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

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK,	Case No. 3:13-cv-03891-EMC (Consolidated)
Plaintiffs,	
v.	Hearing date: May 4, 2023
	Time: 1:30 PM
KAISER PERMANENTE, *et al.*,	Judge: Hon. Edward M. Chen
	Courtroom: 5, 17th Floor
Defendants.	

(caption continued on next page)

UNITED STATES OF AMERICA and
STATE OF CALIFORNIA, *ex rel.*
GLORYANNE BRYANT and
VICTORIA M. HERNANDEZ,

Plaintiffs,

v.

KAISER PERMANENTE, *et al.*,

Defendants.

Case No. 3:18-cv-01347-EMC

RELATORS BRYANT AND HERNANDEZ'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS SECOND AMENDED COMPLAINT

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TABLE OF CONTENTS

Page

I. INTRODUCTION 1

II. BACKGROUND 3

A. The Affordable Care Act 3

1. Risk Adjustment Program 3

2. ACA Tax Credits 6

B. Kaiser Permanente's Structure 7

C. Kaiser Permanente's Fraud 8

D. Procedural History 10

III. LEGAL STANDARDS 10

IV. ARGUMENT 11

A. The SAC Plausibly Alleges Falsity 11

1. Defendants Violated the FCA With False Risk Adjustment Transfers 11

2. Defendants Violated the FCA by Impacting the ACA's Tax Credit System 12

3. The SAC Contains No Procedurally Improper or "New" Arguments 13

4. Defendants' Characterizations of the Risk Adjustment Attestations Are Simply Inaccurate. 14

5. The SAC Plausibly Alleges an Upcoding Scheme 15

6. Defendants Cannot "Maximize Revenue" Through Fraud 16

7. Defendants' Pre-2014 Conduct is Relevant 17

8. The SAC Provides Sufficient Details About Kaiser's Fraudulent Scheme 17

B. The SAC Plausibly Alleges Materiality 18

C. The SAC Plausibly Alleges a Conspiracy Involving All Defendants 20

D. The SAC Plausibly Alleges FCA Violations by All Defendants 22

V. CONCLUSION 23

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

TABLE OF AUTHORITIES

Page

Cases

Ashcroft v. Iqbal,
556 U.S. 662 (2009) 10
Corsello v. Lincare, Inc.,
428 F.3d 1008 (11th Cir. 2005) 21
Ebeid ex rel. United States v. Lungwitz,
616 F.3d 993 (9th Cir. 2010) 11, 17, 18
Godecke v. Kinetic Concepts, Inc.,
937 F.3d 1201 (9th Cir. 2019) 18
Integra Med Analytics LLC v. Providence Health & Servs.,
854 F. App'x 840 (9th Cir. 2021) 16
Kisor v. Wilkie,
139 S. Ct. 2400 (2019) 15
Ruckh v. Salus Rehab., LLC,
963 F.3d 1089 (11th Cir. 2020) 12
United States ex rel. Aflatooni v. Kitsap Physicians Serv.,
314 F.3d 995 (9th Cir. 2002) 18
United States ex rel. Lee v. Corinthian Colls.,
655 F.3d 984 (9th Cir. 2011) 10
United States ex rel. Ormsby v. Sutter Health,
444 F. Supp. 3d 1010 (N.D. Cal. 2020) 12
United States ex rel. Silingo v. WellPoint, Inc.,
904 F.3d 667 (9th Cir. 2018) 11, 12, 22
United States ex rel. Swoben v. United Healthcare Ins. Co.,
848 F.3d 1161 (9th Cir. 2016) 11, 18

United States ex rel. Yannacopoulos v. Gen. Dynamics,
2007 WL 495257 (N.D. Ill. Feb. 13, 2007) 15

United States v. Mariner Health Care, Inc.,
552 F. Supp. 3d 938 (N.D. Cal. 2021) 17, 18, 22

United States v. Toyobo Co.,
811 F. Supp. 2d 37 (D.D.C. 2011) 21

Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.,
953 F.3d 1108 (9th Cir. 2020) 18

Statutes

31 U.S.C. § 3729(b)(4) 18

42 U.S.C. § 18033(a)(6)(A) 1, 19

42 U.S.C. § 18041(a)(1)(C) 15

42 U.S.C. § 18063(a) 1

42 U.S.C. §§ 18001-18122 1

Other Authorities

2023 United Rate Review Instructions, OMB Control No. 0938-1141 7

Rules

Fed. R. Civ. P. 12(b)(6) 10

Fed. R. Civ. P. 9(b) 10

Regulations

26 C.F.R. § 1.36B-3 .... 1, 6

45 C.F.R. § 147.102 3

45 C.F.R. § 153.20 3

45 C.F.R. § 153.610 .... 1, 5, 6

45 C.F.R. § 153.630 .... 1, 4, 5, 6

45 C.F.R. § 153.710 .... 1, 4, 6, 19

45 C.F.R. § 153.740(a) 19

45 C.F.R. § 154.215 .... 1, 7

45 C.F.R. § 156.80(d)(1)(ii) 7
45 C.F.R. § 156.805 19
45 C.F.R. § 162.1002 4
77 Fed. Reg. 17220 (Mar. 23, 2012), to be codified at 45 C.F.R. pt. 153 3
78 Fed. Reg. 15410 (Mar. 11, 2013), to be codified at 45 C.F.R. pts. 153, 155-58 3
81 Fed. Reg. 94058 (Dec. 22, 2016), to be codified at 45. C.F.R. pts. 144, 146-48, 153-58 3

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I. INTRODUCTION

A primary goal of the Affordable Care Act ("ACA") is in the title of the Act: "Quality, Affordable Health Care for All Americans." 42 U.S.C. §§ 18001-18122. Attaining this goal depends on two foundational pillars: (1) a properly functioning Risk Adjustment Program to alleviate risk to private insurers and thus encourage them to participate in the ACA, and (2) a tax credit system to make health insurance more affordable for Americans in need. Both of these pillars require that participating insurers submit accurate information to the Department of Health and Human Services ("HHS"), so that the Government can make the appropriate Risk Adjustment Payments among participating insurers, and set the appropriate level of tax credits.

