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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 RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT

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

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT** Hearing Date: May 4, 2023 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:21-cv-03894-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS RELATORS BRYANT AND HERNANDEZ'S SECOND AMENDED COMPLAINT** Hearing Date: May 4, 2023 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

TABLE OF CONTENTS

Page

I. INTRODUCTION 1

II. ARGUMENT 3

A. Relators Fail to Allege Falsity 3

1. Relators Fail to Allege Any Claims for Payment 3

2. Relators Do Not Allege a Scheme to Defraud the ACA Program 5

3. Relators' Tax-Credit Theory Fails 9

B. Relators Fail to Allege Materiality 10

C. Relators Fail to Allege Conspiracy 12

D. Relators Engage in Impermissible Group Pleading 13

E. Relators Effectively Concede That the Court Should Not Again Grant Leave to Amend 14

III. CONCLUSION 15

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

Barnes v. Sea Hawai'i Rafting, LLC,
493 F. Supp. 3d 972 (D. Haw. 2020), *aff'd*, 2022 WL 501582 (9th Cir. Feb. 18, 2022) 10

Bly-Magee v. California,
236 F.3d 1014 (9th Cir. 2001)........ 7

Bolbol v. City of Daly City,
754 F. Supp. 2d 1095 (N.D. Cal. 2010) 15

DeLeon v. Wells Fargo Bank, N.A.,
2010 WL 4285006 (N.D. Cal. Oct. 22, 2010)........ 10

Dep't of Transp. v. Ass'n of Am. R.R.s,
575 U.S. 43 (2015)........ 8

Integra Med Analytics LLC v. Providence Health & Servs.,
854 F. App'x 840 (9th Cir. 2021) 8

Lacey v. Maricopa Cnty.,
693 F.3d 896 (9th Cir. 2012)........ 10

Perkins v. Albertsons, LLC,
2023 WL 2154034 (C.D. Cal. Jan. 26, 2023) 15

Tietsworth v. Sears,
720 F. Supp. 2d 1123 (N.D. Cal. 2010) 7

United States ex rel. Poehling v. UnitedHealth Grp., Inc.,
2018 WL 1363487 (C.D. Cal. Feb. 12, 2018)........ 11

United States v. Mariner Health Care, Inc.,
552 F. Supp. 3d 938 (N.D. Cal. 2021) 5

United States v. Scan Health Plan,
2017 WL 4564722 (C.D. Cal. Oct. 5, 2017)........ 11

Universal Health Servs., Inc. v. United States ex rel. Escobar,
579 U.S. 176 (2016)........ 11, 12

Zucco Partners, LLC v. Digimarc Corp.,
552 F.3d 981 (9th Cir. 2009)........ 15

STATUTES

32 U.S.C. § 3279(b)(2)(A) 3

RULES

Fed. R. Civ. P. 9(b) 7, 8, 14

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
(continued)

Page

REGULATIONS

42 C.F.R. § 422.504(*l*) 4

45 C.F.R. § 153.710(d) 4

I. INTRODUCTION[1]

After giving it another try, Relators Gloryanne Bryant and Victoria Hernandez still have not alleged that Defendants submitted or caused to be submitted a false claim on the ACA program; Relators have not even alleged a ***claim for payment*** at all. Instead, the SAC adds long explanations of the ACA program without sufficiently alleging specific facts about the conduct of any one of the fifteen Defendants under the program. Relators also base all of their fraud allegations on attestations submitted to HHS, but fail to allege any facts to show that those attestations are demands for payment that can even give rise toto FCA liability. And Relators now contend that Defendants ***paid over $6 billion*** into the ACA program—defeating any plausible inference of fraud and potentially defeating an inference that any Defendant ever made a claim at all on the ACA program. The SAC utterly fails to meet the exacting pleading standards required in fraud cases, and the Court should dismiss Relators' fraud claims yet again.

Falsity. Relators' continued failure to allege the submission of a false claim is fatal to all of their FCA fraud allegations. Relators have failed to plead that the attestations submitted to HHS as part of the ACA program are claims for payment. Indeed, the attestation form that they cite says nothing about demanding money or property from the United States. Nor does the SAC explain the who, what, when, where, and how of Defendants' alleged submissions. Simply describing how the ACA program works and then vaguely asserting that "Kaiser" submitted attestations every year do not suffice. Relators suggest that unified rate review template ("URRT") submissions are claims for payment that support their new and improper tax-credit theory, but Relators' SAC lacks any allegation supporting this conclusion. The SAC explicitly premises liability on the submission of attestations—not URRT submissions—and the SAC does not allege that URRT submissions constitute requests or demands for money or property.

