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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

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

REPLY IN SUPPORT OF MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION

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

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UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

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

REPLY IN SUPPORT OF MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION

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

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

REPLY IN SUPPORT OF MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT-IN-INTERVENTION

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

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I. INTRODUCTION[1]

Defendants moved to dismiss the United States' Amended Complaint because the United States again failed to allege a systemic scheme by five Defendants to defraud the Medicare Advantage program by knowingly submitting clinically false diagnosis codes to CMS. As the Motion explains, the Amended Complaint makes serious accusations of fraud based on little more than scattered references to "contradictions" in member medical records, cherry-picked examples of allegedly clinically inaccurate diagnoses, and allegations that Defendants sent queries to healthcare providers with inaccurate diagnoses that the providers were free to reject. The new allegations do not satisfy the pleading standards of Federal Rules of Civil Procedure 8 and 9(b), which demand plausibility and particularity from the Amended Complaint.

The United States' Opposition should not persuade the Court otherwise. As to falsity, the Opposition argues that a contradiction in a medical record necessarily is equivalent to an incorrect diagnosis—a faulty leap of logic. The Opposition implies that a contradiction in a medical record can also be evidence of a clinically false diagnosis, but the vague and conclusory allegations about undefined contradictions permit no such inference. And the Opposition contends that Defendants coordinated in a years-long effort to pressure healthcare providers to diagnose members with all types of nonexistent medical conditions, but the new allegations about flawed queries and nondescript audits do not suggest with the requisite particularity any such widespread scheme.

On top of all of the flaws with the United States' attempt to plead falsity, the United States' new allegations also fail to plead that Defendants had knowledge of a systemic scheme to submit clinically false diagnosis codes to CMS. The Opposition argues that Defendants knew that queries sent to healthcare providers contained wrong information. But it alleges no facts to plausibly suggest that Defendants knew that healthcare providers accepted the queries' suggestions without using their professional medical judgment or that those queries resulted in the actual submission of a false diagnosis code to CMS. Indeed, the allegations ***in the United States' own complaint*** show that providers exercised their judgment and rejected the suggestions where

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

appropriate. The United States' new audit allegations also do not plead knowledge of a systemic scheme. The United States cites internal audits from two years—2015 and 2016—but neither identified instances in which Defendants submitted diagnosis codes for nonexistent medical conditions to CMS. And allegations about conclusions from unidentified "NCO audits" lack specific facts about those audits, including how many errors were found and how many diagnosis codes were reviewed. These allegations do not support the inference that Defendants had knowledge of a years-long scheme, much less conspired, to defraud the Medicare Advantage program by submitting diagnosis codes to CMS for medical conditions that did not exist.

For these and all the other reasons discussed below and in the Motion, the Court should grant the Motion and dismiss with prejudice all causes of action premised on the new allegations.

II. ARGUMENT

A. The United States Fails to Allege a Plausible Scheme to Submit Diagnosis Codes to CMS for Medical Conditions That Did Not Exist

The Court should once again conclude that the United States has failed to allege a systemic scheme to submit clinically false diagnosis codes to CMS. The Court previously held that the United States failed to allege facts that would allow the Court to infer the existence of a widespread scheme to add nonexistent medical conditions to members' medical records. Order at 14.[2] Specifically, the United States failed to allege that the "scattered anecdotes" about clinical falsity in its original complaint were emblematic of a broader effort to diagnose nonexistent medical conditions in Southern California, Northern California, and Colorado. *Id.*

The Amended Complaint does not cure these failings. Instead of pleading that healthcare providers systematically diagnosed members with medical conditions that did not exist, it only offers a collection of vague references to "contradictions" in medical records. Mot. at 1; *see, e.g.*, Mot., Ex. A ¶¶ 1, 10, 13, 102, 128, 131, 134, 137, 142, 161 (redline comparing complaints). But a contradiction between a diagnosis code and the medical record does not equate to clinical falsity as a matter of common sense. Mot. at 10–11. And the new allegations about contradictions

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[2] The Court allowed the United States to proceed on a narrow theory based on allegedly nonexistent medical conditions that resulted from an initiative to code cachexia. Order at 14. The United States concedes that this initiative was limited to Northern California. Opp'n at 23.

cannot support a plausible inference of a years-long scheme because they do not plead fraud with particularity or rule out plausible alternative explanations for the contradictions. *Id.* at 11–13.

