

June 5, 2023

VIA ECF

The Honorable Joseph C. Spero
Chief Magistrate Judge
United States District Court
Northern District of California
450 Golden Gate Avenue
San Francisco, California 94102

Re: *United States ex rel. Osinek v. Kaiser Permanente, et al.*, No. 3:13-cv-03891-EMC

Dear Judge Spero:

Defendants seek the Court's assistance to resolve a dispute concerning Defendants' First Set of Requests for Admission ("RFAs") propounded on Plaintiff on March 10, 2023. The parties have met and conferred consistent with the Court's Civil Standing Order Part E.9, including over videoconference on April 19, 2023 and with lead trial counsel on May 8, 2023.

Defendants' Position. Defendants originally served 34 narrow RFAs targeted at establishing Plaintiff's contentions regarding specific facts. For 30 of those RFAs, each of the five Defendants asked Plaintiff the same six RFAs—to admit or deny that it contends that one or more of Defendants' medical providers knowingly added diagnoses to patients' medical records that 1) did not exist, 2) did not coexist at the time of the encounter or visit, or 3) did not require or affect patient care, treatment or management. Ex. 1. These three factual questions tie directly to the scheme that Plaintiff alleges Defendants collectively pursued to submit false diagnosis codes to the Medicare Advantage program in violation of the False Claims Act ("FCA").¹ The remaining four RFAs asked Plaintiff to confirm prior representations that Plaintiff's counsel made to defense counsel about the legal standards forming the basis of Plaintiff's theory of FCA liability in this case. During a meet-and-confer spanning over five weeks, Defendants agreed to withdraw 19 of the 34 RFAs as part of a negotiated offer of compromise. This included the 15 RFAs that, based on Plaintiff's representations, would have resulted in Plaintiff *admitting* it does not contend the three specific factual issues described above as well as the four RFAs seeking confirmation of previous representations from counsel. Ex. 2, at 2. Yet Plaintiff steadfastly refused to respond to any of the RFAs and never once offered any compromise. Thus, Defendants seek an order compelling Plaintiff to respond to 15 of the original 34 RFAs that, based on Plaintiff's representations, would result in Plaintiff *denying* that it contends medical care providers knowingly added diagnoses to patients' medical records in the three circumstances outlined above.² This discovery will help confirm the disputed factual issues.

Similar to interrogatories, RFAs may be used "to determine the opposing party's contentions." *Jacobs v. Quinones*, 2014 WL 2091252, at *3 (E.D. Cal. May 16, 2014). Federal

¹ See Pl.'s Opp. to Mot. to Dismiss Pl.'s Am. Compl. at 1, 6, Dkt. No. 253; Pl.'s Opp. to Mot. to Dismiss Pl.'s Compl. at 1, 8, Dkt. No. 197; and Am. Compl. ¶¶ 175-76, 364-73.

² The 15 RFAs are RFA Nos. 1, 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, 23, 25, 27, and 29.

Rule of Civil Procedure 36 also “explicitly permits RFAs that require the application of law to fact.” *Watterson v. Garfield Beach CVS LLC*, 2015 WL 2156857, at *3 (N.D. Cal. May 7, 2015). Despite these well-settled principles, Plaintiff claims to have “address[ed] the substance” of Defendants’ RFAs through informal meet-and-confer correspondence. Ex. 3, at 2. But such a response does not generate admissible evidence and imposes no obligation on Plaintiff to supplement or amend its responses if its position changes as required by Rule 26(e).³

Plaintiff’s Objections Are Meritless. Plaintiff alleges a scheme by Defendants to defraud the Medicare Advantage program that depends, in part, on the conduct of individual medical providers—that they documented diagnoses that Defendants allegedly improperly coded and submitted to CMS in violation of the FCA.⁴ Each of Defendants’ RFAs seeks to confirm Plaintiff’s contentions regarding the “knowledge of” those individual medical providers in adding diagnoses to patient medical records that Plaintiff alleges resulted in diagnosis code submissions to CMS that did not comply with certain ICD Guidelines. These are facts the Court has characterized as necessary to establishing the plausibility of Plaintiff’s claims for relief. See Ex. 4, at 25:1-5, 24:19-23, and 31:1-3. Plaintiff nevertheless objects to all the RFAs because they improperly seek its contentions; are overly broad and premature; and improperly concern “state of mind or knowledge.” See Ex. 5. These objections are baseless.

First, Plaintiff has not cited, nor have Defendants found, Ninth Circuit authority endorsing an objection to RFAs because they seek to establish a party’s contentions regarding specific facts. Just the opposite. Courts in the Ninth Circuit instead interpret Rule 36 as “expressly contemplat[ing]” that RFAs “will be used to take contention discovery.” *Zeleny v. Newsom*, 2020 WL 3057467, at *2 (N.D. Cal. June 9, 2020); see also *Quinones*, 2014 WL 2091252, at *3 (finding that RFAs that “seek only to have the responding Defendants admit or deny the fact stated therein” are allowed by Rule 36). For example, in *Ballew v. City of Pasadena*, the plaintiff served RFAs asking the City whether individual employees violated municipal policy during their encounter with plaintiff. 2019 WL 9341338, at *1 (C.D. Cal. June 10, 2019). The City objected to the RFAs as calling “for an improper legal conclusion”; however, the court held that the RFAs were proper because “they seek only the entity defendants’ contentions as to whether their employees ... violated” municipal policies and were thus “clearly related to the facts of the case.” *Id.* at *6. Just so here: each of Defendants’ RFAs seeks to confirm Plaintiff’s contentions regarding whether any of Defendants’ medical care providers knowingly added medical conditions to patient medical records that violated certain ICD Guidelines—all facts relevant to Plaintiff’s core allegations in this case. The RFAs do not ask Plaintiff to admit or deny that medical providers violated the FCA or Medicare regulations; they instead seek to confirm Plaintiff’s contentions about specific facts relevant to Plaintiff’s claims for relief. See *Friedman v. Godiva Chocolatier, Inc.*, 2010 WL 4009660, at *1 (S.D. Cal. Oct. 13, 2010); see also *Watterson*, 2015 WL 2156857, at *4. Plaintiff relatedly argues that Defendants’ RFAs are improper because they seek disclosure of trial strategy or legal theories.

³ While Defendants disagree with Plaintiff that these responses will not produce admissible evidence, the argument is beside the point. Rule 26 permits discovery of information that is not itself admissible if it is calculated to lead to the discovery of admissible evidence. Fed. R. Civ. P. 26(b). In any event, Plaintiff’s argument reduces to the same argument it makes elsewhere, that contention discovery is improper—an argument that is clearly wrong.

⁴ See *supra* n.1.

But the RFAs do not ask whether Plaintiff intends to use or present any evidence at trial, nor do they seek privileged work product regarding Plaintiff's trial strategy.

Second, Defendants' RFAs are not overly broad. Each RFA asks Plaintiff to confirm a narrow contention concerning the state of mind of Defendants' medical providers in documenting diagnoses that underlie allegedly false claims for payment to CMS—facts that Plaintiff has acknowledged are, at a minimum, relevant to Plaintiff's case. *See* Ex. 6, at 2. For example, Plaintiff has stated that “in the case of a scheme like Kaiser's,” it was reasonable for CMS auditors to “assume that diagnoses appearing in Addenda were added by physicians *of their own volition* and accurately reflected conditions that actually required or affected patient care, treatment, or management at the associated visits.” Ex. 7, at 3 (emphasis added); *see also* Ex. 8, at 2 n.7. And the Court recently observed that the scheme alleged by Plaintiff “requires ... the doctors to cooperate.” Ex. 4, at 25:1-5. Accordingly, each RFA seeks to confirm a singular fact—that is, whether Plaintiff contends that medical care providers employed by a specific Defendant knowingly added diagnoses to patients' medical records in one of three circumstances. Relatedly, Plaintiff attempts to reframe Defendants' RFAs as premature contention interrogatories, which they are not. Defendants served these RFAs over a year into discovery, and, in any event, the RFAs only seek information based on Plaintiff's *current* knowledge. *See, e.g., Knature Co. v. Duc Heung Grp.*, 2021 U.S. Dist. LEXIS 120623, at *4 (C.D. Cal. Jan. 21, 2021). Should Plaintiff's contentions change, Plaintiff is free—and indeed obligated under Rule 26(e)—to amend its responses.

Lastly, Plaintiff argues that Defendants' RFAs are improper because they ask about the state of mind or knowledge of medical care providers employed by Defendants. But the RFAs are limited to Plaintiff's factual contentions in this case—facts within Plaintiff's knowledge—and are thus an appropriate subject for discovery. *See, e.g., Asis Internet Servs. v. Rausch*, 2010 WL 1838752, at *5 (N.D. Cal. May 3, 2010) (finding that defendant's failure to respond to plaintiff's RFAs regarding whether he knew affiliates were violating a federal law constituted an admission). Moreover, contrary to Plaintiff's assertion, *see* Ex. 3, at 3, that the information sought by Defendants' RFAs is within Defendants' own control, the RFAs relate entirely to Plaintiff's *own* contentions regarding its claims of Defendants' liability—information that is solely within Plaintiff's knowledge and possession.

Plaintiff's Position. Defendants' RFAs do not seek admissions of any facts but instead seek “admissions” regarding the United States' contentions about the states of mind of an unknown number of Defendants' individual physicians who added diagnoses to medical records that Defendants used to submit false claims to Medicare. Despite the facial impropriety of such requests under Rule 36, in an attempt to compromise and to avoid burdening the Court, *the United States responded in writing to all of Defendants' RFAs*. Ex. 3. While disclaiming any intent “to force the United States to commit to any factual contention for the remainder of this litigation[.]” Ex. 6 at 1, Defendants claim that the United States' response is insufficient. But there is no requirement to provide further responses to RFAs that do not comply with the Federal Rules to begin with, and the United States' practical approach to this issue is appropriate.⁵

⁵ Defendants have agreed to withdraw RFA Nos. 31-34 based on the United States' responses in written correspondence, reflecting the workability of this approach.

RFAs “are required to be simple and direct, and should be limited to singular relevant facts.” *Bovarie v. Schwarzenegger*, 2011 WL 719206, at *6 (S.D. Cal. Feb. 22, 2011); *Pom Wonderful LLC v. Welch Foods*, 2010 WL 11523591, at *3 (C.D. Cal. Mar. 16, 2010) (facts in RFAs “must be singularly, specifically, and carefully detailed”). Proper RFAs under Rule 36 “presuppose that the party ... knows the facts or has the document and merely wishes its opponent to concede their genuineness,” whereas an RFA for “information [that] may require complex judgments and nuanced appraisals, is generally improper.” *Gibson Brands Inc. v. John Hornby Skewes & Co.*, 2015 WL 12681376, at *6 (C.D. Cal. July 20, 2015); *Jefferson v. Perez*, 2012 WL 671917, at *2 (E.D. Cal. Feb. 29, 2012) (RFAs “that seek to establish legal conclusions or render undisputed the disputed material facts of a case are per se impermissible”); *see* Ex. 5.

Defendants’ RFAs do not seek admission of singular relevant facts. Indeed, they do not seek facts at all. Instead, they seek contentions: specifically, contentions about Defendants’ doctors’ states of mind, and legal conclusions about whether the doctors’ states of mind satisfy the FCA’s statutory definition of “knowing.” But RFAs asking a party to admit that it is contending the existence of particular facts are improper, as such RFAs do not “establish any such facts themselves” and “are not asking [the party] to admit to facts, but to disclose its trial strategy or legal theories. This is not the purpose of Rule 36.” *Paramount Fin. Commc’ns v. Broadridge Inv. Comm’n Sols.*, 2017 WL 495784, at *4 (E.D. Pa. Feb. 7, 2017). Likewise, RFAs calling for legal conclusions, such as whether Defendants’ doctors’ states of mind meet the FCA definition of “knowing,” are improper. *See, e.g., Music Grp. Macao Comm. Offshore Ltd. v. Foote*, 2015 WL 579688, at *2 (N.D. Cal. Feb. 11, 2015) (denying motion to compel where “[a]lthough Defendant has nominally tied his RFA to the facts of the case, the request remains an abstract legal conclusion: whether certain conduct is illegal”). The cases Defendants cited during the parties’ discussions do not hold otherwise. For example, Defendants cited *Crouch v. Teledyne Cont’l Motors*, 2011 WL 13135770 (S.D. Ala. Apr. 21, 2011), which held that RFAs seeking admissions “that [plaintiffs] contend that acts or omissions on the part of [certain third parties] caused or contributed to the Accident” were improper in part because the requests “require lengthy explanations before they could be fairly answered.” *Id.* at *4. Defendants also cited *Jones v. Nutiva, Inc.*, 2016 WL 5900722 (N.D. Cal. Oct. 11, 2016), which held that RFAs about the defendant’s state of mind were improper because they incorporated an interpretation of the legal standards at the heart of the case. *Id.* at *2. Likewise, Defendants’ other cases, *supra*, which the United States previously addressed, Ex. 5 at 3-4, do not establish the RFAs are proper.

Moreover, this dispute should be academic at this point because ***the United States has responded in writing and conveyed its contentions***. Defendants complain that the United States’ response is insufficient because it “does not generate admissible evidence.” But Defendants’ RFAs would not generate admissible evidence in any event—because they ask for *contentions*, and contentions are not evidence. As the Court held, the United States does not need to establish that individual doctors’ states of mind satisfy the “knowing” element of the FCA to prove its claims against Defendants. Ex. 9 at 14-16 (sufficient for scienter against entity if responsible people were warned and failed to act); *see* Ex. 3 at 2-3; Ex. 4 at 27:3-18, 43:1-16. Consequently, as the United States has already told Defendants, it does not intend as of today to prove its case by contending that Defendants’ individual doctors’ states of mind satisfy the “knowing” element of the FCA. But this is a question of trial strategy—it is not evidence of anything. That Defendants are trying to use their RFAs to somehow transform contentions into “admissible evidence” only confirms their misuse of the Rule 36 RFA procedure. *See Paramount*, 2017 WL

495784, at *4; *SEC v. Nutmeg Grp.*, 285 F.R.D. 403, 405-06 (N.D. Ill. 2012) (RFAs for plaintiff's current state of knowledge about facts of case are improper, because plaintiff's current state of knowledge "is not admissible evidence," "is not relevant to or probative of anything," and "would not be a 'fact' admissible at trial"); *Google Inc. v. Am. Blind & Wallpaper Factory*, 2006 WL 2578277, at *3 n.2 (N.D. Cal. Sept. 6, 2006) ("The purpose of Rule 36(a) is to expedite trial by establishing certain material facts as true and thus narrowing the range of issues for trial.... A request for admission directed to an opponent's litigation strategy is improper.").⁶

Defendants claim, *supra*, that the United States' allegations "depend[], in part, on the conduct of individual medical providers." But Defendants' RFAs do not seek admissions about their doctors' conduct and do not specifically identify any conduct. *Cf. Dukes v. Wal-Mart Stores*, 2013 WL 1149754, at *2 (N.D. Cal. Mar. 19, 2013) (denying motion to compel because RFA about defendant's conduct "should have specifically identified" details of conduct at issue). In any event, Defendants have not yet answered the Complaint, Defendants' productions and responses to the United States' requests are not complete, and no depositions have been taken. Discovery at this stage should focus on generating actual evidence "and not on examining the parties' contentions about the legal implications" of that evidence. *In re Convergent Techs. Sec. Litig.*, 108 F.R.D. 328, 338 (N.D. Cal. 1985); *see also, e.g., Campbell v. Facebook Inc.*, 2015 WL 3533221, at *1, *3 (N.D. Cal. June 3, 2015) (holding that contention interrogatories four months before summary judgment deadline were premature).

Defendants previously claimed to need the United States' contentions "to pursue targeted discovery and prepare their defenses." Ex. 2 at 2. When asked what "targeted discovery" Defendants believed they could not pursue without the United States' contentions, Defendants did not provide any explanation, Ex. 10 at 1-2, and apparently have abandoned that argument, not raising it here. Defendants now claim that they need the United States' RFA responses to "help confirm the disputed factual issues." But Defendants' RFAs do not seek admissions regarding actual *facts*, but instead seek contentions well before discovery is complete. In short, Defendants have it backwards. Parties gather facts in discovery and craft contentions based upon the facts; not the other way around. *Convergent*, 108 F.R.D. at 338; *Kennis v. Metro. W. Asset Mgmt.*, 2017 WL 10439122, at *3 (C.D. Cal. Feb. 6, 2017) ("Plaintiff is not required to prove its case in the midst of discovery").

Finally, Defendants complain that the United States' response is insufficient because it imposes no obligation to amend its responses if its position changes. Courts have held, however, that it is "unnecessarily burdensome to constantly revise and update such responses," particularly where (as here) "the defendant appears to have control over or adequate access to much of the evidence relevant to its alleged misconduct." *See, e.g., Campbell*, 2015 WL 3533221, at *4, *6. In any event, there is no obligation to amend responses to RFAs that are improper to begin with, and the obligations imposed by Rule 26 address Defendants' concerns. *See* Ex. 11 at 2.

⁶ Defendants' reliance on Rule 26(b), *supra* n.3, is misplaced. RFAs must comply not only with Rule 26 but also Rule 36, which these RFAs fail to do. *See, e.g., Safeco v. Rawstron*, 181 F.R.D. 441, 445-46 (C.D. Cal. 1998) (RFAs and other discovery procedures "are not interchangeable").

Sincerely,

UNITED STATES OF AMERICA

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10 *Medical Group; and Colorado Permanente*
Medical Group, P.C.
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12
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16 **UNITED STATES DISTRICT COURT**
17 **NORTHERN DISTRICT OF CALIFORNIA**

18 UNITED STATES OF AMERICA, *ex rel.*,
19 RONDA OSINEK

20 Plaintiffs,

21 v.

22 KAISER PERMANENTE,

23 Defendant.
24
25
26
27
28

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

**DEFENDANTS' FIRST SET OF
REQUESTS FOR ADMISSION TO
PLAINTIFF, UNITED STATES OF
AMERICA**

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel.
ANASER AREFI, AJITH KUMAR and
PRIME HEALTHCARE SERVICES, INC.,

Plaintiff,

v.

KAISER FOUNDATION HEALTH PLAN,
INC., et al.,

Defendants.

Case No. 3:16-cv-01558-EMC

**DEFENDANTS' FIRST SET OF
REQUESTS FOR ADMISSION TO
PLAINTIFF, UNITED STATES OF
AMERICA**

UNITED STATES OF AMERICA ex rel.
MARCIA STEIN and RODOLFO BONE,

Plaintiff,

v.

KAISER FOUNDATION HEALTH PLAN,
INC., et al.,

Defendants.

Case No. 3:16-cv-05337-EMC

**DEFENDANTS' FIRST SET OF
REQUESTS FOR ADMISSION TO
PLAINTIFF, UNITED STATES OF
AMERICA**

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

Plaintiff,

v.

KAISER PERMANENTE, INC., et al,

Defendants.

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

**DEFENDANTS' FIRST SET OF
REQUESTS FOR ADMISSION TO
PLAINTIFF, UNITED STATES OF
AMERICA**

UNITED STATES OF AMERICA and STATE
OF CALIFORNIA ex rel. MICHAEL
BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et

Case No. 3:21-cv-03124-EMC

**DEFENDANTS' FIRST SET OF
REQUESTS FOR ADMISSION TO
PLAINTIFF, UNITED STATES OF
AMERICA**

al.,
Defendants.

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

Plaintiff,

v.

KAISER PERMANENTE, INC., et al.,

Defendants.

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

**DEFENDANTS' FIRST SET OF
REQUESTS FOR ADMISSION TO
PLAINTIFF, UNITED STATES OF
AMERICA**

PROPOUNDING PARTY:

Defendants Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.

RESPONDING PARTY:

Plaintiff United States

SET NUMBER:

ONE (Numbers 1 - 34)

Pursuant to Rules 26 and 36 of the Federal Rules of Civil Procedure and the Local Rules for the United States District Court for the Northern District of California ("Local Rules"), Defendants Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C. ("Defendants") propound this First Set of Requests for Admission ("Requests") on Plaintiff United States of America ("Plaintiff"). Defendants ask that Plaintiff answer each of the following Requests separately and fully, and serve those answers upon Defendants in accordance with Federal Rule of Civil Procedure 36(a)(3).

The following definitions and instructions apply to these Requests.

DEFINITIONS

Each word, term, or phrase defined below and used in these Requests is intended to have

1 the broadest meaning permitted under the Federal Rules of Civil Procedure and the Local Rules.

2 1. “Added” means “added” as used in Paragraphs 232, 356, 364-73 of the Complaint.

3 2. “Beneficiaries” means “beneficiaries” as that term is used in Part C of Title XVIII
4 of the Social Security Act, 42 U.S.C. § 1395w-21 *et seq.*

5 3. “Bid” means “bid” as that term is used in 42 C.F.R. Part 422 Subpart F.

6 4. “Complaint” means the amended complaint-in-intervention that Plaintiff filed in
7 the above-captioned case (Dkt. 240) on December 12, 2022.

8 5. “Concerns” or “Concerning” means analyzing, containing, dealing with,
9 constituting, defining, describing, discussing, embodying, evidencing, explaining, identifying,
10 referencing, mentioning, reflecting, relating to, referring to, setting forth, showing, stating,
11 summarizing, supporting, or in any way pertaining to the subject matter of the relevant request.

12 6. “CPMG” means Defendant Colorado Permanente Medical Group, P.C.

13 7. “Defendants” means, collectively, Defendant Kaiser Foundation Health Plan, Inc.;
14 Defendant Kaiser Foundation Health Plan of Colorado; Defendant The Permanente Medical
15 Group, Inc.; Defendant Southern California Permanente Medical Group; and Defendant Colorado
16 Permanente Medical Group, P.C.

17 8. “Division” or “Divisions” means any department, unit, component, arm, section,
18 subdivision, branch, section, sector, or office, and Includes any contractors, vendors, volunteers,
19 agents, affiliates, or anyone acting at HHS’s direction.

20 9. “EDI Enrollment Form” means the Centers for Medicare & Medicaid Services
21 Electronic Data Interchange (EDI) Enrollment Form, available at
22 <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/CMS10164B.pdf>.

23 10. “Exhibit A” means Exhibit A to Defendants’ First Set of Requests for Admission.

24 11. “Exist” means “exist” as used in Paragraph 141 of the Complaint.

25 12. “HHS” means the U.S. Department of Health and Human Services, as used in
26 Paragraph 12 of the Complaint, and all of the Divisions within HHS.

27 13. “Improper” means “improper” as used in Section VII on page 5 of Exhibit A.
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14. “KFHP” means Defendant Kaiser Foundation Health Plan, Inc.
15. “KFHP-CO” means Defendant Kaiser Foundation Health Plan of Colorado.
16. “Knowingly” means “knowingly” as used in 31 U.S.C. § 3729(b)(1).
17. “Liability” means “liability” as used in Sections VI and VII on pages 3 and 5 of Exhibit A.
18. “Medical Care Provider” means “Medical Care Provider” as defined in the United States’ February 25, 2022 First Set of Requests for Production to Defendants.
19. “Medical Condition(s)” means “medical conditions” as used in Paragraph 64 of the Complaint.
20. “Medical Record(s)” means “Medical Records” as defined in the United States’ February 25, 2022 First Set of Requests for Production to Defendants.
21. “Medicare Advantage” means a type of health insurance that provides coverage to Beneficiaries under 42 U.S.C. §§ 1395w-21 through 1395w-29.
22. “Overpayment” means “overpayment” as defined in 42 U.S.C. §§ 1320a-7k(d)(4).
23. “Patient” means “Patient” as defined in the United States’ February 25, 2022 First Set of Requests for Production to Defendants.
24. “Person” or “Persons” means any natural person or entity, firm, association, organization, partnership, business, trust, corporation, electronic mailbox, or public entity, and their officers, directors, members, principals, employees, agents, contractors, representatives, parents, acquisitions, successors or predecessors, all persons acting on their behalf, and any and all persons associated with, affiliated with, or controlled by them.
25. “Report And Return” means “report and return” as used in 42 U.S.C. §§ 1320a-7k(d).
26. “SCPMG” means Defendant Southern California Permanente Medical Group.
27. “Submission” means “submission” as used in Paragraph 59 of the Complaint.
28. “TPMG” means Defendant The Permanente Medical Group, Inc.
29. “You” or “Your” means all Divisions within the United States Department of

1 Health and Human Services.

2 **INSTRUCTIONS**

3 In addition to the instructions set forth in Rule 36 of the Federal Rules of Civil
4 Procedure, which are incorporated herein by reference, the following instructions shall apply to
5 each Request for Admission set forth below.

6 1. The words “and” and “or” shall be construed either conjunctively or disjunctively,
7 as required by the context to bring all information within the scope of these Requests.

8 2. The terms “all,” “any,” and “each” shall be construed as encompassing any and all.

9 3. “Between” and “among” shall be construed as “between or among” as the context
10 so requires, so that each Request shall be construed broadly, rather than narrowly, to bring within
11 the scope of each Request all information that might otherwise be construed to be outside its
12 scope.

13 4. Any noun used in the singular form shall be construed and applied so as to Include
14 the plural form also, and vice versa.

15 5. Answer each Request separately and fully in writing, under oath.

16 6. If You object to a Request, definition, or instruction, or any part thereof, clearly
17 state the specific reasons for the objection.

18 7. If You object to any Request, definition, convention, or instruction as ambiguous,
19 do not use such claim as a basis for refusing to respond, but rather set forth as part of the response
20 the language You claim is ambiguous and the interpretation You have used to respond to the
21 individual Request.

22 8. If a Request is not admitted, Your answer must, to the extent possible, specify the
23 reasons for Your inability to answer in full, and state whatever information is available
24 Concerning the unanswered portion. If You do not have personal knowledge sufficient to
25 respond fully to a Request, You shall so state, but shall make a reasonable and good faith effort to
26 obtain the information by inquiry to other Persons.

10. This set of Requests shall be deemed continuing in nature, in accordance with Federal Rule of Civil Procedure 26(e). If, after responding to the Requests, You obtain or become aware of any further information responsive to this set of Requests, You are required to supplement Your responses.

REQUEST NO. 1:

REQUEST NO. 2:

REQUEST NO. 3:

REQUEST NO. 4:

REQUEST NO. 5:

REQUEST NO. 6:

Admit that You do not contend that KFHP Medical Care Provider(s) Knowingly Added

1 Medical Condition(s) that did not Exist to Patients' Medical Records.

2 **REQUEST NO. 7:**

3 Admit that You contend that KFHP-CO Medical Care Provider(s) Knowingly Added
4 Medical Condition(s) that did not "coexist at the time of the encounter/visit" to Patients' Medical
5 Records.

6 **REQUEST NO. 8:**

7 Admit that You do not contend that KFHP-CO Medical Care Provider(s) Knowingly
8 Added Medical Condition(s) that did not "coexist at the time of the encounter/visit" to Patients'
9 Medical Records.

10 **REQUEST NO. 9:**

11 Admit that You contend that KFHP-CO Medical Care Provider(s) Knowingly Added
12 Medical Condition(s) that did not "require or affect patient care, treatment or management" to
13 Patients' Medical Records.

14 **REQUEST NO. 10:**

15 Admit that You do not contend that KFHP-CO Medical Care Provider(s) Knowingly
16 Added Medical Condition(s) that did not "require or affect patient care, treatment or
17 management" to Patients' Medical Records.

18 **REQUEST NO. 11:**

19 Admit that You contend that KFHP-CO Medical Care Provider(s) Knowingly Added
20 Medical Condition(s) that did not Exist to Patients' Medical Records.

21 **REQUEST NO. 12:**

22 Admit that You do not contend that KFHP-CO Medical Care Provider(s) Knowingly
23 Added Medical Condition(s) that did not Exist to Patients' Medical Records.

24 **REQUEST NO. 13:**

25 Admit that You contend that CPMG Medical Care Provider(s) Knowingly Added Medical
26 Condition(s) that did not "coexist at the time of the encounter/visit" to Patients' Medical Records.

REQUEST NO. 14:

Admit that You do not contend that CPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “coexist at the time of the encounter/visit” to Patients’ Medical Records.

REQUEST NO. 15:

Admit that You contend that CPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “require or affect patient care, treatment or management” to Patients’ Medical Records.

REQUEST NO. 16:

Admit that You do not contend that CPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “require or affect patient care, treatment or management” to Patients’ Medical Records.

REQUEST NO. 17:

Admit that You contend that CPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not Exist to Patients’ Medical Records.

REQUEST NO. 18:

Admit that You do not contend that CPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not Exist to Patients’ Medical Records.

REQUEST NO. 19:

Admit that You contend that SCPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “coexist at the time of the encounter/visit” to Patients’ Medical Records.

REQUEST NO. 20:

Admit that You do not contend that SCPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “coexist at the time of the encounter/visit” to Patients’ Medical Records.

