether *any* unlawful conduct had occurred. In contrast, Kaiser does not even challenge all the representative examples in the Amended Complaint, thus conceding that at least *some* contradicted diagnoses amounted to false claims, rendering its case law inapposite. Instead, Kaiser relies on hypotheticals in which providers used addenda merely to correct errors in original medical records, and then argues that *in those circumstances* it did not submit false diagnoses. But the United States is not bringing claims for addenda used merely to correct innocent mistakes. Indeed, the Amended Complaint specifically alleges that for the claims at issue, there is no evidence addenda were being used for that purpose. FAC ¶ 375. Kaiser's claim—that the *only* plausible reading of the allegations is that Kaiser's physicians were *always* just correcting errors in the original medical record and that *no* false claims were submitted—is plainly not supportable and is foreclosed by the Court's prior ruling. Simply put, when considering all the allegations as true, and with all inferences in favor of the United States, Kaiser's explanation does not come close to meeting its burden to be "so convincing that plaintiff's explanation is *im*plausible." *Starr*, 652 F.3d at 1216-17.

Finally, Kaiser's repeated suggestion that the Court should dismiss these claims on discovery grounds is meritless. There is no legal basis to dismiss a claim based on the amount of discovery that may be necessary to prove it. In any event, because the Amended Complaint details a single scheme involving one set of false claims, it does not entail significant discovery expansion. All the false claims challenged here are merely a subset of the claims that the Court already approved to proceed. The

relevant evidence that the patient did not have the condition, as contradicted by the medical record, is likewise already part of the case because it is also relevant to whether the condition was related to the visit.[5] For example, when a physician documents that a patient had only a history of a condition at the visit, that is relevant evidence that the active condition both did not exist and did not require or affect patient care, treatment, or management. Moreover, Kaiser's discovery concerns are further undercut because the United States intends to prove its case through the use of sampling. And again, the amount of discovery necessary to prove a claim is not a valid basis to dismiss a claim.

In sum, the United States has plausibly alleged falsity.

II. The Amended Complaint Plausibly Alleges Kaiser's Knowledge.

The Amended Complaint plausibly alleges that Kaiser "knowingly" submitted, or caused to be submitted, false diagnosis codes for conditions that did not exist. The FCA specifies "no proof of specific intent to defraud" is required. 31 U.S.C. § 3729(b)(1)(B); *see also Winter*, 953 F.3d at 1122 (recognizing this standard differs from common law fraud). Rather, the United States need only allege that Kaiser acted "knowingly" as that term is broadly defined in the FCA.

The FCA defines "knowing" or "knowingly" to cover: (1) actual knowledge of the information; (2) deliberate ignorance of the truth or falsity of the information; or (3) reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(b)(1)(A). "Instead of pleading specific intent to defraud, it is sufficient to plead that the defendant knowingly filed false claims, or that the defendant submitted false claims with reckless disregard or deliberate ignorance as to the truth or falsity of its representations." *Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1211 (9th Cir. 2019). The deliberate ignorance standard covers "'the ostrich type situation where an individual has buried his head in the sand and failed to make simple inquiries which would alert him that false claims are being submitted.'" *Id.* (quoting *Swoben*, 848 F.3d at 1176). Congress determined that entities, like Kaiser, which receive public funds have "some duty to make a limited inquiry so as to be reasonably certain they are entitled to the money they seek." *Id.* at 1174. "'Protection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law.'" *Winter*, 953 F.3d at 1122; *see also, e.g.*, *United*

[5] The United States' claims regarding conditions that were not relevant to the visit, which the Court found stated a claim, cover conditions that are either clinically accurate or inaccurate. Regardless of clinical accuracy, the claims are false because the condition did not require or affect patient care, treatment, or management.

States ex rel. Wuestenhoefer v. Jefferson, 105 F. Supp. 3d 641, 668 (N.D. Miss. 2015) (explaining that Congress intended the FCA to impose liability on "persons who ignore 'red flags' that the information [they provide to the government] may not be accurate" (quoting H.R. Rep. No. 99-660 (1996)). Thus, as relevant here, "where [an] organization turns a blind eye to [diagnostic-code] over-reporting errors, it exhibits reckless disregard and deliberate ignorance toward the truth or falsity of the data submitted to CMS." *Swoben*, 848 F.3d at 1175-76; *see also United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1083 (N.D. Cal. 2020). Moreover, knowledge may be pleaded generally, with all inferences in favor of the plaintiff. *Silingo*, 904 F.3d at 679.