The few new allegations that reference specific diagnoses and query practices also do not plead a fraudulent scheme with the required particularity. The United States adds only two new examples of clinical falsity in the Amended Complaint, both of which concern malnutrition and amount to just more inadequate and isolated anecdotes that do not give rise to an inference of a systemic scheme. Mot. at 15; FAC ¶¶ 175–76. The United States even admits in its Opposition that both examples involve only SCPMG healthcare providers; they cannot support an inference of a wide-ranging fraud scheme across three regions and five Defendants. *See* Opp'n at 23 n.9.

Nor do the new allegations about purported flaws in queries sent to healthcare providers support a plausible inference of a scheme to defraud. *See* Mot. at 14–17; FAC ¶¶ 137, 141-42, 174, 309–310, 323. For example, the United States alleges that Defendants "failed to alert physicians to information that directly contradicted the existence" of the queried medical condition. *Id.* ¶ 174. The Amended Complaint does not plead any facts that tie the alleged "failure to alert" to actual submissions of clinically false diagnosis codes to CMS. The Amended Complaint also lacks particularized facts that suggest that the healthcare providers failed to review the medical records themselves to assess the purportedly contradictory information or that they even made a diagnosis following a query. In sum, there are no particularized allegations that the thousands of healthcare providers supposedly implicated in the purported scheme failed to exercise their independent medical judgment when recording diagnoses based on suggestions from queries. Mot. at 13–17. None of the allegedly false diagnosis codes could be submitted to CMS without these providers first ***choosing*** to add the diagnosis to the members' medical records, and nothing in the Amended Complaint asserts otherwise. Thus, the absence of any factual allegations that these healthcare providers knowingly disregarded the medical records and the patients' true medical conditions are fatal to the United States' theory of clinical falsity.

In its Opposition, the United States insists that it has now alleged a scheme to submit clinically false diagnosis codes to CMS that reaches beyond cachexia diagnoses in Northern California, but none of the United States' arguments is persuasive:

First, the United States relies on the erroneous premise that if something in a medical record contradicted a diagnosis code for a medical condition, the condition did not exist. *See* Opp'n at 5. Simply pointing to a contradiction between a diagnosis code and the medical record does not plausibly prove clinical falsity. A diagnosis contradicted by information in the medical record does not necessarily mean that the condition does not exist. *See* Mot. at 8–9. A contradiction could exist for manifold reasons, many of which have nothing to do with a clinical inaccuracy. *Id.* Recognizing this point, the United States argues that the Amended Complaint specifically alleges that Defendants diagnosed members with nonexistent medical conditions, but all it can cite from its pleading is conclusory language in four paragraphs that does not satisfy Rule 9(b). *See* Opp'n at 13 (citing FAC ¶¶ 2, 9, 101, 103). The United States glosses over the dozens of new references in the Amended Complaint to "contradictions" and "contradictory" information, but these allegations do not make clear that the relevant medical condition did not exist. *See, e.g.*, FAC ¶¶ 1, 10, 13, 102, 128, 131, 134, 137, 142, 161.