REQUEST NO. 21:

Admit that You contend that SCPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “require or affect patient care, treatment or management” to Patients’ Medical Records.

REQUEST NO. 22:

Admit that You do not contend that SCPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “require or affect patient care, treatment or management” to Patients’ Medical Records.

REQUEST NO. 23:

Admit that You contend that SCPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not Exist to Patients’ Medical Records.

REQUEST NO. 24:

Admit that You do not contend that SCPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not Exist to Patients’ Medical Records.

REQUEST NO. 25:

Admit that You contend that TPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “coexist at the time of the encounter/visit” to Patients’ Medical Records.

REQUEST NO. 26:

Admit that You do not contend that TPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “coexist at the time of the encounter/visit” to Patients’ Medical Records.

REQUEST NO. 27:

Admit that You contend that TPMG Medical Care Provider(s) Knowingly Added Medical Condition(s) that did not “require or affect patient care, treatment or management” to Patients’ Medical Records.

REQUEST NO. 28:

Admit that You do not contend that TPMG Medical Care Provider(s) Knowingly Added

1 Medical Condition(s) that did not “require or affect patient care, treatment or management” to
2 Patients’ Medical Records.

3 **REQUEST NO. 29:**

4 Admit that You contend that TPMG Medical Care Provider(s) Knowingly Added Medical
5 Condition(s) that did not Exist to Patients’ Medical Records.

6 **REQUEST NO. 30:**

7 Admit that You do not contend that TPMG Medical Care Provider(s) Knowingly Added
8 Medical Condition(s) that did not Exist to Patients’ Medical Records.

9 **REQUEST NO. 31:**

10 Admit that You do not contend that Defendants’ Liability in this case arises from any
11 failure to Report And Return Overpayments pursuant to 42 U.S.C. § 1320a-7k(d).

12 **REQUEST NO. 32:**

13 Admit that You do not contend that Defendants’ Liability in this case arises from its
14 violation of any requirements contained in the EDI Enrollment Form.

15 **REQUEST NO. 33:**

16 Admit that You do not contend that Defendants’ Liability in this case arises from its
17 violation of any requirements contained in 42 C.F.R. § 422.503(b)(4)(vi).

18 **REQUEST NO. 34:**

19 Admit that You do not contend that Defendants’ Liability in this case arises from the
20 Submission of Improper Medicare Advantage Bids to the Centers for Medicare and Medicaid
21 Services.

1 Dated: March 10, 2023

O'MELVENY & MYERS LLP

2
3 By: /s/ Stephen M. Sullivan

4 K. LEE BLALACK, II
5 DAVID DEATON
6 STEPHEN M. SULLIVAN
7 CAITLIN M. BAIR
8 DIMITRI D. PORTNOI

9 Attorneys for Defendants Kaiser Foundation
10 Health Plan, Inc.; Kaiser Foundation Health
11 Plan of Colorado; The Permanente Medical
12 Group, Inc.; Southern California Permanente
13 Medical Group; and Colorado Permanente
14 Medical Group, P.C.

EXHIBIT 2



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May 19, 2023

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VIA EMAIL

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**Re: United States ex rel. Osinek v. Kaiser Permanente, Case No. 3:13-cv-03891-EMC—
United States' Responses and Objections to Defendants' First Set of Requests for
Admission**

Dear Mr. Choe:

I write on behalf of Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (together, "Defendants") in response to your May 16, 2023 Letter regarding Defendants' First Set of Requests for Admission ("RFAs").

Your May 16, 2023 Letter claims to "address[] the substance of all of Defendants' RFAs."¹ In particular, you state that because "it is not necessary for the United States' claims, the United States responds that it does not intend as of today to establish scienter for its FCA claims by contending that Defendants' individual medical providers acted 'knowingly,' as defined in the FCA, when adding diagnoses via addenda."² You also state that the United States "maintains its objections to Defendants' RFAs" as improper and will not directly respond to Defendants' RFAs, in part because the United States would be required "to seek leave of the Court if and when its contentions change."³ Defendants do not understand why the need to seek leave of the Court is relevant to the analysis of whether the United States must respond to the RFAs. But in any event, leave of the Court is not required to later amend responses that are not admissions; leave of the Court is only required when amending or withdrawing an *admission*.⁴ And if your contentions change following further discovery, the United States has a duty under

¹ May 16, 2023 Letter from the United States Department of Justice ("DOJ") to KFHP, at 5.

² *Id.* at 3.

³ *Id.* at 4-5.

⁴ Fed. R. Civ. P. 36(b) ("A matter admitted under this rule is conclusively established unless the court, on motion, permits the admission to be withdrawn or amended.").

Federal Rule of Civil Procedure 26(e) “to supplement or correct its disclosure or response...if the party learns that in some material respect the disclosure or response is incomplete or incorrect”—regardless of whether that party obtains leave of the Court.⁵

Defendants’ RFA Nos. 1 through 30 frame the relevant inquiry in two ways—first, as asking the United States to admit that it contends that medical care providers knowingly added medical conditions that did not comply with the relevant ICD Guidelines or otherwise exist to patients’ medical records and second, as asking the United States to admit that it does not contend the same fact. Your May 16, 2023 Letter suggests that the United States does not now contend that medical care providers knowingly added medical conditions that did not comply with specific provisions of the ICD Guidelines or otherwise exist to patients’ medical records and would thus respond to Defendants’ RFAs by either denying that the United States contends or admitting that it does not contend these facts. To resolve the United States’ concern that it would be required to seek leave of the Court to amend or withdraw any admissions, and in a good-faith effort to make one last gesture of compromise, Defendants are willing to withdraw the RFAs that, based on the United States’ explanation of its contentions in its May 16, 2023 Letter, would elicit an admission. In other words, in consideration for Defendants withdrawing RFA Nos. 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, and 30 through 34, the United States would agree to fully answer the remaining RFAs. Please let us know by next Wednesday, May 24, 2023 if the United States agrees to this compromise proposal.

Your May 16, 2023 Letter also suggests that, based on certain statements made by Defendants during the parties’ May 8, 2023 meet-and-confer, “Defendants are more than able to prepare what they view as their defenses.”⁶ To clarify, Defendants explained that regardless of Defendants’ own contentions regarding whether medical care providers knowingly added medical conditions that did not comply with the relevant provisions of the ICD Guidelines or otherwise exist to patients’ medical records, Defendants need to know the United States’ contentions concerning this specific factual question to pursue targeted discovery and prepare their defenses. An explanation of your client’s position in meet-and-confer correspondence as opposed to a formal response to Defendants’ RFAs is insufficient because it does not generate admissible evidence and imposes no obligation on the United States to supplement or amend its responses if its position changes later in the litigation as required by the Federal Rules of Civil Procedure.⁷

* * *

⁵ Fed. R. Civ. P. 26(e).

⁶ May 16, 2023 Letter from DOJ to KFHP, at 3.

⁷ See *supra* n. 5. Similarly, during the parties’ May 8, 2023 meet-and-confer, Defendants made clear that it was not making any definitive representations as to its contentions regarding the actions of medical care providers at this time and noted that Defendants’ contentions in this regard could change following further discovery.

Sincerely,

/s/ Stephen M. Sullivan

Stephen M. Sullivan
Partner
of O'MELVENY & MYERS LLP

cc: (via email only)
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David Moskowitz, Esq.
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EXHIBIT 3



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May 16, 2023

BY EMAIL

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Re: *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC –
Defendants' First Set of Requests for Admission

Dear Mr. Sullivan:

I write on behalf of the United States following our letter of April 28, 2023, our meet and confer on May 8, 2023, and your letter of May 9, 2023, regarding Defendants' First Set of Requests for Admission ("RFAs"). While we maintain that Defendants' RFAs are improper and do not comport with the requirements of Federal Rule of Civil Procedure 36, in the interest of compromise and to avoid burdening the Court, we are willing to address the substance of your RFAs Nos. 1–30 in the same fashion we have addressed RFAs Nos. 31–34, which you have offered to withdraw along with the associated interrogatories, by setting out our position in correspondence.

* * *

During our May 8 meet and confer, your partner Lee Blalack clarified the scope of the disputed RFAs, stating that RFAs Nos. 1–30 seek the United States' contentions as of "today, period, full stop," as to whether Defendants' medical providers acted "knowingly" under the False Claims Act ("FCA"), 31 U.S.C. § 3729(b)(1), in adding medical conditions to patient records.¹ Mr. Blalack further stated that (1) you are not seeking our trial strategy, (2) you recognized that what we might contend today is different from what we might contend in the

¹ Specifically, whether Defendants' medical providers "knowingly" added medical conditions to patient records that did not exist, did not coexist at the time of the patient encounter/visit, and/or did not require or affect patient care, treatment, or management.

future, and (3) you are not seeking to bind the United States to anything going forward, including with respect to what the United States might present at trial. In your May 9 letter, you reconfirm that “the RFAs are not intended to force the United States to commit to any factual contention for the remainder of this litigation[.]” Kaiser May 9, 2023 Ltr. at 1–2. In response to and in reliance on these statements and representations, we address the substance of your RFAs as follows.

The United States contends that the Defendant Kaiser organizations knowingly presented, or caused to be presented, false claims to the Centers for Medicare and Medicaid Services (“CMS”) and knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims, by reporting diagnosis codes for conditions that did not coexist at the time of the patient encounter/visit and/or did not require or affect patient care, treatment, or management, in order to obtain additional payments based on inflated patient risk scores. The Amended Complaint alleges that Defendants pressed Kaiser physicians to add diagnoses to medical records retrospectively using addenda to make it appear as if the conditions had been addressed in some way during the patient visit when in fact they had not. Once diagnoses were added via addenda to the medical record, Defendants took the next step of submitting diagnosis codes from the International Classification of Diseases Official Guidelines for Coding and Reporting (the “ICD Guidelines”) for the conditions to CMS, knowing that the submissions violated applicable regulations and contracts with CMS. Defendants knew that their various risk-adjustment initiatives to generate the diagnoses that physicians were pressed to add, including data mining, refresh, and chart reviews, resulted in the submission of false diagnosis codes to CMS. Based on this conduct, the United States alleges Defendants acted, at a minimum, with deliberate ignorance or reckless disregard and thus “knowingly” under the FCA. 31 U.S.C. § 3729(b)(1); *see, e.g., United States v. United Healthcare Ins. Co. (Swoben)*, 848 F.3d 1161, 1175–76 (9th Cir. 2016) (“[W]here the organization turns a blind eye to the over-reporting errors, it exhibits reckless disregard and deliberate ignorance toward the truth or falsity of the data submitted to CMS.”).

The United States’ claims against Defendants do not require the United States to establish that individual medical providers acted knowingly under the FCA when adding diagnoses to a medical record via addenda. The United States has not named individual medical providers as defendants and does not need to establish the elements of an FCA claim (including knowledge) with respect to non-parties. The United States need only establish that the named Defendants—the Kaiser organizations—acted knowingly. *See, e.g., United States v. Mariner Health Care, Inc.*, 552 F. Supp. 3d 938, 952 (N.D. Cal. 2021) (Chen, J.) (that management pressured staff to improperly bill claims is sufficient in FCA case against organization); *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1084 & n.499 (N.D. Cal. 2020) (“that the defendant organization had scienter” is sufficient in FCA case against organization, regardless of whether individuals who submitted claims “had no scienter themselves”). If, for example, management (which includes non-physicians and physician executives) within the Defendant organizations knew that their risk-adjustment initiatives prompted their medical providers with incorrect diagnoses and knew that “[s]ome clinicians refresh the diagnoses without proper and detailed review of the medical record, and as a result incorrect diagnoses keep being reported,” *see, e.g., Amend. Compl.* ¶ 323, this would establish FCA knowledge as to Defendants, independent of whether a failure by an individual medical provider to review the medical record before adding the diagnosis via addenda would also establish FCA knowledge as to that non-

party individual. *See, e.g., Swoben*, 848 F.3d at 1175–76; *Ormsby*, 444 F. Supp. 3d at 1081 (that organization knew, was deliberately ignorant of, or was reckless about its physicians’ time pressures or inattention regarding improper Medicare Part C codes is sufficient in FCA case against organization).

As it is not necessary for the United States’ claims, the United States responds that it does not intend as of today to establish scienter for its FCA claims by contending that Defendants’ individual medical providers acted “knowingly,” as defined in the FCA, when adding diagnoses via addenda.²

* * *

In offering this response, similar to the approach the United States has taken with respect to the remaining RFAs and related interrogatories that Defendants have offered to withdraw, the United States provides the information Defendants say they need and avoids burdening the Court with either this dispute or potential motions practice in the future. First, Defendants are more than able to prepare what they view as their defenses. During our May 8 meet and confer, Mr. Blalack stated that Defendants’ position is that none of their doctors knowingly added diagnoses that did not exist, did not coexist at the time of the patient encounter/visit, or did not require or affect patient care, treatment, or management. Mr. Blalack further stated that if, hypothetically, we were to issue a request for documents from doctors who acted knowingly, Defendants would respond that there are no responsive documents because there are no such doctors. His response reflects that Defendants can develop—and have developed—a position on whether their doctors acted knowingly, without needing to inquire about the United States’ contentions. Defendants have access to their own doctors, their own medical records, their own communications with their doctors—as well as their own internal documents and audit reports that show that improper diagnoses were being added to medical records and submitted to CMS—and are fully capable of developing their positions with respect to their own doctors and whether their doctors acted knowingly. *Cf., e.g., Campbell v. Facebook Inc.*, No. 13-cv-05996-PJH (MEJ), 2015 WL 3533221, at *4 (N.D. Cal. June 3, 2015) (courts should be “especially vigilant” in evaluating a defendant’s claim that it needs the plaintiff’s contentions where “the defendant appears to have control over or adequate access to much of the evidence relevant to its alleged misconduct”) (cited by Kaiser Apr. 18, 2023 Ltr. at 3); *Ransom v. Herrera*, No. 1:11-cv-01709-LJO-EPG (PC), 2018 WL 4091738, at *6 (E.D. Cal. Aug. 23, 2018) (denying defendants’ motion to compel responses to interrogatories and RFAs where “Defendants already have all of the underlying facts and documents, but wish Plaintiff to take a legal position regarding which pieces of evidence correspond to which claim”). In any event, as discussed above, the United States has addressed Defendants’ question regarding its contentions, obviating any claim of prejudice.

In addition, in the context of contention interrogatories, to which Defendants have likened their RFAs,³ the default rule in this District is that contention interrogatories ordinarily

² The United States is also not contending that Defendants’ individual medical providers did not act knowingly. It simply is not making a contention one way or the other at this time.

³ Because Defendants have repeatedly equated their RFAs to interrogatories, *see* Kaiser May 9, 2023 Ltr. at 3, Kaiser Apr. 18, 2023 Ltr. at 4, we address the standard for contention

need not be answered before discovery is substantially complete. *See, e.g., Campbell*, 2015 WL 3533221, at *4 (collecting cases).⁴ Courts have held that this deferral of contention responses until discovery is substantially complete does not prejudice defendants. For example, the *Campbell* case that you cite in your April 18 letter held that a defendant's contention interrogatories were premature four months before the summary-judgment-motion deadline and rejected the defendant's claims that the plaintiffs' responses to its contention requests were necessary for it to prepare its case. *Id.* at *1, *3–6.

The United States does not waive and maintains its objections to Defendants' RFAs, which remain improper under the Federal Rules of Civil Procedure. Among other things, Rule 36(b) requires a party to obtain leave of the court to amend responses to RFAs. Given Defendants' stated intent not to bind the United States and Defendants' recognition that the United States' contentions may change, it is wholly impracticable and unduly burdensome on both the United States and the Court to require the United States to respond to Defendants' improper contention RFAs and then to have to seek leave of the Court if and when its contentions change.⁵

interrogatories. In so doing, we do not agree that Defendants' attempt to equate RFAs with interrogatories is proper. To the contrary, "[r]equests for admissions and interrogatories are not interchangeable procedures," *Safeco of Am. v. Rawstron*, 181 F.R.D. 441, 445–46 (C.D. Cal. 1998), and an RFA that "is in effect an interrogatory" is "not an appropriate use of a request for admission," *Ochotorena v. Adams*, No. 1:05-cv-01524-LJO-DLB PC, 2009 WL 1953502, at *5 (E.D. Cal. July 7, 2009); *accord, e.g., Spectrum Dynamics Med. Ltd. v. Gen. Elec. Co.*, No. 18-CV-11386 (VSB) (KHP), 2021 WL 735241, at *2 (S.D.N.Y. Feb. 25, 2021) (RFAs that are "tantamount to contention interrogatories" "run afoul of the purpose of Rule 36").

⁴ Discovery here is not substantially complete. Among other things, Defendants have stated that they are still months away from completing their responses to the United States' first set of Interrogatories and Requests for Production. Moreover, Defendants have yet to answer the Amended Complaint.

⁵ The fact that the process for amending RFAs is unworkable when applied to contentions (as opposed to facts) further confirms that RFAs are not proper vehicles for seeking a party's contentions. *See, e.g., Paramount Fin. Comm'n v. Broadridge Inv. Comm'n Sols., Inc.*, No. 15-405, 2017 WL 495784, at *4 (E.D. Pa. Feb. 7, 2017) (it "is not the purpose of Rule 36" to "ask [a party] to admit that its contentions in this case include contentions as to the existence of particular facts"); *Gibson Brands Inc. v. John Hornby Skewes & Co. Ltd.*, No. CV 14-0609 DDP (SS), 2015 WL 12681376, at *6 (C.D. Cal. July 20, 2015) (RFA for "information [that] may require complex judgments and nuanced appraisals, is generally improper"); *Bovarie v. Schwarzenegger*, No. 08cv1661 LAB (NLS), 2011 WL 719206, at *6 (S.D. Cal. Feb. 22, 2011) (RFAs "should be limited to singular relevant facts"); *Crouch v. Teledyne Continental Motors, Inc.*, No. 10-00072-KD-N, 2011 WL 13135770, at *4 (S.D. Ala. Apr. 21, 2011) (denying motion to compel responses to RFAs for party's contentions in part because such RFAs "require lengthy explanations before they could be fairly answered") (cited by Kaiser Apr. 18, 2023 Ltr. at 2). Additionally, even in the context of contention interrogatories, courts do not require plaintiffs to provide defendants with their contentions before discovery is substantially complete or to provide defendants with running updates should their contentions change. *See, e.g., Campbell*, 2015 WL 3533221, at *6 (denying defendant's

* * *

Defendants' RFAs are improper and objectionable and, as such, the United States is not required to respond to them. That said, in the interest of trying to reach a compromise, we have now addressed the substance of all of Defendants' RFAs. The United States does not intend as of today to establish scienter for its FCA claims by contending that Defendants' individual medical providers acted "knowingly," as "knowingly" is defined in the FCA, when adding diagnoses via addenda. The United States further does not seek to impose liability in this case based on failures to report or return overpayments under 42 U.S.C. § 1320a-7k(d), violations of requirements contained in the EDI Enrollment form, violations of the requirements of 42 C.F.R. § 422.503(b)(4)(vi), or submissions of improper Medicare Advantage bids to CMS. We trust that this letter resolves the disputes regarding Defendants' RFAs.

Very truly yours,

ISMAIL J. RAMSEY
United States Attorney

By: s/Shiwon Choe
SHIWON CHOE
Assistant United States Attorney

request to compel plaintiffs to answer contention interrogatories and then update their responses should their answers change, because it is "unduly burdensome to constantly revise and update such responses"); *Quinio v. Aala*, No. 19-CV-4686-PKC-SJB, 2021 WL 9561320, at *1 (E.D.N.Y. Apr. 9, 2021) ("The defendant's suggestion that plaintiffs answer [contention interrogatories] based upon their current knowledge and supplement the responses as discovery proceeds is impracticable and points out the burdensome nature of its requests.").

EXHIBIT 4

1 UNITED STATES DISTRICT COURT
2 IN THE NORTHERN DISTRICT OF CALIFORNIA
3 SAN FRANCISCO DIVISION
4

5 UNITED STATES OF AMERICA)
6 ex rel. RONDA OSINEK,) Case No. 3:13-cv-03891-EMC
7 Plaintiffs,)
8 vs.) San Francisco, California
9 KAISER PERMANENTE, et al.,) May 4, 2023
10 Defendants.) 3:11 p.m.
11

12 BEFORE: THE HONORABLE EDWARD M. CHEN, JUDGE
13

14 REPORTER'S TRANSCRIPT OF PROCEEDINGS

15 MOTIONS TO DISMISS
16
17
18
19
20

21 Official Court Reporter:
22 Scott M. Coniam, RDR, CRR
23 Sandra Day O'Connor U.S. Courthouse, Suite 312
24 401 West Washington Street, Spc 43
25 Phoenix, Arizona 85003-2151
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24 Proceedings Reported by Stenographic Court Reporter
25 Transcript Prepared by Computer-Aided Transcription

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PROCEEDINGS

(Proceedings commenced at 3:11 p.m.)

THE CLERK: Case is Osinek, et al., v. Kaiser
Permanente, Case Number 13-3891.

Counsel, please state your appearance for the record,
beginning with the plaintiff.

MR. CHOE: Good afternoon, Your Honor. Shiwon Choe on
behalf of the United States.

THE COURT: All right. Thank you, Mr. Choe.

MR. MOSKOWTIZ: Good afternoon, Your Honor. David
Moskowitz on behalf of the United States.

THE COURT: All right. Thank you, Mr. Moskowitz.

MR. LEWIS: Good afternoon, Your Honor. Roger Lewis
on behalf of Bryant and Hernandez relators.

THE COURT: All right.

MR. VOLDMAN: Hi, Your Honor. Max Voldman on behalf
of relator Taylor.

THE COURT: All right. Thank you.

MS. ZEMAN: Good afternoon, Your Honor. Amy Zeman on
behalf of relator Osinek.

THE COURT: All right. Thank you.

MR. BLALACK: Afternoon, Your Honor. Lee Blalack,
lead counsel for defendants, along with my partner, Dimitri
Portnoi, who will be doing the argument for us today.

THE COURT: All right. Great. Thank you.

1 All right. I'm not going to be able to cover 03:12:11
2 everything today but I have a few questions. 03:12:18

3 Let me ask -- given that the -- that we're still at 03:12:20
4 the motion to dismiss stage here and that all presumptions and 03:12:28
5 facts are reasonably construed, all inferences reasonably can 03:12:31
6 be drawn -- are to be drawn in favor of the plaintiff, why 03:12:36
7 isn't there enough here -- we sort of talked about this before, 03:12:41
8 but I -- I don't know if there's any new arguments about why 03:12:43
9 the United States has not sufficiently alleged a systemic 03:12:46
10 scheme to defraud, putting aside the question about conspiracy 03:12:52
11 and scope of conspiracy for a moment which I do want to talk 03:12:55
12 about, but especially, you know, given the specific allegations 03:12:58
13 here about the systemic nature of the risk adjustment program, 03:13:03
14 the refresh program, which as I understand it is a systematic 03:13:07
15 way of using algorithms to mine the records and then querying 03:13:13
16 physicians and pressuring physicians to add the diagnosis via 03:13:19
17 addenda, as I recall, through requiring justification if they 03:13:24
18 refuse to -- they fail to add an addendum. I don't know if 03:13:33
19 there's some forms of financial pressure, et cetera, et cetera, 03:13:39
20 but the idea that this was -- this was a systematic program -- 03:13:42
21 and whether it's true or not I guess we'll find out at some 03:13:48
22 point if we get to that point, but why isn't that enough to at 03:13:51
23 least allege a systemic scheme to defraud here? 03:13:54

24 MR. PORTNOI: Well -- Your Honor, thank you for that 03:14:01
25 question. Dimitri Portnoi on behalf of Kaiser. 03:14:02

1 Your Honor, the allegations in the complaint don't
2 reach what Your Honor asked the plaintiff, the United States,
3 to do here which is that we don't have -- while we have a few
4 more specific instances of potentially contradictory,
5 potentially false diagnoses, those aren't connected in a way
6 that makes them emblematic of a broader scheme. Emblematic
7 being the standard that Your Honor used in the order.

8 What we have here is a few more allegations regarding
9 the -- regarding some new diagnoses. We have a few allegations
10 that are very similar to the original ones regarding audit.

11 I hope I can clarify with respect to refresh which is
12 that refresh, even as alleged in the complaint at paragraph
13 178, is not a program that is in any way specifically related
14 to addenda. And, in fact, as we review some of the case
15 diagnoses that are present in the complaint, we see that
16 refresh occurs sometimes at the -- sometimes at the -- at the
17 patient visit itself. So it's actually not something that is
18 part of the addendum scheme that is alleged here. I'm
19 specifically referring to -- well, yes, some of the specific
20 diagnoses that come later, but what I wanted --

21 THE COURT: Well, even if it's not exclusive doesn't
22 mean it's not related to part of the larger --

23 MR. PORTNOI: It may be but it doesn't demonstrate a
24 scheme or something with scienter. Refresh was obviously
25 not -- refresh was obviously not created in order to -- in

1 order to promote addendum and there's no allegation of that. 03:15:51

2 THE COURT: What about the allegation in paragraph 162 03:15:54
3 that if the physicians fail to rediagnose these conditions on a 03:15:56
4 patient visit, then a query is sent to them and then, quote, 03:16:02
5 systematically pressured the physician to add the diagnosis via 03:16:06
6 addenda. I mean, that may be true, may be false, but why isn't 03:16:11
7 that a pretty systemic kind of allegation there? 03:16:14

8 MR. PORTNOI: Well, Your Honor, as with almost all of 03:16:17
9 the refresh allegations, 162 is in the last complaint. And 03:16:20
10 Your Honor held that it did not demonstrate something that was 03:16:24
11 emblematic. 03:16:27

12 I would also emphasize that allegations like 162 -- 03:16:28
13 allegations that there was pressure, allegations that there 03:16:32
14 were leading queries or inappropriate queries, this is all 03:16:36
15 directly in the Ninth Circuit's decision in Integra where we 03:16:40
16 saw similar allegations to those and that was found to not give 03:16:44
17 rise because -- and for a very important reason, because what 03:16:48
18 is missing in all of those is that, as the Ninth Circuit held, 03:16:52
19 in order to credit such a broad scheme, you need to find that 03:16:57
20 it is plausible that thousands of doctors participated in the 03:17:01
21 conspiracy or participated in the scheme, whether through 03:17:07
22 knowledge or reckless disregard but, nonetheless, you have to 03:17:10
23 find the doctors vitiated and did not comply with their duty to 03:17:13
24 exercise independent judgment when they looked at the records 03:17:18
25 and that's something that is broadly missing throughout the 03:17:21

1 complaint. It's as if the plaintiffs had written something 03:17:24
2 that said -- or as if the United States had alleged something 03:17:27
3 that said, well, there's all this stuff that happens and then 03:17:31
4 something occurs in a black box and then a diagnosis is 03:17:35
5 submitted. That -- 03:17:38

6 THE COURT: Well, but then there's -- there's 03:17:39
7 systematic evidence in terms of some statistical presentations, 03:17:41
8 the results of some of the audits that were done, so it's not 03:17:45
9 just a narrative of, well, doctors were pressured and we don't 03:17:48
10 know what came out on the output end of things. 03:17:52

11 MR. PORTNOI: Well -- 03:17:54

12 THE COURT: There's some indication of that, isn't 03:17:55
13 there? 03:17:56

14 MR. PORTNOI: We certainly know some of what came out 03:17:56
15 on the outcome, which is that we have allegations that doctors 03:17:58
16 objected to the queries and did not comply with them and did 03:18:00
17 not -- did not do so and that's at 274 that -- for instance, 03:18:03
18 where we see something like that. 03:18:07

19 We do have audits. But, Your Honor, most of these 03:18:09
20 audits were present in the prior complaint. And Your Honor, 03:18:12
21 focusing on the cachexia allegations, noted that for those 03:18:16
22 audits, there were audits that specifically showed an increased 03:18:20
23 rate of unsupported or false cachexia diagnoses in one region. 03:18:25
24 And that provided a link between the examples of the three 03:18:31
25 diagnoses that were there that made them emblematic of the 03:18:35

1 scheme that was being alleged, that along with other things 03:18:38
2 such as being cachexia being uniquely vulnerable to 03:18:41
3 exploitation, as well as the routine nature of those particular 03:18:44
4 queries, the specific audit, that created what Your Honor 03:18:48
5 referred to and what the complaint refers to as the cachexia 03:18:51
6 initiative in Northern California. 03:18:54

7 Broad audits that honestly do know more than state 03:18:56
8 that there were times when there were problems -- when we look 03:19:00
9 at the 2015 and 2016 Northern California audit, for instance, 03:19:05
10 we don't know -- there we're talking about a single region in a 03:19:09
11 single year, the same region that Your Honor has already found 03:19:14
12 that was sufficient for the cachexia initiative, and there's no 03:19:17
13 information about how many errors were found. Was it two? Was 03:19:20
14 it five? Was it 20? 03:19:23

15 When we look at the other new audits that exist in 03:19:25
16 this complaint, when we look at the 2012 root cause analysis, 03:19:28
17 that fails to even identify what region that is in. It could 03:19:33
18 be in Hawaii. It could be in Puerto Rico. We don't know how 03:19:35
19 many diagnoses codes were reviewed. We don't know if any of 03:19:39
20 those -- if those diagnosis codes have any relevance to this 03:19:42
21 complaint. 03:19:46

22 And then with respect to the NCO audits, that shows 03:19:47
23 that the medical -- that speaks only to a certain narrow 03:19:50
24 category, but it also says nothing about what was reviewed and 03:19:54
25 when. And, again, we're in a Rule 90(b) world and we have 03:19:58

1 audits that simply don't say anything about who, what, where,
2 when. This is all information that is in the government's
3 possession. The United States is not like a typical litigant.
4 The typical plaintiff does not have eight years with subpoena
5 power. They have the -- if they have these documents, if they
6 have these audits, then they can allege what is in them. The
7 fact that they don't gives rise to the possibility that they
8 don't really support anything.