Relators also fail to plead falsity under the FCA for additional reasons. They do not plead sufficient facts to show that Defendants improperly diagnosed the four specific risk-adjusting medical conditions identified in the SAC. Their allegations depend on third-party statements—

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

statements that do not bind Defendants—as well as suggestions that Defendants' desire to increase revenue was improper, even though this Court has recognized that there is nothing wrong with such behavior. Relators also raise a wholly new theory of liability unsupported by the SAC—that Defendants violated the "ICD Guidelines" in diagnosing these medical conditions. Not only does the SAC not allege any such violations, but Relators fail to identify what provisions of the ICD Guidelines they believe are at issue. The ICD Guidelines are over 100 pages and contain all types of technical coding guidelines, such as the requirement to use "a placeholder character 'X'" to fill certain characters in certain codes. *See* Dkt. No. 179-1 at 433. Defendants do not have sufficient information to defend themselves against a nondescript and blanket accusation that they violated the ICD Guidelines.

And as to Relators' tax-credit theory, Defendants explained in their Motion that the SAC's convoluted allegations required numerous inferential leaps and did not plead a plausible fraud scheme with particularity. Relators' allegations that Defendants paid billions of dollars into the ACA program and had healthier-than-average members cut against any inference of fraud. In any event, the theory was not pleaded in the FAC and the Court did not give leave for Relators to introduce it in their SAC. A lone mention of "tax credits" in the FAC's background section does not give Relators carte blanche to inject that theory into the SAC now.

Materiality. With no plausible materiality argument, Relators once again rely on references to "material" in the ACA and its implementing regulations to argue that they have satisfied the FCA's rigorous materiality requirement. Relators do not address the Court's prior concerns about relying on references to the word in the ACA—specifically, they do not explain how the concept of materiality as used in the ACA and its implementing regulations equates to materiality under the FCA. And they fail to recognize that their arguments would mean that materiality is satisfied in virtually any FCA action against any health plan participating in the ACA program, which cannot possibly be the case.

Group Pleading and Conspiracy. The Court asked for more specificity from Relators in describing the conduct of each Defendant and whether Defendants agreed to engage in a scheme to defraud the ACA program. But the SAC still groups Defendants together indiscriminately and

relies on boilerplate conspiracy allegations.

For the reasons discussed here and in the Motion, the Court should grant the Motion and dismiss Relators' fraud claims with prejudice.

II. ARGUMENT

A. Relators Fail to Allege Falsity

Relators do not plead falsity in support of their FCA fraud claims. First, all of their fraud allegations fail because they have not sufficiently alleged that Defendants submitted or caused to be submitted any false claims for payment to HHS. Second, Relators' fraud claims independently fail because they do not allege that Defendants inappropriately coded diagnoses for any medical condition, let alone engaged in a widespread scheme to defraud the ACA. And third, their tax-credit theory fails because it relies on unsupported leaps of logic untethered from specific facts, and the Court did not allow Relators to allege such a theory in their SAC.

1. Relators Fail to Allege Any Claims for Payment

The SAC does not adequately allege that the attestations submitted in connection with the ACA program are claims for payment under the FCA, dooming all of Relators' fraud claims.

A "claim" under the FCA is a "request or demand . . . for money or property." Mot. at 10 (citing 32 U.S.C. § 3279(b)(2)(A)). Relators identify the attestations as the allegedly false "claims" for payment underlying all of their fraud claims: they contend that Defendants "knowingly presented or caused to be presented ***a false or fraudulent Risk Adjustment Attestation*** to the United States in order to receive and retain . . . higher premiums and premium tax credits and a greater share of the ACA insurance pool under the ACA program." SAC ¶¶ 234–35 (emphasis added); *see also id.* ¶¶ 239–40, 245, 249, 251.