Second, while the United States also suggests that contradictions in medical records ***can*** serve as ***evidence*** of a nonexistent diagnosis, *see* Opp'n at 13, a point which Defendants concede, the United States fails to articulate why this inference is plausible rather than merely possible, nor has it defined the "contradictions" at issue with the requisite particularity. In a medical record, "contradictions" are routine and even expected, such as where a healthcare provider determines a member has a medical condition despite the existence of a clinical indicator that might suggest otherwise, or where the provider concludes that a medical condition that previously receded has returned. The Opposition responds as if such plausible explanations are absurd, *see id.* at 14–15, without giving attention to its own vague allegations that permit such inferences. The Amended Complaint continually uses nebulous phrases criticizing "contradictory information" or diagnoses "contradicted by the medical record." *See, e.g.*, FAC ¶¶ 1, 2, 9, 10, 13, 127, 131. But the United States does not allege with specific facts what these "contradictions" mean, especially in the context of medical records that are always changing to reflect members' health over time. It is not even clear what medical record files contain the contradiction for a given member. For example, in some instances the United States suggests that the addended diagnosis contradicts the

medical record for the relevant face-to-face visit, *see id.* ¶¶ 1, 134, but in other places the United States suggests only that members' medical records contain contradictions generally, *see* ¶¶ 2, 13. Thus, the United States does not allege the who, what, when, where, and how to support the new "contradiction" theory—or to give Defendants notice of the allegations against them. *See Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010).

The United States also misconstrues the Motion as arguing that every contradiction is just a sign of a healthcare provider "correcting" errors in the medical record. Opp'n at 14. But Defendants have noted the obvious truth that there may be good reasons for a contradiction that have nothing to do with "correcting" information in the medical record, such as when the status of a medical condition changes over time. Mot. at 12. Or there may be errors left uncorrected, which gives rise to the contradiction, but does not mean the diagnosed condition does not exist. *Id.* The problem is that the Amended Complaint leaves open all of these plausible explanations because it does not adequately define the contradictions alleged with particularity. And the Amended Complaint does not provide enough notice of the nature of the alleged contradictions for Defendants to articulate a response that could provide alternative explanations to each contradiction. *See Bly-Magee v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001).

Third, the United States offers no reason to infer that Defendants engaged in a widespread ***scheme*** to submit diagnosis codes to CMS for medical conditions that did not exist. In seven bullets, the United States lists allegations that it argues provide "substantial detail" of the scheme. Opp'n at 16. Only the first and seventh bullets—which allege that Defendants created flawed queries "for conditions that were contradicted by the medical record" and "pressured and incentivized" healthcare providers to add the suggested medical conditions to records—address any affirmative conduct. *Id.* Virtually every one of the allegations related to pressuring providers was in the original complaint, and the Court did not find those allegations sufficient to allege a systemic scheme. *See* Mot., Ex. A ¶¶ 182, 201, 202, 252, 253, 270, 272, 282, 285, 305, 361 (redline comparing complaints).

The query allegations do not plausibly allege a scheme with particularity either. As the Motion explained and the Amended Complaint alleges, a query is "a communication tool used to

clarify documentation in the health record." Mot. at 14; FAC ¶ 10. Queries are sent to healthcare providers, who in turn exercise their professional judgment and decide whether to diagnose a particular medical condition. Because the query itself is not a submission to CMS, a flawed query is not a false claim. *See Integra Med Analytics LLC v. Providence Health & Servs.*, 854 F. App'x 840, 844 (9th Cir. 2021). Even if this Court accepts that Defendants sent healthcare providers queries that had incomplete or inaccurate information, to show a widespread scheme based on those purportedly flawed queries, the United States must also allege with specific facts a widespread failure by thousands of healthcare providers to exercise their professional judgment, adequately review members' medical records, or diagnose medical conditions that they knew their patients did not have.

While the United States contends that the allegedly flawed queries led healthcare providers to incorrectly diagnose members, the Ninth Circuit has rejected similar allegations as a basis for fraud claims. *Id.* In *Integra*, the relator asserted FCA claims alleging that the defendant "trained . . . specialists to send allegedly 'leading queries' to doctors that were designed to change [the doctors'] initial assessments" to result in higher revenue. *Id.* at 842. The relator also alleged that this pressure "would sometimes result in the creation of contradictory medical records[.]" *Id.* The Ninth Circuit accepted these allegations as true, but nevertheless concluded that "we need not—***and cannot***—accept the conclusion that these allegations resulted from fraud or that doctors recorded unsupported medical conditions." *Id.* at 844 (emphasis added).