9 THE COURT: All right. Well, let me put the burden on
10 the U.S. to tell me what's different this time to allow for
11 more expansive complaint to go forward beyond what I --

12 MR. MOSKOWITZ: Thank you, Your Honor.

13 As we understood it last time, our complaint -- and I
14 think, you know, fairly so, we had given three examples and we
15 had not tied those examples in toward what was going on with
16 the refresh and the data mining and the other risk adjustment
17 program.

18 So what we've done here is twofold. We now have seven
19 examples, none of which Kaiser contests. Right. They don't
20 actually contest any of those. So we're in a world where --
21 that's completely different than any other case they've ever
22 cited -- where there are seven representative examples of false
23 claims that they don't contest. And so we're starting from
24 there where we have representative examples. And then we've
25 added a significant number of allegations that explain why

1 those examples are representative and how they fit into the 03:21:30
2 overall systematic issue why there's a pattern here. Because 03:21:33
3 as we understood, it was that Your Honor was concerned that 03:21:37
4 these were just essentially three isolated incidents; they 03:21:39
5 don't have any connection to each other. 03:21:43

6 And so what we've alleged here is a pattern of 03:21:45
7 behavior and that pattern of behavior starts with a medical 03:21:47
8 record where the provider does not diagnose a particular 03:21:53
9 diagnosis at issue. The provider had their -- exercised their 03:21:57
10 medical judgment and they chose not to diagnose this issue or 03:22:00
11 this particular diagnosis, condition. 03:22:05

12 And what happens then is that Kaiser engages in a 03:22:07
13 pressure campaign afterwards, through the refresh and the data 03:22:12
14 mining program, where they send queries to the providers trying 03:22:16
15 to get the provider to add those diagnoses. 03:22:20

16 We presented all sorts of allegations showing that 03:22:24
17 Kaiser knew that there were all sorts of flaws with the queries 03:22:27
18 that they were sending and with the information that were 03:22:30
19 coming up in the data mining and refresh program. They knew 03:22:33
20 that those programs had flaws that were repeatedly generating 03:22:36
21 queries for conditions that were contradicted by the medical 03:22:41
22 records of the visit. And the overall issue is that these 03:22:44
23 programs, they go look through history. They look at things 03:22:48
24 that happened way in the past and they might come up with 03:22:53
25 something that they're looking about the patient's medical 03:22:55

1 record at some point in time. But there's a data lag problem 03:22:58
2 that Kaiser itself has identified as a huge problem, as a flaw, 03:23:02
3 a red flag that they identified because the programs don't then 03:23:05
4 look at what happened at the visit. They generally ignore what 03:23:11
5 occurred at the visit. And so that leaves this issue of 03:23:15
6 diagnoses that Kaiser is querying doctors to add these 03:23:19
7 diagnoses, without actually looking at the visit. And Kaiser 03:23:25
8 knew that they were generating queries that were not -- you 03:23:30
9 know, that were inaccurate, but then they further knew that 03:23:33
10 many physicians receiving these queries were just adding on the 03:23:38
11 requested query and they knew it was resulting in repeated 03:23:41
12 submission of inaccurate diagnoses. 03:23:45

13 THE COURT: And that allegation that they knew -- 03:23:47
14 first of all, the allegation of systemic nature and the 03:23:49
15 breadth, that's in the 161 et seq section of the complaint? 03:23:54

16 MR. MOSKOWTIZ: Yes. So that's -- I mean, generally 03:24:00
17 speaking, it's in the 161, but it's also 141 to 142. 03:24:02

18 You know, the -- there's a whole bunch of different 03:24:07
19 areas where we've kind of -- you know, there's a lot of 03:24:13
20 different things going on and so it's hard to point to one 03:24:16
21 single area, but that is generally where it is, is this is a 03:24:18
22 systematic program and -- 03:24:22

23 THE COURT: And where would I find the best paragraph 03:24:26
24 or two that alleges this was systematic, this was not 03:24:29
25 particular to, you know, some region or some -- you know, some 03:24:35

1 local program, but this was a more system wide program? 03:24:42

2 Is there a set of paragraphs that -- I see -- you 03:24:46
3 know, I understand what the effect was, et cetera, et cetera, 03:24:53
4 but what tells me the scope and the regularity of this -- 03:24:56

5 MR. MOSKOWTIZ: I don't think in here there's a 03:25:02
6 particular paragraph that I would say point to for the scope 03:25:03
7 that -- other than these programs were not region specific and 03:25:08
8 so the issue here is the data lag issue, right. So if they 03:25:15
9 were running these programs in real time, like at the time of 03:25:18
10 the visit, none of these things would pop up because you would 03:25:22
11 say, in fact, you know, there's -- the records show they didn't 03:25:27
12 have this, so we're not going to ask them to add it. The 03:25:33
13 problem is, as we've explained, like the way the data mining 03:25:37
14 worked -- and they all were running like a giant data mining 03:25:41
15 working group together. They all are doing the same thing and 03:25:44
16 so -- 03:25:47

17 THE COURT: When you say "all," who's the all? 03:25:50

18 MR. MOSKOWTIZ: Sorry. All is all of the defendants. 03:25:52
19 It also includes other regions as well, but all of the 03:25:55
20 defendants. There are representatives from every defendant. 03:25:58
21 They're all in a data mining working group. They're all in 03:26:01
22 a -- they're all participating in the regional reporting group. 03:26:04
23 They're all participating as part of the National Kaiser 03:26:08
24 Permanente Risk Adjustment Initiative. Refresh is not 03:26:14
25 something that is -- for example, that's not a thing in the 03:26:14

1 medical world. That's a thing in the Kaiser world. Right. So
2 Kaiser Permanente came up with a plan on a national scope to
3 run the refresh program. And that's how they identify these
4 particular diagnoses. They look at things in the past and they
5 send things in the future. And so --

6 THE COURT: The participants you're accusing would
7 include the physicians groups; right?

8 MR. MOSKOWTIZ: Yes.

9 THE COURT: What -- explain to me -- I understand
10 Kaiser's incentive, but the pressure being placed on
11 physicians -- they almost seem adverse to a certain extent, I
12 mean, one could argue. And there's some evidence, I guess, of
13 that that some physicians resisted.

14 Why would they -- what's in the interest -- why would
15 the physicians groups like the TPMG go ahead and conspire along
16 with this program?

17 MR. MOSKOWTIZ: Sure. So the more money -- I mean,
18 it's an integrated consortium, so the more money that Kaiser
19 Permanente gets, the more money boils down to TPMG and to the
20 Permanente medical groups. And there's a chart of this in
21 our -- from Kaiser itself that explains this in our complaint,
22 for example, at paragraph 109 that they're reporting on this at
23 the regional reporting group, right. The regional reporting
24 group is everyone from all of these different defendants
25 working together as part of the National Kaiser Permanente Risk

1 Adjustment Initiative and they're talking about this is how it 03:27:51
2 works. We're going to get more money and then that all helps 03:27:53
3 everyone because they view themselves as operating as a single 03:27:56
4 enterprise under one roof and that they say we operate 03:28:00
5 seamlessly as one enterprise and -- 03:28:04

6 THE COURT: Do the physician groups -- maybe you 03:28:08
7 can -- maybe it's in here and I missed it. Do the physician 03:28:11
8 groups like TPMG and the Colorado Medical Group -- is it a 03:28:15
9 negotiated, like, contract by vendor with respect to the 03:28:21
10 provider and the health care organization or is it a 03:28:28
11 partnership where there's money that accrues to KPF -- KFHP, 03:28:32
12 sort of automatically then gets distributed to the medical 03:28:41
13 groups, doctor groups? 03:28:48

14 MR. MOSKOWTIZ: There's a contract. It's an extremely 03:28:48
15 complicated contract. There's the incentives and things like 03:28:52
16 that. But there's a contract and essentially all of the money 03:28:56
17 that operates TPMG or CPMG or any of the other Permanente 03:29:00
18 medical groups comes from Kaiser Permanente, from the health 03:29:06
19 plan. So they're like interconnected in a way that if the 03:29:09
20 health plan -- something goes wrong with the health plan, they 03:29:13
21 don't have any other -- that's their, essentially, sole source 03:29:15
22 of money. 03:29:18

23 THE COURT: But if the health plan increases their 03:29:19
24 profits by 20 percent, does that automatically translate into 03:29:22
25 some kind of bonus or share? 03:29:27

1 MR. MOSKOWTIZ: So it essentially works -- part of 03:29:31
2 this risk adjustment program works is that when you submit a 03:29:33
3 diagnosis code, you're not actually getting paid directly for 03:29:36
4 that diagnosis in that year. It's fitting into the -- what you 03:29:41
5 get paid in the following year for that patient. And so every 03:29:46
6 year the health plan and the medical groups negotiate an amount 03:29:52
7 of payment for the beneficiary. So it's a capitated rate. And 03:29:59
8 the higher the risk score, the better off they are to get a 03:30:06
9 higher capitated rate. So if Kaiser Permanente is doing 03:30:10
10 better, then that's more money for the medical group. 03:30:14

11 THE COURT: So the medical group negotiates a 03:30:18
12 capitated rate with the health foundation -- with the -- 03:30:20

13 MR. MOSKOWTIZ: Health plan, yes. 03:30:24

14 THE COURT: So you're saying they -- by submitting to 03:30:26
15 this pressure or exceeding to this pressure and essentially 03:30:30
16 lining the pockets of the health plan, they will get benefits 03:30:36
17 because they're going to get a higher capitation rate as well? 03:30:40
18 Is that -- 03:30:44

19 MR. MOSKOWTIZ: That's generally the framework, yes. 03:30:45

20 So the health of everyone benefits the health of 03:30:48
21 everyone. All -- this is a shared money, one source, and the 03:30:51
22 pot of money is all coming from the health plan and so the 03:30:56
23 better that the health plan is doing, the better off everyone 03:31:00
24 is. 03:31:02

25 THE COURT: And that is one of the basis of your 03:31:04

1 conspiracy that there's a motive here, there's parallel motives
2 to engage in this risk adjustment program because everybody
3 benefits in the end?

4 MR. MOSKOWTIZ: Yes. Certainly -- and I do have to
5 clarify. We are generally -- we don't need to prove that the
6 individual providers, a particular state of mind of them, but
7 the people who are running these programs and running the
8 medical groups, right, who are the business side, the business
9 people, they're the ones who -- they understand this. They
10 understand everything and they're the ones who are creating
11 these programs to push the doctors -- along with the health
12 plan to push the doctors to add the diagnoses.

13 THE COURT: And that is -- but that is sort of core to
14 the larger conspiracy theory, which I want to talk about in a
15 minute, that there are incentives to engage in this
16 conspiratorial agreement according to your -- if the doctors
17 didn't benefit, why would they -- you know, they get a flat
18 rate. Why would they care.

19 MR. MOSKOWTIZ: Right. There are certainly incentives
20 because we're talking about the way things are negotiated and
21 how it all works out. There are incentives that everyone's
22 incentives here are aligned. In fact, that's what -- one of
23 the particular things -- like, for example, in paragraph 111
24 where they talk about that Kaiser viewed it had a strategic
25 advantage over all of the other MAOs because of this integrated

1 structure. That they had control over everyone and every
2 process. The health plan controls all of the dollars going to
3 the medical group and with that comes a -- you know, they say
4 they're operating under one roof. They are one integrated
5 consortium. Their incentives are all aligned. And I think,
6 you know, one thing that we see here is all of these different
7 groups are represented by the same counsel because they're
8 effectively one consortium. They're one entity.

9 THE COURT: What's your response to the Integra case?
10 I know it's unpublished, but why is this case that much
11 different? There was similar allegations about queries and
12 incentivizing doctors, et cetera. Why is this case different?

13 MR. MOSKOWTIZ: So our case is completely different
14 than Integra. And other than there's a sentence about leading
15 queries and incentives, besides that, we have nothing alike.

16 Integra -- the relator had never looked at a single
17 medical record. They didn't have access to any medical
18 records. They simply ran a statistical analysis and they said
19 based on that statistical analysis, because you are submitting
20 more of these particular claims, we think that that's likely a
21 false claim. And it's even worse because it actually turns out
22 that all of the competitors in the industry caught up, you
23 know, a couple of years later and were submitting at the exact
24 same rate. And the court essentially there said is you have
25 not alleged anything that would remotely suggest that there is

1 falsity here. What you've alleged is that they submitted more
2 claims for these conditions than other hospitals but then the
3 other hospitals caught up to them so that doesn't give rise to
4 an inference that these claims are false. And they in a
5 footnote said statistical analysis is not irrelevant and that
6 you could rely on it in conjunction with allegations about
7 particular false claims.

8 Well, we have allegations here about particular false
9 claims. We also have allegations about insider information,
10 which they don't have in Integra. We have all sorts of
11 allegations where Kaiser's own documents show that they knew
12 that they were continually submitting false claims.

13 THE COURT: What are the most -- what are the most
14 powerful on point paragraphs in there?

15 MR. MOSKOWTIZ: If you look at paragraph 323, they're
16 identified that, "Internally, Kaiser recognized that many times
17 the physicians were not properly reviewing the diagnoses..."
18 because physicians are being inundated with these. They're
19 being constantly asked to change things. So they're not --
20 they're just adding them at Kaiser's request.

21 The one document identifies this program as a weakness
22 and say "some clinicians refresh the diagnoses without proper
23 and detailed review of the medical record, and as a result
24 incorrect diagnoses keep being reported."

25 That's Kaiser's own statement.

1 THE COURT: Sometime. We don't know if that means
2 1 percent of the time or 90 percent of the time.

3 MR. MOSKOWTIZ: Sure. But it doesn't matter if it's a
4 small number of the time or any. It's they know it's
5 happening. And it's really important here, right, that none of
6 these errors existed in the original record. All of these
7 errors are generated at Kaiser's request. And they know that
8 when they're generating these queries that there's a whole
9 bunch of inaccurate diagnosis codes in there. And they're just
10 disclaiming any obligation to check the accuracy of it. So
11 take simple inquiries to make sure that we're not asking
12 physicians to add inaccurate diagnosis codes. And doing that
13 when they know that some clinicians keep reporting these things
14 inaccurately, we know now that there are some false claims.

15 A big difference between Integra and here and the
16 other cases that Kaiser cites is Integra -- there's no
17 allegation of a single false claim. Right. So the problem
18 that the Ninth Circuit had was we don't know that any of these
19 at all are false. If Integra had included allegations of
20 representative false claims, I have little doubt that the Ninth
21 Circuit would have said you can go forward because the number
22 of false claims, well, that's something to deal with at summary
23 judgment and at trial. The question is are there any and in
24 this case there definitely are. And the only question that
25 they're saying is, well, there might not be as many as the

1 government says. And we just think that like that's an issue
2 for summary judgment and trial.

3 And, you know, we know, for example, that Kaiser did
4 an addenda audit and in a short period of time they found
5 hundreds of these exact same errors. So it's not just a these
6 happen to be three things that got through. We now have a
7 bunch of them. We've cited the representative types of claims
8 we're bringing and we've explained a significant reason to
9 believe that these are representative of a broader set of
10 diagnosis codes that were inaccurate because the condition did
11 not exist at the time.

12 THE COURT: All right. Let me give the defense a
13 chance to respond quickly and I want to move on to the question
14 about the conspiracy.

15 MR. PORTNOI: I'll do my best, Your Honor. There's a
16 lot to respond to there and there's a lot that, honestly, was
17 just stated that contradicts both the Ninth Circuit and the
18 complaint itself.

19 So let's reset to point out that what we're talking
20 about here is the clinically inaccurate diagnoses. There's a
21 lot that went in here about inappropriate addenda or
22 inappropriate queries which would go to the second category of
23 false claims that Your Honor identified as being both legally
24 and factually false.

25 Very important, my point that I made earlier and the

1 incentive point that I think Your Honor was making with counsel
2 for the United States, it's not about the particular -- the
3 provider groups, it's about the individual doctors. It is
4 about the fact that we're not talking about just the defendants
5 that are the provider groups. This has to, as it would have in
6 Integra, required thousands of doctors, maybe tens of thousands
7 of doctors to commit what is more or less what would be a
8 violation of their ethical duty and to not use any clinical
9 judgment when making diagnosis. That is the claim that
10 Your Honor has to find plausible in order to make this happen.
11 And we've asked the government point blank about that
12 allegation, what evidence they have for it, and they flatly
13 refuse to provide any discovery on that point at all, stating
14 that they don't have to disclose anything on that point until
15 after trial has begun.

16 Let me also point out something about refresh. What I
17 just heard is that refresh is something that only occurs after
18 the patient visit. That's not true as a matter of fact. And
19 that's not true -- it directly contradicts the complaint
20 itself. At paragraphs 133, 134, 138 we have specific
21 allegations that refresh actually is a process that begins
22 before the patient visit. It is something that the physicians
23 look over during the patient visit. So that simply is a
24 situation where we're creating new facts and contradicting the
25 complaint in order to get around it.

1 Also heard some information about Integra that frankly
2 is a gross misrepresentation --

3 THE COURT: Well, let me -- hold on for a second.

4 Looking at paragraph 133, 134, where does it say that
5 refresh only occurred during the patient visit?

6 MR. PORTNOI: I'm not saying that it only occurs, but
7 what I heard from the counsel for the United States is that
8 part of the design of this scheme is that refresh we don't give
9 to doctors at visits on purpose so it can be done only after
10 the visit in addenda and --

11 MR. MOSKOWTIZ: Your Honor, if I could just chime in
12 on that. That's not what we said.

13 THE COURT: I didn't hear that and I think that's a
14 mischaracterization.

15 MR. PORTNOI: Then we need to be clear that the
16 refresh program has nothing to do with an addendum conspiracy
17 or an addendum scheme. I heard it that way, but if I didn't --
18 if that wasn't stated correctly, then I'll move on and talk
19 about Integra, because I just wanted to correct that point in
20 the record.

21 Integra is not a case in which there was only
22 allegations of statistical analysis. In fact, at 842 there's
23 specific allegations that diagnoses of delirium were changed to
24 diagnoses of encephalopathy -- I'm not great at that word,
25 Your Honor. So as a result, there were, in fact, specific

1 information that they -- specific diagnoses. There was also
2 information about contradictions in the record that there was
3 evidence that the medical records contradicted the diagnoses
4 that were submitted to CMS.

5 There is -- there were allegations about a higher
6 rate, specifically they're twice or higher than the national
7 average for some diagnoses and also, yes, the analysis that was
8 not the result of chance or variations in patient population.
9 There was allegations of pressuring doctors. There was
10 allegations of incentivizing doctors. There was allegations of
11 improper queries and leading queries. And the Ninth Circuit
12 said we accept all of those factual allegations -- this is at
13 844 -- and then they stated, after summarizing all of those
14 allegations one by one: We need not and cannot accept the
15 conclusion that these allegations resulted from fraud or that
16 doctors recorded unsupported medical conditions.

17 And doctors recording unsupported medical conditions,
18 that's in that black box, that thing that the government does
19 not want to allege and does not want to provide discovery on
20 that is extremely important.

21 I also want to respond to the point, Your Honor, about
22 this being a single enterprise. This is not a single
23 enterprise. And, in fact, the complaint alleges that when --
24 for instance, when the cachexia initiative was going on in
25 Northern California, in Southern California and in Colorado

1 they disagreed with that and they did a different thing. 03:43:13

2 So there's allegations that Your Honor has to take as 03:43:16
3 true that show that the various different regions operated 03:43:19
4 independently and that they actually disagreed with them and 03:43:23
5 engaged in different practices. This is why Rule 9(b) requires 03:43:26
6 not just who, what, and when but where conduct occurred and why 03:43:30
7 Your Honor correctly limited the cachexia allegations to 03:43:36
8 Northern California because they do differ from region to 03:43:39
9 region and that just simply stating everybody does the same 03:43:45
10 thing is insufficient as a matter of group pleading and as a 03:43:47
11 matter of alleging under 9(b) that some -- that there was 03:43:50
12 actually fraud across the board. 03:43:55

13 THE COURT: Let me ask the United States to respond to 03:43:57
14 two questions. One is there's things about what doctors are 03:44:03
15 incentivized to do, what they're instructed to do, pretty 03:44:09
16 explicit, but what about the point that, well, where's the 03:44:13
17 beef? Where are examples of a doctor doing X? A sampling of 03:44:20
18 doctors, you know, using refresh to add diagnoses that were no 03:44:26
19 longer current for instance? And what about the idea that is 03:44:29
20 it really plausible that thousands or hundreds -- tens of 03:44:33
21 thousands or hundreds of thousands of doctors would violate the 03:44:38
22 ICD guidelines and whatever codes of ethics there are to go 03:44:42
23 along with this program? Is that plausible? 03:44:47

24 MR. MOSKOWTIZ: I want to be clear that our complaint 03:44:49
25 is not based on that this is a doctor run program. 03:44:52

1 THE COURT: But it requires doctor -- in order for it 03:44:57
2 to happen, you need the doctors to cooperate. 03:45:00

3 MR. MOSKOWTIZ: You need some cooperation, but what 03:45:01
4 happens is they're being inundated with these queries. They're 03:45:05
5 getting huge amounts of queries. They're being told don't 03:45:09
6 spend anytime on it. We've already done the work for you. 03:45:13
7 Don't spend anytime on it. One doctor, I think in the 03:45:15
8 allegation, they're saying you shouldn't spend more than 03:45:19
9 30 seconds or a minute on one of these things. So they're 03:45:22
10 being told we're not going to give you time to do this. We 03:45:26
11 want you to actually do your job. This is just a coding for 03:45:29
12 dollars thing. Right. And so the issue is, is they have to 03:45:32
13 hit crazy high refresh rates, like 99 percent or something. 03:45:36
14 And that's alleged in the complaint. They're being tracked on 03:45:42
15 all of these things. And Kaiser, the one who's doing this, 03:45:45
16 they're not looking at and finding these issues and alerting 03:45:51
17 the doctor and saying, hey, you know, for example, if you look 03:45:54
18 at -- we have a bunch of representative examples in the 03:45:59
19 complaint where the doctors are adding these things and it very 03:46:04
20 well could be that the doctor just didn't notice that there was 03:46:07
21 something in the record because they were told not to spend 03:46:10
22 anytime on it and -- 03:46:12

23 THE COURT: So what's the -- can you give me a 03:46:14
24 paragraph where there's a good example -- a concrete example of 03:46:16
25 a doctor -- 03:46:19

1 MR. MOSKOWTIZ: Sure. 03:46:20

2 THE COURT: -- admitting to this? 03:46:20

3 MR. MOSKOWTIZ: So, for example, we had paragraph 366 03:46:22

4 where the doctor adds a severe obesity diagnosis, but the BMI 03:46:30

5 at that visit is too low to met the definition of that 03:46:39

6 diagnosis for that visit. Likely they assumed Kaiser wouldn't 03:46:44

7 have queried them if the BMI was within the right range. And 03:46:53

8 so I think, you know -- and this doctor, they were asked to add 03:46:58

9 12 or 13 different diagnoses via addenda. They're just being 03:47:02

10 asked to refresh all of these things. And part of the whole 03:47:08

11 overall marketing from Kaiser is you're not actually being 03:47:11

12 asked to diagnose this, you're just asking to refresh a 03:47:14

13 diagnosis that's already been made. Well, the problem is, is 03:47:18

14 that oftentimes for these certain types of things clinical 03:47:21

15 indicators change over time and the doctor very well may just 03:47:27

16 have not noticed that in this visit. But Kaiser knew that was 03:47:30

17 a problem because they knew that a lot of clinicians, because 03:47:34

18 they told them not to spend anytime, a bunch that they would 03:47:37

19 just go through and add all the diagnoses that Kaiser 03:47:40

20 requested. And Kaiser, as we allege, labeled this as a red 03:47:44

21 flag. They knew this was a problem and they knew that that was 03:47:48

22 resulting in inaccurate diagnoses being reported. 03:47:52

23 There are other ones where the -- there's another 03:47:56

24 example in paragraphs 155, 157 involving obesity 03:47:59

25 hypoventilation syndrome. Again, another condition that 03:48:04

1 requires that you be obese and yet the record for the visit 03:48:08
2 shows the patient was, in fact, under weight. And so they 03:48:12
3 didn't have this condition. Again, whether or not the 03:48:17
4 doctor -- their state of mind just doesn't matter here. It's 03:48:20
5 the fact that -- and this gets to what the Ninth Circuit ruled 03:48:24
6 in Swoben, right. If you look at the Swoben case, they said 03:48:28
7 when an organization turns a blind eye to overreporting here, 03:48:34
8 it exhibits reckless disregard and deliberate ignorance towards 03:48:39
9 the truth or falsity of the data submitted to CMS. Swoben does 03:48:43
10 not require there that there be some type of effort on the part 03:48:49
11 of the clinician to add diagnoses that didn't exist and to say 03:48:52
12 that the state of mind of those doctors mattered. It doesn't. 03:48:57
13 The issue is, is when Kaiser, the entity, do the people running 03:49:01
14 these programs know of a problem, which they definitely do and 03:49:06
15 we've alleged in numerous ways how they were aware of that 03:49:10
16 problem, they then can't turn a blind eye to it, but that's 03:49:14
17 exactly what they did. 03:49:17

18 THE COURT: All right. Okay. I understand. 03:49:18

19 Let me just get -- we've got to move on. Let me ask 03:49:20
20 you about the conspiracy allegations here. 03:49:23

21 What -- I mean, I kind of covered this a little bit 03:49:26
22 here. I wanted to figure out what exactly is the incentive for 03:49:30
23 all five groups, including physician groups, to go along and 03:49:35
24 agree to join this alleged conspiracy. 03:49:38

25 Is the conspiracy here one that's just alleged based 03:49:42

1 on implication, circumstantial evidence? What is the evidence
2 that there was an agreement across the board, not just
3 bilateral agreements in one state, one region, but really one
4 that goes across the board?

5 MR. MOSKOWTIZ: Right. So these risk adjustment
6 programs only function by everyone being involved in it. And
7 so the allegations -- and I would point Your Honor to a lot of
8 the background allegations in paragraph 30 to 42 and 105 to 25
9 and 146 to 49. These are the -- there's an agreement to run
10 these programs jointly. They're having weekly meetings
11 together steering information --

12 THE COURT: "They" being?

13 MR. MOSKOWTIZ: They being all of the defendants,
14 representatives from all of the defendants.

15 My apologies for not being specific there.

16 THE COURT: Yeah.

17 MR. MOSKOWTIZ: All of the defendants are part of
18 these groups, so the -- the data mining working group which
19 handles the operations of data mining and refresh and shares
20 the information and runs the algorithm, this is all being done
21 through that. There's a group called National Medicare Finance
22 that is in the health plan that is tasked with working with all
23 of the groups together to come up with -- they tell them here's
24 the risk score you're going to meet this year and then they
25 work with them to -- how they're going to reach that risk

1 score.

03:51:26

2 They have a shared reporting tracking and metrics.

03:51:28

3 They have a national risk adjustment initiative that all of the

03:51:32

4 defendant are involved in. There's a regional reporting group

03:51:38

5 that meets several times a year. Again, all of the defendants

03:51:44

6 are meeting together where they're talking about how to run

03:51:48

7 these programs. And so there are very minor variations in

03:51:52

8 the -- in how on the programs are run, but there's a reason why

03:51:58

9 refresh is national in scope and that's because Kaiser, at the

03:52:01

10 national level, required it.