But the SAC does not allege any facts that would allow the Court to infer that such attestations requested money or property from the United States. Mot. at 11. The SAC includes a snapshot of an attestation form that says nothing about requesting money or property from the United States. *Id.* (citing SAC ¶ 73). And the regulations that Relators contend require such attestations say nothing about payment or requests for money or property either—a direct contrast to the Medicare Advantage regulations that require Medicare Advantage Organizations

("MAOs") to submit an attestation to CMS that specifically references conditions for payment and requests for money. *Compare* 45 C.F.R. § 153.710(d) (ACA program regulation requiring health plans to confirm that data provided to HHS in a final data report matches the data available to HHS or describe discrepancies), *with* 42 C.F.R. § 422.504(*l*) (Medicare Advantage regulation requiring MAOs to "request payment . . . on a document that certifies . . . the accuracy, completeness, and truthfulness of relevant data that CMS requests").

The Opposition notes that the form states that "the data submitted . . . ***may*** be subject to the False Claims Act," Opp'n at 14 (emphasis added; quoting SAC ¶ 73), but nowhere does the form address whether the attestation document itself is a claim for payment. Under the regulations that Relators cite, the purpose of the attestation is not to demand money, but to confirm that the final data report submitted to HHS matches data HHS previously received. *See* 45 C.F.R. § 153.710(d). A statement that some other data referenced in the document "may" be subject to FCA liability also says nothing about whether the document in question is a "claim" for payment under the FCA. Relators cite no authority construing this language—much less similar language in a similar context—as evidence that the document in question is a claim for payment within the meaning of § 3279(b)(2)(A).

The SAC also does not plead particularized facts about Defendants' submission of any false attestations to HHS under the ACA program. Relators fail to allege which Defendants even submitted the attestations, what entities or regions each attestation covered, when the attestations were submitted, or which employees prepared the attestations. Mot. at 11. Without such basic facts, the Court cannot infer that Defendants knowingly submitted materially false attestations to HHS. *See id.* Relators' response is to point to one paragraph in the SAC that describes the "dedicated distributed environment" that health plans use to provide data to HHS, Opp'n at 11; SAC ¶ 68, which does not provide any specific facts about Defendants' conduct. They also cite two paragraphs that explain that "Kaiser" submitted attestations each year, *id.* ¶¶ 204, 207, which lacks detail specific to each Defendant and says nothing about how each Defendant prepared and submitted the attestations.

In addition, the Court should reject any attempt by Relators to argue that URRT

submissions are claims for payment that can support their FCA claims. In their Opposition, Relators suggest that the URRT submissions support their improperly pleaded tax-credit theory. Opp'n at 12, 18. But the SAC does not allege that URRT submissions are claims. Relators base their causes of action on the alleged submission of false attestations to HHS—not false URRTs. SAC ¶¶ 234–35, 239–40, 245, 249, 251. The SAC also lacks any specific factual allegations about the submission of URRTs and does not allege that URRTs constitute requests or demands for money or property. Instead, the SAC just generally alleges that "Kaiser" submitted "actuarial memoranda and written descriptions as part of the URRT process to justify increasing its rates." SAC ¶ 78; *see also id.* ¶¶ 212–13 (generally alleging that "Kaiser" submits yearly URRTs).

Finally, misconstruing this Court's *Mariner* decision, Relators argue that they need not allege that Defendants ever submitted attestations ***or*** URRTs to HHS. Opp'n at 18 (citing *United States v. Mariner Health Care, Inc.*, 552 F. Supp. 3d 938, 949 (N.D. Cal. 2021)). Relators are wrong. In *Mariner*, this Court determined that an FCA plaintiff could rely on statistical allegations where such allegations were pleaded with enough specificity to support the inference that fraudulent conduct occurred. *Mariner Health*, 552 F. Supp. 3d at 949. Notably, the Court observed that the relator there "provided specific details concerning the fraudulent scheme," including the who, what, when, where, and how of the fraud charged. *Id.* By contrast, Relators here have not pleaded any of these details about either the URRT submissions or the attestations. The Court cannot simply infer those submissions occurred without particularized facts supporting that inference.

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

Relators' FCA fraud claims also fail because they do not allege that a single false diagnosis code was submitted to HHS through the ACA program—let alone that there was a widespread scheme across multiple regions to improperly diagnose members. The SAC added conclusory phrases such as "and the ACA program" to preexisting allegations about the Medicare Advantage program. *See* Mot. at 13. But these halfhearted attempts to transfer the dismissed Medicare Advantage allegations to the ACA context do not plausibly allege that the conduct that occurred under the Medicare Advantage program actually occurred under the ACA program.