The Opposition discusses none of this relevant analysis and instead focuses solely on *Integra*'s holdings about statistical allegations. Opp'n at 17. That misses the point—the relator in *Integra* failed to state a claim while pleading a statistical analysis ***as well as*** allegations about leading queries and contradictory medical records. The relevant holding is that an allegation that a defendant sent flawed queries to healthcare providers does not necessarily support the inference that healthcare providers recorded nonexistent medical conditions. As *Integra* shows, the United States' theory of fraud depends on the inference that healthcare providers recorded such nonexistent medical conditions. And to adequately allege a scheme, the United States must allege with specific facts that healthcare providers did so on a widespread and routine basis. *See Ebeid*,

616 F.3d at 998–99. The United States has not done so here. *See* Mot. at 16.

The United States also asserts that Defendants' audits show the existence of a scheme, Opp'n at 7, but this argument fails for two reasons. First, an audit is an after-the-fact review. To show the type of affirmative "programmatic" scheme the Amended Complaint attempts to allege, *id*. at 10, the United States must plead facts that show a coordinated effort by the Defendants to diagnose medical conditions that did not exist ***in the first instance***. Second, the audit allegations are narrow in scope and scattered throughout the Amended Complaint such that they cannot be plausibly read to show a widespread effort spanning all medical conditions across three regions for over a dozen years. One of the audits identified in the Amended Complaint is from 2015 and another from 2016—and both from the Northern California region. FAC ¶¶ 334, 337–38. Neither describes the purported "errors" in a way that suggests a widespread scheme infecting all medical conditions and all Kaiser regions. The United States also describes a "root cause analysis" from 2012, but it is not clear what that analysis even addressed. *Id.* ¶ 346. Finally, the references to "NCO audits" lack any detail about when those audits occurred, what they reviewed, and how many errors they purportedly uncovered. *Id.* ¶ 345.

The United States further contends that its new "representative examples" help illustrate the alleged scheme, Opp'n at 11–12, but they plainly do not. Calling an example "representative" does not make it so, without more allegations that plead the fact of a widespread practice. As noted *supra* at 2–3, the Court did not find the prior examples in the original complaint sufficient to support a systemic scheme. Order at 13. Adding two additional examples that the United States admits came from the same region and concerned the same medical condition does nothing to show a scheme by five Defendants to falsify various medical conditions for Medicare Advantage members in multiple geographic regions across the country.

The United States' far more detailed allegations about the cachexia initiative in Northern California demonstrate why its new scattered references to "contradictions" do not allege a systemic scheme. The United States alleges that the TPMG cachexia initiative was a specific initiative in one region that was discussed during meetings and had a specific revenue goal. FAC ¶ 315. It also alleges that cachexia has particular attributes—that it is "based on clinical judgment

rather than clinical indicators"—that purportedly made it amenable to such a coordinated initiative. *Id.* ¶ 316. But in attempting to expand the Court's holding on the TPMG cachexia program, the United States argues that the alleged coding of nonexistent medical conditions was "not specific to any particular condition but [was] programmatic." Opp'n at 10. The United States would have this Court conclude that all other risk-adjusting medical conditions were similarly subject to specific, particularized initiatives with revenue goals, meetings, and the like. That conclusion belies common sense in the absence of more particularized factual allegations.

It also conflicts with the United States' own allegations. The United States specifically alleges that Colorado and Southern California ***did not*** have cachexia initiatives similar to the initiative in Northern California, FAC ¶ 321, yet the scope of its current complaint would encompass any cachexia diagnoses from those regions that "contradicted" the medical record (for example, for a member who had at any time previously been overweight). Such a blatant inconsistency demonstrates that the United States cannot simply allege that these initiatives were "programmatic" for a period spanning more than a decade.