03:52:09

11 And so, for example, there's an allegation that Kaiser

03:52:11

12 required every region to lower in multiple years the number of

03:52:15

13 unrefreshed diagnoses. And they did it -- said you will -- in

03:52:20

14 2006, you will lower the number of unrefreshed diagnoses by

03:52:26

15 two-thirds. And in 2007, you will lower that number again by

03:52:29

16 two-thirds. This is a national in scope program. It is not

03:52:34

17 specific to Northern California or Southern California or

03:52:40

18 Colorado. There's a reason why they are all running the exact

03:52:44

19 same program and for the most part running the exact same

03:52:48

20 algorithms in the exact same way, because they're sharing that

03:52:51

21 information and working together to run it because they say the

03:52:55

22 interconnectedness and the interdependence of the hospital

03:53:01

23 health plans and medical groups that make up Kaiser Permanente

03:53:03

24 have advanced their efforts to operate seamlessly as an

03:53:06

25 enterprise under one roof.

03:53:10

1 THE COURT: All right. Let me hear the response
2 briefly.

3 MR. PORTNOI: Your Honor, let me start with the
4 allegations regarding the doctors before. It isn't, as
5 Your Honor just said, that this is something that where the
6 doctors enter false diagnoses that this violates the ICD
7 guidelines. This is something that the doctor has to do that
8 may cause the doctor to lose their license. This may be
9 something that subjects the doctor to criminal sanctions in
10 some states for issuing false diagnoses. These are not things
11 that just violate the ICD guidelines. This is deciding to
12 diagnose somebody with a diagnosis like diabetes or depression
13 when you have -- either know for a fact that there's not going
14 to be a -- that the diagnosis is not supported or where you
15 just decide to do it without any -- without looking at the
16 records and without verifying it at all. That is an immense
17 and defamatory allegation against the thousands of physicians
18 and it is implausible that thousands of physicians did that.
19 What we heard instead is, oh, it's likely that they assumed
20 Kaiser verified it or the allegation they thought or assumed
21 that it was there. That is not something -- that still
22 requires a reckless disregard at a minimum, if not knowledge,
23 on behalf of the doctor -- individual doctors with names and
24 licenses who are dealing with individual patients.

25 THE COURT: Right. So you're reiterating your

1 plausibility point. I've heard that. Go on. 03:54:44

2 MR. PORTNOI: Well, then -- but that also leads to the 03:54:46
3 fact that, again, we have to follow Integra which -- or which 03:54:49
4 leads to -- cites to the -- cites to -- excuse me -- published 03:54:53
5 authority that where we see an obvious alternative explanation, 03:54:59
6 there needs to be facts that go against that. When there's two 03:55:03
7 possibilities, one -- both of which are possible, one of which 03:55:06
8 leads to liability, the other one of which doesn't, the fact 03:55:10
9 that there are allegations consistent with the one that lead to 03:55:13
10 liability you cannot get past a motion to dismiss under not 03:55:16
11 just Rule 9(b) but even Rule 12(b)(6) unless you have 03:55:21
12 allegations that tend to exclude the possibility. 03:55:25

13 THE COURT: Well, your opponent would argue that there 03:55:30
14 are such allegations here. I mean, given all the -- both the 03:55:33
15 examples and now the seven examples of conditions where there 03:55:36
16 were problems, at some point you can say, well, that tends to 03:55:41
17 exclude it because how many times do we have to prove that it's 03:55:44
18 a problem? 03:55:48

19 MR. PORTNOI: Seven examples out of -- five of which 03:55:49
20 were in the original complaint. The two new ones both come 03:55:51
21 from the same region and they have to do with the same 03:55:54
22 diagnosis which is extremely similar to cachexia. You look at 03:55:57
23 155 and -- 03:56:01

24 THE COURT: So but how did that happen? If you're 03:56:02
25 saying you can't get doctors to do this, they'd lose their 03:56:04

1 license, how do we even get those five examples? 03:56:07

2 MR. PORTNOI: Your Honor -- 03:56:10

3 THE COURT: Doesn't that tell you something? 03:56:11

4 MR. PORTNOI: Your Honor, CMS acknowledges that this 03:56:13
5 is a massive program and, as a result, there are always going 03:56:15
6 to be some amount of error rates -- 03:56:18

7 THE COURT: Some amount of errors but not 03:56:20
8 systematically in one direction and not for which there's an 03:56:22
9 allegation of a cause. These are not just random errors. 03:56:25

10 MR. PORTNOI: Your Honor -- 03:56:29

11 THE COURT: So -- wait a minute. 03:56:29

12 So you're saying this whole thing is implausible and 03:56:31
13 the obvious counter to that is we've given seven examples, even 03:56:34
14 if it's just regional, it's not one physician, two physicians. 03:56:38
15 And there's -- there's documentation of a systematic 03:56:43
16 explanation for that, so that does tend to exclude. That 03:56:47
17 doesn't win the case. We're talking 12(b)(6). 03:56:50

18 MR. PORTNOI: We're talking 12(b)(6) and we're talking 03:56:54
19 about 9(b) where we do have to care about the when, what years 03:56:56
20 are we talking about, and the regions. 03:56:59

21 But also we are talking -- we're talking about seven 03:57:01
22 diagnoses across three geographic regions, across a decade-long 03:57:04
23 period. We're not even talking about one example per year, 03:57:11
24 Your Honor. 03:57:13

25 There's citation to 155 and 157 as paragraphs in here. 03:57:14

1 Those are situations where -- those are examples where there 03:57:19
2 are -- where no diagnosis was even alleged to have ever been 03:57:24
3 made. There's no allegation that doctor salaries are impacted 03:57:28
4 by this. And, furthermore, again, after eight years not only 03:57:32
5 were there subpoenas but there were depositions of individual 03:57:37
6 doctors, there is not one allegation that they could find one 03:57:39
7 doctor who said you know what, you're right, that diagnosis was 03:57:44
8 wrong. Not one instance where a doctor said that. That's the 03:57:48
9 point. There's that black box -- 03:57:54

10 THE COURT: What about what Mr. Moskowitz quoted in 03:57:55
11 paragraph three -- the three hundreds, the examples, the case 03:57:59
12 examples?

13 MR. PORTNOI: Those are examples where they are making 03:58:05
14 assumptions based off of the medical records that because 03:58:07
15 there's a contradiction, there's clinical falsity, but we don't 03:58:10
16 have individual doctors who say I was not just pressured, but I 03:58:14
17 know that I entered diagnoses that are false, not one. 03:58:20

18 MR. MOSKOWTIZ: To be clear, there is no requirement 03:58:24
19 in the False Claims Act that a doctor had to specifically 03:58:26
20 intend to defraud the United States. And we're not alleging -- 03:58:30
21 we don't need to allege or prove that the doctors acted 03:58:33
22 knowingly if the -- 03:58:36

23 THE COURT: No, no. Well, but the claim of 03:58:37
24 Mr. Portnoi is that it's not plausible, you know, that there's 03:58:40
25 widespread -- because your theory assumes that there's going 03:58:45

1 to have to be some doctor complicity for this to be a 03:58:48
2 systemic -- 03:58:51

3 MR. MOSKOWTIZ: Right. 03:58:52

4 THE COURT: -- program and he's saying it's not 03:58:52
5 plausible because doctors wouldn't do such a thing. 03:58:54

6 MR. MOSKOWTIZ: Right. And our point back is that 03:58:56
7 they may have done it accidentally. They might not have spent 03:58:58
8 as much time as Kaiser would say they're required to, but I 03:59:02
9 can't imagine that anyone would criminally prosecute this 03:59:07
10 doctor because they submitted the false submission that the 03:59:12
11 diagnosis was inaccurate. The cause here was Kaiser. It's not 03:59:18
12 the doctor's fault. If it was up to the doctor and they had 03:59:22
13 left the doctor alone, he didn't diagnose it at the time of the 03:59:25
14 visit. His visit had nothing to do with it. And this is part 03:59:30
15 of the problem is that they're pushing doctors to add diagnoses 03:59:32
16 to the visits that have nothing to do with it and the results 03:59:35
17 of that is inevitable. They know it's going to lead to error. 03:59:37
18 And they saw it themselves when they looked at it -- 03:59:41

19 THE COURT: But Mr. Portnoi's point is how could you 03:59:44
20 assume that the doctors would be such poor gatekeepers they 03:59:47
21 would just allow this to go on? 03:59:50

22 MR. MOSKOWTIZ: They're not necessarily poor 03:59:52
23 gatekeepers. There are hundreds of thousands of diagnoses 03:59:54
24 potentially that are not supposed to be added and they very 03:59:59
25 well may be -- you know, they're playing goalie here because 04:00:03

1 Kaiser's running an incredibly reckless program that doesn't
2 monitor in any way what actually happened at the visit and some
3 things may get through. And, in fact, we know some things get
4 through because we found it. We presented some examples that
5 they don't actually contest. They found it. They found it in
6 internal documents that say they know that inaccurate diagnoses
7 keep being reported through these programs because of this
8 issue. And there are audits of the addenda, right, so those
9 audits were specifically of -- not of just all the codes going
10 through. They specifically were looking at the addenda, the
11 things that Kaiser was pushing the doctors to add and they
12 found hundreds of instances in a short period of time of the
13 exact error we're talking about.

14 Now, again, it doesn't matter here if this is
15 happening a few hundred times or a thousand times. The point
16 of it is all of those are false claims. Kaiser knew there was
17 a problem and they didn't take the simple inquiries which would
18 be done at -- as we allege in paragraph 376 -- right there are
19 several simple inquiries they could have done to just stop
20 this. They could have insured that when they queried the
21 physician for physician, that they looked at what was in the
22 medical record for the visit and said this is contradicted. We
23 shouldn't be querying for it. They could have informed the
24 physician about the contradictory information; they didn't.
25 And then they could have reviewed the addenda at the end just

1 to double-check and make sure that there wasn't a problem here 04:01:39
2 with the contradictory information, but they didn't do that. 04:01:44

3 And so all of these things together -- these are the 04:01:48
4 simple inquiries that were on Kaiser. And so Kaiser's 04:01:50
5 defense -- I mean, they're effectively -- it's their defense 04:01:55
6 which is to blame the doctors. Our view is it's not the 04:01:57
7 doctors, it's Kaiser. Kaiser shouldn't have been doing this to 04:02:00
8 the doctors. And they didn't give the doctors time to look at 04:02:04
9 these and they pressured the doctors to just add it and they 04:02:07
10 told them you're not really diagnosing things, you're just 04:02:09
11 refreshing them. All these things combined, that's what leads 04:02:11
12 to the inevitable result here. And Kaiser knew that they had 04:02:17
13 this problem but they didn't fix it. 04:02:20

14 MR. PORTNOI: Your Honor, what I hear now is that 04:02:23
15 possibly the doctors just did this by accident and now we're 04:02:25
16 talking about a scheme, a conspiracy where multiple entities 04:02:28
17 got together and the whole premise of this scheme is maybe the 04:02:32
18 doctors will hit "A" when they meant to hit "B" it's going to 04:02:35
19 be by accident. That's not the way doctors look at records. 04:02:38

20 With respect to time, that's one paragraph that 04:02:41
21 describes one instance in which one doctor told another doctor 04:02:45
22 that for these specific addendum -- for these specific queries, 04:02:49
23 you should be able to get them done in a minute. It has 04:02:53
24 nothing to do with multiple regions. It has nothing to do with 04:02:55
25 multiple years. And it's a communication between one doctor 04:02:57

1 and another doctor.

04:03:01

2 We also -- to be clear, we do contest the seven
3 examples that are in the complaint. We can't do so on a motion
4 to dismiss because we have to take the allegations as true. I
5 heard it said that we don't contest them but we absolutely do,
6 to be absolute -- to be clear.

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7 The -- and finally, again, Your Honor said it exactly
8 correct, the complaint assumes doctor complicity. It assumes
9 doctors abdicating their duty. That is on all fours with
10 Integra. There needs to be more.

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11 Your Honor looked at most of these examples and
12 substantially the same allegations on the first complaint and
13 found that there could only be an adequately pled scheme for
14 cachexia in Northern California and there's -- nothing has been
15 added to this complaint to change that. We don't have
16 something that plausibly gets at the doctors.

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17 The government wants to have its cake and eat it, too.
18 It wants to say, well, the doctors did this. The doctors
19 addend the records, hundreds of thousands of times, and they
20 did so and they did it for diagnoses that the -- for diagnoses
21 that were not true. But they also want to say this isn't a
22 case about doctors. That this isn't a case where they have to
23 provide one page of discovery with respect to doctors.

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24 Your Honor noted in the -- that this is an important
25 point because the scope of this scheme that is going to go

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04:04:23

1 forward defines the scope of discovery that is going to go 04:04:26
2 forward as well. And if this is the case that we're talking 04:04:29
3 about hundreds of thousands of diagnoses for clinical 04:04:32
4 inaccuracy and with tens of thousands or thousands of doctors, 04:04:35
5 that is going to be thousands or tens of thousands of 04:04:40
6 depositions. That is going to be potentially going to the 04:04:42
7 patients to find out if the -- if there's a clinical 04:04:46
8 inaccuracy. If something is clinically inaccurate, presumably 04:04:51
9 it will be swept up in the existing allegations that have been 04:04:53
10 permitted to go forward about noncompliance with the ICD 04:04:58
11 guidelines. But going to clinical inaccuracy and asking the 04:05:01
12 company to defend in this lawsuit and asking the United 04:05:05
13 States -- and allowing the United States to impugn the 04:05:10
14 integrity of these thousands of doctors, that simply is not 04:05:13
15 justified by the pleading that we have in front of us. 04:05:17

16 THE COURT: Let me ask, Mr. Moskowitz, if you don't 04:05:18
17 have to demonstrate purposeful conduct by the -- by doctors, 04:05:23
18 some of this could be just, you know, because of the pressure, 04:05:30
19 succumbing to the pressure, how does that square with the 04:05:34
20 conspiracy theory naming the doctor groups, the physician 04:05:36
21 groups, the -- you know, if they're not doing this conspiring 04:05:39
22 purposefully but they're acting under pressure, under pressure 04:05:45
23 of time, et cetera, et cetera, how is their inclusion in a 04:05:47
24 conspiracy justified? 04:05:53

25 MR. MOSKOWTIZ: So it's important to understand that 04:05:53

1 the doctors groups and the people that we're talking about in 04:05:55
2 the doctors groups are part of the conspiracy are not like 04:05:59
3 you're line level doctor. They're the people at these groups 04:06:03
4 who are running these programs who are aware of the problem. 04:06:07
5 So they're the ones who know that there's an issue, know that 04:06:10
6 they're repeatedly reporting inaccurate diagnoses, but then 04:06:13
7 failing to do the things that I talked about, the simple 04:06:17
8 inquiries, that would prevent it. 04:06:20

9 And so this case is exactly something like Swoben, 04:06:22
10 right, where the doctor -- we're talking about all sorts of 04:06:25
11 things. Their allegation there is all sorts of inaccurate 04:06:28
12 diagnoses. And nobody is talking about, well, then you're 04:06:31
13 alleging that all the doctors must have done this. That's just 04:06:36
14 not necessary because the issue is once the MAO or the doctors 04:06:40
15 group, the people running this program, are aware of an 04:06:45
16 overreporting error, they need to take the simple inquiries to 04:06:48
17 fix it. 04:06:52

18 And it is really important to acknowledge here that 04:06:53
19 none of these were things that existed in the original record. 04:06:55
20 The people running these groups pushed these diagnoses onto the 04:06:59
21 doctors and now they're just, you know, proclaiming they have 04:07:03
22 no responsibility for what the result is, even though they know 04:07:06
23 that the result is that some amount of inaccurate diagnoses are 04:07:10
24 coming through. 04:07:14

25 I wanted to make one more point which is that half 04:07:15

1 of -- only one part of the inaccurate diagnoses here even have 04:07:17
2 anything to do with doctors documenting something inaccurately. 04:07:23
3 A significant part of our complaint is that the doctors were 04:07:26
4 diagnosing things that's historical, including in the addenda, 04:07:31
5 but Kaiser was then reporting them as active, accurate 04:07:35
6 conditions. And so we have an example of that in paragraph 220 04:07:39
7 where Kaiser asked the doctor to amend the record to add 04:07:45
8 thrombocytopenia, which is a low blood platelet condition that 04:07:51
9 can come and go, and the doctor documented that the patient had 04:07:57
10 a history of thrombocytopenia and yet Kaiser submitted the 04:08:00
11 active condition. And that's important because under the HCC 04:08:03
12 model, the MAO only gets paid for the active condition. And so 04:08:10
13 notwithstanding that the doctors were many times in response to 04:08:16
14 these programs documenting them as historical, Kaiser would 04:08:20
15 submit it as active and get paid and that's a false claim. 04:08:24

16 THE COURT: What's the evidence that this was a 04:08:27
17 systemic practice, the latter? 04:08:30

18 MR. MOSKOWTIZ: Sure. So there are numerous -- so 04:08:33
19 paragraphs 178 to 179 and paragraph 345 all deal with this. 04:08:36
20 The audits showed for each of these regions over a lengthy 04:08:41
21 period of time starting before even the dates of these 04:08:45
22 allegations that there is an issue that Kaiser knew about with 04:08:50
23 this historical versus active condition. 04:08:54

24 Paragraphs 178 to 179 talk about internal documents 04:08:59
25 where they recognize that this was a continuous issue. 04:09:02

1 And that the other paragraph where it's alleged that 04:09:06
2 they knew that the refresh kept capturing these active 04:09:15
3 diagnoses when they were documented to be historical. So 04:09:20
4 there's knowledge throughout. I mean, this is one of the 04:09:24
5 clearest things that they -- that every region everywhere 04:09:27
6 everyone knew about. 04:09:30

7 MR. PORTNOI: Your Honor, now this is a fundamentally 04:09:34
8 different complaint. So now we're hearing, oh, well, we have 04:09:37
9 allegations in the complaint that show that when the doctors 04:09:39
10 were queried, they were actually -- they actually put the 04:09:42
11 correct diagnosis in so we have -- there's a request to put in 04:09:45
12 thrombocytopenia; the doctor said no. 04:09:50

13 Now something happened after that for sure that -- 04:09:52
14 well, for sure depending if the facts bear out what's in the 04:09:56
15 complaint, but that doesn't support a conspiracy to get doctors 04:09:58
16 to addend medical records with clinically inaccurate diagnoses. 04:10:02
17 It does the opposite. It's one of the many internal 04:10:07
18 contradictions of the complaint. And where the complaint makes 04:10:11
19 allegations that completely violate the premise of the scheme 04:10:13
20 and the premise of the conspiracy, we don't have a clear idea 04:10:17
21 of the scheme or -- 04:10:19

22 THE COURT: Well, a conspiracy could exist with 04:10:20
23 respect to one kind of practice but not necessarily with all 04:10:23
24 practices. 04:10:25

25 MR. PORTNOI: Absolutely. And that's why the 04:10:27

1 practices have to be narrowly drawn so we understand. Again,
2 that's what Rule 9(b) is, the how of the practices, the --

3 THE COURT: Right. Let me ask, Mr. Moskowitz, are you
4 claiming that this latter practice is part of the
5 conspiratorial agreement?

6 MR. MOSKOWTIZ: So the overall agreement was to
7 operate these programs knowing that they resulted in false
8 claims.

9 And the Supreme Court -- or -- my apologies.
10 Congress, through FERA, they overruled Allison Engine, which
11 has previously required a specific intent to defraud. And they
12 modified the language of the statute to remove any words that
13 would require an intent to defraud because all you have to have
14 is a conspiracy to violate. Well, violating occurs if you
15 knowingly submit false claims or rely upon false statements
16 that are material to false claims. And knowingly can be done
17 through reckless disregard or deliberate indifference. And so
18 if you are for two -- for over a decade agreeing to operate
19 these programs knowing that they are resulting in false claims
20 for diagnoses that didn't exist in the original record but
21 you're asking the doctors to add, that is sufficient to satisfy
22 the conspiracy requirements of this particular statute.

23 THE COURT: So your allegation --

24 MR. MOSKOWTIZ: I'd be happy to brief this more if
25 that would be useful.

1 THE COURT: Well, are you alleging that the doctor
2 groups -- not the individual doctors but you're basically
3 placing it in the hands of upper management, the money people,
4 knew about this other problem, this active --

5 MR. MOSKOWTIZ: Yes.

6 THE COURT: -- historic thing?

7 MR. MOSKOWTIZ: Yes. So everyone knew about -- what
8 we're pleading is that representatives from each of these
9 groups knew about these problems. They knew about the problems
10 of the historic versus active. They knew about the problems
11 with some inaccurate diagnoses being added because of the way
12 that the program runs. They knew about these things and yet
13 they all failed to act to correct them and they continued to
14 jointly -- they all agreed to jointly operate this program
15 knowing about these flaws. That's sufficient for a False
16 Claims Act conspiracy.

17 MR. PORTNOI: Your Honor --

18 THE COURT: Let me -- we got to move on. It's now
19 4:12.

20 I want to ask questions about the ACA claim and the
21 Bryant and Hernandez theory -- complaint here.

22 What I want to know from the plaintiffs is -- I guess
23 there are two theories here. There's a claim for payment --
24 it's really kind of a reverse false claim, as I understand it.

25 MR. LEWIS: That's right.

1 THE COURT: Now, I guess it doesn't matter whether the 04:13:23
2 overpayment -- or not paying enough in the pool, et cetera, 04:13:28
3 et cetera, et cetera -- it doesn't matter that in the end it's 04:13:33
4 a readjustment between various insurers so much as it went 04:13:36
5 through the treasury and that's enough if there's an 04:13:40
6 inaccuracy. Am I correct that's your position? 04:13:43

7 MR. LEWIS: With respect to that -- with respect to 04:13:47
8 that issue, yes, Your Honor. Even if it's budget neutral to 04:13:50
9 the United States, it can still give rise to a false claim. 04:13:53
10 And of course the second half of our theory is on tax credits 04:13:56
11 and that is not budget neutral to the United States. 04:14:00

12 THE COURT: Okay. I understand that. And I take it 04:14:03
13 you have cited, rely upon section 18033(a)(6)(a) which sort of 04:14:06
14 emphasizes the fact that as long as you participate in the 04:14:13
15 exchange and you make some false statements, whether it's a 04:14:17
16 reverse false claim or a positive false claim, that is -- falls 04:14:21
17 under the auspices of the False Claims Act? 04:14:27

18 MR. LEWIS: That's right, Your Honor. And Congress in 04:14:29
19 passing the ACA was entirely clear of its intent and that was 04:14:31
20 to make these insurance pools work and they only work to the 04:14:35
21 benefit of the citizens of the United States and to the 04:14:40
22 government if the insurers are being honest about their risk 04:14:42
23 adjustment data. 04:14:47

24 THE COURT: All right. So -- 04:14:48

25 MR. LEWIS: Our allegations is they were not. 04:14:49

1 THE COURT: All right. So I understand that theory. 04:14:51

2 Why do you need theory number two, the tax credits? I 04:14:52

3 mean, does that make a difference if you -- if you are able to 04:14:56

4 succeed on the first theory, which it seems a little more 04:14:59

5 straightforward and has statutory language to support that, is 04:15:01

6 this superfluous? This is sort of like icing on the cake or 04:15:06

7 this does have implications that are separate and distinct from 04:15:10

8 the first theory? 04:15:13

9 MR. LEWIS: Well, I wouldn't say it's superfluous, 04:15:15

10 Your Honor. I think it actually resounds to the detriment of 04:15:17

11 the government that the tax credits are being overcharged or 04:15:21

12 causing the insurers in other parts -- in other plans to 04:15:25

13 overcharge due to Kaiser's fraud. So this is real money to the 04:15:28

14 government. 04:15:33

15 The other scheme may be budget neutral. So, no, I 04:15:34

16 don't think it's superfluous, but I think we allege both and we 04:15:39

17 would like to pursue both if we can. 04:15:42

18 THE COURT: All right. So let me finish asking a 04:15:43

19 question. So it's not budget neutral, has different 04:15:48

20 implications but of course it's more complicated? 04:15:50

21 MR. LEWIS: That's correct. I would agree with that. 04:15:53

22 THE COURT: And the causal chain has several links to 04:15:55

23 it. And so my -- I guess my question I -- I guess there's not 04:15:57

24 exactly a lot of case law on this, but if you borrow from RICO, 04:16:02

25 from other areas -- as you know, the courts have been more and 04:16:07

1 more skeptical about causation issues. The City of Oakland
2 case, the en banc case which reversed me, is an example of
3 that. And the Supreme Court litany of cases that talk about,
4 you know, only direct injury, not derivative injury, et cetera,
5 et cetera. Why wouldn't that genre of causation which kind of
6 borrows from -- I forget historic tort law or something -- why
7 wouldn't that -- shouldn't that be imported into the ACA?

8 MR. LEWIS: I think, Your Honor, the answer is that
9 this is not guesswork as to causation. It's actually rather
10 mechanical. It's complicated, granted, but it's rather
11 mechanical. If the risk adjustment data of one insurer -- a
12 large insurer in the pool is false, that is showing the other
13 insurers and the government that it has a healthier patient
14 base than -- I'm sorry -- a sicker patient base than is in
15 reality true, the other insurers mechanically think that they
16 are going to get less out of the insurance pool and
17 mechanically will set their premiums higher. And mechanically
18 when the benchmark is set on one of those plans, the government
19 and the beneficiary, the taxpayer, pay more in premiums. So
20 this is not guesswork. It's not supposition. It's just math,
21 Your Honor.

22 THE COURT: Well, but somewhat complicated math and
23 that's one of the things that drives some of these cases, that
24 one policy basis for requiring that very tight causation chain
25 is having to make a lot of inferences and using regression

1 analysis and everything else which the courts don't seem to
2 like.

3 MR. LEWIS: Your Honor, I don't know if any of that
4 would be necessary here. I think, you know, the facts will
5 show that insurers, in fact, do this work. They have to do
6 this work. It's mechanical. Yes, they have professionals that
7 have to do it because it's complicated but it's explainable and
8 it happens in the real world.

9 THE COURT: All right. Mr. Portnoi, your response.

10 MR. PORTNOI: Your Honor, there is, quite frankly, no
11 claim with respect to either theory. Whether you're in reverse
12 false claims or you're not in reverse false claims, you
13 nonetheless need to have at some point had a request or demand
14 for money or property and then for the government to have paid
15 money or property. There's not one case cited by the Bryant
16 relators of any type in the history of the False Claims Act
17 since the Civil War where somebody has gotten a successful
18 False Claims Act when they have not asked for a penny from the
19 government or received a penny from the government and that
20 goes to both.

21 That also means that when we think about the risk
22 adjustment transfer theory, that means that we have -- we don't
23 have any kind of distinctions. We look across each of these
24 various different defendants and each of these years.