Specifically, HHS relies on data submitted by insurers to determine which insurers have a riskier patient base, and which have a healthier patient base. 45 C.F.R. §§ 153.610, 153.630. It then balances out these risks by requiring the insurers with healthier patient bases to pay money into the Risk Adjustment Program, and sending that money to those insurers with less healthy patient bases. 42 U.S.C. § 18063(a). This patient data also has a direct impact on the amount of federally funded tax credits available under the ACA. *E.g.* 45 C.F.R. § 154.215; 26 C.F.R. § 1.36B-3. Stressing the importance of accurate information, the ACA mandates how health information, including diagnostic codes consistent with specified guidelines, be recorded, maintained, and submitted to HHS. *E.g.* 45 C.F.R. §§ 153.630, 153.710. The ACA requires that insurers attest to the accuracy of diagnostic data that they submit on an annual basis, and expressly warns insurers that inaccurate submissions and data may be subject to False Claims Act ("FCA") liability. 42 U.S.C. § 18033(a)(6)(A); 45 C.F.R. § 153.710(d); EDGE Attestation & Discrepancy Reporting, Web Form Guide.

As set forth in the Second Amended Complaint (ECF No. 238, the "SAC"), Defendants—a set of closely related medical groups, hospitals, and health insurers—engaged in a scheme to systematically "over-document" and "upcode" patient encounters and transmit this upcoded data to HHS, to fatten their bottom line to the detriment of the

1 taxpayer. By over-documenting and upcoding patient encounters, Defendants' patient base
2 appeared to HHS to be less healthy than it actually was. As a result, Defendants' Risk
3 Adjustment Transfers were significantly skewed.

4 Defendants' Motion to Dismiss and supporting Memorandum of Points and
5 Authorities (ECF No. 251; the Memorandum is cited herein as "Memo.") rests on
6 fundamentally faulty propositions and logic. It posits that since Defendants make payments
7 into the ACA's Risk Adjustment Program, they simply cannot be engaging in fraud, as such
8 payments "undermine[] any allegation of fraud." Memo. at 2. Yet making payments to the
9 Government does not inoculate Defendants from FCA liability. The SAC plausibly alleges
10 that but-for Defendants' fraud, Defendants' Risk Adjustment Payments would have been
11 higher. Reducing an amount due to the Government through fraud is still fraud.

12 Similarly, the Motion claims confusion over how Defendants can have a "relatively
13 healthy patient base," as alleged in the SAC, yet still engage in systematic over-
14 documenting and upcoding to make its patients appear more risky. *E.g.* Memo at 17
15 (averring that such allegations "fatally undermine the plausibility of Relators' fraud theory"
16 related to Risk Adjustment Payments), 18 (same for tax credit fraud). Similar to Defendants'
17 previous attack, this argument is premised on a false dichotomy. Defendants can have a
18 comparatively healthy patient yet still be engaged in upcoding. The key is that absent the
19 over-documenting and upcoding, the patient base would appear even more healthy, meaning
20 Kaiser would have to make even higher Risk Adjustment Payments.

21 The Motion also rests, improperly, on Defendants' disagreements with Relators'
22 factual allegations of fraud in the SAC, and argues that all claims fail because the SAC fails
23 to definitively rule out that Defendants did *not* engage in fraud. These arguments do not
24 belong in a motion to dismiss. The Court must accept Relators'—not Defendants—
25 allegations as true for purposes of this motion. Factual disputes are saved for trial.

26 All of Defendants' attacks on the SAC fail, and the motion should be denied in full.

27

28

II. BACKGROUND

A. The Affordable Care Act

The ACA was groundbreaking in its ambition: expand healthcare coverage to uninsured Americans by making health insurance more accessible and less expensive. SAC ¶ 51. Central to this goal and the functioning of the ACA, and directly relevant to this lawsuit, are two critical components of the ACA: the Risk Adjustment Program and tax credits based on financial need.

1. Risk Adjustment Program

Under the ACA, insurers cannot set premiums based on the health status of prospective enrollees. SAC ¶ 51; 45 C.F.R. § 147.102. This feature presented a very real risk that insurers would either flee the market rather than open up their plans to potentially unhealthy enrollees, or raise rates for everyone to price in the added risk. SAC ¶ 54; 2012 Final Rule, 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012), to be codified at 45 C.F.R. pt. 153. To keep this from happening, Congress required the adoption of a Risk Adjustment Program. The purpose of the ACA's Risk Adjustment Program is to spread risk evenly among participating insurers. SAC ¶ 55. It "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." *Id.* ¶ 55, quoting 2012 Final Rule, 77 Fed. Reg. at 17221.

HHS operates the Risk Adjustment Program for all states. SAC ¶¶ 63-64. It utilizes a hierarchical condition category ("HCC") model (the "HHS-HCC" model), which is modeled after the Medicare Advantage risk adjustment model. SAC ¶ 65, citing 2013 Final Rule, 78 Fed. Reg. 15410, 15420 (Mar. 11, 2013), to be codified at 45 C.F.R. pts. 153, 155-58. The Risk Adjustment Program determines an "individual risk score" for each enrollee of a health plan, based on criteria including medical diagnoses. SAC ¶ 66, citing 45 C.F.R. § 153.20; 2013 Final Rule, 78 Fed. Reg. at 15422; and 2016 Final Rule, 81 Fed. Reg. 94058, 94071 (Dec. 22, 2016), to be codified at 45 C.F.R. pts. 144, 146-48, 153-58. To document

diagnoses, the ACA requires the use of International Classification for Diseases ("ICD") standards, specifically ICD-9-CM and ICD-10-CM. SAC ¶ 67; 45 C.F.R. § 162.1002. It also requires adherence to the Official Guidelines for Coding and Reporting. *Id*. The ACA further requires insurers to submit the diagnostic data via a dedicated distributed data collection environment called "EDGE," through which insurers must give HHS "access to enrollee-level plan enrollment data, enrollment claims data, and enrollee encounter data as specified by HHS." SAC ¶ 70, quoting 45 C.F.R. § 153.710(a).