The Motion also addresses every one of the medical conditions identified in the SAC—vent dependence, malnutrition, arrhythmia, and major depression—and explains why the corresponding allegations for each condition do not support a reasonable inference that Defendants incorrectly diagnosed the condition.[2] Mot. at 12–16. Specifically, Relators' allegations rely on nonbinding coding guidelines as well as assertions that Defendants targeted certain medical conditions to increase revenue, which is not fraudulent conduct on its own, as this Court already has recognized. *Id.*

And the Motion explains why the SAC fails to allege a systemic scheme to fraudulently diagnose any medical condition. *Id.* at 16–18. As the Court previously concluded, "Relators' claim of falsity [is] problematic to the extent they assert that the scope of their case extends to upcoding a number of diagnoses made under the ACA program beyond the . . . codes described in the complaint." Order at 8. The inference of a widespread scheme is even less supported in the SAC than in the FAC: Relators now allege that Defendants report a healthier-than-average member population and for that reason ***have paid over $6 billion*** into the ACA transfer program. Mot. at 16–18. These allegations defeat any inference of a widespread effort to diagnose members so that they appear less healthy than they actually are. *Id.*

None of the Opposition's arguments has any merit. Rather than address Defendants' arguments directly, Relators advance a new theory in their Opposition, arguing that the SAC instead alleges that Defendants' coding of vent dependence and arrhythmia violated the "ICD Guidelines."[3] Opp'n at 15. But they do not cite a single sentence in the SAC that alleges that

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[2] Relators' allegations that predate 2014 and the start of the ACA program cannot support the inference that Defendants submitted false claims to HHS under the ACA program as such actions could not have resulted in the submission of claims to HHS. Mot. at 14. Relators argue that these allegations can support a finding of falsity because they show that "Defendants prepared and plotted to exploit the program for years." Opp'n at 17. But that argument makes no sense: if Relators allege that they uncovered a list of invalid vent-dependence diagnoses from 2013, for example, corresponding diagnosis codes would not have been submitted to HHS under the ACA program and thus are irrelevant to Relators' causes of action.

[3] Relators do not even attempt to respond to Defendants' arguments about major depression and malnutrition, other than to make general assertions that their allegations about those medical conditions were "detailed" and "specific examples of upcoding," Opp'n at 8–9, and that it was fraudulent for Defendants to attempt to maximize revenue, *id.* at 16.

Defendants violated the ICD Guidelines.[4] The Opposition cannot supply factual allegations that the SAC omitted. *Tietsworth v. Sears*, 720 F. Supp. 2d 1123, 1145 (N.D. Cal. 2010) ("It is axiomatic that the complaint may not be amended by briefs in opposition to a motion to dismiss."). Regardless, it is not enough for Relators to state that the use of a time-based vent-dependence standard and diagnosing arrhythmia in patients who have received a pacemaker violate the ICD Guidelines as a general matter.[5] To give Defendants notice of the allegations against them, Relators must identify which provision of the ICD Guidelines prohibits these practices.[6] They fail to do so in both the SAC and their Opposition. Relators instead base their vent-dependence allegations on nonpublic statements by private entities, and they cite no authority whatsoever for their allegations that Defendants' arrhythmia coding was improper. Mot. at 13–16; *see also* SAC ¶¶ 119, 125–26.

Relators attempt to avoid their pleading obligations by arguing that the American Hospital Association ("AHA") is "the official clearinghouse for ICD coding guidance," but this argument suffers from several flaws. *See* Opp'n at 15. First, it implies that HHS, and in turn Congress, has delegated the ability to issue binding guidance to a private entity—contrary to the principle that

[4] While Relators cite a specific portion of the "Official Coding and Reporting Guidelines" in paragraph 93 of their SAC, that provision is about diagnostic tests and related to allegations about aortic atherosclerosis ("AA"), which Relators concede are no longer relevant to this case because there "is no corresponding HHS-HCC for AA in the ACA program." SAC ¶ 93.

[5] To the extent that Relators argue that members with pacemakers simply do not have arrhythmia as a matter of fact, *see* Opp'n at 16, they have alleged zero facts to allow the Court to conclude that to be the case, *see* SAC ¶¶ 150–51. They do not cite any diagnostic standards or any healthcare provider statements. *Id.* To the contrary, as explained in the Motion, they describe healthcare provider statements that indicate that it is appropriate to diagnose arrhythmia in members who have pacemakers. Mot. at 15–16.