25 The ACA operates in part on a state by state level so

1 that various different entities in the different states are 04:19:31
2 going to either request money or pay money at a different level 04:19:34
3 for each entity. There are 15 different defendant entities 04:19:40
4 here across many states and across -- and in some years, they 04:19:44
5 may be payers and in some years they may receive money. And we 04:19:48
6 don't have an allegation that in one year and for one defendant 04:19:52
7 Kaiser received or any Kaiser entity received one penny of 04:19:57
8 money here. That also means that there's also -- even if we 04:20:01
9 assume the attestation is a request for payment, there's no 04:20:05
10 allegation that any individual entity submitted an attestation 04:20:09
11 here. 04:20:14

12 When we go to the tax credit theory, the document 04:20:14
13 that's being purported -- and I would also point out that I 04:20:17
14 don't believe the tax credit theory was within the scope of 04:20:20
15 leave to amend, it's a completely new claim that was filed 04:20:23
16 without leave to amend. The document that is being cited is 04:20:26
17 the Unified Rate Review Template. It's the URRT. That's a 04:20:29
18 form completed by health insurers offering plans on individual, 04:20:34
19 small group, and combined markets that explain the rates that 04:20:38
20 insurers charge. It's not a request for payment. It's not a 04:20:43
21 demand for payment. Across the entire tax credit theory there 04:20:45
22 is no statement that there is a request or demand for payment 04:20:49
23 that ever occurred and as a result before -- 04:20:53

24 THE COURT: Well, is it the lack of a demand for 04:20:56
25 payment or the lack of payment you're alleging here? 04:20:59

1 MR. PORTNOI: It is both, Your Honor. It is both -- 04:21:01

2 THE COURT: Well, what about paragraph -- 04:21:03

3 MR. PORTNOI: Oh. Go ahead, Your Honor. 04:21:05

4 THE COURT: What about paragraph 56 that says: After 04:21:06

5 completion of the risk adjustment process for a given benefit 04:21:11

6 year, the government shifts funds by issuing invoices to those 04:21:14

7 insurers who owe risk adjustment payments and those insurers 04:21:17

8 who then submit due funds directly from the government and 04:21:21

9 issues payments from the treasury to those who are due risk 04:21:25

10 adjustment factors. 04:21:27

11 MR. PORTNOI: That is how the program generally works. 04:21:29

12 That does not allege that any of the 15 defendants ever 04:21:31

13 actually were any position to request money and receive money. 04:21:36

14 That's the key. It is not -- you can't simply say -- this 04:21:41

15 is -- Your Honor, this is a little bit like if you had a claim 04:21:43

16 for trespass and you said, look, there's a family of ten people 04:21:46

17 across the road and I think between zero and three of them have 04:21:50

18 crossed over and have trespassed on my land. So in other 04:21:54

19 words, what I'm saying is, yes, of course it would be a 04:21:58

20 violation if they trespassed, but I can't possibly allege that 04:22:00

21 even one of them has but maybe up to three of them have. And 04:22:03

22 so I'm going to sue ten of them and ask a court to let them get 04:22:07

23 past -- let that get past a motion to dismiss. 04:22:10

24 THE COURT: So what's missing is specific allegations 04:22:13

25 that money were either received or demand made or something of 04:22:16

1 federal funds through the exchange program that went to the -- 04:22:23
2 resounded to the benefit of any of the defendants. 04:22:28

3 MR. PORTNOI: Of an actual defendant. That would 04:22:30
4 still -- that would be getting at your claim. That's the 04:22:33
5 fundamental -- where I can make arguments about falsity, 04:22:33
6 materiality -- 04:22:36

7 THE COURT: I know. I understand. I understand. 04:22:37

8 MR. PORTNOI: -- that would get you to an allegation 04:22:40
9 of a claim. 04:22:42

10 THE COURT: All right. Then let me ask, Mr. Lewis, 04:22:42
11 what about that? 04:22:47

12 MR. LEWIS: Yeah. Your Honor, we allege 208, 209 that 04:22:47
13 in the aggregate, Kaiser was a net payor into the program and 04:22:51
14 to the tune of over \$6 billion. We allege that that payment is 04:22:56
15 grossly understated because if it were actually submitting 04:23:00
16 appropriate risk adjustment data, it would be paying much more 04:23:05
17 into it. That is a classic reverse false claim. It owed more 04:23:09
18 to the government than it paid. It was participating and a 04:23:18
19 condition of participation in the program was submission of 04:23:21
20 risk attestation forms which attested to the idea that the 04:23:24
21 information submitted was accurate and which stated that -- in 04:23:30
22 the attestation itself that the data submitted is the basis 04:23:34
23 upon which final risk adjustment transfers are calculated and 04:23:38
24 may be subject to False Claims Act. It's right there in the 04:23:42
25 attestation. They had to submit them every year. Every single 04:23:45

1 one of the health plans had to. And in the aggregate we have a 04:23:49
2 significant dollar value on what they did, Your Honor. 04:23:53

3 THE COURT: So the paragraph that contains the amounts 04:23:56
4 that were paid or should have been paid, what number is that 04:24:02
5 again? 04:24:06

6 MR. LEWIS: 208, 209, Your Honor. 04:24:07

7 THE COURT: Just look here. 04:24:09

8 These are long paragraphs. 04:24:23

9 MR. LEWIS: I apologize, Your Honor. 04:24:25

10 THE COURT: All right. So rather than identifying a 04:24:30
11 specific instance, it is sort of in the aggregate and there's a 04:24:32
12 figure and the allegation is that Kaiser would have paid more 04:24:37
13 to the risk pools had it not been for the inaccuracies. 04:24:46

14 MR. PORTNOI: And that is not a classic reverse false 04:24:54
15 claims theory, Your Honor. A classic reverse false claims 04:24:58
16 theory is when a company has -- when any entity or person has 04:25:00
17 received money and realizes later it received too much. 04:25:04

18 THE COURT: Well, that may be the classic but I 04:25:07
19 mean -- it seems to me now you're exalting form over substance. 04:25:10
20 If somebody owed a bunch of money to the federal government and 04:25:12
21 they lied and ended up paying less to the federal government 04:25:15
22 they should have, I -- why -- as a matter of policy -- I mean, 04:25:18
23 why should that matter? Why shouldn't that be a false claim 04:25:22
24 if they made a false attestation in order to get out of paying 04:25:25
25 what they should have paid? 04:25:28

1 MR. PORTNOI: Well, because a fundamental element of 04:25:29
2 the False Claims Act is that you have to have a request or 04:25:32
3 demand for money or property that is successful. It is not the 04:25:35
4 case that everybody that -- 04:25:39

5 THE COURT: Well, it was successful. They paid less 04:25:41
6 than they should have paid. That was success. 04:25:43

7 MR. PORTNOI: A request or demand for money or 04:25:45
8 property. It's called the False Claims Act. You have to -- 04:25:47

9 THE COURT: Yeah, but the ACA also says something 04:25:51
10 different, doesn't it. The ACA doesn't just simply echo the 04:25:53
11 False Claims Act. It says payments made by, through, or in 04:25:56
12 connection with an exchange are subject to the False Claims 04:25:59
13 Act, if those payments include any federal funds. 04:26:05

14 MR. PORTNOI: Right. Payments, Your Honor. If 04:26:08
15 payments are made. They cannot amend -- they do not -- 04:26:10
16 Congress did not amend the False Claims Act when it passed the 04:26:13
17 Affordable Care Act, Your Honor. 04:26:16

18 And, again, if you want -- to be very clear, if 04:26:17
19 somebody hasn't paid enough money to the United States, the 04:26:20
20 United States has a panoply of ways of recovering that. The 04:26:22
21 False Claims Act is not an all purpose recovery mechanism as -- 04:26:26
22 there are common law claims that are statutory claims. If 04:26:31
23 somebody has not paid enough taxes, that doesn't mean that you 04:26:34
24 need the False Claims Act. The IRS knows how to go get that 04:26:38
25 money. 04:26:42

1 THE COURT: Well, but does that preclude it? I mean,
2 section 3729(a)(1)(g) provides for liability any person who
3 knowingly conceals or knowingly and improperly avoids or
4 decreases an obligation to pay or transmit money or property to
5 the government.

6 Why doesn't that literally apply here?

7 MR. PORTNOI: I'm sorry. What was the -- where were
8 you?

9 THE COURT: 3729(a)(1)(G) talks about a person who
10 knowingly conceals or knowingly and improperly avoids or
11 decreases an obligation to pay or transmit money or property to
12 the government, why isn't that what we have here at least as
13 alleged?

14 MR. PORTNOI: What we have here, Your Honor, is we
15 don't have a record or statement material to that obligation.

16 The attestation of the Medicare Advantage Program
17 states that -- states that it is a request for payment, demand
18 for payment. We don't have that here. But even if we don't,
19 we also don't have false claims as well. And we also don't --

20 THE COURT: All right. I understand that. I mean,
21 I -- I'm running out of time, so I'm not going to -- I
22 understand. I got the papers on that.

23 I'll give you one chance to comment on the second
24 theory, the tax credit theory. Do you have any comment about
25 the causation chain or if there's any other case law I should

1 be aware of? 04:28:06

2 MR. PORTNOI: I certainly -- there's very little case 04:28:07
3 law in this area because there have been no relator claims 04:28:10
4 under the ACA and it's obviously relevant to materiality. And 04:28:14
5 I don't think there's any reasons regardless to reverse 04:28:19
6 Your Honor's ruling before that section 18033(a)(6)(A) is 04:28:21
7 insufficient under Escobar's plead materiality. 04:28:27

8 I think that's simply, to be honest, enough. 04:28:30
9 Your Honor commanded or gave leave to amend to allege facts 04:28:32
10 related to materiality. How many times has HHS pursued money, 04:28:37
11 for instance, in the past? The facts that are outlined in 04:28:43
12 Escobar. Your Honor already had law but Your Honor asked for 04:28:45
13 there to be facts added to the complaint and they were not. 04:28:49
14 This is almost precisely the same allegation that existed that 04:28:53
15 Your Honor rejected in your order at pages 8 to 9. 04:28:57

16 THE COURT: All right. Let me -- that's an important 04:29:00
17 point, Mr. Lewis, I'd like you to respond to that materiality 04:29:03
18 argument. 04:29:06

19 MR. LEWIS: Certainly, Your Honor. Yeah. I think 04:29:07
20 I -- started talking about tax credits and went to materiality, 04:29:12
21 so I don't think he wound up getting very far on tax credits. 04:29:16

22 THE COURT: I'll -- let's go to materiality. 04:29:18
23 That's -- 04:29:21

24 MR. LEWIS: Sure. You know, again, the attestation 04:29:22
25 itself is a new allegation and it goes directly to materiality. 04:29:24

1 With respect to our theories on the ACA, it says expressly that
2 risk adjustment data is the basis upon which final risk
3 adjustment transfers are calculated and may be subject to the
4 False Claims Act. It's right there. The government cares
5 about this. The government has investigatory powers and, in
6 fact, has investigated it, risk adjustment fraud in the ACA,
7 and we allege that in our complaint, among other things,
8 Your Honor.

9 Turning to the materiality section of our complaint
10 under the Affordable Care Act at paragraph 224 all the way
11 through 232. You know, we cite Congress explicitly stating
12 that the violations of material conditions of participation in
13 the ACA subject the defendants to the False Claim Act
14 liability. And they necessarily affect government payments.
15 And when tax credits are inflated because of this conduct, it
16 is almost per se material, Your Honor, when the government
17 overpays. Of course they care. They have to. And it's not by
18 trivial amounts but by amounts across the board that would
19 impact significant dollars to the government.

20 THE COURT: Does that rely on your tax credit theory
21 of the ACA?

22 MR. LEWIS: The latter does but the other points are
23 both. Just because it might be budget neutral, the government
24 has made it entirely clear that they care about the function of
25 the risk adjustment pool, how insurers deal with one another

1 and, in fact, take the money into the treasury as a token of
2 them caring because they want to manage this program. They
3 want it to be done correctly and they say exactly that in the
4 attestation program -- attestation form itself.

5 MR. PORTNOI: Your Honor, that's entirely general. If
6 it was the case that any attestation because of the existence
7 of an attestation provided materiality, there would never be
8 either an ACA case or a Medicare Advantage case that would lack
9 materiality. If we -- and so as a result, what we're talking
10 about here is there has to be a link between the alleged
11 falsity and the particular -- and the materiality. And there
12 isn't one. We have some information that HHS has some ability
13 to investigate, but there are -- but we don't have allegations
14 that they've engaged in enforcement actions with -- enforcement
15 actions in support of that that are similar, factually similar
16 to the ones here. This is not a new program and these are not
17 new claims. They've existed for a long time and we've made it
18 all the way to the third amended complaint.

19 With respect to the tax credit theory, I certainly
20 have more to say about that. I want to make clear, yes,
21 there's a massive causal chain problem here.

22 Let's just understand what we're talking about when we
23 talk about this theory. This suggests that somebody could use
24 the False Claims Act anytime some relator thinks an insurance
25 company has made insurance rates too affordable under the

1 Affordable Care Act that it violates the False Claims Act to
2 charge insureds too little for insurance. And that under the
3 False Claims Act, presumably it is possible for Your Honor or
4 another judge to order higher insurance rates under the False
5 Claims Act because it was fraudulent to not charge individual
6 citizens more money.

7 That simply -- is an implausible idea and that's the
8 entire theory of this. And, again, the URRT is not a claim.
9 There's nothing on the URRT that constitutes a claim or request
10 for money. This is a situation where what we're talking about
11 is getting funds from individuals who pay for insurance on the
12 exchanges.

13 THE COURT: All right. Give you the last word.
14 30 seconds, Mr. Lewis.

15 MR. LEWIS: Thank you, Your Honor.

16 This is not about a plan that is charging too little.
17 Kaiser is able to manipulate its risk adjustment data and
18 charge less because they're expecting to get a windfall from
19 the insurance pool and they can charge less and still -- and
20 benefit greatly because they're now at a competitive advantage
21 over their competitors who had to charge higher because they're
22 getting underpaid by the insurance pool. So when the Kaiser
23 plan is not the benchmark, the benchmark is one of these other
24 plans, Kaiser's the only one that benefits. They got a
25 competitive advantage, but the government and the taxpayer, the

1 recipient of health care, they're overpaying. And that's what
2 this is about.

3 THE COURT: All right. Thank you, Counsel. I will
4 take the matter under submission.

5 Thank you.

6 (Proceedings adjourned at 4:34 p.m.)
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C E R T I F I C A T E

I, SCOTT M. CONIAM, do hereby certify that I am duly appointed and qualified to act as Official Court Reporter for the United State District Court.

I FURTHER CERTIFY that the foregoing pages constitute a full, true, and accurate transcript of all of that portion of the proceedings contained herein, had in the above-entitled cause on the date specified therein, and that said transcript was prepared under my direction and control.

DATED this 5th day of May 2023.

s/Scott M. Coniam
SCOTT M. CONIAM, RDR, CRR

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EXHIBIT 5



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April 28, 2023

BY EMAIL

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Re: *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC –
Defendants' First Set of Requests for Admission

Dear Mr. Sullivan:

I write on behalf of the United States in response to your April 18, 2023 letter and our April 19, 2023 meet and confer regarding Defendants' First Set of Requests for Admission ("RFAs").

The RFAs do not seek the admission of facts, the application of law to facts, or opinions about either, and thus are improper on their face. Fed. R. Civ. P. 36(a)(1)(A). At most, the RFAs are nothing more than contention interrogatories that are grossly premature given the current stage of discovery.

Defendants' first thirty RFAs are all variants of the same form of request, namely, a request that the United States make so-called admissions about its contentions rather than actual facts. The United States is being asked to admit that it contends (or does not contend) that since January 1, 2009, any health care professional associated with any of the Defendants acted "knowingly," as used in the False Claims Act ("FCA"), 31 U.S.C. § 3729(b)(1), to add medical diagnoses to any form or kind of Document showing any aspect of medical treatment or care, performed by any health care professional associated with any of the Defendants, where the medical condition (a) did not co-exist at the time of the encounter, (b) did not "require or affect patient care, treatment or management," or (c) did not exist.

Case law both within and outside the Ninth Circuit—including cases cited in your April 18 letter—make clear that Defendants' RFAs are improper for multiple reasons. First, RFAs

“should be limited to singular relevant facts.” *Bovarie v. Schwarzenegger*, No. 08cv1661 LAB (NLS), 2011 WL 719206, at *6 (S.D. Cal. Feb. 22, 2011) (quotation marks omitted); *see also*, e.g., *Jefferson v. Perez*, No. CIV S-09-3008 GEB CKD P, 2012 WL 671917, at *1 (E.D. Cal. Feb. 29, 2012) (RFAs should be “singularly, specifically, and carefully detailed”); *Gibson Brands Inc. v. John Hornby Skewes & Co. Ltd.*, No. CV 14-0609 DDP (SS), 2015 WL 12681376, at *6 (C.D. Cal. July 20, 2015) (RFA for “information [that] may require complex judgments and nuanced appraisals, is generally improper”). RFAs seeking admissions “that you contend that acts or omissions on the part of [certain third parties] caused or contributed to the Accident,” were found to be improper in part because the requests “require lengthy explanations before they could be fairly answered.” *Crouch v. Teledyne Continental Motors, Inc.*, No. 10-00072-KD-N, 2011 WL 13135770, at *4 (S.D. Ala. Apr. 21, 2011) (cited by Kaiser Apr. 18, 2023 Ltr. at 2). Defendants’ RFAs concerning what the United States contends about the Defendants’ employees’ actions and states of mind—broadly over the entire case, spanning more than a decade and multiple regions, and untethered to any specific facts set forth in the RFAs—could not be further from these requirements.

Second, courts generally do not allow a party to serve RFAs asking its opponent to provide responses about the requesting party’s state of mind or knowledge. *See, e.g., Hankins v. Alpha Kappa Alpha Sorority, Inc.*, No. 19 CV 00147, 2021 WL 10312277, at *8 (N.D. Ill. Feb. 3, 2021) (RFA to one party for admissions about another party’s knowledge are improper); *Williams v. City of Albany*, No. 1:18-CV-1446 (LEK/DJS), 2019 WL 4071777, at *3 (N.D.N.Y. Aug. 28, 2019) (same).

Third and relatedly, asking a party to “admit that its contentions in this case include contentions as to the existence of particular facts” is not a proper request for admission and instead seeks disclosure of “trial strategy or legal theories. This is not the purpose of Rule 36.” *Paramount Fin. Commc’ns v. Broadridge Inv. Comm’n Sols., Inc.*, No. 15-405, 2017 WL 495784, at *4 (E.D. Pa. Feb. 7, 2017). Defendants’ requests all ask what the United States “contend[s]” about the conduct and mental states of Defendants’ healthcare provider employees—in substance, requesting admissions about the evidence and theories the United States’ attorneys will present at later stages of this case. Multiple courts have held RFAs of this type impermissible. In *Howell v. Maytag*, 168 F.R.D. 502 (M.D. Pa. 1996), the court rejected a defendant’s four RFAs about what theories the plaintiff would present at trial (e.g., “Request No. 1: Plaintiffs will not present evidence of a manufacturing defect in the microwave at trial of this matter”) for several reasons. To start, the court held that those RFAs sought “trial strategy” rather than factual admissions, and therefore exceeded Rule 36(a)(1)’s requirement that RFAs be limited to the scope of Rule 26(b)(1). *Id.* at 504. Next, the court held that “compelling discovery of trial strategy would violate the work product doctrine.” *Id.* Finally, the court held that it would be “unreasonable to expect a party to have determined what evidence it will choose to present at trial before the close of discovery.” *Id.* The Northern District of California agreed with *Howell*’s analysis, reiterating that a “request for admission directed to an opponent’s litigation strategy is improper.” *Google Inc. v. Am. Blind & Wallpaper Factory, Inc.*, No. C 03-5340 JF (RS), 2006 WL 2578277, at *3 n.2 (N.D. Cal. Sept. 6, 2006) (citing *Howell*). Defendants’ requests—seeking admissions about what the United States does or does not contend about Defendants’ doctors’ mental states—suffer from all the defects identified by the above cases.

None of the cases cited in your April 18 letter support Defendants' RFAs.¹ Your first case, *Jones v. Nutiva, Inc.*, No. 3:16-cv-00711-HSG(KAW), 2016 WL 5900722 (N.D. Cal. Oct. 11, 2016) (cited by Kaiser Apr. 18, 2023 Ltr. at 1), held that a plaintiff's RFAs to a defendant about the defendant's own state of mind were *improper* because they incorporated an interpretation of the legal standards at the heart of the case. *Id.* at *2. *Jones* is directly contrary to Defendants' position, given that Defendants' RFAs likewise implicitly incorporate an analysis of the regulatory benchmarks and the legal standards in the FCA at the heart of this litigation.

Ballew v. City of Pasadena, No. CV 18-0712 FMO (ASx), 2019 WL 9341338 (C.D. Cal. June 10, 2019) (cited by Kaiser Apr. 18, 2023 Ltr. at 2), is also inapposite. For starters, the issue in *Ballew* was whether the RFAs, which sought admissions from the City of Pasadena that individual police officer defendants had violated municipal policy, improperly sought legal conclusions. The RFAs did not concern the defendants' litigation contentions, neither party addressed the propriety of such RFAs in their briefing, and other than a single mention of the word "contentions," the district court's analysis had nothing to do with the subject. *Id.* at *3. Moreover, the court's passing reference to "the entity defendants' contentions" was not an endorsement of "contention RFAs" like Defendants', but rather was merely an acknowledgment that the individual officers might dispute the City's "contentions" that they had violated municipal policy.

As discussed above, *Crouch*, 2011 WL 13135770 (cited by Kaiser Apr. 18, 2023 Ltr. at 2), held that a defendant's RFAs to a plaintiff about the plaintiff's contentions were *improper*. *Id.* at *4.

The other cases in your April 18 letter similarly provide no support for Defendants' RFAs here.²

¹ We also asked at our April 19 meet and confer whether you were aware of any cases that have overruled objections to RFAs similar to the ones Defendants issued here, and you were not able to identify any.

² RFAs were not at issue in either *Zeleny v. Newsom*, No. 17-cv-07357-RS (TSH), 2020 WL 3057467 (N.D. Cal. June 9, 2020) (cited by Kaiser Apr. 18, 2023 Ltr. at 2), or *Campbell v. Facebook Inc.*, No. 13-cv-05996-PJH (MEJ), 2015 WL 3533221 (N.D. Cal. June 3, 2015) (cited by Kaiser Apr. 18, 2023 Ltr. at 3). *Rockwell v. Air and Liquid Sys. Corp.*, No. CV 21-3963-GW-PLAx, 2022 WL 2784395 (C.D. Cal. May 20, 2022) (cited by Kaiser Apr. 18, 2023 Ltr. at 2), addressed the effect of a party's failure to respond to RFAs, *id.* at *4–5, which is not at issue here, where the United States timely responded to Defendants' RFAs. *Stampley v. Fred's Dollar Store of Miss., Inc.*, No. 5:07-cv-153(DCB)(JMR), 2008 WL 480002 (S.D. Miss. Feb. 16, 2008) (cited by Kaiser Apr. 18, 2023 Ltr. at 2), analyzed the standard of proof for the \$75,000-threshold requirement for removal jurisdiction, *id.* at *2–4, an issue not relevant here, and mentioned RFAs only in passing. *Regan v. Conway*, No. CV 07-3207 (ADS)(ARL), 2010 WL 11629513 (E.D.N.Y. May 10, 2010) (cited by Kaiser Apr. 18, 2023 Ltr. at 2), did not address any challenges to the RFAs. *Id.* at *15–16. *Jacobs v. Quinones*, No. 1:10-cv-02349-AWI-JLT (PC), 2014 WL 2091252 (E.D. Cal. May 16, 2014) (cited by Kaiser Apr. 18, 2023 Ltr. at 2), involved a plaintiff's RFAs to defendants about the defendants' knowledge and whether the defendants had been subjected to prior disciplinary actions, lawsuits, or inmate appeals, *id.* at *4, and did not address a defendant's RFAs to a plaintiff about the defendant's own actions or knowledge. *Knature Co. v. Duc Heung Grp.*, No. 2:20-cv-03877-DMG-AFMx, 2021 U.S. Dist. LEXIS 120623 (C.D. Cal. Jan. 21, 2012) (cited by Kaiser Apr. 18, 2023 Ltr. at 3), involved a party's

Defendants claim that their RFAs “are similar to the interrogatories that the United States has already answered identifying their claims for payment that Defendants allegedly submitted to the Centers for Medicare and Medicaid Services that form the basis of the alleged False Claims Act violations in this case.” Kaiser Apr. 18, 2023 Ltr. at 4. This is a non sequitur. It is axiomatic that RFAs and interrogatories are different, and different standards apply. “Requests for admissions and interrogatories are not interchangeable procedures,” and courts do not permit parties to use “interrogatories disguised as requests for admissions in an attempt to circumvent a local rule limiting the number of interrogatories,” finding such conduct to be “an abuse of the discovery process.” *Safeco of Am. v. Rawstron*, 181 F.R.D. 441, 445–46 (C.D. Cal. 1998); see *Ochotorena v. Adams*, No. 1:05-cv-01524-LJO-DLB PC, 2009 WL 1953502, at *5 (E.D. Cal. July 7, 2009) (“Here, [the requesting party]’s request for admission is in effect an interrogatory in that its purpose is to find evidence This is not an appropriate use of a request for admission.”). More specifically, RFAs that are “tantamount to contention interrogatories” “run afoul of the purpose of Rule 36.” *Spectrum Dynamics Med. Ltd. v. Gen. Elec. Co.*, No. 18-CV-11386 (VSB) (KHP), 2021 WL 735241, at *2 (S.D.N.Y. Feb. 25, 2021). The Federal Rules of Civil Procedure subject interrogatories and RFAs to different rules, and in this case the parties negotiated a case management order that treats interrogatories and RFAs differently. Dkt. 150 at 18. Under the rule Defendants propose, no party would ever need to serve a contention interrogatory; they could simply swamp their opponent with unlimited contention RFAs instead.

Even if the distinctions between RFAs and interrogatories were set aside, Defendants’ requests would still be, at a minimum, premature. Courts in the Northern District of California—including the *Campbell* case you cite—hold that contention interrogatories ordinarily need not be answered before discovery is substantially complete, that a party seeking earlier responses bears “a burden of justification,” and that when the defendant is the party seeking contention interrogatories from the plaintiff, “courts should be ‘especially vigilant’” in evaluating those justifications when “the plaintiff’s complaint is not ‘facially infirm’ and the defendant appears to have control over or adequate access to much of the evidence relevant to its alleged misconduct.” *Campbell*, 2015 WL 3533221, at *4 (collecting cases); accord, e.g., *Amgen Inc. v. Sandoz Inc.*, No. 14-cv-04741-RS (MEJ), 2016 WL 1039029, at *3 (N.D. Cal. Mar. 15, 2016) (collecting cases). Here, discovery is not substantially complete—for example, Defendants still have not responded to the United States’ interrogatories, and represent that they are still months away from completing their document productions.³ What the United States will ultimately contend or prove at trial about Defendants’ medical providers’ actions and knowledge is a question of trial strategy that will depend on, among other things, the outcome of discovery and depositions. Defendants cannot meet their “burden of justification” for requiring the United States to respond to requests into its future trial strategy at this juncture. See, e.g., *Haggarty v. Wells Fargo Bank, N.A.*, No 10-2416 CRB (JSC), 2012 WL 4113341, at *2 (N.D. Cal. Sept. 18, 2012) (“[A]t least in

obligation to supplement RFA responses after the court overruled an objection based on ambiguity, *id.* at *10–11, an issue not relevant here. Finally, *Asis Internet Servs. v. Rausch*, No. 08-03186 EDL, 2010 WL 1838752 (N.D. Cal. May 3, 2010) (cited by Kaiser Apr. 18, 2023 Ltr. at 5), like *Rockwell*, addressed the effect of a party’s failure to respond to RFAs, *id.* at *5, which is not at issue here, where the United States timely responded to Defendants’ RFAs.

³ Additionally, the United States is likely to take additional written discovery after Defendants answer the complaint and fully respond to the United States’ interrogatories.

cases where defendants presumably have access to most of the evidence about their own behavior, it is not at all clear that forcing plaintiffs to answer these kinds of questions, early in the pretrial period, is sufficiently likely to be productive to justify the burden that responding can entail.”); *In re Convergent Techs. Sec. Litig.*, 108 F.R.D. 328, 337–38 (N.D. Cal. 1985) (same); *Ransom v. Herrera*, No. 1:11-cv-01709-LJO-EPG (PC), 2018 WL 4091738, at *6 (E.D. Cal. Aug. 23, 2018) (denying defendants’ motion to compel responses to interrogatories and RFAs requesting that plaintiff identify which pieces of evidence support which claims); *Quinio v. Aala*, No. 19-CV-4686-PKC-SJB, 2021 WL 9561320, at *1 (E.D.N.Y. Apr. 9, 2021) (“The defendant’s suggestion that plaintiffs answer based upon their current knowledge and supplement the responses as discovery proceeds is impracticable and points out the burdensome nature of its requests.”).

Defendants’ thirty-first through thirty-fourth RFAs, which also request admissions regarding the United States’ contentions, are similarly improper and do not fall within the scope of Rule 36, and the United States properly objected on that basis. In any event, as you note, there should be no confusion over the issues underlying these RFAs, given our discussions on these issues over the course of prior meet and confers. *See* Kaiser Apr. 18, 2023 Ltr. at 5. As we have previously said (and as is clear from the face of the Complaint and Amended Complaint), the United States does not seek to impose liability in this case based on failures to report or return overpayments under 42 U.S.C. § 1320a-7k(d), violations of requirements contained in the EDI Enrollment form, violations of the requirements of 42 C.F.R. § 422.503(b)(4)(vi), or submissions of improper Medicare Advantage bids to CMS.⁴

We trust that this letter explains how the United States’ Responses and Objections to Defendants’ First Set of RFAs comport with Rule 36 and the relevant authorities both within and outside the Ninth Circuit.

Sincerely,

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United States Attorney

By: s/Shiwon Choe
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Assistant United States Attorney

⁴ This is not to say that issues that may touch on these requirements are per se irrelevant to this case. For example, Defendants’ compliance program may be relevant to this case, notwithstanding that the program may also be related to 42 C.F.R. § 422.503(b)(4)(vi). But the United States’ Amended Complaint does not seek to impose liability in this case based on failures or violations of these requirements.

EXHIBIT 6



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**Re: United States ex rel. Osinek v. Kaiser Permanente, Case No. 3:13-cv-03891-EMC—
United States' Responses and Objections to Defendants' First Set of Requests for
Admission**

Dear Mr. Choe:

I write on behalf of Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (together, "Defendants") to confirm our understanding of the parties' respective positions from our May 8, 2023 meet-and-confer videoconference regarding the United States' objections to Defendants' First Set of Requests for Admission ("RFAs").