The ACA requires insurers to validate the accuracy of the data submitted as part of the risk adjustment process. This includes a requirement of "[v]alidating medical records according to industry standards for coding and reporting." SAC ¶ 69, quoting 45 C.F.R. § 153.630(b)(7). At the end of the EDGE data submission process, HHS issues a final EDGE server report to each insurer for each plan for each benefit year. SAC ¶ 72; 45 C.F.R. § 153.710. The insurer must describe any "material" discrepancy in the data that it identifies, with the ACA expressly providing a materiality threshold of the lesser of $100,000 or 1% of the Risk Adjustment Payment due to or from the insurer. SAC ¶ 72, citing 45 C.F.R. § 153.710(d) and (e). If there are no material discrepancies, the insurer must submit an EDGE attestation, completed by an individual "authorized to legally and financially bind" the insurer. SAC ¶ 73; EDGE Attestation & Discrepancy Reporting, Web Form Guide. In the annual EDGE attestation, the insurer makes certifications including the following:

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.

SAC ¶ 73, providing screenshot of the Edge Attestation Form for the 2017 Benefit Year (yellow highlighting added). This attestation is required from every plan, for every year.

As part of the Risk Adjustment Program, HHS takes the diagnostic data that insurers have attested to, evaluates each insurer's risk in a given market based on the risk profile of its members as compared to the risk profile of members in other insurance plans, and calculates risk transfer payments due to or from each insurer. SAC ¶ 56; 45 C.F.R. §§ 153.610, 153.630. Specifically, for those insurers with a healthier patient base, as compared

to the market collectively, the Government issues an invoice to the insurer, and the insurer then makes a risk transfer payment directly to the Government. *Id*. For those insurers with a sicker patient base, as compared to the market collectively, the Government issues risk transfer payments from the Treasury to those insurers. *Id*.

Thus, the ACA's Risk Adjustment Program depends on the accuracy of the data submitted by insurers so that the Government has full transparency into the risk profile of each insurer. SAC ¶ 57. Underlying its importance, as outlined above, the ACA requires insurers to submit attestations as to the accuracy of the data. *Id*.; *see also* 45 C.F.R. § 153.710. The ACA also provides substantial penalties for noncompliance. *Id*. Inaccurate data from insurers leads to inaccurate risk payments made to or from insurers, and fundamentally undermines one of the ACA's central goals of spreading risk fairly among all participating insurers.

2. ACA Tax Credits

The ACA also provides tax credits to qualifying individuals to make health insurance more affordable and accessible. SAC ¶ 51. Under this program, federal funds are used to pay private insurers for all or part of the premiums charged to qualifying individuals. *Id.* ¶ 79. The amount of the tax credit depends on two things – (1) the cost of the benchmark plan for a given market, defined as the "second lowest cost silver plan… offered through the Exchange for the rating area where the taxpayer resides," and (2) the individual's expected contribution, determined by a sliding scale depending on family size and income. SAC ¶¶ 80-83; 26 C.F.R. § 1.36B-3. An individual's tax credit is the cost of the benchmark plan minus his or her expected contribution. SAC ¶ 83; 26 C.F.R. § 1.36B-3. An individual can then use the tax credit for any plan available to him or her, with the insurer ultimately receiving federal funds provided by the Government in the amount of the tax credit. SAC ¶ 84.

Thus, the determination of the benchmark plan is a critical step of the ACA's system of tax credits, as the amount of the tax credit is pegged directly to the premium cost of the benchmark plan. Premium costs, in turn, are determined after the completion of a Unified

Rate Review Template form ("URRT"), submitted by insurers to the Government as part of the mandated annual rate filing justification they must submit for every plan offered. SAC ¶¶ 74-75; 45 C.F.R. § 154.215(a). Through the URRT, an insurer derives an ultimate price that it will charge for its plan. SAC ¶ 76; 2023 United Rate Review Instructions, OMB Control No. 0938-1141. This premium price must take into account the payments that the insurer expects to either make or receive through the ACA's Risk Adjustment Program. SAC ¶ 77, citing 45 C.F.R. § 156.80(d)(1)(ii); 2023 United Rate Review Instructions, OMB Control No. 0938-1141. They also take into account historical and estimated claims data. SAC ¶ 75; 45 C.F.R. § 154.215(d).

Like its Risk Adjustment Program, the ACA's tax credit system depends on transparency into risk, and accurate information and data being submitted by insurers. Inaccurate data leads to inflated premiums. SAC ¶ 213. Inflated premiums lead to higher tax credits funded with taxpayer dollars. *Id.* ¶¶ 213-16.

B. Kaiser Permanente's Structure

Kaiser Permanente is a massive healthcare consortium with a total operating revenue of $93.1 billion in 2021. SAC ¶ 27. It is comprised of three main divisions: health plans, physician and physician-service organizations, and hospital chains. *Id.* ¶ 25. These three divisions operate closely with one another.

Kaiser offers health insurance to people all over the United States through its plans, including the health plan entities that are defendants in this case, referred to herein as the "Kaiser Health Plans."[1] *Id.* ¶¶ 29, 40. As of 2014, Kaiser Health Plans insured approximately 1,000,000 people through the ACA, and its ACA plans generated billions of dollars of revenue for Kaiser as a whole. *Id.* ¶ 26. Defendant Kaiser Foundation Health Plan, Inc. is the parent of the other five Kaiser Health Plans. *Id.* ¶ 40. Kaiser also employs doctors

[1] The six Kaiser Health Plan defendants are: (1) Kaiser Foundation Health Plan, Inc.; (2) Kaiser Foundation Health Plan of Colorado; (3) Kaiser Foundation Health Plan of Georgia, Inc.; (4) Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.; (5) Kaiser Foundation Health Plan of the Northwest; and (6) Kaiser Foundation Health Plan of Washington.

and other medical professionals, and provides direct medical services through its Permanente Medical Groups, a for-profit set of regional affiliates that includes eight defendants in this lawsuit, referred to herein as the "Kaiser PMGs."[2] *Id.* ¶¶ 31-38. The Kaiser PMGs have a shared national leadership and consulting organization. *Id.* ¶ 39. In addition to health insurers and medical groups, the third leg of Kaiser's empire is formed by Defendant Kaiser Foundation Hospitals ("Kaiser Hospitals"), which operate and provide acute hospital care in California, the Pacific Northwest, and Hawaii. *Id.* ¶ 25.