[6] The ICD Guidelines span over one hundred pages and include detailed information about appropriate diagnostic standards for a variety of medical conditions. Defendants cannot be forced to guess which provision they purportedly violated. So even if the SAC had included the allegation that Defendants violated the ICD Guidelines, such an allegation would not be specific enough to satisfy Rule 9(b). *See Bly-Magee v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001) (holding that the allegations must be "specific enough to give [a defendant] notice of the particular misconduct which is alleged to constitute the fraud charged so that [the defendant] can defend against the charge and not just deny that [it has] done anything wrong" (quotations omitted)).

1 "Congress cannot delegate regulatory authority to a private entity." *Dep't of Transp. v. Ass'n of*
2 *Am. R.R.s*, 575 U.S. 43, 61 (2015) (Alito, J., concurring) (quotations omitted). Second, it
3 assumes without explanation that because AHA is the "clearinghouse" for the ICD Guidelines—a
4 role that Relators do not define—any nonpublic statements from AHA would somehow bind any
5 entity that follows the ICD Guidelines. And third, to the extent that Relators imply that AHA is
6 interpreting a provision of the ICD Guidelines, they do not identify that provision.

7 Relators' defense of their malnutrition and major-depression allegations also fails because
8 Relators rely on factual assertions that are not alleged. Relators base their malnutrition and
9 major-depression allegations entirely on the contention that Defendants pursued revenue for those
10 medical conditions. *See* SAC ¶¶ 142–49, 152. Without more, these allegations do not support a
11 fraud claim. Ninth Circuit precedent and this Court's prior statements confirm that attempts to
12 maximize revenue do not equate to fraud. *See* Dkt. No. 225 at 10 ("Looking for ways to increase
13 revenue is not in and of itself illegal."); *Integra Med Analytics LLC v. Providence Health &*
14 *Servs.*, 854 F. App'x 840, 844 n.4 (9th Cir. 2021) ("CMS has acknowledged that there is nothing
15 inappropriate, unethical or otherwise wrong with [providers] taking full advantage of coding
16 opportunities to maximize Medicare payment that is supported by documentation in the medical
17 record." (quotations omitted)). Relators accuse the medical group and hospital Defendants of
18 coding these medical conditions "when those diagnoses were not supported by the patient's status
19 and condition." Opp'n at 16 (emphasis omitted). But then ***Relators cite no factual allegations*** to
20 support this argument, *see id.*—and they cannot, because there are none in the complaint.[7]

21 Finally, Relators have added nothing to their SAC that suggests a widespread scheme that
22 would apply beyond the four enumerated medical conditions. Relators argue that the examples
23 they cite in the SAC sufficiently allege a scheme and cite caselaw for the proposition that specific
24 examples are not necessary where other allegations support the inference of a scheme. *See* Opp'n
25

26 [7] As explained in the Motion, the solitary allegation about a purported "short list" of unsupported malnutrition diagnoses, *see* SAC ¶ 145, falls far short of the requirements of Rule 9(b). Mot. at
27 15. That paragraph does not even allege that any Defendant submitted a diagnosis code for one of these medical conditions to HHS. *See* SAC ¶ 145. Relators do not address Defendants'
28 arguments about this paragraph.

at 17–18. But that argument ignores that the FAC included scattered examples of what Relators alleged were the submission of false claims, and the Court previously found those allegations insufficient. Order at 8. The SAC adds nothing new to change that conclusion.

3. Relators' Tax-Credit Theory Fails

Relators' newly added tax-credit theory of liability independently fails for multiple reasons. First, it relies on a causal chain of several unsupported inferential leaps, including inferences about how and why both Defendants and other health plans participating in the ACA program set their premiums and how those premiums impact tax credits. Mot. at 18–20. While Relators contend that Defendants' fraud had an "impact" on the tax credits, Opp'n at 1, they do not explain with particularity how the alleged upcoding of the four medical conditions described in the SAC would cause the United States to pay private individuals more tax credits based on the fact that other health plans charge more than Defendant health plans charge.