The Amended Complaint plausibly alleges Kaiser "knowingly" submitted diagnosis codes for conditions that the patient did not have at the visit. Kaiser does not contest that the Amended Complaint plausibly alleges that it knew its risk-adjustment programs, such as refresh and data-mining, were flawed because they regularly queried physicians to addend diagnoses for conditions that did not exist. Indeed, the Amended Complaint alleges that Kaiser specifically knew about these flaws in its programs but nevertheless ignored them because of the money generated from these programs. FAC ¶¶ 141-43, 161. Kaiser knew that when it sent queries to physicians after a visit, that its queries routinely did not take into account and did not alert the physician as to what actually occurred at the visit, including where the medical record showed the patient did not have the condition. *Id.* ¶¶ 10, 134, 137, 141-42, 174-76, 375. Numerous physicians warned Kaiser that it was repeatedly querying for conditions the patient did not have at the time of the visit, putting Kaiser on further notice. *Id.* ¶¶ 12, 274, 309-11. Internal analyses confirmed Kaiser's programs were prompting physicians to add diagnoses for conditions that patients never had or did not have at the time. *E.g.*, *id.* ¶ 347. These allegations show that Kaiser knew that it was repeatedly requesting physicians to add diagnoses that did not exist. Notably, even without these repeated warnings, any reasonable person would recognize that a program whose design entails generating queries for physicians to add diagnoses to medical records without properly taking into account what actually occurred at the visit is flawed and highly likely to lead to inaccurate diagnosis code submissions.

Nevertheless, Kaiser argues that even though it knew that it was querying physicians to add diagnoses that patients did not have at the visit, that does not mean Kaiser "knew" that this resulted in

the submission of false claims. This argument fails for two reasons. *First*, Kaiser refuses to accept the truth of the allegations or draw all reasonable inferences in favor of the government. The Amended Complaint specifically alleges that Kaiser was aware that these issues were leading to the submission of false claims. *E.g.*, *id.* ¶¶ 178-79, 323, 337-38, 345. Internally, Kaiser recognized that "[s]ome clinicians refresh the diagnoses without proper and detailed review of the medical record, and as a result *incorrect diagnoses keep being reported*." *Id.* ¶ 323 (emphasis added). In the few audits that reviewed this issue, Kaiser found hundreds of erroneous diagnoses added via addenda where the existence of the condition was contradicted by the medical record.[6] *Id.* ¶¶ 337-38. Similarly, Kaiser's documents and audits show that it was aware that it was repeatedly improperly submitting for payment diagnosis codes for active conditions when the patients had only a history of the condition at the visits.[7] *Id.* ¶¶ 178-79, 345. Simply put, the allegations plausibly show that Kaiser knew not only the flaws in its risk-adjustment programs but also knew that they were leading to the submission of false diagnosis codes to CMS.

Second, Kaiser's knowledge of the significant flaws in its risk-adjustment querying alone would be sufficient to plausibly allege Kaiser acted "knowingly" under the FCA. When an MAO, like Kaiser, is aware of significant flaws in its programs such that it knows it is repeatedly querying physicians to add diagnoses contradicted by the medical record, it has the legal obligation "to make simple inquiries which would alert [it] that false claims are being submitted.'" *Godecke*, 937 F.3d at 1211 (quoting *Swoben*, 848 F.3d at 1174). Kaiser cannot just bury its head in the sand and fail to inquire whether these known flaws were leading to false claims. *See, e.g.*, FAC ¶ 376 (alleging Kaiser failed to take numerous

[6] Kaiser refuses to accept the allegations regarding these audits as true, with all reasonable inferences drawn in favor of the government. With respect to morbid obesity, the auditors found specific evidence of erroneous diagnoses where the medical record contradicted Kaiser's own definition of the condition and concluded these errors could not be fixed. FAC ¶ 337; *id.* ¶ 336 (placing this subcategory into a category of non-fixable errors). Kaiser's speculation—that these errors were unrelated to the existence of the condition and instead were related to unidentified violations of the ICD Guidelines—is contrary to the allegations. These audits also show that Kaiser's earlier speculation—that the physician was merely correcting errors in the original record—was not in fact what the auditors found. Likewise, with respect to the second audit, auditors found hundreds of errors for addenda diagnoses where the existence of the condition was contradicted by information in the encounter note. *Id.* ¶ 338. Kaiser's suggestion that these audit findings are not evidence of notice of any issues defies logic and certainly does not accept all inferences in favor of the government.