C. Kaiser Permanente's Fraud

Through nearly every aspect of its operations, Kaiser teaches, encourages, and demands that its employees utilize techniques to improperly diagnose, document, and upcode patient encounters. *See, e.g*., SAC ¶¶ 88, 153-158, 176. The SAC pleads that Kaiser's policies and procedures emphasize profits over compliance with statutory and regulatory coding requirements through a variety of means, including: (1) deploying improper documentation query templates aimed at prompting Kaiser PMGs and Hospitals to code for various high-risk diagnoses (SAC ¶¶ 159-168), (2) discouraging and punishing those employees, like Relators, who try to do the right thing and encourage accurate documentation and coding (*id*. ¶¶ 169-175), (3) developing an apocryphally named "Clinical Documentation Integrity" program which served only to increase coding of certain diagnoses (*id*. ¶¶ 177-184), (4) developing a "data mining" technology and team to capture "missed opportunities" through the creation of addenda to patient records (*id*. ¶¶ 191-195), and (5) using computer assisted coding, a practice that led to overcoding of diagnoses. Relators further allege that when Kaiser was confronted with evidence of its over-documenting and upcoding practices, it took steps to actively hide any evidence of the upcoding (*id*. ¶¶ 198-202). In addition, the SAC provides detailed allegations and specific examples of upcoding diagnoses of aortic atherosclerosis (*id.* ¶¶ 91-117), vent dependence

[2] The eight Kaiser PMG defendants are: (1) The Permanente Medical Group ("TPMG"); (2) Southern California Permanente Medical Group ("SCPMG"); (3) Colorado Permanente Medical Group, P.C.; (4) The Southeast Permanente Medical Group, P.C.; (5) Hawaii Permanente Medical Group, Inc.; (6) Mid-Atlantic Permanente Medical Group, P.C.; (7) Northwest Permanente, P.C.; and (8) Washington Permanente Medical Group, P.C.

(*id*. ¶¶ 118-141), malnutrition (*id*. ¶¶ 142-149), arrhythmia and pacemakers (*id*. ¶¶ 150-51), and depression (*id*. ¶ 152).

Kaiser's upcoding scheme directly impacts the ACA's Risk Adjustment Program and its system of tax credits. Each Defendant has a role in this scheme. Kaiser PMGs and Kaiser Hospitals see the patients, and it is during and/or following the patient visits that the fraudulent upcoding for these encounters occurs. *E.g. id.* ¶¶ 94-99, 121-23, 142-43, 150, 152, 163-65. Kaiser Health Plans then transmit the upcoded patient data to the Government for use in the ACA's Risk Adjustment Program. *E.g. id.* ¶¶ 7-9, 11, 51-61. The Government, unknowingly using the fraudulently upcoded data, then computes Risk Adjustment Transfers for Kaiser Health Plans and the other participating insurers in the ACA Exchanges. Due to Kaiser's upcoding scheme, Kaiser Health Plans benefit financially. Though they cumulatively have paid over $6 billion into the Risk Adjustment Program, had the Kaiser Health Plans provided accurate risk data to the Government as they were required to do by law, they would have had to pay substantially *more*. *Id*. ¶ 209.

The money that Kaiser wrongly retains is money that should have gone to other insurers; since it did not, those insurers have to raise the prices on their own health plans to account for their fraudulently lowered Risk Adjustment Payments. *Id.* ¶ 213. The Kaiser Health Plans, in turn, are able to artificially lower the cost of their own health plans (since they fraudulently retained money that should have gone to other insurers through Risk Transfer Payments). *Id.* ¶ 213. Accordingly, Kaiser's fraud causes both its own Health Plans and its competitors to submit inaccurate URRTs for every plan and every year. *Id.* ¶¶ 213-14. Since the ACA tax credit is tied to the price of the benchmark plan, and since the price of the benchmark plan is not Kaiser's plan over 70% of the time (*id.* ¶ 217), over 70% of the time the price of the benchmark plan is artificially inflated due to Kaiser's fraud. *Id.* ¶¶ 216-17. Thus, the Government is paying more in tax credits directly tied to Kaiser's upcoding scheme.

Kaiser Health Plans share the financial fruits of their upcoding scheme with Kaiser PMGs and Kaiser Hospitals. *Id*. ¶ 26. All of the defendant Kaiser entities have a role in this scheme, and all benefit from it.

D. Procedural History

On November 14, 2022, the Court granted in part, and denied in part, Defendants' motion to dismiss Relators' Amended Complaint. ECF No. 226 (the "Order"). The Court dismissed Relators' FCA claims based on the ACA without prejudice. It summarized the Amended Complaint's main allegations related to the ACA, including an allegation relating to the ACA's tax credit system, and found the allegations to be insufficient. *Id*. at 3, 17. The Court concluded that the Amended Complaint did not adequately allege that "false claims for payment were in fact made to HHS, which is the relevant government agency with respect to the ACA program," nor that HHS would have found Defendants' fraud to be material, and granted Relators leave to "amend their complaint to address the deficiencies with the FCA claims." *Id*. at 7, 8, 17. The Court denied the motion to dismiss with respect to Relator Hernandez's retaliation claims under the FCA and California Labor Code. *Id.* at 17. On December 12, 2022, Relators filed the SAC. On February 2, 2023, Defendants filed a subsequent motion to dismiss, seeking dismissal of the FCA claims once again.

III. LEGAL STANDARDS

To survive a motion to dismiss under Fed. R. Civ. P. 12(b)(6), a complaint must allege "sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 663 (2009). 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*. at 678. The facts alleged in the SAC are assumed to be true, and are construed in the light most favorable to Relators. *See United States ex rel. Lee v. Corinthian Colls*., 655 F.3d 984, 991 (9th Cir. 2011).

An FCA complaint must satisfy the heightened pleading standard of Fed. R. Civ. P. 9(b), but to do so, it need not list every detail of the alleged fraud, nor provide representative

examples. *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998-99 (9th Cir. 2010). Further, "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." *United States ex rel. Swoben v. United Healthcare Ins. Co*., 848 F.3d 1161, 1180 (9th Cir. 2016) (internal citations omitted). Moreover, Rule 9(b) does not apply to allegations of a defendant's knowledge, which may be pleaded generally. *United States ex rel. Silingo v. WellPoint, Inc*., 904 F.3d 667, 679 (9th Cir. 2018).