The United States attempts to downplay the importance of these pleading requirements by describing the failure to allege a scheme to submit clinically inaccurate diagnoses as a "narrow issue." Opp'n at 12. But the United States has accused Defendants and healthcare providers of diagnosing tens of thousands of members with medical conditions that those members did not have. These allegations constitute a serious charge of misconduct against Defendants, but they also call into question the professional conduct of the thousands of healthcare providers who work for Defendants and who actually recorded those challenged diagnoses in the members' medical records. Proceeding on this theory will dramatically expand the scope of discovery, because the parties will need to develop fact and expert evidence on every medical record at issue not only for purported violations of the ICD Guidelines, but for the clinical accuracy of the underlying diagnoses. *See* Mot. at 7. In other words, the medical conditions of thousands of individual members, and the subjective state of mind of thousands of healthcare providers, would need to be subjects of discovery to substantiate or refute accusations that these members did not

have the medical conditions at issue.[3]

B. The United States Fails to Allege That Defendants Knew Healthcare Providers Diagnosed Medical Conditions That Members Did Not Have

The United States also has not sufficiently alleged that Defendants had the requisite knowledge of a systemic scheme to submit clinically inaccurate diagnosis codes to CMS. While the FCA's knowledge element can be pleaded generally, it is still rigorous and requires alleging some specific facts to support that Defendants knowingly submitted false claims. *See Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 192 (2016); *United States ex rel. Modglin v. DJO Glob. Inc.*, 48 F. Supp. 3d 1362, 1405 (C.D. Cal. 2014).

Query Allegations. The Opposition focuses on Defendants' alleged knowledge of the queries sent to healthcare providers asking about members' medical records. Opp'n at 19. But queries do not add diagnoses to medical records—healthcare providers do. *See* Mot. at 14–15. The United States incorrectly asserts that allegations about query flaws "show that Kaiser knew that it was repeatedly requesting physicians to add diagnoses that did not exist." Opp'n at 19. But even if that statement were true, and it is not, it would not support the inference that the healthcare providers who received those queries mindlessly and without any exercise of independent judgment recorded diagnoses in their patients' medical records that did not exist, or that those clinically false diagnosis codes were later submitted to CMS. Again, the Ninth Circuit has held that it is impermissible to infer that "doctors recorded unsupported medical conditions" based on allegations of flawed queries alone.[4] *Integra*, 854 F. App'x at 844.

The United States argues that any holding that does not equate flawed queries with clinically inaccurate diagnoses allows Defendants to "bury [their] head in the sand." Opp'n at 20.

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[3] The United States asserts that these discovery concerns are meritless because it intends to prove its case through sampling, Opp'n at 18, but the United States cannot rely on sampling here. This "is a fraud case that depends on whether . . . the coding of a medical condition was appropriate, and fraud will have to be proved on a claim-by-claim basis based on the patient's actual medical condition and actual medical care." *United States ex rel. Conroy v. Select Med. Corp.*, 307 F. Supp. 3d 896, 905–06 (S.D. Ind. 2018) (rejecting statistical sampling in FCA case).

[4] While the United States continues to disparage Defendants for applying an incorrect standard and argues that they "refuse[] to accept the truth of the allegations or draw all reasonable inferences in favor of the government," Opp'n at 19–20, it is the United States that misapplies applicable precedent. The *Integra* court specifically held that the requirement to draw all reasonable inferences in favor of the plaintiff did not require a court to infer that healthcare providers diagnosed nonexistent medical conditions based solely on allegations of flawed queries.

This argument makes no sense. It is entirely reasonable for Defendants to rely on trained healthcare providers to exercise their professional medical judgment when assessing whether a member had a medical condition. To adequately allege knowledge, the United States must do more than allege that Defendants knew the queries were flawed. It must also allege facts that show that Defendants knew that healthcare providers recorded unsupported diagnoses based on those queries—rather than properly review the medical record and make a diagnosis based on their professional medical judgment—and that those false diagnoses were then submitted to CMS.