As explained during our meet-and-confer, Defendants understand the United States' objections to the RFAs to include the following: (1) RFAs seeking an opponent's contentions are improper; (2) Defendants' RFAs improperly seek to discover the United States' legal theories and trial strategies; (3) Defendants' RFAs are premature because discovery is ongoing; and (4) Defendants' RFAs improperly seek legal conclusions. For purposes of our discussion during the meet-and-confer, we noted that the parties have different views on these objections as detailed in our meet-and-confer correspondence, but nevertheless attempted to address your concerns and explore potential resolutions that would obviate the need to burden the Court.

First, we emphasized that Defendants' RFAs seek only to discover the United States' contentions regarding the specific factual questions raised in RFA Nos. 1 through 30. We explained that the RFAs are not intended to force the United States to commit to any factual contention for the remainder of this litigation and that, to the extent the United States' position

does change based on discovery of additional facts, it may supplement or amend its responses as necessary consistent with the Federal Rules of Civil Procedure.¹

Second, we explained that Defendants' RFAs seek an admission or denial of a straightforward factual contention as opposed to any legal conclusions. That is, the requests ask whether the United States contends that medical care providers knowingly added medical conditions to a patient's medical record that did not (1) require or affect patient care, treatment, or management, (2) coexist at the time of the visit, or (3) exist at all. Affirming or denying the United States' own factual contentions in this case does not require any legal judgments or conclusions. We also noted that, based on your statements to the Court during the Motion to Dismiss hearing on May 4, 2023, it appears that the United States could easily answer these RFAs. Judge Chen expressly noted that the medical care providers were instrumental in the United States' theory of the fraudulent scheme because, regardless of Defendants' corporate conduct, the diagnoses underlying the allegedly false diagnosis codes were added to the patients' medical record by the medical care providers. In particular, when asked by Judge Chen whether it is "really plausible that ... tens of thousands or hundreds of thousands of doctors would violate the ICD guidelines and whatever codes of ethics there are to go along with this program" to submit false diagnosis codes for payment, Assistant United States Attorney David Moskowitz, on behalf of the United States, said, "I want to be clear that our complaint is not based on that this is a doctor run program" and that the United States does not "need to allege or prove that the doctors acted knowingly" because "[t]he cause here was Kaiser."²

Despite stating to the Court that the United States does not need to establish that medical care providers acted knowingly in adding medical conditions that did not comply with the Contested Provision or otherwise exist to prove Defendants' liability in this case, during our May 8, 2023 meet-and-confer, you claimed that the conduct of individual medical care providers is relevant "but not necessary" to the United States' theory of liability and there would be "no grounds for barring" presentation of evidence concerning the conduct of individual medical care providers at trial. The United States cannot keep taking inconsistent positions on this foundational point. Withholding your factual contentions prejudices Defendants from adequately preparing their defenses because it prohibits Defendants from obtaining information

¹ See Fed. R. Civ. P. 26(e). Defendants also note that these RFAs are not premature contention discovery. They were not served at the outset of the case before discovery actively commenced. Instead, we are well over 15 months into the fact discovery period and there are less than 9 months left in the fact discovery period. As we explained, it is imperative that Defendants obtain this discovery regarding the United States' factual contentions early enough in the discovery period that they may pursue follow-up discovery of the United States and non-parties depending upon the answers your client provides.

² May 4, 2023, Mot. to Dismiss Hr'g (Judge Chen, Tr. 24:19-23, 33:20-22, 34:11). Relatedly, Judge Chen noted that the scheme Mr. Moskowitz described still "requires ... the doctors to cooperate" and Mr. Moskowitz replied, "You need some cooperation" but the "state of mind" of the doctor adding the medical condition to a patient medical record that did not comply with the ICD Guidelines or otherwise exist "just doesn't matter" because "when an organization turns a blind eye to overreporting ..., it exhibits reckless disregard and deliberate ignorance towards the truth or falsity of the data submitted to CMS." *Id.* at 25:1-5, 27:4-9. Judge Chen then asked the United States, "[I]f you don't have to demonstrate purposeful conduct by ... doctors ... acting under pressure of time, et cetera ..., how is their inclusion in a conspiracy justified?" Mr. Moskowitz replied, "[T]he doctors [sic] groups and the people that we're talking about in the doctors [sic] groups are part of the conspiracy are not like you're [sic] line level doctor." *Id.* at 39:1-3.

that you have admitted is relevant to the case, and thus discoverable under the Federal Rules of Civil Procedure.³ The United States cannot simultaneously agree that this information is relevant to its claims but also assert that it is non-discoverable by Defendants.

Given this admission of relevance, we sought to clarify the basis of your objection that it is improper for Defendants to ask for your contentions regarding relevant facts. You stated that the United States interprets Defendants' RFAs as seeking information regarding whether the United States currently "believes" that individual medical care providers in fact knowingly added medical conditions to a patient's medical record that did not comply with relevant aspects of the Contested Provision or otherwise exist. We clarified, again, that Defendants only seek to confirm the United States' *contentions* regarding this fact. We also discussed the similarity of these RFAs to interrogatories the United States has already answered regarding its factual contentions about which claims for payment submitted by Defendants were allegedly false, what information in those claims was false, and why the information was false. We asked you to explain why the knowledge of a medical care provider in taking an action is any less of a factual question than the actual action the medical care provider took. Both are factual questions and both are subject to contention discovery under Rule 36 and Rule 33. Yet you maintained that there is a distinction that renders discovery of contentions about knowledge impermissible. We disagree.

You then suggested that the United States may be willing to answer Defendants' RFAs to the extent the requests seek the United States' contentions regarding the conduct of individual medical care providers as alleged in the United States' Complaint as opposed to the United States' contentions regarding the conduct of medical care providers as it relates to the United States' overall theory of liability in this case. We explained that this distinction is immaterial given that, presumably, your Complaint reflects the United States' theory of Defendants' liability more generally. To the extent it does not, the United States may respond to Defendants' RFAs accordingly.

Lastly, as discussed, although we maintain that each of Defendants' RFAs is appropriate, in the interest of compromise and to avoid further burdening the Court, Defendants are willing to withdraw RFA Nos. 31 through 34 and the associated interrogatories in exchange for the United States providing full and complete responses to RFA Nos. 1 through 30. Please let us know by Wednesday, May 10, 2023 if the United States agrees to this compromise proposal.

* * *

³ See Fed. R. Civ. P. 26(b)(1).

Sincerely,

/s/ Stephen M. Sullivan

Stephen M. Sullivan
Partner
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EXHIBIT 7



U.S. Department of Justice

Civil Division

JAY:PLH:GRDyal
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Washington, DC 20530

January 27, 2023

VIA EMAIL

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Re: *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-03891-EMC – United States' Responses to Kaiser Foundation Health Plan, Inc.'s First Set of Requests for Production and First Set of Interrogatories

Dear Mr. Sullivan:

I am writing on behalf of the United States in response to your January 20 letter regarding Defendant Kaiser Foundation Health Plan, Inc.'s ("KFHP" or "Kaiser") Requests for Production ("RFP") Nos. 14 and 86.¹ As explained previously, the United States has agreed to respond in part to these requests, including by searching for Documents concerning standards for Addenda and various categories of Documents relating to RADV audits of Kaiser. *See* United States' Jan. 10 Ltr. at 1-2. What remains in dispute is whether the United States also must search for Documents concerning the agency's review of Addenda submitted by MAOs other than Kaiser, including more than 500 non-Kaiser RADV audits involving hundreds of thousands of non-Kaiser patient medical records. As discussed below, your letter mischaracterizes the relevance of such Documents while unfairly discounting the burdens of collecting, reviewing, and producing the hundreds of thousands of medical records reviewed during these audits and countless additional Documents concerning that review. Nevertheless, we remain hopeful that we can reach a compromise that is proportional to the needs of this case and offer potential next steps toward such an agreement.

¹ While not directly relevant to this dispute, your letter incorrectly states that the United States' January 10 letter "identifies only a single instance" in which Kaiser's December 23, 2022 letter inaccurately described the parties' December 21 meet-and-confer discussion. *See* KFHP Jan. 20 Ltr. at 1. Our letter notes multiple instances of such inaccuracies. *See* United States' Jan. 10 Ltr. at 1-2, 4 n.3.

I. Kaiser's Arguments Do Not Justify the Expansive Additional Discovery It Seeks.

Kaiser's arguments regarding the relevance of the agency's review of Addenda misunderstand both the nature of that review and the issues in this litigation. First, Kaiser's claim that such Documents could support its knowledge defense by showing the agency applied "[m]ultiple interpretations of the Contested Provision," *see* KFHP Jan 20 Ltr. at 5, overlooks the fact that Kaiser has not provided *any* interpretation of the Contested Provision under which its conduct would have been permissible. Rather, according to Kaiser (but contrary to the plain language of the ICD Guidelines), "any documented reference to a medical condition by the healthcare provider is sufficient," even if that condition *did not* require or affect patient care, treatment or management at the visit in question. *See* KFHP Jan. 20 Ltr. at 5.² Given Kaiser's apparent position that it could simply ignore the Contested Provision when adding diagnoses via Addenda, we fail to see how Documents showing nuanced or varying applications of that requirement—in the context of RADV audits or otherwise—are relevant to Kaiser's knowledge defense.³

Similarly, Documents relating to "CMS's handling [of] deviations or errors" in Contractors' application of the Contested Provision, which Kaiser claims "will further elucidate the boundaries of what the Contested Provision does and does not require," *see* KFHP Jan 20 Ltr. at 7, are irrelevant given Kaiser's position that the Contested Provision does not require *anything*. Nor has Kaiser explained how "the rate of those errors" bears on the materiality of Kaiser's knowing violations of the Contested Provision. *See id.* In any event, the purported relevance of such Documents cannot justify the requests at issue. The United States has already agreed to produce CMS Documents concerning the Contested Provision, whereas Kaiser's current requests seek RADV audit Documents regardless of whether they discuss that requirement.

Kaiser's remaining relevance arguments all rely on the premise that auditors' "validation" of diagnoses contained in Addenda could show that Kaiser's violations of the Contested Provision were not material to CMS. *See, e.g.,* KFHP Jan. 20 Ltr. at 3 (describing various hypothetical scenarios in which this "validation" may have occurred). But as discussed in our prior letter, any such "validation" is irrelevant, because RADV audits and other similar reviews of MAO medical records are neither designed to detect nor capable of detecting the type of fraud Kaiser perpetrated. Kaiser declares this explanation "preposterous," *see* KFHP Jan 20

² In our January 10 Letter, we invited Kaiser to clarify how, if at all, this purported "interpretation" of the Contested Provision relates to the provision's requirement that conditions "require or affect patient care, treatment, or management." *See* United States' Jan. 10 Ltr. at 3 n.10. Kaiser declined to provide any such explanation. *See generally* KFHP Jan. 20 Ltr.

³ Kaiser provides no support for its further suggestion that the United States' Amended Complaint contains "varying interpretations of what the [Contested Provision] does or does not require." *See* KFHP Jan 20 Ltr. at 5. In making this claim, Kaiser points to the United States' allegation that Kaiser added diagnoses "to the medical records of unrelated patient visits." *Id.* (quoting Am. Compl. ¶ 103). But it is self-evident that conditions that were "unrelated" to patient visits could not have required or affected patient care, treatment, or management at those visits, as required by the Contested Provision.

Ltr. at 5, but fails to address its substance. As we have repeatedly explained, RADV audits assess only whether the medical record documentation an MAO submits for review supports the risk adjustment diagnoses reported for a patient. The audits do not and cannot assess whether information in those medical records is false or misleading. For example, if an MAO simply fabricated the documentation supporting its diagnoses, RADV audits would have no way to detect this practice. And in the case of a scheme like Kaiser's, auditors would not know that diagnoses documented in Addenda by physicians did not actually require or affect patient care, treatment, or management at a patient visit. To the contrary, without knowledge of the MAO's broader practices, auditors could reasonably assume that diagnoses appearing in Addenda were added by physicians of their own volition and accurately reflected conditions that actually required or affected patient care, treatment, or management at the associated visits.

Thus, Kaiser's argument that RADV audits may have validated MAO medical records "in circumstances *identical* to those alleged by the United States in this case," *see* KFHP Jan. 20 Ltr. at 5 (emphasis in original), ignores the fact that the records auditors reviewed did not show the "circumstances" of Kaiser's fraudulent scheme. For example, they did not show that Kaiser sent thousands of queries to doctors asking them to alter those records using Addenda. They did not show that Kaiser used financial incentives and performance evaluations to pressure doctors to comply with those requests. And they did not show that Kaiser sent those queries and applied that pressure for conditions that had nothing to do with patient visits and instead were identified through separate data mining initiatives. Again, RADV auditors assessed only whether the medical records from a visit supported the diagnosis codes submitted by an MAO. They could not identify—much less "validate"—instances where an MAO's systematic alteration of those records meant the records no longer accurately reflected the visits they purported to describe.

Kaiser contends that this distinction between what appeared in its medical record documentation and what in fact happened at patient visits is "odd" and "beside the point." *See* KFHP Jan 20 Ltr. at 5. To the contrary, it demonstrates both why Kaiser's conduct was fraudulent and why Kaiser's relevance arguments are misguided. Kaiser used Addenda to make it appear to auditors as though conditions represented by diagnosis codes existed at the time of patient visits and required or affected patient care, treatment or management at those visits, when *in fact* they did not. Having implemented a scheme to evade detection by agency audits, Kaiser cannot claim that those audits' inability to uncover that scheme means its violations were not material to CMS. Nor can Kaiser demand records from hundreds of audits of other MAOs in the hope that such audits may have "validated" similar schemes perpetrated by those entities. Because RADV audits could not detect a scheme like Kaiser's, the fact that a medical record containing an Addendum passed RADV review is irrelevant to whether Kaiser's violations of the Contested Provision were material.⁴

⁴ Kaiser's argument fails regardless of whether the audits in question were performed by the agency directly or by agency contractors. The fact that RADV audits were performed by contractors merely further attenuates their relevance because contractors' analysis reflects only "a secondary reflection of the agency's views," and Kaiser will receive the primary source material in the form of direction and guidance the agency provided to those contractors. *See* United States' Jan. 10 Ltr. at 4.

II. Kaiser's Requests are Unduly Burdensome.

Given the limited relevance of the Documents in question, the burdens of Kaiser's requests—which demand hundreds of thousands of sensitive medical records and potentially millions of additional documents relating to more than 500 audits of other MAOs—are plainly disproportional to the needs of this case.⁵ Kaiser's purported rebuttals to the United States' burden objections rely entirely on mischaracterizations and false equivalencies.

As an initial matter, Kaiser's claim of an "imbalance" between the parties' discovery to date is irrelevant. *See* KFHP Jan. 20 Ltr. at 9. Under the federal rules, the relevant question is not whether the parties' productions are proportional to *each other*, but whether the discovery each party requests is "proportional to the needs of the case." Fed. R. Civ. P. 26(b)(1). Given that this litigation concerns Kaiser's conduct, it is unsurprising that Kaiser would possess a far larger volume of relevant documents.

Kaiser's comparison of its requests to the United States' RFP No. 11 also fails. First, Kaiser ignores that the United States agreed to limit its request for Kaiser audit materials to instances where Kaiser's diagnoses were found to have violated the requirements at issue in this case. *See* United States' Nov. 1, 2022 Ltr. at 7. Kaiser's request for all documents concerning any instance in which the agency reviewed an Addendum contains no such limitation. Second, Kaiser's claim that the United States' request raises "[s]imilar concerns" about the confidentiality of patient health information ignores the fact that, unlike the United States, Kaiser is a private entity demanding the health records of its competitors' patients. *See* KFHP Jan 20 Ltr. at 9. Regardless of the terms of the parties' protective order, Kaiser's request for hundreds of thousands of such records implicates privacy risks that must be weighed against the limited relevance of these records to the issues in this litigation.

Most importantly, Kaiser cannot claim its requests are comparable to the United States' RFP No. 11 because the United States' request only seeks Documents relating to Kaiser's audits of its own medical records. In contrast, Kaiser has requested Documents relating not only to the agency's audits of Kaiser (which the United States has agreed to produce) but also to audits of *every other MAO*, including the hundreds of thousands of medical records these MAOs submitted for review. Courts have recognized that this type of unfettered inquiry into the conduct of non-parties risks discovery "deteriorat[ing] into 'extended mini-trials' regarding each arguable comparator." *United States ex rel. Goodman v. Arriva Med., LLC*, 471 F. Supp. 3d 830, 844-45 (M.D. Tenn. 2020) (quoting *First Horizon Nat'l Corp. v. Houston Cas. Co.*, No. 2:15-CV-2235-SHL-DKV, 2016 WL 5869580, at *9 (W.D. Tenn. Oct. 5, 2016)). Because only Kaiser's conduct is at issue in this litigation, the burden of locating, reviewing, and producing

⁵ Kaiser claims the United States' description of the Documents requested is "demonstrably untrue" because Kaiser has limited its request to "the categories of documents articulated in [its] December 5, 2022 Letter." *See* KFHP Jan 20 Ltr. at 9. However, as Kaiser elsewhere notes, those categories include not just medical records and RADV audit determinations, but also "documents concerning those medical records and RADV Audit determinations." *See id.* at 2 n.9. We fail to see how this category limits Kaiser's request for RADV audit documents in any meaningful way, much less one that renders the United States' description of the Documents requested "untrue."

every Document from the agency's audit of every other MAO vastly outweighs any potential relevance of these materials.

III. The United States Will Respond to Reasonable Requests for Documents Relating to Other MAOs.

As it currently stands, Kaiser's requests amount to a fishing expedition for at least hundreds of thousands of medical records and other documents regarding patients from other MAOs, virtually none of which are relevant to this case. This fishing expedition is especially unwarranted because we have already agreed to produce Documents regarding directions and guidance the agency provided to contractors relating to the Contested Provision as well as records regarding audits of Kaiser. Those records alone will allow Kaiser to make whatever arguments it wishes to make regarding RADV audits, including those identified in your letter, without the need for unnecessary and burdensome discovery regarding audits of every other MAO.

Nevertheless, in an attempt to compromise, the United States is willing to discuss whether Documents from audits of a limited set of MAOs would satisfy Kaiser's requests. For example, Kaiser's letter indicates it has knowledge that other MAOs were engaged in similar practices, such that audits of those MAOs could involve "circumstances *identical* to those alleged by the United States in this case." See KFHP Jan. 20 Ltr. 5 (emphasis in original). To further our discussions, please explain (1) what "circumstances" Kaiser is referencing as being "identical" to those at issue in this case; and (2) which MAOs submitted Addenda under such identical circumstances within the relevant time frame.

Sincerely,



Gary R. Dyal
Trial Attorney
DOJ Civil Division

Cc: Assistant U.S. Attorney Shiwon Choe (N.D. Cal.)
Assistant U.S. Attorney David DeVito (N.D. Cal.)
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EXHIBIT 8



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April 18, 2023

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**Re: United States ex rel. Osinek v. Kaiser Permanente, Case No. 3:13-cv-03891-EMC—
United States' Responses and Objections to Defendants' First Set of Requests for
Admission**

Dear Mr. Choe:

I write on behalf of Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (together, "Defendants") in response to the United States' objections to Defendants' First Set of Requests for Admission ("Objections").¹

I. Defendants' Requests for Admissions Are Proper Under Ninth Circuit Case Law.

As you know, Defendants served the United States with 34 Requests for Admission ("RFAs") that ask the United States to admit or deny certain factual allegations at issue in this litigation and confirm the scope of Defendants' alleged liability in this case, but the United States did not respond to a single RFA. Not one. The United States instead flatly objects to each of Defendants' RFAs and characterizes the requests as improper and premature. But in RFA Nos. 1 through 30, Defendants seek to confirm the factual basis for certain key allegations the United States has lodged against Defendants in this case. These types of RFAs are common practice under Federal Rule of Civil Procedure 36, which "authorizes a party to serve" written requests "to admit ... the truth of any matters within the scope of Rule 26(b)(1) relating to ... facts, the application of law to fact, or opinions about either."² The purpose of RFAs is "first, to facilitate

¹ While this letter focuses on your objections to Defendants' First Set of Requests for Admission, we also intend to discuss the bases for your objections to Defendants' corresponding Interrogatories and Request for Production during our meet-and-confer on Wednesday, April 19, 2023.

² *Jones v. Nutiva, Inc.*, 2016 WL 5900722, at *1 (N.D. Cal. Oct. 11, 2016) (citing Fed. R. Civ. P. 36(a)(1)(A)).

proof with respect to issues that cannot be determined from the case, and second, to narrow the issues by eliminating those that can be.”³

In the Objections, the United States asserts that it is improper for Defendants to use RFAs to discover your contentions in this case. That is incorrect. Courts in the Ninth Circuit interpret Rule 36 as “expressly contemplat[ing]” that this discovery tool “will be used to take contention discovery.”⁴ For example, in *Ballew v. City of Pasadena*, the plaintiff issued RFAs asking the City to respond to questions relating to whether individual employees violated municipal policy during their encounter with plaintiff.⁵ The City objected to the RFAs as calling “for an improper legal conclusion”; however, the court held that the RFAs were proper because “they seek only the entity defendants’ contentions as to whether their employees, the individual defendants, violated any policies” of the Pasadena Police Department and were thus “clearly related to the facts of the case.”⁶ Just so here. Like in *Ballew*, Defendants’ RFAs seek the United States’ contentions about the conduct of individual medical care providers—*i.e.*, facts that the United States has put directly at issue in the Complaint, in prior discovery correspondence, and in briefing to the Court on Defendants’ motions to dismiss. For example, you have explained that “in the case of a scheme like Kaiser’s,” it was reasonable for auditors to “assume that diagnoses appearing in Addenda were added by physicians of their own volition and accurately reflected conditions that actually required or affected patient care, treatment, or management at the associated visits.”⁷

The United States’ Objections that Defendants’ RFAs are premature “because ... the material facts and evidence regarding such are still being developed through discovery” is equally meritless.⁸ First, Defendants are not serving these RFAs at the beginning of the discovery period as your letter implies; the parties have been engaged in substantial discovery for well over a year. Defendants thus properly seek to use these RFAs and accompanying Interrogatories and Request for Production to “narrow[] the issues that will be addressed at

³ *Id.* (citing *Conlon v. United States*, 474 F.3d 616, 622 (9th Cir. 2007)).

⁴ *Zeleny v. Newsom*, 2020 WL 3057467, at *2 (N.D. Cal. June 9, 2020); *see also Rockwell v. Air & Liquid Sys. Corp.*, 2022 WL 2784395 (C.D. Cal. May 20, 2022); *Stampley v. Fred’s Dollar Store of Miss., Inc.*, 2008 WL 480002 (Feb. 16, 2008); *Crouch v. Teledyne Cont’l Motors, Inc.*, 2011 WL 13135770 (S.D. Ala. Apr. 21, 2011); and *Regan v. Conway*, 2010 WL 11629513 (E.D.N.Y. May 10, 2010).

⁵ 2019 WL 9341338, at *1 (C.D. Cal. June 10, 2019).

⁶ *Id.* at *3; *see also Jacobs v. Quinones*, 2014 WL 2091252, at *4 (E.D. Cal. May 16, 2014) (explaining that “one function of RFAs is similar to interrogatories in that they are allowed and are not improper simply for requesting information upon which to determine the opposing party’s contentions”).

⁷ Jan. 27, 2023 Letter from DOJ to KFHP, at 3; *see also* Pl.’s Opp. to Defs.’ Mot. to Dismiss Pl.’s Am. Compl. at 1, Dkt. No. 253 (“All of the false claims alleged stem from the same basic defect in these programs: when Kaiser pressured and incentivized physicians to add diagnoses to medical records, Kaiser routinely ignored what actually occurred at the patient visit.”); *id.* at 6 (“Some physicians who were pressured to add diagnoses for conditions that did not exist complained that Kaiser was asking them to participate in fraud.”) (citation omitted); Pl.’s Opp. to Defs.’ Mot. to Dismiss Pl.’s Compl. at 1, Dkt. No. 197 (“Kaiser engaged in this scheme for money, pressuring and incentivizing physicians to add diagnoses improperly via addenda, especially at the end of the year as part of Kaiser’s ‘dash for cash.’”; *id.* at 8 (“Kaiser ignored numerous red flags and internal warnings that it was violating Medicare rules, including concerns raised by its own physicians that these were false claims[.]”) (citation omitted); and Am. Compl. ¶¶ 175-76, 356, 364-73.

⁸ Apr. 10, 2023, United States’ Resps. & Objs. to Defs.’ First Set of RFAs, at 4.

trial.”⁹ Second, the United States is only obliged to respond based on the information it currently possesses. In the event that the United States obtains new or additional information that alters the nature of its response, Rule 26(e) permits – indeed, requires – the United States to supplement the response to these RFAs. Thus, it is not a proper basis to deny Defendants responses to the RFAs based on the information currently in your possession and control simply because the United States may supplement or amend its responses at a later date based on later-acquired information.¹⁰

II. The United States’ Objections Are Unsupported by the Case Law It Cites.

Ignoring relevant Ninth Circuit authority, the United States’ Objections to Defendants’ RFAs rely on a collection of out-of-circuit cases. But, even assuming the United States’ cases apply here, each is materially distinguishable, as Defendants’ RFAs here seek to confirm facts supporting allegations that the United States has asserted in this case and to narrow the issues for summary judgment and/or trial.

A. RFAs Seeking a Party’s “Contentions” Are Appropriate Under Rule 36.

The United States objects that “what a party ‘contends’ is not a proper subject of” an RFA.¹¹ The United States first cites *Paramount Financial Communications, Inc. v. Broadridge Investor Communication Solutions, Inc.*, an Eastern District of Pennsylvania case, in which plaintiffs moved to compel full and complete responses to their first set of RFAs, some of which asked defendant to “admit that it ‘alleges’ certain information”—e.g., “that [defendant] ‘alleges to have fully performed all of its obligations under Section 14 of the Marketing Agreement.’”¹² The court sustained defendant’s objection and explained that “plaintiffs are not asking defendant to admit to facts, but to disclose its trial strategy or legal theories”¹³ However, the court also observed that “[t]he presence of legal conclusions in an RFA does not warrant objection if the RFA applies the law to facts.”¹⁴ Unlike in *Paramount*, Defendants’ RFAs do not ask the United States to admit that it contends medical care providers have complied with certain laws or regulations for the purpose of determining the United States’ trial strategy or legal theories. Rather, the requests are similar to those in *Ballew* and only ask about the United States’ factual contentions regarding the conduct and state of mind of medical care providers described in the Complaint as adding allegedly false medical conditions to patient medical records that resulted in the submission of false claims to the United States.¹⁵ On their face, the RFAs do not call for any

⁹ See *Campbell v. Facebook Inc.*, 2015 WL 3533221, at *3 (N.D. Cal. June 3, 2015).

¹⁰ See e.g., *Knature Co. v. Duc Heung Group*, 2021 U.S. Dist. LEXIS 120623, *4 (C.D. Cal. Jan, 21, 2012) (rejecting plaintiff’s objections to interrogatories asking it to state the facts supporting its allegations and claims in the case on the basis that litigation was “in its early stages” and the plaintiff had not yet “had a full opportunity to take discovery from” the defendants because plaintiff “must identify any underlying facts that support the claims and allegations at issue—to the extent Plaintiff knows of them at the time of its response”).

¹¹ Apr. 10, 2023, United States’ Resps. & Objs. to Defs.’ First Set of RFAs, at 4.

¹² 2017 WL 495784, at *4 (E.D. Pa. Feb. 7, 2017).

¹³ *Id.*

¹⁴ *Id.* at *3.

¹⁵ See *supra* n.7.

legal conclusion by the United States. But to the extent Defendants' RFAs implicate a legal conclusion, it is only in the context of applying the law to the facts. Nor do the RFAs call for disclosure of your trial strategy or work product. Indeed, they are similar to the interrogatories that the United States has already answered identifying the claims for payment that Defendants allegedly submitted to the Centers for Medicare and Medicaid Services that form the basis of the alleged False Claims Act violations in this case. In those interrogatories, we asked the United States to disclose its contentions about which claims for payment were allegedly false, to identify what information in those claims was false, and to explain why the information was false. This discovery is similar.