IV. ARGUMENT

A. The SAC Plausibly Alleges Falsity

The SAC sets forth precisely how Defendants submitted false claims to the Government, via ACA risk adjustment data and URRTs used to set premiums, which affected payment of funds.

1. Defendants Violated the FCA With False Risk Adjustment Transfers

As required by law, the Kaiser Health Plans submitted risk adjustment data, via the EDGE system, to the Government for all of its ACA plans. SAC ¶ 68. As required by law, Defendants also verified the accuracy of the risk adjustment data by completing an attestation. *Id.* ¶ 204. The SAC alleges that for every year and for every ACA plan that it offered, Kaiser submitted this attestation. *Id.* ¶ 207.

As alleged in the SAC, Kaiser Health Plans submitted false risk adjustment data to the Government even though they expressly attested that the information was accurate. The data was infected with falsified and upcoded diagnoses and with inaccurate ICD diagnosis codes that were entered onto patient records by Kaiser's other two divisions, its PMGs and Hospitals. Based on the false risk adjustment data, HHS calculated Risk Adjustment Payments. Since the risk profile of Kaiser Health Plan's patient base was fraudulently inflated, Kaiser Health Plans benefited in the form of either receiving a Risk Adjustment transfer that was higher than it would have been but-for the upcoding, or having to pay a lower amount than it would have but-for its fraud.

Upcoding is a well-recognized form of fraud covered by the FCA. *See, e.g.*, *Silingo*, 904 F.3d at 673-74; *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1082 (N.D. Cal. 2020) (citations omitted) (relator alleged "particular details of a scheme…to submit false diagnosis codes;" FCA claim properly alleged). While upcoding cases deal primarily with upcoding in either Medicare or Medicaid programs, "[a]t its core, the concept of upcoding is a simple and direct theory of fraud," *Ruckh v. Salus Rehab., LLC*, 963 F.3d 1089, 1105 (11th Cir. 2020), and there is no reason their logic should not apply in the ACA context. "Payments based on unsupported diagnosis codes are 'improperly inflated.'" *Ormsby*, 444 F. Supp. 3d at 1068, citing *Silingo*, 904 F.3d at 673. This is precisely what the SAC alleges – HHS makes Risk Adjustment Payments and uses federal funds for tax credits based on the "unsupported diagnosis codes" created and entered by Kaiser PMGs and Hospitals, and transmitted to the Government by the Kaiser Health Plans.

2. Defendants Violated the FCA by Impacting the ACA's Tax Credit System

Kaiser's upcoding resulted in FCA violations related to the ACA's tax credit system as well. The premiums charged for ACA health plans are determined by the rate filing justification, which includes a completed URRT, submitted by each insurer, each year. SAC ¶¶ 74-75. The URRT forms contain patient encounter data including diagnostic codes, and also estimate Risk Adjustment Transfer payments that the insurer will make or receive. Kaiser Health Plan's URRT's contain upcoded data. Further, since Kaiser's upcoding results in lower Risk Adjustment Transfers from Kaiser to the Government, the Kaiser Health Plans' URRT submissions underreport the amount of money that they should have to pay in the form of Risk Adjustment Transfers, had they been using accurate claims data. The URRT forms, containing false data, allow Kaiser Health Plans to justify charging lower premiums. At the same time, when competitor insurers are completing their own URRTs, they have to factor in the artificially lowered Risk Adjustment Transfers that they will receive from the Risk Adjustment Program. *Id.* ¶ 213. Kaiser's artificially low transfers

cause these other insurers to raise their premium prices to compensate for the revenue gap. *Id.* ¶ 214.

This scheme is not a "financial wash" for Kaiser, as Defendants state. Memo. at 19. Kaiser Health Plans, with their artificially low premiums (subsidized by the taxpayer and other insurers' inflated Risk Adjustment Payments) have a competitive edge, allowing them to enroll more patients, and receive more revenues and tax credits. This is a clear benefit for Defendants to engage in this scheme. When these other plans, with their premiums inflated due to Defendants' fraud, qualify as the benchmark for a given area – which the SAC alleges happens more than 70% of the time – the tax credits funded by the Government become artificially inflated as well. SAC ¶ 215.

3. The SAC Contains No Procedurally Improper or "New" Arguments

Defendants' initial attack on the SAC has nothing to do with the merits of this lawsuit, but instead is an ill-conceived procedural argument that (1) the SAC improperly includes allegations about Defendants' rampant Medicare Advantage fraud; and (2) the fraud relating to the tax credits is a "new" theory of Defendants' massive ACA fraud. Memo. at 9-10. Both arguments are easily dispelled.

First, the SAC expressly acknowledges that the Court dismissed Relators' Medicare Advantage claims pursuant to the FCA's "first-to-file" rule, and explains that the SAC nonetheless retains the Medicare Advantage allegations for two reasons: (1) to preserve these claims for purposes of appeal, and (2) because those allegations "remain relevant to the ACA-related allegations and claims, as they overlap with and relate to one another." SAC ¶ 1, n.1. There is nothing improper with this pleading practice nor inconsistent with any previous Court order.

Second, Relators' theory regarding Defendants' fraudulent manipulations impacting tax credits under the ACA is not "new." Relators' Amended Complaint alleged that Defendants' ACA fraud affected the tax credits provided and funded by the Government, and further that Defendants' scheme led to ACA premiums being artificially increased,

which in turn led to higher tax credits funded by the Government. *See* ECF No. 117, ¶ 50. The Court's Order dismissing the Amended Complaint quoted this paragraph. Order at 3. The SAC reasonably expands on these allegations, in recognition of the Court's admonition and instruction that more was needed to explain how "false claims for payment were in fact made to HHS… Relators have not clearly done so in the operative pleading." *Id.* at 7. There is nothing improper about an amended pleading expanding on allegations that a court found to be deficient; indeed, that is the expectation with an amended pleading.

4. Defendants' Characterizations of the Risk Adjustment Attestations Are Simply Inaccurate

Defendants argue that the risk adjustment attestations submitted to the Government for every Kaiser plan each year were not tied to payments "at all," and that the attestations say "nothing about requesting or demanding money or property." Memo. at 11. The plain language of the attestation, provided in the SAC, belies these assertions. Through the attestation form, a person "authorized to legally and financially bind my organization" attests that "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." SAC ¶ 73 (emphasis added).