Second, inconsistencies in Relators' tax-credit allegations prevent any inference of fraud. Mot. at 18–20. Relators have alleged that Defendants paid over $6 billion in risk-adjustment transfers into the HHS risk pool so that Defendants could charge ***less*** for premiums. SAC ¶¶ 208–16. Relators allege no facts that would allow the Court to infer that such a scheme would financially benefit Defendants. *Id.* The Opposition now argues that Defendants' "artificially low premiums . . . have a competitive edge, allowing them to enroll more patients, and receive more revenues and tax credits." Opp'n at 13. But again, the SAC alleges no facts that would support the inference that any of this conduct actually occurred, and it fails to account for Relators' own allegation that Defendants paid billions of dollars into the risk pool. The SAC does not explain how such high payments into the pool would simultaneously allow Defendants to artificially lower their premiums or that any such structure would financially benefit Defendants.

Third, the tax-credit theory also fails because it was not alleged in the FAC and the Court did not grant Relators leave to amend to include that theory.[8] Mot. at 9. Courts in this Circuit are

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[8] Relators' new Medicare Advantage allegations fail for the same reason. Mot. at 9. Relators argue that the allegations are included to preserve them for appeal. Opp'n at 13. But the Ninth Circuit is clear that repleading dismissed allegations is not required to preserve them for appeal.

clear that leave to cure the deficiencies in one theory of liability does not imply leave to add other theories. *Barnes v. Sea Hawai'i Rafting, LLC*, 493 F. Supp. 3d 972, 978–79 (D. Haw. 2020), *aff'd*, 2022 WL 501582 (9th Cir. Feb. 18, 2022) ("[A]mended pleadings may not exceed the scope of leave granted by the district court. When leave is granted to amend certain claims against specific parties, the Court may dismiss and strike any portions of the amended pleading not expressly permitted."); *DeLeon v. Wells Fargo Bank, N.A.*, 2010 WL 4285006, at *3 (N.D. Cal. Oct. 22, 2010) ("[W]here leave to amend is given to cure deficiencies in certain specified claims, courts have agreed that new claims alleged for the first time in the amended pleading should be dismissed or stricken.").

Relators incorrectly assert that the FAC included the tax-credit theory. *See* Opp'n at 13–14. It did not. All the FAC said was: "Pursuant to the ACA, the United States contributes, through tax credits, to premiums paid by low-income individuals to private health insurance companies, including Kaiser, based upon a sliding scale calibrated to the poverty line." FAC ¶ 50. This single sentence, which merely refers to a snippet of the ACA's mechanisms, does not convey the entire complex theory of liability based on tax credits that now appears in the SAC. Relators alleged a theory of fraud based on risk-adjustment transfers under the ACA program in the FAC. The Court granted leave to amend that theory, and that theory only.

B. Relators Fail to Allege Materiality

Relators allege no facts that would allow the Court to conclude that the attestations on which Relators base their claims are material to HHS. Mot. at 20–24. They do not allege, for example, that HHS would not pay Defendants if Defendants failed to submit the attestations or if the attestations were somehow incomplete.[9] As noted, *supra* at 3–5, Relators do not even

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Lacey v. Maricopa Cnty., 693 F.3d 896, 928 (9th Cir. 2012) (en banc). Additionally, Relators do more than preserve the previously dismissed allegations for appeal—they add new allegations about Medicare Advantage that were not pleaded at all in the FAC and thus are not eligible to be preserved. *See* SAC ¶¶ 142–52.

[9] While Relators include boilerplate allegations that HHS "would have refused to fund premium tax credits for Kaiser plans, would have refused to make risk adjustment payments to Kaiser, and/or would have demanded additional risk adjustment payments from Kaiser" based on the submission of "falsified . . . risk adjustment data," SAC ¶ 227, they fail to tie materiality to either

properly allege that the attestations are claims for payment, so it is not at all clear how the attestations could factor into any HHS payment decision. Even in the Medicare Advantage context, where parties have not disputed that attestations are requests for payment, courts in this Circuit have dismissed FCA claims for failure to allege that the attestations themselves were material to the payment decision. *United States ex rel. Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487, at *9 (C.D. Cal. Feb. 12, 2018) ("[T]he key allegation that the Attestations have a direct impact on CMS' risk adjustment payments is missing. It is not enough to allege that Defendants were obligated by various regulations and contracts to comply with the Attestation requirements."). Nor do Relators allege any facts that would allow the Court to conclude that the conduct alleged in the SAC is material to HHS. They do not allege, for example, that had HHS known that Defendants relied on a time-based standard to diagnose vent dependence, it would have refused to pay Defendants.