The United States also ignores its own allegations that cut against an inference of knowledge. The Amended Complaint contains statements from multiple healthcare providers that show that the healthcare providers engaged with queries, compared them to the medical record, and rejected their suggestions according to their own professional judgment. FAC ¶¶ 220, 274, 310–11. These allegations conflict with the inference that healthcare providers either ignored the medical record or diagnosed medical conditions that they did not believe members had. Mot. at 16. Rather than address this argument, the United States contends that the complaints of some healthcare providers show that Defendants "knew" that other providers "were not complaining and were adding diagnoses from queries without properly reviewing the medical record." Opp'n at 21. In other words, the United States suggests that the Court should ***assume*** that because some providers reported that they rejected queried suggestions, and no providers reported that they blindly acceded to queries, that most providers did not exercise any medical judgment and Defendants knew it. Or that every single healthcare provider who did not actively complain instead misdiagnosed members with nonexistent medical conditions and that Defendants should have treated the failure to complain as tantamount to a failure to consider the medical records when diagnosing conditions. But this is utterly twisted logic. There are no plausible factual allegations that would support such a charge against Defendants' healthcare providers.

To support its assertion that Defendants knew that thousands of healthcare providers across three states treating millions of members diagnosed conditions that those members did not have, the United States highlights only a few vague allegations that say nothing about the diagnostic practices of healthcare providers. *Id.* at 20. One allegation highlights a single

unidentified internal document that purportedly concluded that "some" healthcare providers do not complete a full and proper review of the medical record before refreshing diagnoses. FAC ¶ 323. But even if fully credited, this allegation says nothing about the context of this document and what it was intended to cover. For example, it says nothing about whether "some" means five healthcare professionals or fifty. Nor does it state that the document even concerns the purportedly flawed queries that Defendants sent to healthcare providers, which is the key predicate supporting the scheme alleged by the United States.

A second allegation states that unspecified "[i]nternal documents" shows "Kaiser" knew "that its risk-adjustment initiatives were generating inaccurate diagnoses, including identifying, for example, that refresh reports would ask for a diagnosis to be refreshed even though it was only captured as a history of the condition." *Id.* ¶ 178. But this allegation is just a bare assertion that the documents show knowledge. There is no specific information about what the documents said or even what member population they purported to cover. And, critically, nothing in this paragraph says anything about the submission of any diagnosis codes to CMS. It points only to purported flaws in the query process. And the allegation in the very next paragraph—that other documents "identified this as a key problem area for cancer and stroke," *id.* ¶ 179—suffers the same flaws: queries are not equivalent to false diagnosis-code submissions to CMS.

Audit Allegations. The United States' audit allegations also do not sufficiently plead knowledge. The United States focuses on one audit that allegedly found "inconsistent" morbid obesity diagnoses, Opp'n at 20 (citing FAC ¶ 337), yet the United States fails to address Defendants' arguments about that audit. *See* Mot. at 19. The United States itself alleges that this audit "did not expressly categorize diagnoses where the medical record contradicted the existence of the condition," FAC ¶ 337, yet asks the Court to infer that Defendants knew that healthcare providers diagnosed nonexistent medical conditions. Rather than respond to that argument, the United States again accuses Defendants of "refus[ing] to accept the allegations regarding these audits as true," Opp'n at 20 n.6, but Defendants never argued that the audit results were untrue. Defendants simply observed that this audit, which does not identify any diagnosis as contradicting the medical record or otherwise not existing, could not put Defendants on notice of

the particular type of falsity that the United States has attempted to allege. Mot. at 19. In other words, even accepting that the auditors found that morbid obesity diagnoses were "inconsistent" with the medical record, that singular audit (in a singular market and in a singular time period)—in the absence of any other report about nonexistent medical conditions—could not have put Defendants on notice of the purported widespread diagnosing of clinically inaccurate medical conditions by healthcare providers across three markets for more than a decade.