[7] Kaiser ignores the actual allegations in paragraph 178 in the Amended Complaint, which states that internal documents indicate Kaiser was aware it was "generating inaccurate diagnoses" through these programs. The paragraph further alleges Kaiser knew that one of the ways it was generating these inaccurate diagnoses was through the refresh program wrongly capturing historical conditions. *Id.* ¶ 178.

simple steps to ensure it was not submitting inaccurate diagnosis codes). This failure to make simple inquiries is all the more evident when compared to the fact that Kaiser regularly required physicians who *refused* to add diagnoses from queries to justify those refusals and obtain approvals from higher-ups. *Id.* ¶¶ 245-50. That Kaiser conducted no similar review if physicians simply added the diagnoses further demonstrates Kaiser's deliberate ignorance and reckless disregard for the truth or falsity, especially given that Kaiser knew that its queries repeatedly contained inaccurate diagnoses that did not exist. Nor can Kaiser rely on the fact that *some* physicians complained of repeatedly receiving queries for conditions that did not exist. To the contrary, that again only makes Kaiser's conduct more troubling because it knew that *other* physicians were not complaining and were adding diagnoses from queries without properly reviewing the medical record, including some who were just adding every condition on the list. *Id.* ¶ 323. And all of these issues were made worse by Kaiser instituting numerous mechanisms to pressure and incentivize physicians to simply add the requested diagnoses while also telling them not to spend any significant time evaluating them. *Id.* ¶¶ 11, 193, 234-59. Finally, Kaiser's conduct is particularly egregious because the errors at issue did not exist in the original record and were inserted at Kaiser's request. With simple inquiries at various stages in the process, Kaiser could have easily ensured that it did not submit inaccurate diagnoses whose very existence was contradicted by the medical record. *Id.* ¶ 376. This is a classic case of reckless disregard and deliberate ignorance.

In sum, collectively, the allegations plausibly show that Kaiser "knowingly" submitted false claims for conditions that did not exist at the visit, and at a bare minimum, acted with deliberate ignorance or reckless disregard to the truth or falsity.

III. The Amended Complaint Plausibly Alleges Materiality.

Kaiser's arguments regarding materiality are based entirely on a clear misconstruction of the Amended Complaint, which alleges that Kaiser "falsely submitted diagnosis codes for conditions that the patient did not actually have at the time of the visit." FAC ¶ 2; *see also, e.g.*, *id.* ¶ 9 ("the very existence of the condition at the time of the visit was contradicted by the medical record"). Kaiser concedes that "Defendants agree that CMS would not pay Defendants based on diagnosis codes for a nonexistent condition." MTD at 20-21 n.10. That fully resolves the materiality issue. Moreover, the ICD Guidelines—indeed the same guideline that the Court already addressed at length—provides that only

conditions that exist at the time of the visit may be reported. FAC ¶¶ 5-6, 85, 88, 91, 96, 99. The Court already ruled that the United States plausibly alleged that Kaiser's submission of inaccurate diagnosis codes that did not comply with the ICD Guidelines is material. That identical reasoning applies here. The United States has plausibly alleged that Kaiser's submission of diagnosis codes for conditions that the patient did not have at the visit is material.

IV. The Amended Complaint Covers All Kaiser Defendants.

Kaiser next argues that the allegations in the Amended Complaint address only two of the Kaiser Defendants. Not so. The Amended Complaint covers a single scheme in which all the Kaiser Defendants jointly participated, resulting in false claims in all the Kaiser regions at issue.