Relators argue that three facts make materiality a foregone conclusion: (1) the use of the word "material" in statutes and regulations relevant to the ACA program (an argument this Court already rejected, *see* Order at 8–9); (2) the alleged size of Defendants' risk-adjustment transfers; and (3) HHS's ability to investigate health plans participating in the ACA program. Opp'n at 18–20. But if these allegations were sufficient to show FCA materiality, then noncompliance with every minor requirement in a statute or regulation would be material. Indeed, all three facts would be true in ***any*** FCA case filed against Defendants related to the ACA program. The Supreme Court rejected this type of argument in *Escobar*. *See Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 194 (2016). The Supreme Court was clear that a "misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the

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the particular conduct alleged in the complaint or the attestations on which they base their causes of actions. *See United States v. Scan Health Plan*, 2017 WL 4564722, at *6 (C.D. Cal. Oct. 5, 2017) (United States failed to plead materiality where it did not plead "that [CMS] would not have paid ***these claims*** had it known of ***these violations***" (emphases added)).

option to decline to pay if it knew of the defendant's noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial." *Id.* That holding compels the conclusion that Relators' proffered arguments for materiality fall flat. *See also* Mot. at 20–24 (explaining why each of Relators' materiality allegations fails).

C. Relators Fail to Allege Conspiracy

Relators have not properly alleged a conspiracy claim against the fifteen named Defendants. This Court previously explained what Relators needed to do to remedy their defective FCA conspiracy allegations: "Relators should clarify in their amended pleading whether they are claiming one overarching conspiracy involving all Kaiser entities or rather multiple bilateral conspiracies (*i.e.*, between a health plan and its affiliated medical group)." Order at 10. The Court directed Relators to "include allegations ***as to each specific defendant***." *Id.* (emphasis added). And the Court stated that it was "somewhat skeptical as to whether an overarching conspiracy can be plausibly pled – *e.g.*, even if other regions followed what TPMG was doing with coding of AA and vent dependence, that does not mean that those regions entered into an agreement with TPMG to defraud the government." *Id.* The Opposition cites a string of paragraphs in the SAC, but all are virtually identical to the allegations in the FAC and none adds any new factual allegations that would allow the Court to conclude that any ***agreement*** existed between the Defendants. Opp'n at 20–21; Mot., Ex. A ¶¶ 122–23, 136, 139, 141, 165, 170, 185–86 (redline comparing complaints).

Not only did Relators fail to add any specific facts—let alone facts about each of the fifteen Defendants—that would allow the Court to infer a conspiracy, *see* Mot. at 24, but the Opposition makes clear that Relators are alleging the exact conspiracy about which the Court expressed skepticism about: "that the Kaiser PMGs, Kaiser Hospitals, and Kaiser Health Plans worked together to defraud the United States." Opp'n at 20. As the Court aptly observed, given that "each region was financially independent," it is not plausible to infer a conspiracy without more concrete factual allegations. Order at 10. The SAC adds nothing beyond boilerplate statements about conspiracy; they cannot save Relators' conspiracy claim. Mot. at 24.

1 **D. Relators Engage in Impermissible Group Pleading**

2 Relators again engage in impermissible group pleading. The Court's prior dismissal order
3 recognized that allegations against Defendants other than TPMG were "conclusory in nature" and
4 noted that "just because presentations were made or practices promoted by one region to other
5 regions does not thereby mean that the latter regions adopted the recommendations." Order at 9.
6 As the Motion explains, Relators added no new allegations to the SAC to cure this defect. Mot.
7 at 25.

8 The Opposition completely fails to explain how the SAC avoids the same group pleading
9 issues that plagued the FAC. Relators rely almost entirely on allegations that were previously
10 alleged in the FAC with the small change to add general references to "Kaiser" in some. Opp'n at
11 22; *see, e.g.*, Mot., Ex. A ¶¶ 52 (new allegation with generalized references to "Kaiser Health
12 Plans"); 141 (addition of "in all of its regions" to "Kaiser" and "across all Kaiser regions"); 204
13 (new allegation with general references to "Kaiser"); 217 (new allegation with general references
14 to "Kaiser" and "Kaiser Health Plans"); 39, 155, 157 (no relevant changes). The few new
15 paragraphs that Relators cite in support of their position, *see* Opp'n at 22, either just explain the
16 concepts of risk adjustment and tax credits under the ACA or refer generally to "Kaiser," which
17 does nothing to differentiate Defendants in a way that would change this Court's previous
18 conclusion. *See* SAC ¶¶ 149, 205–17.