The other audit allegations fare even worse. While the United States alleges that NCO audits "consistently showed that Kaiser's California and Colorado regions erroneously submitted active condition diagnosis codes to CMS for payment when the medical records indicated that the patient had only a history of the condition," FAC ¶ 345, there are no specific allegations that show that such audits put Defendants on notice of a widespread scheme to diagnose members with nonexistent medical conditions. There are no facts pleaded about how many such errors were found, how many diagnosis codes were reviewed, which healthcare providers were reviewed, or what actions were taken following these audits. And while the allegations about a 2015 audit in Northern California do allege that the audit "identified hundreds of instances" where healthcare providers "added diagnoses via addenda where the existence of the condition was contradicted by information in the encounter note," *id.* ¶ 338, the Amended Complaint lacks specific facts about how many diagnoses were reviewed or what the purported contradiction was.

C. The United States Does Not Plead Materiality in Support of Its New Contradiction Theory

The United States focuses its entire materiality argument on clinical falsity. Opp'n at 21. It does not even attempt to argue that the conduct actually alleged in the Amended Complaint—*i.e.*, the submission of diagnosis codes to CMS where the diagnosis was "contradicted" by information in the medical record—would on its own be material to CMS. *Id.* And that is because it cannot. The Amended Complaint lacks any allegations that CMS would refuse to pay Defendants simply because a risk-adjusting diagnosis was contradicted by some other information in the medical record. Mot. at 20–21. Thus, to find that the Amended Complaint adequately alleges materiality under the FCA, the Court must conclude that alleging that a diagnosis code is

contradicted by the medical record is, by itself, enough to plead clinical falsity.

D. The United States Fails to Allege Claims Based on Clinical Falsity Against KFHP-CO, CPMG, and SCPMG Due to Impermissible Group Pleading

The Motion explained that the United States fails to differentiate among Defendants and does not include sufficiently specific allegations about KFHP-CO, CPMG, and SCPMG. *Id.* at 22-23. Plaintiffs must "differentiate their allegations when suing more than one defendant and inform each defendant separately of the allegations surrounding [its] alleged participation in the fraud." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016) ("*Swoben*") (quotations omitted). While courts do allow collective allegations where each defendant has an identical role and functions in the exact same manner, collective allegations are not permitted where the defendants presumably did not engage in the exact same conduct. *See Hausauer v. City of Mesa*, 2020 WL 2735970, at *3 (D. Ariz. May 26, 2020).

The United States relies on its allegations from the original complaint to show that it adequately alleged falsity as to all Defendants. Opp'n at 22. But that complaint failed to allege a single scheme to diagnose nonexistent medical conditions (other than cachexia) by any Defendant and so, by definition, those allegations cannot satisfy the United States' pleading burden here. And there is nothing new in the Amended Complaint that would change that conclusion.

The "representative examples" of clinically false diagnoses do not suffice for similar reasons. *See* Opp'n at 23. The United States argues that paragraph 365 implicates SCPMG and paragraphs 154 and 155 implicate CPMG and KFHP-CO. But these paragraphs were all in the original complaint and remain unchanged. *See* Mot., Ex. A ¶¶ 154–155, 365 (redline comparing complaints). The Court did not find these paragraphs sufficient to allege that these Defendants engaged in a fraudulent scheme previously, and it should not change its conclusion now. Paragraphs 154 and 155 do not even allege that healthcare providers in Colorado misdiagnosed members. The United States also argues that paragraphs 175 and 176, the two new allegations that healthcare providers misdiagnosed malnutrition in two patients, support a claim against SCPMG. Opp'n at 23. But the United States does not allege that the providers in these examples worked at SCPMG, and thus fails to allege the "who" of the fraud charged. In any event, these

two examples do not suggest SCPMG engaged in a coordinated scheme.[5] And the conclusory allegation that these examples are "representative" of "thousands" of others does not show with particular facts that ***each*** Defendant engaged in a systemic scheme. *See* FAC ¶ 374.