Defendants also try to downplay the attestations as serving no purpose other than to fulfill a requirement for "the health plan to confirm that the data in the report matches the data separately submitted to HHS." Memo. at 11. Again, the clear language of the attestation, a document that legally and financially binds the submitter, shows Defendants are wrong. It provides: "Qualified by any discrepancy reported for the 2017 benefit year set forth herein, the final dedicated data environment (EDGE server) reports **accurately reflect the enrollment, claims and encounter data submitted to the EDGE server[.]**" SAC ¶ 73 (emphasis added). It also attests that the enrollment, claims and encounter data "is accurate and has been submitted in accordance with the regulatory and operational guidance for the EDGE server and risk adjustment program, as applicable." *Id*. Defendants' attempts to

1 downplay the significance and clear meaning of the Attestations must fail – certainly at the
2 motion to dismiss stage.

3 **5. The SAC Plausibly Alleges an Upcoding Scheme**

4 As set forth above, the SAC alleges an upcoding scheme and provides illustrative
5 examples including ventilator dependence, malnutrition, arrhythmia, and depression. Kaiser
6 argues that its over-documenting and upcoding with respect to ventilator dependence is not
7 actionable because, according to Kaiser, it does not involve violating any "legally binding
8 requirements." Memo. at 13. Congress expressly grants HHS the authority to "issue
9 regulations setting standards for meeting the requirements" of the ACA, including the Risk
10 Adjustment Programs. SAC ¶ 60, citing 42 U.S.C. § 18041(a)(1)(C). Among the binding
11 requirements set forth by the regulations promulgated by HHS include that insurers use
12 ICD-9-CM and ICD-10-CM classifications, and adhere to the Official ICD Guidelines for
13 Coding and Reporting. SAC ¶¶ 65-67. Just as the Court previously found that similar
14 regulations pertaining to Medicare Advantage meant that Kaiser had to comply with ICD
15 Guidelines under that program (ECF No. 223 at 22), the same logic applies to the ACA.

16 The SAC plausibly alleges that Kaiser did not code ventilator dependence pursuant
17 to ICD guidelines. SAC ¶¶ 118-41. As one example of Kaiser's failure to follow ICD
18 guidelines, the SAC cites guidance by the American Hospital Association's Coding Clinic,
19 which is the official clearinghouse for ICD coding guidance, showing that Kaiser knew
20 what ICD required, and knew that it violated those requirements. *Id.* ¶¶ 92, 119. Relators'
21 theory is not that Kaiser violated Coding Clinic guidelines; instead, it is that Kaiser violated
22 ICD Official Guidelines and requirements. Kaiser's authority is inapposite. *See Kisor v.*
23 *Wilkie*, 139 S. Ct. 2400, 2404 (2019) (administrative law decision regarding the deference
24 due to the Department of Veterans Affairs' interpretation of its own "genuinely ambiguous
25 regulations"); *United States ex rel. Yannacopoulos v. Gen. Dynamics*, 2007 WL 495257, at
26 *3 (N.D. Ill. Feb. 13, 2007) (relator's theory rested entirely on two paragraphs of guidance
27 issued by the Defense Security Assistance Agency when there was no requirement that
28 defendant adhere to the guidance). Here, there is no "ambiguous" regulation at issue, and

Kaiser is required to adhere to ICD Official Guidelines. It did not, and is liable under the FCA as a result.

Defendants similarly argue that the SAC lacks an allegation that Defendants violated binding guidelines with respect to arrhythmia. Memo. at 15. Patients with arrhythmia can receive pacemakers to correct this condition. SAC ¶ 150. Once a person suffering from arrhythmia receives a pacemaker, the person typically no longer suffers from arrhythmia. *Id*. Nonetheless, Defendants, including TPMG and Colorado PMG, instructed doctors to document and report *both* arrhythmia and pacemaker status for patients after receiving a pacemaker to correct the arrhythmia, regardless of whether the patient continued to suffer from arrhythmia, the very condition the pacemaker was installed to counteract. *Id*. As this Court held, "[i]f a diagnosis of a medical condition was claimed but that condition did not exist… then a claim for payment based on that diagnoses is literally false." ECF No. 223 at 10. Since the patient no longer had arrhythmia, including a diagnosis of arrhythmia was false.

6. Defendants Cannot "Maximize Revenue" Through Fraud

Defendants argue that the alleged scheme to increase malnutrition diagnoses was nothing more than legal efforts to increase their revenues. Memo. at 14-15. They make a similar argument with respect to their depression diagnoses. *Id*. at 16 ("Again, the pursuit of valid diagnoses is not fraud."). This argument entirely ignores the allegations of the SAC, wherein Relators allege that Kaiser PMGs and Hospitals coded for malnutrition and depression when those diagnoses were *not* supported by the patient's status and condition. As Defendants' own authority states, health care providers can pursue revenue only when diagnoses are "supported by documentation in the medical record." *Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 n.4 (9th Cir. 2021). The thrust of the SAC's plausible allegations is that Kaiser's upcoded diagnoses are *not* supported by the medical record, and are therefore false. On a motion to dismiss, Defendants cannot simply ignore these well-pleaded allegations.

1 **7. Defendants' Pre-2014 Conduct is Relevant**

2 Defendants further argue that their vent-dependence and malnutrition upcoding
3 fraud is excused by the fact that some of the relevant allegations in the SAC predate the
4 start of the ACA Risk Adjustment Program. *E.g.* Memo. at 14 (discounting a December
5 2013 validation audit because the Risk Adjustment Program started on January 1, 2014).
6 This argument is a red herring. The ACA was enacted in 2009; though the Risk Adjustment
7 Program did not begin until 2014, Defendants prepared and plotted to exploit the program
8 for years. Further, Medicare Advantage was in full swing prior to 2014, and as alleged in
9 the SAC, the scheme to defraud Medicare Advantage shares many of the same tactics, and
10 affects the same diagnoses (including vent-dependence and malnutrition), meaning that
11 Defendants had been upcoding these conditions prior to 2014 for purposes of Medicare
12 Advantage, and then applied the same upcoding practices to ACA patients starting in 2014.[3]
13 Further, the SAC alleges that Defendants' practices continued after 2014, and inflated the
14 diagnoses well into the time period after the ACA was enacted. *See, e.g.*, SAC Exhibit 28
15 (showing upward trend of vent-dependence diagnoses into 2016); SAC ¶ 147 (alleging
16 specific conduct perpetuating the malnutrition scheme in late 2016).