19 Nor does the SAC's new allegation about the health plan Defendants avoid group-
20 pleading defects. Relators allege that "[u]nless stated otherwise, references to the actions or
21 conduct of a Kaiser health plan taking place in a particular Kaiser region refers to the actions or
22 conduct of the specific Kaiser Health Plan that operates in that region." SAC ¶ 40. The
23 allegation misses the mark for three reasons. First, it does not address the impermissible and
24 pervasive use of "Kaiser," which lumps together all Defendants—including the health plans,
25 medical groups, and Kaiser Foundation Hospitals—across several regions. As Relators
26 recognize, each one of these entities serves a different role and function, so it is not reasonable to
27 ascribe conduct to all Kaiser entities without specific allegations. *See id.* ¶¶ 25–40; *see also id.*
28 ¶ 121 ("Kaiser's directives on vent dependence documentation and coding differ region by

region.").

Second, in many instances, it is not possible to understand which region the Relators target with the use of the collective "Kaiser"—let alone whether they are referring to conduct by a health plan or medical group. For example: "Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that the Vent Dependence status code is or was being captured frequently by Kaiser." *Id.* ¶ 137. Such vague allegations do not allege with particularity the "who" and therefore fail to meet the requirements of Rule 9(b).

Third, to the extent that a specific region can be inferred from the surrounding allegations, the references to Kaiser almost always relate to the Northern California region. *See, e.g.*, *id.* ¶¶ 122, 124, 130. For example, they allege that "given the high number of [vent-dependence] codes at Kaiser, it thus appeared that ***TPMG*** was focusing on capturing this status code inappropriately." *Id.* ¶ 124 (emphasis added). What remains is a small smattering of insufficient group allegations that cover other regions.[10] And ultimately, Relators continue to rely on group pleading with allegations that "all Kaiser regions" engaged in specific conduct without any specific allegations that would plausibly support that inference. *See, e.g.*, SAC ¶¶ 136 ("Kaiser's improper practice for coding the ventilation status code was migrated systemically throughout the Kaiser regions."), 141 ("Kaiser's proprietary, diagnoses electronic 'pick list' was being utilized by Kaiser in all of its regions to easily and falsely capture this inaccurate status code in all clinical settings across all Kaiser regions.").

E. Relators Effectively Concede That the Court Should Not Again Grant Leave to Amend

The SAC is Relators' third complaint, and Relators should not get yet another opportunity

[10] The SAC contains a couple of allegations about Southern California's vent-dependence standard and technical changes to its electronic document system related to major depression. SAC ¶¶ 121, 135, 152. The SAC also references the Colorado region's efforts to diagnose arrhythmia. *Id.* ¶¶ 150–51. And it references coding malnutrition in the Northwest region and contends that Relator Bryant disagreed with healthcare providers in the Northwest region about the proper diagnostic criteria for arrhythmia. *Id.* ¶¶ 144, 146, 151. There are no specific allegations related to the Georgia, Hawaii, Southeast, or Mid-Atlantic regions. Yet Relators ask the Court to infer that there was a widespread scheme to upcode all medical conditions in every one of these regions based on a handful of scattered allegations or nothing at all.

to correct repeated deficiencies in their allegations. Mot. at 25. The Court has already explained what they needed to allege to fix their pleading deficiencies, and they have failed to do so—making clear that they have no additional facts to allege. Relators do not address Defendants' argument that the Court should not permit yet another chance to amend, nor do they attempt to argue that leave to amend would be appropriate if the Court grants the Motion. By failing to address Defendants' argument, they effectively concede that leave to amend would not be appropriate. *See Bolbol v. City of Daly City*, 754 F. Supp. 2d 1095, 1115 (N.D. Cal. 2010) ("[P]laintiff fails to address this issue in her opposition brief and apparently concedes that she may not proceed on this claim."); *Perkins v. Albertsons, LLC*, 2023 WL 2154034, at *4 n.4 (C.D. Cal. Jan. 26, 2023) ("Plaintiff apparently concedes as much by failing to oppose that portion of Defendant's motion"); *see also Zucco Partners, LLC v. Digimarc Corp*., 552 F.3d 981, 1007 (9th Cir. 2009).

III. CONCLUSION

For the reasons explained here and in the Motion, the Court should dismiss Relators' FCA fraud claims with prejudice, leaving only Relator Hernandez's employment claims.

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Respectfully submitted,

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