The United States' reliance on *Spectrum Dynamics Medical Ltd. v. General Electric Co.* is similarly misplaced. In *Spectrum*, for "each of the over 60 individuals," plaintiff had "22 separate RFAs" asking defendant to admit that certain individuals executed particular agreements, were "subject to the terms, including confidentiality obligations," of the agreements, and accessed plaintiff's information during certain time periods.¹⁶ Defendant moved for a protective order "on the grounds that the RFAs are designed to obtain new information, not to narrow or limit issues for trial."¹⁷ The court granted the protective order, explaining that the RFAs did "not narrow the issues" and, instead, would result in "numerous other follow-on questions."¹⁸ As a threshold matter, it is not an accurate statement of the law that RFAs may only be used to narrow disputed factual issues. To the extent the United States reads *Spectrum* as suggesting such a rule of law, we disagree with that interpretation. Nonetheless, contrary to the RFAs issued in *Spectrum*, Defendants' RFAs are not designed to obtain new information because the United States has already alleged that medical care providers documented medical conditions in patient's medical records that were submitted as false claims for payment.¹⁹ In fact, your entire theory of FCA liability necessarily depends upon medical providers taking action to add documentation to the patient's medical record via addenda reflecting diagnoses that were not originally recorded in the medical record for the associated patient encounter.²⁰ As such, Defendants' RFAs are designed to help narrow the issues for trial by confirming and otherwise clarifying these existing allegations. In particular, Defendants need to know if the United States contends that the medical care providers implicated by your allegations knowingly added medical conditions that did not exist or that did not comply with the so-called Contested Provision that is at the heart of this case. The admissions or denials of the United States to these RFAs will then allow Defendants to focus future discovery by, for example, developing evidence relating to the specific medical care providers, if any, the United States is claiming knowingly added false medical conditions to patient medical records.

¹⁶ 2021 WL 735241, at *1-2 (S.D.N.Y. Feb. 25, 2021).

¹⁷ *Id.* at *2.

¹⁸ *Id.*

¹⁹ See *supra* n.7.

²⁰ See e.g., Pl.'s Opp. to Defs.' Mot. to Dismiss Pl.'s Compl. at 20, Dkt. No. 197 ("Kaiser instituted numerous mechanisms to pressure and incentivize physicians to add diagnoses, while also telling physicians not to spend any significant time evaluating the requested new diagnoses. These were not instances of a physician mistakenly clicking on the wrong diagnosis; they resulted from a deliberate and reckless scheme to alter patient records to obtain money.") (citation omitted).

Relatedly, the United States objects to Defendants' RFA Nos. 31 through 34, which ask about the United States' contentions regarding the scope of Defendants' liability in this case. But these requests, too, are appropriately within the scope of Rule 36 because they seek to narrow the issues for trial by confirming the scope of Defendants' alleged liability in this case.²¹ We might add that each of these RFAs merely seeks to confirm representations that you and your colleagues have already made to us during meet and confer discussions over the last year. Thus, we are surprised by the Objections the United States has asserted to these RFAs.

B. Defendants' RFAs Do Not Seek Information Concerning the United States' Knowledge.

The United States also objects to Defendants' RFAs to the extent they seek "information regarding the United States' or HHS's theory of the case or current knowledge regarding the actions of Defendants' Medical Care Providers" or "information regarding the United States' or HHS's knowledge regarding the knowledge or scienter of Defendants' Medical Care Providers."²² These Objections misconstrue Defendants' RFAs, which are solely focused on establishing the facts upon which the United States is basing its FCA claims against Defendants. In particular, you cite three out-of-circuit cases to support your Objections that RFAs asking a party about another party's "current state of knowledge" or asking a party about the knowledge of a third party are inappropriate.²³ But RFAs seeking to establish a party's knowledge are acceptable in the Ninth Circuit,²⁴ and we are unaware of any Ninth Circuit case law limiting RFAs concerning knowledge to knowledge of the answering party only. The United States' allegations put the decision making of individual medical providers at issue, given that those providers allegedly added medical conditions via addenda for medical conditions that you contend either did not exist or did not comply with the Contested Provision. It is entirely appropriate, and indeed essential, for Defendants to know whether the United States alleges that these medical providers did so knowingly and, if so, the factual basis for those allegations.

* * *

We look forward to discussing how your position and stated Objections comport with the relevant Ninth Circuit authorities discussed above during our meet-and-confer on Wednesday, April 19, 2023 at 10:00 am PDT.

²¹ See *Spectrum Dynamics*, 2021 WL 735241, at *2 (explaining that RFAs seeking to limit or narrow the issues for trial are appropriate).

²² Apr. 10, 2023, United States' Resps. & Objs. to Defs.' First Set of RFAs, at 4.

²³ See *id.* (citing *SEC v. Nutmeg Grp.*, 285 F.R.D. 403, 405–06 (N.D. Ill. 2012); *Hankins v. Alpha Kappa Alpha Sorority, Inc.*, 2021 WL 10312277, at *8 (N.D. Ill. Feb. 3, 2021); and *Williams v. City of Albany*, 2019 WL 4071777, at *3 (N.D.N.Y. Aug. 28, 2019)).

²⁴ See, e.g., *Asis Internet Servs. v. Rausch*, 2010 WL 1838752, at *5 (N.D. Cal. May 3, 2010) (finding that defendant's failure to respond to plaintiff's RFAs regarding whether he knew affiliates were violating a federal law regarding transmission of unsolicited commercial email constituted an admission and satisfied the statute's knowledge requirement such that it was appropriate to grant summary judgment).

Sincerely,

/s/ Stephen M. Sullivan

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EXHIBIT 9

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel.
RONDA OSINEK,

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC.,
et al.,

Defendants.

Case No. [13-cv-03891-EMC](#)

CONSOLIDATED MEMBER CASES

Case No. [16-cv-01558-EMC](#)

Case No. [16-cv-05337-EMC](#)

Case No. [18-cv-01347-EMC](#)

Case No. [21-cv-03124-EMC](#)

Case No. [21-cv-03894-EMC](#)

**ORDER GRANTING IN PART AND
DENYING IN PART DEFENDANTS'
MOTION TO DISMISS UNITED
STATES' COMPLAINT IN
INTERVENTION**

Docket No. 178

The above-referenced case consists of several consolidated cases that charge Kaiser entities with making false claims for payment to the federal government. The main claims asserted against the Kaiser entities are violations of the federal False Claims Act ("FCA"). Following the Court's order of May 5, 2022, *see* Docket No. 171 (order), the following cases remain:

- (1) The United States' complaint in intervention (Docket No. 110);
- (2) The first amended complaint in *Osinek* (Docket No. 87);
- (3) Parts of the second amended complaint in *Taylor* (Docket No. 118); and
- (4) Parts of the first amended complaint in *Bryant* (Docket No. 117).¹

¹ The Court's order also dismissed the claims in *Bicocca* except to the extent the first amended complaint (Docket No. 16 in Case No. C-21-3124 EMC) pled claims under the California False

Currently pending before the Court are four motions to dismiss filed by the relevant Kaiser entities. The motions are targeted at all of the cases that remain. This order addresses only the motion to dismiss the United States’ complaint in intervention. Having considered the parties’ briefs, the Court hereby **GRANTS** in part and **DENIES** in part the motion to dismiss.

I. FACTUAL & PROCEDURAL BACKGROUND

In its complaint, the United States alleges as follows.

“Medicare is a federally operated health insurance program.” U.S. Compl. ¶ 52. It has four parts:

- Part A, which covers inpatient and institutional care.
- Part B, which covers outpatient care.
- Part C, which is the Medicare Advantage program at issue in this case.
- Part D, which covers prescription drugs.

See U.S. Compl. ¶ 52.

Parts A and B are “traditional” Medicare.

[T]he Government reimburses healthcare providers using a fee-for-service system, in which providers submit claims to CMS [Centers for Medicare and Medicaid Services] for healthcare services actually rendered, such as a provider office visit or hospital stay. CMS then pays the providers directly for each service based on payment rates predetermined by the Government.

U.S. Compl. ¶ 53.

A Medicare beneficiary can opt out of traditional Medicare and enroll instead in a Medicare Advantage plan (“MA plan”) managed by a Medicare Advantage organization (“MA organization” or “MAO”). *See* U.S. Compl. ¶ 54. “CMS reimburses MA plans differently than traditional Medicare.” U.S. Compl. ¶ 57. Specifically, Medicare Advantage uses a “capitation” payment system.” *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under that system, “private health insurance organizations provide Medicare benefits in

Claims Act. *See* Docket No. 171 (Order at 46). However, prior to the Court’s order, the plaintiff in *Bicocca* had dismissed those state law claims. *See* Docket No. 159 (notice of voluntary partial dismissal with respect to Counts III and IV of FAC). Accordingly, there is nothing left in *Bicocca*.

1 exchange for a fixed monthly fee per person enrolled in the program – regardless of actual
 2 healthcare usage.” *Id.* The fixed monthly fee for an enrollee is set as follows. First, there is a
 3 predetermined base payment for each enrollee in a Medicare Advantage plan. *See* U.S. Compl. ¶
 4 57. Second, the base payment is then adjusted “to account for (1) demographic factors such as age
 5 and gender (among others) and (2) health status. This is known as risk adjustment.” U.S. Compl.
 6 ¶ 58.

7 Risk adjustment is accomplished by assigning each beneficiary a risk score, which “acts as
 8 a multiplier that is applied to the MA plan’s base rate to determine the overall monthly payment
 9 for the beneficiary.” U.S. Compl. ¶ 58. A beneficiary’s risk score is determined through a model
 10 called the CMS Hierarchical Conditions Category (“HCC”) model, which, as indicated above, is
 11 based on the patient’s demographic factors and health status. *See* U.S. Compl. ¶ 59. “The CMS-
 12 HCC model is prospective in the sense that it uses diagnoses made in a base year (the ‘service
 13 year’), along with demographic information (such as age and gender, among others), to predict
 14 costs for Medicare benefits and adjust payments for the following year (the ‘payment year’).” U.S.
 15 Compl. ¶ 60.

16 With respect to health status, the model relies on diagnosis codes from the International
 17 Classification of Diseases (“ICD”). *See* U.S. Compl. ¶ 60. “ICD diagnosis codes are
 18 alphanumeric codes used by healthcare providers, insurance companies, and public health
 19 agencies to represent medical conditions; every disease, injury, infection, and symptom has its
 20 own code.” U.S. Compl. ¶ 62. In general, the more severe an enrollee’s medical diagnoses are,
 21 the greater the risk adjustment is, and the more a MA organization is paid. *See* U.S. Compl. ¶ 2
 22 (alleging that “CMS adjusts these payments for various ‘risk’ factors that affect expected
 23 healthcare expenditures, to ensure that MA Organizations are paid more for sicker enrollees
 24 expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower
 25 costs”); U.S. Compl. ¶ 3 (alleging that “the amount of payment that CMS made to [a MA
 26 organization] for a Medicare Advantage patient depended directly on the diagnoses that [the MA
 27 organization] submitted to CMS for that patient”).

28 To participate in Medicare Advantage, a MA organization “must enter into and execute a

written contract with CMS for the MA plans [it] operate[s].” U.S. Compl. ¶ 74. According to the government, both under its contract with CMS and under federal regulations, a MA organization is required to provide CMS with risk adjustment data for its enrollees conforms with not just the ICD diagnosis codes but also the ICD Guidelines. *See, e.g.*, U.S. Compl. ¶¶ 61, 81. “The ICD Guidelines impose numerous requirements and limitations on what diagnoses may be coded in a particular visit and in a particular setting.” U.S. Compl. ¶ 82. For example, “[f]or an outpatient visit . . . , the ICD Guidelines only permit the coding of documented conditions that [1] both exist at the visit *and* that [2] ‘require or affect patient care treatment or management.’” U.S. Compl. ¶ 83 (emphasis in original; quoting ICD Guidelines).

In its complaint, the United States has sued several Kaiser entities. As alleged, “Kaiser Permanente” is “an integrated health-care consortium comprised of three components: [1] health plans (‘Health Plans’); [2] physician medical group practices (referred to as ‘Permanente Medical Groups’); and [3] hospitals.” U.S. Compl. ¶ 19. The Health Plans are MA organizations, and they contract with the federal government to provide MA plans. In turn, the Permanente Medical Groups contract with the Health Plans to provide medical services to patients who enroll in the plans. *See* U.S. Compl. ¶¶ 20-26. The United States has sued those Health Plans and the Permanente Medical Groups affiliated with California and Colorado (collectively, “Kaiser”).

According to the United States,

Kaiser engaged in a coordinated scheme to unlawfully obtain payments from the Medicare Part C program Kaiser obtained these payments by systematically altering patient medical records to add diagnoses that either [1] did not exist or [2] were unrelated to the patient’s visit with the Kaiser physician. Kaiser altered the patients’ medical records to add these diagnoses retrospectively – after the patient medical visit – using a mechanism called an addendum. Often, these addenda were added months or even a year or more after the visit. In many cases, patients were not even told that they supposedly had the diagnoses that Kaiser had added to their medical records. Kaiser knew that it could not lawfully submit diagnoses that were unrelated to the patient’s visit, but it nevertheless routinely used these diagnoses to obtain additional payments from Medicare. Between 2009 and 2018, Kaiser added roughly half a million diagnoses using addenda. Kaiser submitted the diagnoses from these addenda to the Centers for Medicare and Medicaid Services (“CMS”) and received additional Medicare payments in the range of \$1 billion from these diagnoses.

U.S. Compl. ¶ 1; *see also* U.S. Compl. ¶ 7 (referring to practices such as “data mining,” “chart review,” and “refreshing” that Kaiser used to find diagnoses to add); Opp’n at 7 (discussing the above practices of data mining, chart review, and refreshing).

Based on, *inter alia*, the above allegations, the government has asserted the following causes of action:

- (1) Violation of the federal False Claims Act (“FCA”) by presenting or causing to be presented false claims for “risk-adjustment payments in the form of improper diagnoses codes for Defendants’ Medicare patients, in violation of CMS regulations and policies, which Defendants agreed to and were obligated to comply with.” U.S. Compl. ¶ 349; *see also* 31 U.S.C. § 3729(a)(1);\.
- (2) Violation of the FCA by “making, using, and causing to be made or used, false records or statements material to false or fraudulent claims resulting in [Defendants’] receiving inflated Medicare payments from CMS to which they were not entitled.” U.S. Compl. ¶ 352; *see also* 31 U.S.C. § 3729(a)(1)(B).
- (3) Violation of the FCA by conspiring “to submit and cause the submission of false claims and to make, use, and cause to make or use, false records and statements material to false or fraudulent claims to the United States and use false records and statements material to false or fraudulent claims.” U.S. Compl. ¶ 357; *see also* 31 U.S.C. § 3729(a)(1)(C).
- (4) Payment by mistake.
- (5) Unjust enrichment.

II. DISCUSSION

A. Legal Standard

Federal Rule of Civil Procedure 8(a)(2) requires a complaint to include “a short and plain statement of the claim showing that the pleader is entitled to relief.” Fed. R. Civ. P. 8(a)(2). A complaint that fails to meet this standard may be dismissed pursuant to Federal Rule of Civil Procedure 12(b)(6). *See* Fed. R. Civ. P. 12(b)(6). To overcome a Rule 12(b)(6) motion to dismiss after the Supreme Court’s decisions in *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), and *Bell Atlantic*

Corp. v. Twombly, 550 U.S. 544 (2007), a plaintiff’s “factual allegations [in the complaint] ‘must . . . suggest that the claim has at least a plausible chance of success.’” *Levitt v. Yelp! Inc.*, 765 F.3d 1123, 1135 (9th Cir. 2014). The court “accept[s] factual allegations in the complaint as true and construe[s] the pleadings in the light most favorable to the nonmoving party.” *Manzarek v. St. Paul Fire & Marine Ins. Co.*, 519 F.3d 1025, 1031 (9th Cir. 2008). But “allegations in a complaint . . . may not simply recite the elements of a cause of action [and] must contain sufficient allegations of underlying facts to give fair notice and to enable the opposing party to defend itself effectively.” *Levitt*, 765 F.3d at 1135 (internal quotation marks omitted). “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.” *Iqbal*, 556 U.S. at 678. “The plausibility standard is not akin to a probability requirement, but it asks for more than a sheer possibility that a defendant has acted unlawfully.” *Id.* (internal quotation marks omitted).

B. FCA Claims

1. General Law

“[T]he essential elements of False Claims Act liability are: (1) a false statement or fraudulent course of conduct, (2) made with scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due.” *United States ex rel. Campie v. Gilead Scis.*, 862 F.3d 890, 902 (9th Cir. 2017); *see also United States v. Corinthian Colls.*, 655 F.3d 984, 992 (9th Cir. 2011).

With respect to the first element, a claim for payment can be factually false or legally false. “A factually false claim is one in which ‘the claim for payment is itself literally false or fraudulent,’ such as when the claim ‘involves an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided.’” *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 675 (9th Cir. 2018); *see also United States ex rel. Druding v. Druding*, 952 F.3d 89, 96 (3d Cir. 2020) (noting that there is factual falsity “when the facts contained within the claim are untrue”).

A legally false claim generally involves a “‘knowingly false certification of compliance with a regulation or contractual provision as a condition of payment.’” *United States ex rel.*

1 *Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 741 (10th Cir. 2018); *see also United States ex rel.*
 2 *Greenfield v. Medco Health Sols., Inc.*, 880 F.3d 89, 94 (3d Cir. 2018) (stating that a claim “is
 3 legally false when the claimant lies about its compliance with a statutory, regulatory, or
 4 contractual requirement”). “[L]egal falsity can be express, such as a false affirmative statement of
 5 compliance with a statutory, regulatory, or contractual prerequisite, or it can be implied – for
 6 instance, the absence of a material disclosure that would have prevented compliance with a
 7 statutory, regulatory, or contractual prerequisite.” *Druding*, 952 F.3d at 96; *see also Silingo*, 904
 8 F.3d at 675-76 (stating that “[e]xpress false certification involves an entity’s representation of
 9 compliance with the law as part of the process for submitting a claim when it is actually not
 10 compliant,” while “[i]mplied false certification occurs when an entity has previously undertaken
 11 to expressly comply with a law, rule, or regulation, and that obligation is implicated by submitting
 12 a claim for payment even though a certification of compliance is not required in the process of
 13 submitting the claim”).

14 The Supreme Court addressed the theory of implied false certification in *Universal Health*
 15 *Services v. United States ex rel. Escobar*, 579 U.S. 176 (2016) (hereinafter “*Escobar*”). In
 16 *Escobar*, a teenager was a beneficiary of Massachusetts’s Medicaid program and was receiving
 17 counseling services at a mental health facility in Massachusetts. The teens’ parents filed suit after
 18 learning that few employees at the facility were actually licensed to provide mental health
 19 counseling and that supervision of them was minimal. *See id.* at 183-84. They asserted “an
 20 implied false certification theory of liability” – *i.e.*, the defendant “submitted reimbursement
 21 claims that made representations about the specific services provided by specific types of
 22 professionals, but that failed to disclose serious violations of regulations pertaining to staff
 23 qualifications and licensing requirements for these services.” *Id.* at 184-85.

24 The Supreme Court took note that there is a

25 rule that half-truths – representations that state the truth only so far
 26 as it goes, while omitting critical qualifying information – can be
 actionable misrepresentations. . . .

27 So too here, by submitting claims for payment using payment codes
 28 that corresponded to specific counseling services, [the defendant]
 represented that it had provided individual therapy, family therapy,

preventive medication counseling, and other types of treatment. Moreover, [facility] staff members allegedly made further representations in submitting Medicaid reimbursement claims by using National Provider Identification numbers corresponding to specific job titles. And these representations were clearly misleading in context. Anyone informed that a social worker at a Massachusetts mental health clinic provided a teenage patient with individual counseling services would probably – but wrongly – conclude that the clinic had complied with core Massachusetts Medicaid requirements (1) that a counselor “treating children [is] required to have specialized training and experience in children’s services,” and also (2) that, at a minimum, the social worker possesses the prescribed qualifications for the job. By using payment and other codes that conveyed this information without disclosing [the facility’s] many violations of basic staff and licensing requirements for mental health facilities, [the defendant’s] claims constituted misrepresentations. By using payment and other codes that conveyed this information without disclosing [the facility’s] many violations of basic staff and licensing requirements for mental health facilities, [the defendant’s] claims constituted misrepresentations.

Accordingly, we hold that the implied certification theory can be a basis for liability, at least where two conditions are satisfied: First, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant’s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.

Id. at 189-90.

For the second element, *i.e.*, scienter, a person “knowingly” submits false information if he or she “(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.” 31 U.S.C. § 3729(b)(1)(A). A defendant cannot be held liable for an “[i]nnocent mistake” or “mere negligence,” *U.S. ex rel. Hagood v. Sonoma Cnty. Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991), but “no proof of specific intent to defraud” is required. 31 U.S.C. § 3729(b)(1)(B).

Regarding the third element of an FCA claim, *i.e.*, materiality, “the term ‘material’ means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” *Id.* § 3729(b)(4). “[The] materiality requirement descends from ‘common-law antecedents.’” *Escobar*, 579 U.S. at 193.

Under any understanding of the concept, materiality “look[s] to the

effect on the likely or actual behavior of the recipient of the alleged misrepresentation.” In tort law, for instance, a “matter is material” in only two circumstances: (1) “[if] a reasonable man would attach importance to [it] in determining his choice of action in the transaction”; or (2) if the defendant knew or had reason to know that the recipient of the representation attaches importance to the specific matter “in determining his choice of action,” even though a reasonable person would not. Materiality in contract law is substantially similar

The materiality standard is demanding. The False Claims Act is not “an all-purpose antifraud statute,” or a vehicle for punishing garden-variety breaches of contract or regulatory violations. 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 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.

In sum, when evaluating materiality under the False Claims Act, the Government’s decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive. Likewise, proof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement. Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.

Id. at 193.

Thus, under *Escobar*, factors that should be considered on materiality include the following:

(1) “the Government’s decision to expressly identify a provision as a condition of payment”; (2) whether “the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement” or if, with actual knowledge of the non-compliance, it consistently pays such claims and there is no indication that its practice will change; and (3) whether the “noncompliance is minor or insubstantial” or if it goes “to the very essence of the bargain.”

United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc., 892 F.3d 822, 831 (6th Cir. 2018); *see also United States ex rel. Ling v. City of L.A.*, No. CV 11-974 PSG (JCx), 2018 U.S.

Dist. LEXIS 136589, at *36 (C.D. Cal. July 25, 2018) (identifying the same basic considerations).

2. Government's Liability Theories

As a preliminary matter, the Court considers what the government's theories of liability are and whether those theories are predicated on factual falsity, legal falsity, or both.

As noted above, the gist of the government's complaint is that Kaiser submitted false claims for payment because it "alter[ed] patient medical records to add diagnoses that either [1] did not exist or [2] were unrelated to the patient's visit with the Kaiser physician." U.S. Compl. ¶ 1.

With respect to (1), only factual falsity is implicated. If a diagnosis of a medical condition was claimed but that medical condition did not exist (*i.e.*, the diagnosis was "clinically inaccurate," Reply at 1), then a claim for payment based on that diagnosis is literally false. *See Silingo*, 904 F.3d at 675 ("A factually false claim is one in which 'the claim for payment is itself literally false or fraudulent,' such as when the claim 'involves an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided.'"); *Druding*, 952 F.3d at 96 (noting that there is factual falsity "when the facts contained within the claim are untrue").

With respect to (2), there is both factual falsity and legal falsity.² There is factual falsity because a claim for payment was based on a diagnosis of a medical condition that did exist, *but* the condition did not "require[] or affect[]" patient care, treatment, or management for the visit." U.S. Compl. ¶ 87; *see also* Opp'n at 16-17 (noting that, "when Kaiser submitted for payment inaccurate ICD codes in contravention of the ICD Guidelines, those were factually false claims because they incorrectly described the valid ICD codes for the patient visit"). There is legal falsity because – as claimed by the government – both the CMS/Kaiser contract and federal regulations required Kaiser to comply with the ICD Guidelines, and "the ICD Guidelines only permit the

² There does not appear to be anything that would prevent a claim for payment from being both factually false and legally false (in the appropriate circumstances). The Third Circuit has noted that "legal falsity necessarily encompasses situations of factual falsity, for instance, where a physician's lies about medical test results would render certifications for reimbursement inaccurate and non-compliant with regulations." *Druding*, 952 F.3d at 96-97.

coding of documented conditions that [1] both exist at the visit *and* that [2] ‘require or affect patient care treatment or management.’” U.S. Compl. ¶ 83 (emphasis in original; quoting ICD Guidelines); *see also Polukoff*, 895 F.3d at 741 (stating that a legally false claim involves a “‘knowingly false certification of compliance with a regulation or contractual provision as a condition of payment’”).

The government’s complaint largely seems to focus on the second theory of liability. *See also* Opp’n at 16 (suggesting that “the Court need not [even] reach Kaiser’s argument that the Complaint fails to allege Kaiser submitted ‘factually false’ claims for non-existent diagnoses” because the second theory of liability – *i.e.*, “Kaiser’s submission of diagnoses that did not require or affect patient care, treatment, or management, in violation of the [ICD] Guidelines” – is viable). However, the Court begins with an evaluation of the first theory of liability because, as Kaiser argues, if that theory is indeed viable, it significantly expands the scope of the case. *See* Reply at 1-2 (“It is imperative for the Court to decide now whether the United States can prosecute allegations of clinical falsity because discovery regarding such allegations will be broad and voluminous. To support such a fraud theory, the United States will need to prove that each Medicare Advantage member at issue did not have the diagnosed condition and Defendants will be entitled to documentary and testimonial discovery to rebut that proof.”).

3. Diagnoses That Did Not Exist/Clinically Inaccurate Diagnoses

For the government’s first theory of liability – that Kaiser had patient medical records amended to add diagnoses that did not exist (*i.e.*, were clinically inaccurate) – Kaiser makes two arguments: (1) the government has failed to plead factual falsity and (2) the government has failed to plead knowledge of falsity on the part of Kaiser.

a. Falsity

As an initial matter, the Court notes that the government has sufficiently pled three specific instances of clinically inaccurate diagnoses in paragraphs 338, 339, and 210-11 of its complaint.

- In paragraph 338, the government describes an incident relating to “Patient #2.” Patient #2 was seen by a Kaiser doctor on 5/30/2012 “for a blood pressure check and to review lab results.” U.S. Compl. ¶ 338(a). Six months after the visit, a

Kaiser coder contacted the doctor, informing the doctor that Patient #2 had “several uncoded diagnoses the region thinks should be picked up” – including prostate cancer. U.S. Compl. ¶ 338(c). The medical record from the original visit indicated that “Patient #2 had a *history of* prostate cancer (identified with a different ICD history code) and did not have active prostate cancer.” U.S. Compl. ¶ 338(d) (emphasis in original). Nevertheless, the doctor responded to the query by creating an addendum to add, *inter alia*, a diagnosis of prostate cancer. *See* U.S. Compl. ¶ 338(e).

- In paragraph 339, the government describes an incident relating to “Patient #3.” Patient #3 was seen by a Kaiser doctor on 1/17/2013 for shortness of breath. He was diagnosed with exacerbation of chronic obstructive pulmonary disease (“COPD”). The doctor ordered a chest x-ray to rule out pneumonia. The results of the x-ray showed that Patient #3 did not have pneumonia. *See* U.S. Compl. ¶ 339(a). Approximately eight months later, a Kaiser data quality trainer contacted the doctor, informing him that “the imaging you ordered showed Positive Aortic Atherosclerosis” and asking him to amend his medical notes to “capture” AA. U.S. Compl. ¶ 339(c). The doctor responded to the query by adding a diagnosis of AA via an addendum. *See* U.S. Compl. ¶ 339(d). The doctor later created two more addenda, ultimately adding “twelve more diagnoses to Patient #3’s medical record.” U.S. Compl. ¶ 339(h). One of these diagnoses was for severe obesity equivalent; however, this diagnosis was not justified because it “requires a BMI of at least 35” and Patient #3’s BMI at the time of the visit was only 31. U.S. Compl. ¶ 339(i).
- In paragraphs 210-11, the government alleges that, in Colorado, Kaiser used to data mine and query doctors to add hypoxia for patients receiving oxygen; however, after CMS removed hypoxia as a condition from the HCC model, Kaiser queried doctors to add different diagnoses – acute and/or chronic respiratory failure and obesity hypoventilation syndrome. *See* U.S. Compl. ¶ 210. On one occasion, a

1 doctor in Colorado “created an addendum to add the diagnosis of obesity
2 hypoventilation syndrome – a breathing disorder found in some *obese* individuals –
3 to a patient who was clearly *not* obese (she was 5’9” and weighed 108 pounds).”
4 U.S. Compl. ¶ 211 (emphasis in original).

5 However, presumably, the government has not filed suit to seek relief for these three
6 specific instances alone – *i.e.*, it is essentially claiming that Kaiser had a *scheme* to include to
7 include nonexistent diagnoses in patients’ medical records. These three specific examples,
8 however, are not enough to make out a plausible case for such a systemic scheme. The complaint
9 does not contain specific allegations which plausibly establish these three instances were
10 emblematic of a wider pattern of similar practices.