First, Kaiser wrongly limits its analysis only to the new allegations when the Court is required to review the Amended Complaint as a whole. The Amended Complaint alleges at length the integrated nature of Kaiser's risk-adjustment programs and how the Defendants jointly operated these programs for the purpose of submitting additional diagnosis codes to CMS to increase risk-adjustment revenue. FAC ¶¶ 30-42, 104-25, 146-49, 153-54, 164-65, 170-71. These risk-adjustment programs, such as refresh and data mining, were nationwide in scope with small variations by region.[8] *Id.* ¶¶ 133, 149, 164-65. Kaiser operated nationwide working groups, with representatives from each of the Defendants, to assess these programs and ensure that information was shared between the Kaiser Health Plans and the Permanente Medical Groups and across regions. *E.g.*, *id.* ¶¶ 111, 146-49, 165. Some of these groups met weekly with "a focus on moving toward common national practices to the greatest extent possible." *Id.* ¶ 119. Kaiser's National Medicare Finance Department monitored these programs, meticulously tracked results, and worked with each region (covering all Defendants) on these programs as part of the risk-adjustment improvement plans. *Id.* ¶¶ 113, 165. Indeed, Kaiser touted the integrated nature of its entities as a "strategic advantage" in running these programs. *Id.* ¶ 111. The false claims alleged derive from the basic design flaw of how Kaiser's risk-adjustment programs generated queries without taking into account what actually occurred at patient visits. *E.g.*, *id.* ¶¶ 142-43, 376-77. These issues apply equally to all Defendants who agreed to jointly operate these flawed programs over more than a decade.

Second, and relatedly, Kaiser ignores that the Amended Complaint contains specific

[8] Refresh itself is a data-mining program. FAC ¶ 8.

representative examples that cover all of the Defendants. *Id.* ¶ 365 (SCPMG and the Health Plan); *id.* ¶ 366 (TPMG and the Health Plan); *id.* ¶¶ 154-55 (CPMG and the Colorado Health Plan); *id.* ¶¶ 175-76 (SCPMG and the Health Plan); [9] *id.* ¶ 220 (TPMG and the Health Plan). Kaiser also ignores that the Amended Complaint specifically alleges that these examples are representative of the false claims at issue. *Id.* ¶ 375. Kaiser claims that the United States has failed to meet its Rule 9(b) obligations, MTD at 22, but the Ninth Circuit has repeatedly held that a plaintiff can meet its Rule 9(b) obligations by pleading representative examples. That the United States has pled representative examples covering each entity fully resolves Kaiser's argument.

Third, in any event, Kaiser wrongly ignores all allegations that refer to Kaiser collectively, when the Ninth Circuit has repeatedly emphasized that a complaint need not differentiate between defendants when they are all alleged to have engaged in the same conduct. *See, e.g.*, *Silingo*, 904 F.3d at 677-78; *Swoben*, 848 F.3d at 1184. When particular Kaiser regions or entities acted differently than others, the Amended Complaint identifies so, as it did with the cachexia initiative. *See, e.g.*, FAC ¶¶ 315-21. But the allegations at issue here, concerning the basic design flaw of Kaiser's risk-adjustment programs and resulting false claims, concern programs that were jointly operated by Defendants, all of whom together comprise the integrated Kaiser health-care consortium.

In sum, the Amended Complaint alleges that all Defendants jointly participated in the alleged scheme and offers representative examples that cover each Defendant. The allegations are not limited to two Defendants, as Kaiser wrongly argues.

V. The Amended Complaint Plausibly Alleges a Conspiracy.

Kaiser's extremely brief conspiracy argument is similarly flawed. Kaiser again wrongly limits its analysis to three paragraphs of the Amended Complaint and claims that, based solely on these three paragraphs, the United States has only made a conclusory allegation of an agreement with no factual support. MTD at 21 (discussing only FAC ¶¶ 386-88). But the factual support comes from the detailed allegations that precede these paragraphs. As described in Section IV, the Kaiser Defendants jointly agreed to operate Kaiser's risk-adjustment programs over the course of more than a decade for the purpose of submitting diagnosis codes to CMS to increase risk-adjustment revenue. FAC ¶¶ 30-42, 104-

[9] Kaiser is aware that these allegations pertain to SCPMG. *See supra* FN 1.

25, 146-49, 153-54, 164-65, 170-71. Defendants all knew that the purpose of these programs was to add diagnoses that the Health Plan and the Colorado Health Plan could submit to CMS to falsely claim entitlement to millions of dollars in additional risk-adjustment payments, which the Health Plans then shared with the Permanente Medical Groups. Indeed, the Defendants routinely tracked these programs in great detail to identify the diagnoses added, money earned, and return on investment. *Id.* ¶ 104. Further, as detailed in Section III, the Defendants jointly operated these risk-adjustment programs "knowing" that they resulted in the submission of false claims. Collectively, the numerous allegations in the Amended Complaint plausibly allege that there was a conspiracy among the Kaiser Defendants to violate the FCA. Kaiser's contrary suggestion that there was no agreement, but that Kaiser happened to conduct the same programs involving the same misconduct in each region, is not plausible. These programs were a giant undertaking, at the behest of the Health Plan, that only functioned with the joint participation of all Defendants. With all inferences in favor of the United States, as required, the allegations at a minimum raise an inference of an agreement.