17 **8. The SAC Provides Sufficient Details About Kaiser's Fraudulent**
18 **Scheme**

19 In addition to the above misguided arguments, Defendants also misconstrue
20 Relators' pleading burden in arguing that the SAC must be dismissed for a purported failure
21 to "Identify Any False Claims for Payment." Memo. at 10-12. In FCA litigation, a relator
22 does not have to "'identify representative examples of false claims to support *every*
23 allegation,' but must 'allege with particular details of a scheme to submit false claims paired
24 with ***reliable indicia*** that lead to a ***strong inference*** that claims were actually submitted."
25 *United States v. Mariner Health Care, Inc.*, 552 F. Supp. 3d 938, 946 (N.D. Cal. 2021) (J.
26 Chen), quoting *Ebeid*, 616 F.3d at 998-99 (emphasis supplied by Court).

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28 [3] Indeed, this overlap is one of the reasons Relators have kept allegations pertaining to Medicare Advantage in the SAC (*see* SAC ¶ 1 n.1).

Here, the SAC has done just that. In great detail, Relators allege that the Kaiser PMGs and Hospitals over-document and upcode patient encounter data. *E.g.* SAC ¶¶ 94-99, 121-23, 142-43, 150, 152, 163-65. Relators allege that the Kaiser Health Plans submitted this upcoded data to HHS and, for every year and for every plan, falsely attested to the accuracy of the data. *E.g. id.* ¶¶ 7-9, 11, 51-61, 207. Also for every year and for every plan, the Kaiser Health Plans submitted URRTs to HHS, and those URRTs contained the upcoded data and also factored in the fraudulently impacted Risk Adjustment Payments. *Id.* ¶¶ 74-78, 211-215. These allegations satisfy Rule 9(b); Plaintiffs do not need to identify specific risk adjustment attestations or URRT submissions. *See Mariner*, 552 F. Supp. 3d at 949.

Defendants rely on *United States ex rel. Aflatooni v. Kitsap Physicians Serv.*, 314 F.3d 995 (9th Cir. 2002), to argue the SAC fails under Rule 9(b). Memo. at 10. Yet *Aflatooni* was decided on summary judgment, after the plaintiff engaged in discovery and still was unable to present any specific false claim. *Aflatooni*, 314 F.3d at 995, 997. What is or is not permissible *at summary judgment* is not at issue at this stage of the litigation. The most recent Ninth Circuit authority dealing with motions to dismiss has unequivocally confirmed that the identification of specific false claims at this stage is *not* required. *See, e.g.*, *Swoben*, 848 F.3d at 1180; *Ebeid*, 616 F.3d at 998-99.

B. The SAC Plausibly Alleges Materiality

The SAC plausibly alleges that Defendants' upcoding fraud, and resulting submissions of false attestations to the Risk Adjustment Program and false submission of URRT forms when setting premium rates, was material. The SAC shows that it had "a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property" by the Government. *See* 31 U.S.C. § 3729(b)(4). While no one factor establishes materiality under the FCA, to establish materiality a plaintiff must plausibly allege that violations are "so central" to claims for payment that the Government would not have paid the claims had it known of the defendants' behavior. *See, e.g.*, *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1121 (9th Cir. 2020); *Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1213 (9th Cir. 2019).

1 The SAC easily surpasses this test. It plausibly alleges that the Government would
2 not have paid Defendants if it knew of Defendants' fraud, and possibly would have expelled
3 Defendants from participating in the ACA program altogether. SAC ¶ 227. Supporting these
4 allegations are numerous specific allegations of materiality. For instance, Congress has
5 expressly stated that it views risk adjustment fraud as material to the ACA program.
6 Defendants should be ineligible to participate in the ACA Exchanges due to their
7 manipulations as alleged in the SAC. *Id.* ¶ 227, citing 42 U.S.C. § 18033(a)(6)(A).
8 Eligibility to participate in an Exchange is "a material condition of an issuer's entitlement
9 to receive payments" related to the ACA. 42 U.S.C. § 18033(a)(6)(A). Since Kaiser should
10 be ineligible to participate in the ACA, it is ineligible to receive any funds through the ACA.
11 The size of Defendants' fraud is another factor that establishes materiality; as this
12 Court has stated, "the magnitude of the noncompliance weighs in favor of materiality[.]"
13 ECF No. 223 at 24. The SAC plausibly alleges that Defendants' Risk Adjustment
14 manipulations have benefitted them by tens of millions of dollars each year in the form of
15 risk adjustment transfers in their favor. SAC ¶ 226. The ACA views this magnitude of fraud
16 as material; for instance, it sets a threshold of only $100,000 before it considers risk
17 adjustment discrepancies material. *Id.* ¶¶ 225-26, citing 45 C.F.R. § 153.710(e).
18 The plain language of the attestations shows materiality as well. In the annual EDGE
19 attestation, the insurer certifies that "the data submitted to the EDGE server and made
20 available for the permanent risk adjustment program established under Section 1343 of the
21 Affordable Care Act, upon which final risk adjustment transfers are calculated, may be
22 subject to the False Claims Act." SAC ¶ 73. The explicit reference to FCA liability is
23 another indicator that the EDGE data, including diagnostic data, is materially important to
24 the Government.
25 In addition, the ACA empowers HHS to investigate and monetarily penalize insurers
26 who manipulate risk adjustment data. SAC ¶ 230, citing 45 C.F.R. §§ 153.740(a), 156.805.
27 Indeed, as shown in the SAC, the Government has initiated such investigations. SAC ¶ 231
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(describing 2017 FBI investigation, including issuing subpoenas, regarding Oregon insurer manipulating risk adjustment data).

Finally, Defendants' attempts to recast their fraud as nothing more than "minor and insubstantial" violations of the ACA, akin to buying foreign staplers on a health services contract that requires domestic staplers (Memo. at 22), trivializes their conduct to an almost comic degree. A fraudulent scheme that undermines the very purpose of the ACA and threatens its ability to meet its goals of providing more health insurance to more people at lower costs is a far cry from a health services provider ordering the wrong kind of staplers.