Finally, the United States' attempt to rely on the general term "Kaiser" falls short here. The United States itself alleges that the health plans and CPMG, TPMG, and SCPMG are distinct entities and do not engage in the same conduct. They have different members, employ different healthcare providers, cover different regions, and engage in different business practices. FAC ¶¶ 22–28. So it is not possible for each Defendant, and particularly the medical groups, to make the same diagnoses or to employ the same healthcare providers.

E. The New Allegations Do Not Support a Conspiracy Claim

The Amended Complaint's new allegations do not allege a conspiracy claim against Defendants, because they do not show an agreement among Defendants to record clinically false diagnoses and submit corresponding diagnosis codes to CMS. As with the group pleading argument, the United States' reliance on the original complaint is misplaced. *See* Opp'n at 23. The original complaint failed to allege any conspiracy claim—or any claim at all—based on a clinical falsity theory beyond TPMG's alleged cachexia initiative. The United States contends that Defendants "jointly operated these risk-adjustment programs." *Id.* at 24. But its clinical falsity theory has nothing to do with any joint program. To the contrary, it relies on a purported failure to correct flawed queries. And according to the United States, there was not agreement on how to respond to queries. In fact, the United States' complaint alleges that Defendants' official programs labeled these flawed queries as a problem. FAC ¶¶ 178–79 (alleging that internal documents identified certain "risk adjustment initiatives" as a "problem area for cancer and stroke in particular"). And the United States makes clear that healthcare providers at the provider-run

[5] The United States argues that Defendants know where providers worked and therefore it can identify healthcare providers by name without identifying which Defendant employed the healthcare provider in question. Opp. at 12 n.1. But that each Defendant knows who works for it and ***may*** know who works for other Defendants does not relieve the United States of its obligation to identify when specific allegations implicate specific Defendants. Additionally, this argument cuts directly against the United States' assertion that "[w]hen particular Kaiser regions or entities acted differently than others, the Amended Complaint identifies so." *Id.* at 23. For the two examples in paragraphs 175 and 176, there is no indication that the allegations are specific to SCPMG. To the contrary, the United States uses "Kaiser," imputing the conduct to all Defendants. Neither Defendants nor the Court is responsible for deciphering such ambiguities.

medical groups did not always act on the queries. *Id.* ¶¶ 221, 225, 274, 309, 363. The Amended Complaint does not allege that Defendants conspired or otherwise agreed to rely on flawed queries to submit false diagnosis codes to CMS.

F. The New Allegations Do Not Support Any of the Common-Law Claims

The United States incorrectly argues that Defendants waived any argument for dismissal of the common-law claims. Opp'n at 24. That argument ignores the contents of the Motion, the applicable law, and the interplay between the United States' claims and the underlying allegations. The Motion made clear that the common-law claims should be dismissed for the same reasons the FCA claims should be dismissed. Mot. at 2. That position makes good sense: both the FCA and common-law claims are based on the same factual allegations. FAC ¶¶ 390, 393. And courts have dismissed common-law claims brought in FCA actions where they are derivative of the flawed FCA claims. *See, e.g.*, *United States v. Aegis Therapies, Inc.*, 2015 WL 1541491, at *14 (S.D. Ga. Mar. 31, 2015) (dismissing claims for unjust enrichment and payment by mistake because they were "purely derivative" of dismissed FCA claims). The United States failed to allege a scheme to diagnose medical conditions that members did not have. So it cannot premise any common-law claims on that purported scheme.

G. The Court Should Deny Leave to Amend

The Court should reject the United States' request for yet another opportunity to amend its complaint. Opp'n at 25. The United States has already had its opportunity to cure the defects that persist in its Amended Complaint. And, as explained in the Motion, it has access to evidence from an eight-year investigation into the conduct described in the Amended Complaint. Mot. at 24. The Court identified the United States' pleading failures; if there were additional facts that could cure those failings, the United States is well positioned to know them. Yet it has again failed to adequately allege its theory based on a widespread scheme to diagnose medical conditions that members did not have.

III. CONCLUSION

For the foregoing reasons, the Court should grant the Motion.

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Respectfully submitted,

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