VI. The Common Law Claims Should Proceed Regardless.

In a single, passing sentence Kaiser addresses the United States' common law claims: "The Court should reject the United States' new theory, as the amended complaint fails to allege several elements of the False Claims Act ('FCA') and the derivative common-law claims." MTD at 2. Kaiser offers no other argument regarding the United States' claims for payment by mistake and unjust enrichment. But contrary to Kaiser's assertion, these claims are not "derivative": they have different elements and are subject to a different pleading standard—Rule 9(b) does not apply—than the FCA claims. Yet, Kaiser's briefing does not contain a single sentence explaining what element(s) of these claims are supposedly not properly pleaded under the appropriate standard. Nor does it support its contention with any relevant authority. "Arguments made in passing and not supported by citations to the record or to case authority are generally deemed waived." *United States v. Graf*, 610 F.3d 1148, 1166 (9th Cir. 2010) (argument made in two sentences without citation to authority was waived); *see also, e.g.*, *McLeod v. Bank of Am., N.A.*, No. 16-CV-03294-EMC, 2017 WL 6373020, at *6 (N.D. Cal. Dec. 13, 2017) ("Arguments made in passing and inadequately briefed are waived."). Having failed to raise any arguments regarding the common law claims in its motion, Kaiser likewise is precluded from

doing so in its reply. *See, e.g.*, *United States v. Wilde*, 74 F. Supp. 3d 1092, 1099 (N.D. Cal. 2014) (arguments raised for the first time on reply are waived).

VII. Any Dismissal Should Be With Leave to Replead.

For the reasons explained above, the Court should deny Kaiser's motion in its entirety. However, should the Court find any pleading defect, it should grant the United States leave to replead. Rule 15 requires that leave to amend "shall be freely given," and the Ninth Circuit has emphasized that this must be applied "with extreme liberality" towards amendment. *Eminence Cap., LLC v. Aspeon, Inc.*, 316 F.3d 1048, 1051 (9th Cir. 2003) (reversing denial of leave to replead, even after "three bites at the apple"). "Dismissal with prejudice and without leave to amend is not appropriate unless it is clear on de novo review that the complaint could not be saved by amendment." *Id.* at 1052; *see also Bly-Magee v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001) ("We consistently have held that leave to amend should be granted unless the district court 'determines that the pleading could not possibly be cured by the allegation of other facts.'"). Moreover, "prejudice is the 'touchstone of the inquiry under rule 15(a),'" *Eminence Cap.*, 316 F.3d at 1052, but Kaiser makes no showing in its motion. The only case that Kaiser relies on does not suggest that leave should be denied after one amendment, as Kaiser wrongly asserts.

The United States has attempted to balance providing substantial detail regarding the allegations, now covering 100 pages, with its competing obligation to provide "a short and plain statement of the claim." Fed. R. Civ. P. 8(a). To the extent the Court concludes that the United States should provide additional factual detail in some area, the Court should liberally grant the United States an opportunity to do so.

CONCLUSION

For the foregoing reasons, the Court should deny Kaiser's motion to dismiss. To the extent any claim or portion thereof is dismissed, the United States requests leave to amend.

DATED: March 3, 2023

Respectfully submitted,

BRIAN M. BOYNTON
Principal Deputy Assistant Attorney General

STEPHANIE M. HINDS
United States Attorney

s/Shiwon Choe
SHIWON CHOE
DAVID M. DEVITO
Assistant United States Attorneys

JAMIE ANN YAVELBERG
PATRICIA L. HANOWER
ARTHUR S. DI DIO
GARY R. DYAL
LAURIE A. OBEREMBT
JONATHAN T. THROPE
United States Department of Justice
Civil Division
Commercial Litigation Branch

DAVID MOSKOWITZ
Special Attorney to the U.S. Attorney General

Attorneys for the United States of America