C. The SAC Plausibly Alleges a Conspiracy Involving All Defendants

The SAC alleges that the Kaiser PMGs, Kaiser Hospitals, and Kaiser Health Plans worked together to defraud the United States. The fraud scheme could not have been accomplished without the collaboration between all aspects of Kaiser's empire.

The PMGs and Hospitals saw and treated ACA patients, and schemed to over-document and upcode the visits. For instance, as alleged in the SAC, the Kaiser PMGs and Hospitals implemented an HCC initiative to increase vent dependence diagnoses. SAC ¶¶ 122-23, 136. The SAC describes the concerted effort among all Kaiser PMGs and Hospitals nationwide to follow the centralized directive to increase that diagnosis, and how that directive was systematically adopted throughout the nation in both inpatient and outpatient settings. *Id*. The vent dependence scheme worked, and diagnoses skyrocketed throughout all Kaiser regions. *Id*. ¶ 139. The SAC includes other examples of coordination in upcoding efforts among the PMGs and Hospitals. *E.g. id.* ¶¶ 165, 177. Defendants also used the Kaiser Coding Governance Group, comprised of representatives from the PMGs, as a roadblock to people like Relators trying to do the right thing and determine proper, legal documentation and coding techniques and practices. *Id*. ¶ 170.

The Health Plans then took this upcoded data and transmitted it to HHS, causing HHS to view the Health Plans' ACA patient base to be more risky to insure than it actually was. *See, e.g.*, *id.* ¶ 136. The Kaiser Health Plans never tried to validate the diagnostic data; they simply parroted it to the Government. *E.g. id.* ¶¶ 141, 149. Senior personnel from the

Health Plans and PMGs also collaborated to create and lead Kaiser's Regional Reporting Group, a group that shared "best practices" for increasing documentation, coding and revenue specifically directed towards risk adjustment. *Id*. ¶¶ 185-86

This collusive scheme resulted in the Health Plans having to pay less into the Risk Adjustment Program than they should have, had they submitted accurate data. *Id.* ¶¶ 205-210. It also resulted in the Government paying higher tax credits than it otherwise would have, if the Health Plans had used accurate risk information in their plan pricing. *Id.* ¶¶ 211-217. The Kaiser Health Plans, PMGs, and Hospitals have inter-company agreements, whereby the Health Plans share revenue with the PMGs and Hospitals. *Id.* ¶ 28. Thus, all Defendants gained financially by their systemic fraud. In sum, the SAC alleges that all Defendants conspired with one another to defraud the United States through an upcoding scheme.

Defendants' authority is inapposite. In *United States v. Toyobo Co*., the complaint lacked any allegation that the defendants "entered into any agreements for the purpose of getting the government to pay a claim." 811 F. Supp. 2d 37, 51 (D.D.C. 2011). Here, in contrast, the SAC is full of allegations that the PMGs, Hospitals, and Health Plans all worked together to upcode patient encounter data so that they would receive more funds through the ACA. And in *Corsello v. Lincare, Inc*., the complaint contained only "bare legal conclusion" that the defendants "conspired to defraud the Government." 428 F.3d 1008, 1014 (11th Cir. 2005). As outlined above, the SAC contains much more than a "bare legal conclusion" as to the conspiracy among the Defendants. And contrary to Defendants argument in the motion, paragraph 245 of the SAC is not the "only new conspiracy allegation," nor is it "utterly useless." Memo. at 24. There is both a bilateral fraud conspiracy and an overarching fraud conspiracy alleged in the SAC. There were universal efforts across the Kaiser empire to over-document, upcode, and defraud the ACA (overarching conspiracy), and simultaneously there were regional efforts between the PMGs and Hospitals in a region and the corresponding Health Plan (bilateral conspiracy). The SAC credibly and plausibly alleges both.

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D. The SAC Plausibly Alleges FCA Violations by All Defendants

Defendants' contention that the SAC uses "impermissible group pleading" for everyone except TPMG (Motion at 25) is without merit. "[A] complaint alleging fraud 'need not distinguish between defendants that had the exact same role in a fraud.'" *Mariner*, 552 F. Supp. 3d at 952 n.6, quoting *Silingo*, 904 F.3d at 677. Defendants cannot use the fact that they are a group of very closely related entities engaged in the same scheme as a shield to obfuscate their fraud.

As the SAC alleges, the eight Kaiser PMGs, along with Kaiser Hospitals, saw the ACA patients. They were responsible for the actual upcoding. The PMGs are closely related; they have a shared national leadership and consulting organization, and collectively spearheaded the corporate culture leading to massive upcoding. *E.g. id.* ¶¶ 39, 155, 157, 170. The six Health Plans, operating in different regions, sold health insurance through the ACAs exchanges, submitted the upcoded data to the Government as part of the Risk Adjustment Process, and impacted the calculation of the benchmark rates and tax credits in the same way. *E.g. id.* ¶¶ 52, 136, 141, 204, 217. These group allegations are permissible. *Silingo*, 904 F.3d at 678 ("there was no reason (and no way) for [Relator] to differentiate among those allegations that are common to the group" of defendants that "allegedly passed on [] inflated diagnosis information in the same way").

The SAC further clarifies that, unless otherwise specified, references to "Kaiser actions" in a particular region refer to actions of the specific PMG in that region, and references to the conduct of a Kaiser Health Plan likewise refers to the particular region where the conduct takes place. SAC ¶¶ 39-40. And, where appropriate, the SAC specifies when particular Defendants had particular roles in the fraud. *See, e.g.*, *id.* ¶¶ 121 (SCPMG's vent dependence upcoding), 135 (same), 144 (Northwest PMG's malnutrition upcoding), 150 (Colorado PMG's arrhythmia upcoding), 152 (SCPMG and other PMG regions' major depression upcoding), 165 (Northwest PMG's query templates), 168 (same), 188 (SCPMG's "competition" to increase risk scores). The SAC properly pleads claims against all Defendants.

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V. CONCLUSION

The SAC plausibly alleges a comprehensive upcoding scheme by Kaiser PMGs, Kaiser Hospitals, and Kaiser Health Plans that resulted in fraud on the ACA. Defendants' arguments to the contrary lack merit. The motion should be denied in full.

Dated: March 3, 2023

Respectfully submitted,

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