11 On the other hand, the Court concludes that the government has alleged a plausible scheme
12 with respect to one specific disease in particular – *i.e.*, cachexia. In its pleading, the government
13 has alleged as follows: “Cachexia is a complex metabolic syndrome associated with physical
14 wasting, weight loss and muscle atrophy.” U.S. Compl. ¶ 207. A diagnosis of cachexia “is based
15 on clinical judgment rather than clinical indicators,” U.S. Compl. ¶ 295 – which implicitly makes
16 it more vulnerable to exploitation. According to the government, in 2009, as part of a training,
17 “the N. California Medical Group identified cachexia as one of a few diagnoses that would help
18 them ‘Find \$100 million dollars in NCal.’”; then, in or about 2011, “the N. California Medical
19 Group created a data-mining algorithm to identify potential cachexia diagnoses,” and the results of
20 the algorithm were “sent to physicians with queries for them to addend their patient medical
21 records to add cachexia diagnoses.” U.S. Compl. ¶ 295. Queries were “routinely” sent to doctors
22 to add diagnoses of cachexia even “for patients who were merely thin.” U.S. Compl. ¶ 296; *cf.*
23 U.S. Compl. ¶ 296 (noting that cachexia “is not simply low body weight”). As a result,
24 “physicians in Northern California added cachexia via addenda over *120 times* more than
25 physicians in Southern California and Colorado, regions that did not have a cachexia initiative.”
26 U.S. Compl. ¶ 300 (emphasis in original). Furthermore, audits revealed that “many of these
27 diagnoses were invalid[] because the patient did not . . . have cachexia.” U.S. Compl. ¶ 300.
28 Specifically, as part of an audit, “the Clinical Review Team (within [the Encounter Information

Operations office]) found that *over 90%* of the time a physician added the cachexia diagnosis based on a Kaiser query, the documentation is ‘either lacking or contradict[s] the definition of Cachexia.’” U.S. Compl. ¶ 321 (emphasis added); *see also* U.S. Compl. ¶ 346(f) (discussing Patient #10, whose doctor created an addendum to add cachexia as a diagnosis even though the doctor stated “‘patient has no general debility” and only “‘lost some lbs of weight”)). Based on the above allegations, the government has sufficiently alleged that Kaiser had a scheme to include to include nonexistent diagnoses of cachexia in patients’ medical records.

Kaiser protests that the fact that “the medical-record documentation was ‘lacking’ or inconsistent say[s] nothing about the member’s actual health status” – especially since cachexia is (as alleged) based on clinical judgment rather than clinical indicators. Reply at 7-8. Although Kaiser’s argument is not without some merit, at this juncture all reasonable inferences are to be made in the government’s favor. If documentation was lacking or if documentation contradicted the definition of cachexia, then it can reasonably be inferred that a diagnosis of cachexia was not justified. Thus, based on the government’s allegations, it can reasonably be inferred that a large number of cachexia diagnoses, which were made through addenda, were literally false.

Hence, thus far, the only systemic scheme sufficiently alleged by the government relates to cachexia only. Admittedly, if Kaiser (as alleged) was willing to make clinically false diagnoses for cachexia, one could imagine that Kaiser could easily have had a scheme far broader in scope, reaching any number of medical conditions as well. But at this point, given the allegations in the complaint, it cannot reasonably be inferred that Kaiser’s scheme was broader in scope. The government has leave to amend its complaint if it wishes to expand the scope of its allegations on clinically false diagnoses. Identifying scattered anecdotes alone will not suffice.

b. Knowledge

The next issue raised by Kaiser is whether the government has sufficiently pled the element of knowledge. The Court considers this issue only with respect to the allegedly false cachexia diagnoses. As noted above, under the FCA, a person “knowingly” submits false information if he or she “(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or

falsity of the information.” 31 U.S.C. § 3729(b)(1)(A). A defendant cannot be held liable for an “[i]nnocent mistake” or “mere negligence,” *U.S. ex rel. Hagood v. Sonoma Cnty. Water Agency*, 929 F.2d 1416, 1421 (9th Cir. 1991), but “no proof of specific intent to defraud” is required. 31 U.S.C. § 3729(b)(1)(B).

Given that reckless disregard can satisfy the knowledge requirement and that all reasonable inferences are to be made in the government’s favor at this early stage, the government has alleged enough with respect to scienter. According to the government, Kaiser higher-ups were warned about sending queries to doctors prompting them to add diagnoses for cachexia. *See, e.g.*, U.S. Compl. ¶ 297 (“After noting that physicians were protesting that naturally thin patients did not have cachexia, Dr. Inna Ravkin (an internal medicine physician in Northern California) warned Karen Graham³ and Dr. David Bliss⁴ in 2011 that the prompting would result in ‘inappropriate assignment of this diagnosis.’”); U.S. Compl. ¶ 298 (“Also in 2011, Dr. Patrick Kan (a CMS Lead) reported to Dr. David Bliss and Karen Graham that ‘they [the treating physicians] do not see any physical signs of cachexia.’”); U.S. Compl. ¶ 299 (“And in 2013, Norma Gonzalez (a Senior Consultant for CMS matters) wrote to Danielle Sheetenhelm (Clinical Review Manager) that because she had ‘a couple of thousand datamining diagnoses in my area,’ it would be ‘impossible’ to review them all. She further stated that the feedback from the physicians was that the queries were ‘garbage.’”). If responsible persons at Kaiser were warned, then Kaiser was on notice and a failure to act in response to indications of inaccurate diagnoses could reasonably be deemed reckless disregard of the falsity of cachexia diagnoses.

Reckless disregard could also be inferred based on allegations that queries were being sent to doctors about cachexia diagnoses simply because the patients at issue were thin. That a cachexia diagnoses is based on a clinical judgment does not mean that Kaiser was justified in prompting doctors about diagnosing cachexia simply because of an underweight patient. It may

³ As alleged, Ms. Graham was the Managing Director of the N. California Medical Group’s Encounter Information Operations office. *See* U.S. Compl. ¶ 119.

⁴ As alleged, Dr. Bliss was the N. California Medical Group Regional Director of Documentation and Coding. *See* U.S. Compl. ¶ 248.

1 be inferred that Kaiser officials were looking for the results Kaiser allegedly obtained.

2 Finally, the government has alleged that an audit revealed a high error rate with respect to
3 cachexia diagnoses made through addenda but that Kaiser failed to respond. *See* U.S. Compl. ¶
4 322 (“Despite this knowledge [about the audit], the N. California Medical Group did not modify
5 its cachexia data-mining algorithm or stop-prompt program for several years.”). This further
6 supports a finding of scienter. For false cachexia diagnoses thereafter, one could reasonably infer
7 reckless disregard on the part of Kaiser.

8 4. Diagnoses Unrelated to Doctors’ Visits

9 As noted above, the government’s second theory of liability – that Kaiser altered patient
10 medical records by adding diagnoses that were not related to the doctors’ visits – is its main one.
11 And as noted above, this theory of liability implicates both factual falsity and legal falsity. In its
12 papers, Kaiser argues that the government has failed to adequately plead falsity for the second
13 theory of liability. Kaiser further argues that, even if falsity were adequately pled, the government
14 still has not sufficiently pled materiality.

15 a. Falsity

16 As an initial matter, the Court notes that Kaiser seems to have ignored the fact that the
17 second theory of liability can be construed as being predicated on factual falsity. *See* Opp’n at 16-
18 17 (noting that, “when Kaiser submitted for payment inaccurate ICD codes in contravention of the
19 ICD Guidelines, those were factually false claims because they incorrectly described the valid ICD
20 codes for the patient visit”). Because the Court agrees with the government that factual falsity is
21 implicated, then that alone is a sufficient basis for the Court to reject Kaiser’s argument that falsity
22 has not been sufficiently alleged.

23 Even if the Court were to consider only legal falsity, Kaiser would fare no better. A
24 legally false claim for payment involves an assertion (either express or implied) that there is
25 compliance with a statute, regulation, or contract. *See, e.g., Escobar*, 579 U.S. at 181 (“[L]iability
26 can attach when the defendant submits a claim for payment that makes specific representations
27 about the goods or services provided, but knowingly fails to disclose the defendant’s
28 noncompliance with a statutory, regulatory, or contractual requirement. In these circumstances,

liability may attach if the omission renders those representations misleading.”). In the case at bar, the government argues that both the CMS/Kaiser contract and federal regulations required Kaiser to comply with ICD Guidelines – and under the ICD Guidelines, a diagnosis can be made on a medical record only if it required or affected patient care treatment or management at the doctor’s visit. In response, Kaiser contends that the neither the contract nor regulations required Kaiser to comply with the ICD Guidelines – and therefore the ICD Guidelines are at best “subregulatory” documents that lack the force of law.⁵ Kaiser underscores that the Medicare Act contains the following provision:

No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

42 U.S.C. § 1395hh(a)(2).⁶ In *Azar v. Allina Health Services*, the Supreme Court noted that, under § 1395hh(a)(2), “Congress has told the government that, when it wishes to establish or change a ‘substantive legal standard’ affecting Medicare benefits, it must first afford the public notice and a chance to comment.” *Allina*, 139 S. Ct. at 1808.

i. Contract

As noted above, the government contends as an initial matter that Kaiser is bound by the ICD Guidelines because the CMS/Kaiser contract requires compliance with the Guidelines.

A copy of the CMS/Kaiser contract can be found at Exhibit I to Kaiser’s RJN. Article II.A

⁵ To the extent Kaiser has argued that there is no contractual provision or regulation cited by the government that expressly applies to *addenda* of medical records (*i.e.*, the means by which Kaiser allegedly achieved its upcoding), the government correctly contends that this is a red herring. *See* Opp’n at 15 (“[A]n addendum is merely a change to the medical record for a patient visit made after the close of that visit record. Nothing in Kaiser’s contracts, the relevant regulations, or the ICD Guidelines indicates that diagnoses added after patient visits are subject to different standards.”). Notably, Kaiser somewhat backtracked from this argument in its reply brief. *See* Reply at 10 n.7 (“Defendants agree [that there is no ‘addenda exception’], but because the United States’ case rests entirely on coding from addenda, the Motion focuses on the standards that apply to such coding. And the Court’s decision can be similarly narrow.”).

⁶ “While the APA requires many other agencies to offer public notice and a comment period before adopting new regulations, it does not apply to public benefit programs like Medicare.” *Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019).

of the contract provides as follows: “The MA Organization agrees to operate one or more coordinated care plans . . . and in compliance with the requirements of this contract and applicable Federal statutes, regulations, *and policies (e.g., policies as described in the Call Letter, Medicare Managed Care Manual, etc.)*.” Def.’s RJN, Ex. I (CMS/Kaiser Contract, art. II.A) (emphasis added). The Medicare Managed Care Manual contains a chapter – Chapter 7 – on “Risk Adjustment.” *See* Def.’s RJN, Ex. C (CMS/Kaiser Contract Ch. 7). There are twelve sections in Chapter 7. The fourth section (§ 40) covers the “Role and Responsibilities of Plan Sponsors,” which include MA organizations. With respect to risk adjustment data submission requirements, § 40 states in relevant part as follows:

Medicare Advantage Organizations (MAOs) . . . must . . . [e]nsure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. *The diagnosis must be coded according to [the ICD Guidelines].*

Def.’s RJN, Ex. C (CMS Medicare Managed Care Manual, Ch. 7, § 40) (emphasis added); *see also* U.S. Compl. ¶ 81.

Accordingly, based on the Article II.A of the CMS/Kaiser Contract, its incorporation of the CMS Medicare Managed Care Manual, and the Manual’s incorporation of the ICD Guidelines, the government argues that a MA organization must comply with the ICD Guidelines in providing risk adjustment data to CMS.

In response, Kaiser makes several arguments, none of which is convincing.

First, Kaiser contends that the government’s reliance on Article II.A is flawed:

The location of [this] clause . . . confirms that the contract does not require MAOs to comply with nonbinding guidance in order to receive payment from CMS. The clause appears in Article II of the contract, which describes the network and benefit structures of a coordinated care plan. But the section that addresses *payment* is Article IV, which does not reference subregulatory guidance at all and cites only statutes and regulations.

Mot. at 17 (emphasis in original); *see also* Reply at 10-11 (arguing that Article II “concerns plan design” or “plan structure”). But this argument is questionable if only because Kaiser’s characterization of Article II is not on point. Article II is titled “Coordinated Care Plan.” The article simply lays out broad principles – *e.g.*, Article II.A provides that the MA organization

1 agrees to operate a coordinated care plan(s) and in compliance with federal law and policies;
 2 Article II.B provides that the contract incorporates changes required by statute to be implemented
 3 during the term of the contract; Article III.C provides that, other than at the beginning of a
 4 calendar year, CMS will not implement regulatory requirements that impose new significant costs
 5 or burdens on the MA organization; etc. Nothing about the article is limited or targeted to plan
 6 design or plan structure, as Kaiser claims. Indeed, it is notable that Article II.A refers to now a
 7 coordinated care plan is to be *operated*.

8 In any event, just because the reference to compliance with CMS policies (including the
 9 Manual which then incorporates the ICD Guidelines) is in Article II and not in Article IV does not
 10 mean that compliance with ICD Guidelines is not required for risk adjustment data. As the
 11 government correctly contends, although “Kaiser argues that it is not bound by this term because it
 12 appears at the beginning of the contract[] rather than in the payment section, . . . there is no such
 13 rule of contract law.” Opp’n at 11.

14 Second, Kaiser argues that it would be improper for it to be bound by the ICD Guidelines
 15 as a result of two general incorporations by reference (*i.e.*, incorporation of the Manual which then
 16 incorporates the Guidelines):

17 [T]he government cannot seriously contend that the broad, non-
 18 specific language of the contract provision means that the Health
 19 Plan Defendants must adhere to every word of the ICD Guidelines
 20 simply because they are generally referenced in the [Manual], which
 itself is referenced in a parenthetical in a single sentence of a CMS
 contract.

21 Mot. at 17; *see also* Reply at 11. This argument is unpersuasive, especially in the context of this
 22 instant case. Kaiser is a sophisticated entity and incorporation by reference is a common
 23 contractual tool. It defies reality to suggest a contract is too complicated for an entity like Kaiser
 24 to understand. In any event, ICD Guidelines and their importance to medical procedure is not
 25 some obscure bit of minutiae. Further, the government has alleged here that Kaiser was in fact
 26 well aware of the ICD Guideline requirement at issue. *See, e.g.*, U.S. Compl. ¶¶ 88-96 (alleging
 27 that, “[a]s far back as 2008,” Kaiser had issued to all regions a “Program Advisory” which was
 28 “intended to clarify the minimum amount and type of documentation necessary to support the

1 diagnoses submitted to [CMS] as Medicare Advantage risk adjustment data””; the Program
 2 Advisory specified, *inter alia*, that documentation must comply with the ICD Guidelines).
 3 Finally, it is worth noting that, as a practical matter, Kaiser’s concerns are essentially addressed
 4 through the FCA requirement of materiality (*i.e.*, that the false statement must have been material,
 5 causing the government to pay out money). *See Campie*, 862 F.3d at 902.

6 Third, Kaiser points out that the CMS/Kaiser contract specifies that federal
 7 statutes/regulations should prevail if there is a conflict between such and the contract. *See* Def.’s
 8 RJN, Ex. I (CMS/Kaiser Contract, art. IX.D) (“In the event that any provision of this contract
 9 conflicts with the provisions of any statute or regulation applicable to an MA Organization, the
 10 provisions of the statute or regulation shall have full force and effect.”). Kaiser then argues that
 11 “[a]llowing CMS to create contractual obligations that are not reflected in the Medicare Act or any
 12 regulations guts Congress’s intent to require notice-and-comment rulemaking for gap-filling
 13 guidance.” Mot. at 18 (referring to § 1395hh(a)(2) of the Medicare Act and the Supreme Court’s
 14 decision in *Allina*). *See, e.g., Allina*, 139 S. Ct. at 1808 (noting that, under § 1395hh(a)(2) of the
 15 Medicare Act, “Congress has told the government that, when it wishes to establish or change a
 16 ‘substantive legal standard’ affecting Medicare benefits, it must first afford the public notice and a
 17 chance to comment”).

18 The government, however, has provided a strong counter-argument – *i.e.*, that “§
 19 1395hh(a)(2) does not address the government’s ability to contract, nor suggest that contractual
 20 terms must first go through notice and comment. The statute applies to the Secretary’s rulemaking
 21 authority, not his contracting authority.” Opp’n at 11. The government also fairly points out that
 22 Congress “*mandated* that the Secretary execute contracts with MAOs.” Opp’n at 12 (emphasis in
 23 original). In fact, Congress even gave some discretion to the Secretary as to contract terms –
 24 specifying that “[t]he contract shall contain such other terms and conditions not inconsistent with
 25 this part [42 U.S.C. § 1395w-21 *et seq.*] . . . as the Secretary may find necessary and appropriate.”
 26 42 U.S.C. § 1395w-27(e)(1). Although there is a statutory limitation that contract terms may not
 27 be “inconsistent with this part,” the government correctly notes that “§ 13955hh(a)(2) is not . . . in
 28 ‘this part’ (*i.e.*, Part C).” Opp’n at 12. There is no statutory bar to incorporation of the ICD

Guidelines.

Accordingly, the Court rejects Kaiser’s argument that the terms of the CMS/Kaiser contract cannot be read to require compliance with the ICD Guidelines.

ii. Federal Regulations

Because the Court concludes that the CMS/Kaiser contract requires Kaiser to comply with the ICD Guidelines, it need not address the government’s contention that compliance is also required by federal regulations. However, out of an abundance of caution, the Court has considered the regulatory scheme and concludes it does, in fact, require compliance.

The main regulation that supports the government’s position is 42 C.F.R. § 422.310(d)(1). That regulation (which addresses risk adjustment data) provides in relevant part as follows: “MA organizations must submit data that conform to [1] CMS’ requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to [2] all relevant *national standards*.” 42 C.F.R. § 422.310(d)(1) (emphasis added). As the government notes, CMS has adopted the ICD code sets for diseases, including the ICD Guidelines, as a national standard – pointing to 45 C.F.R. § 162.1002. *See, e.g.*, 45 C.F.R. § 162.1002(c)(2)(i) (“The Secretary adopts the following maintaining organization’s code sets as the standard medical data code sets: . . . (c) For the period on and after October 1, 2015: . . . (2) International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) (including The Official ICD-10-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions: (i) Diseases.”)⁷; *see also* 42 C.F.R. § 422.504(h)(2) (“The MA organization agrees to comply with – . . . (2) HIPAA administrative simplification rules at 45 C.F.R. part[] . . . 162 . . .”).⁸

In response, Kaiser argues that § 422.310(d)(1) just addresses “the form of data submitted

⁷ In 45 C.F.R. § 1002(a)(1)(i) and § 1002(b)(1), the Secretary essentially adopts the ICD code sets (including the ICD Guidelines) for earlier periods of time.

⁸ The government points out that the ICD code sets for diseases and the related ICD guidelines are also used in the Medicare fee-for-service context, and therefore there is a fair argument that they should be applied in the MA context as well. *See* Opp’n at 13 (adding that “[a]dherence to the same ICD standard in both traditional Medicare fee-for-service and Medicare Advantage is important because . . . the risk-adjustment model calculates expected costs for MA patients based upon Medicare fee-for-service diagnosis data”).

to CMS, not the content.” Mot. at 16; *see also* Reply at 14. But nothing about § 422.310(d)(1) suggests it is limited to the format of data. Moreover, to the extent Kaiser relies on *United States ex rel. Rasmussen*, No. 17-3273-CV-S-BP, 2020 U.S. Dist. LEXIS 137953 (W.D. Mo. Apr. 29, 2020), that case does little, if anything, to support its position. *Rasmussen* addressed an entirely different subsection of § 422.310 – specifically, § 422.310(g). Furthermore, Kaiser’s attempt to make an analogy between the § 422.310(g) and § 422.310(d)(1) falls flat. The text of § 422.310(g) is markedly different from that in § 422.310(d)(1), providing as follows: “*Deadlines for submission of risk adjustment data.* Risk adjustment factors for each payment year are based on risk adjustment data submitted for items and services furnished during the 12-month period before the payment year that is specified by CMS.” 42 C.F.R. § 422.310(g). Based on, *inter alia*, this language, the *Rasmussen* court rejected the relator’s argument that “a diagnosis can be coded only if the patient received treatment for that condition within the past year.” *Rasmussen*, 2020 U.S. Dist. LEXIS 137953, at *17. The court noted: “§ 422.310(g) appears to address the deadline for submitting risk adjustment data. It is not directed toward specifying the procedure for properly coding patients’ medical conditions, so it seems to be a poor source for ascertaining such details.” *Id.* at *19 n.10.

Finally, the Court should take into account that it is not just § 422.310(d)(1) that is relevant here. Section 422.310(d)(1) should be read in conjunction with § 422.504(l), *i.e.*, the regulation that requires a MA organization to provide accurate risk adjustment data to CMS. *See* 42 C.F.R. § 422.504(l) (“As a condition for receiving a monthly payment under subpart G of this part, the MA organization agrees that its chief executive officer (CEO), [etc.] must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests.”). While § 422.504(l) requires accuracy from a MA organization, § 422.310(d)(1) essentially provides a benchmark to assess the accuracy of the information provided. Kaiser does not dispute that adherence to the ICD Guidelines facilitates the accuracy of medical information provided. The Ninth Circuit’s decision in *United States ex rel. Swoben v. United Healthcare Insurance Co.*, 848 F.3d 1161 (9th Cir. 2016), is not the contrary. *See id.* at 1179 (noting that “nothing in §

422.310(d)[(1)] speaks to a Medicare Advantage organization’s obligations to ensure the accuracy of risk adjustment data, [and therefore] it does not modify a Medicare Advantage organization’s obligations under [§] . . . 422.504(1)’’).

b. Materiality

For the reasons stated above, the Court agrees with the government that Kaiser is required to comply with the ICD Guidelines, both as a matter of contract and under the applicable regulations – and thus it has a plausible case of legal falsity (*i.e.*, Kaiser implicitly certified that it had complied with the ICD Guidelines in making a claim for payment). Kaiser argues that, even if this is true, the legal falsity claim must still be dismissed because the government has not adequately alleged that the false statement regarding compliance with the ICD Guidelines was material.

As noted above, under the FCA, “the term ‘material’ means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” 31 U.S.C. § 3729(b)(4). The Supreme Court in turn has noted that the FCA is not

a vehicle for punishing garden-variety breaches of contract or regulatory violations. 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 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.

Escobar, 579 U.S. at 193.

In the case at bar, the government has adequately alleged materiality – particularly when the considerations below are taken collectively. First, as the government explains,

submitting accurate ICD diagnosis codes is material because CMS makes risk-adjustment payments based directly on the codes submitted by MAOs. . . . An ICD code that violates the ICD Guidelines because the condition had nothing to do with a patient visit is not an accurate ICD code

Opp’n at 21. Under MA, risk adjustment payments in the aggregate are obviously substantial. Misrepresentations which affect those payments can undoubtedly have a substantial financial effect on the MA program. Health risk assessments are a core element of the program.

Second, the CMS Medicare Managed Care Manual makes explicit the importance of complying with the ICD Guidelines, including the ones that are the focus of the government’s case. The Manual notes as follows:

Medicare Advantage Organizations (MAOs) . . . must . . . [e]nsure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to [the ICD Guidelines].

Def.’s RJN, Ex. C (CMS Medicare Managed Care Manual, Ch. 7, § 40); *see also* U.S. Compl. ¶ 81. And notably, Kaiser’s own internal documents (*e.g.*, its Program Advisories on risk adjustment) recognized the need to comply with the ICD Guidelines, including the ones that are the focus of the government’s case here. *See, e.g.*, U.S. Compl. ¶ 90 (noting that Kaiser’s 2008 Program Advisory specified, *inter alia*, that risk adjustment data must be obtained as a result of a face-to-face visit and that the doctor must have considered or addressed the coded diagnosis during the encounter); *see also Escobar*, 579 U.S. at 193 (noting that “[w]hat matters is not the label the Government attaches to a requirement, but whether the defendant knowingly violated a requirement that the defendant knows is material to the Government’s payment decision.”).

Finally, as indicated above, the magnitude of the noncompliance weighs in favor of materiality, as the government has asserted that Kaiser has “reap[ed] thousands of dollars for each inaccurate diagnosis code and hundreds of millions of dollars for its scheme.” Opp’n at 23; *see also* U.S. Compl. ¶ 335 (alleging that “false claims inflated CMS’s reimbursements to the Kaiser Health Plans by hundreds of millions of dollars”). *See, e.g., United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1022 (9th Cir. 2018) (indicating that noncompliance can be deemed minor or insubstantial where there is no real monetary impact – “[f]or instance, were a school to offer admissions representatives cups of coffee or \$10 gift cards for recruiting higher numbers of students, there would be no viable claim under the False Claims Act”).

5. Statute of Repose/Statute of Limitations

Kaiser argues that, even if the government has adequately pled FCA causes of action, those claims should still be trimmed because part of the claims are time barred. Below is the relevant provision from the FCA:

- (b) A civil action under section 3730 [31 U.S.C. § 3730] may not be brought –
- (1) more than 6 years after the date on which the violation of section 3729 [31 U.S.C. § 3729] is committed, or
 - (2) more than 3 years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed,
- whichever occurs last.
- (c) If the Government elects to intervene and proceed with an action brought under [section] 3730(b) [31 U.S.C. § 3730(b)], the Government may file its own complaint or amend the complaint of a person who has brought an action under section 3730(b) [31 U.S.C. § 3730(b)] to clarify or add detail to the claims in which the Government is intervening and to add any additional claims with respect to which the Government contends it is entitled to relief. For statute of limitations purposes, any such Government pleading shall relate back to the filing date of the complaint of the person who originally brought the action, to the extent that the claim of the Government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of that person.

31 U.S.C. § 3731(b)-(c).

Kaiser contends that the provision above contains not just a statute of limitations but also a statute of repose.

Statutes of limitations and statutes of repose both are mechanisms used to limit the temporal extent or duration of liability for tortious acts. Both types of statute can operate to bar a plaintiff's suit, and in each instance time is the controlling factor. There is considerable common ground in the policies underlying the two types of statute. But the time periods specified are measured from different points, and the statutes seek to attain different purposes and objectives. . . .

In the ordinary course, a statute of limitations creates "a time limit for suing in a civil case, based on the date when the claim accrued." Measured by this standard, a claim accrues in a personal-injury or property-damage action "when the injury occurred or was discovered." . . .

A statute of repose, on the other hand, puts an outer limit on the right to bring a civil action. That limit is measured not from the date on which the claim accrues but instead from the date of the last culpable act or omission of the defendant. A statute of repose "bar[s] any suit that is brought after a specified time since the

defendant acted (such as by designing or manufacturing a product), even if this period ends before the plaintiff has suffered a resulting injury.” The statute of repose limit is “not related to the accrual of any cause of action; the injury need not have occurred, much less have been discovered.” The repose provision is therefore equivalent to “a cutoff,” in essence an “absolute . . . bar” on a defendant’s temporal liability, C. J. S. §7, at 24.

CTS Corp. v. Waldburger, 573 U.S. 1, 8 (2014).

Although the Supreme Court in *CTS* underscored the distinction between a statute of limitations and a statute of repose, it also recognized that “general usage of the legal terms [statute of limitations and statute of repose] has not always been precise” – e.g., “Congress has used the term ‘statute of limitations’ when enacting statutes of repose,” and “petitioner does not point out an example in which Congress has used the term ‘statute of repose.’” *Id.* at 13-14; *see also Fed. Hous. Fin. Agency v. Nomura Holding Am., Inc.*, 873 F.3d 85, 113 (2d Cir. 2017) (noting that, “although Congress has indisputably created statutes of repose in the past, it ‘has never used the expression “statute of repose” in a statute codified in the United States Code”)). Even after *CTS*, the Supreme Court itself has not always been precise about the use of the terms, including in a FCA case. In *Cochise Consultancy, Inc. v. United States ex rel. Hunt*, 139 S. Ct. 1507 (2019), the Court stated as follows:

The False Claims Act contains two limitations periods that apply to a “civil action under section 3730” – that is, an action asserting that a person presented false claims to the United States Government. The first period requires that the action be brought within 6 years after the statutory violation occurred. The second period requires that the action be brought within 3 years after the United States official charged with the responsibility to act knew or should have known the relevant facts, but not more than 10 years after the violation. Whichever period provides the later date serves as the *limitations period*.

Id. at 1510 (emphasis added).

In the instant case, Kaiser maintains that, although § 3731(b) of the FCA contains a statute of limitations, it also contains a statute of repose – specifically in (b)(2) – due to the following language: “but in no event more than 10 years after the date on which the violation is committed.” 31 U.S.C. § 3731(b)(2).

Kaiser then argues that, because the government did not file its complaint until October 25,

2021, the statute of repose dictates that the government’s claims are valid only to the extent they are based on conduct occurring on or after October 25, 2011. Thus, according to Kaiser, the government’s attempt to implicate conduct as far back as 2009 should be rejected. *See* U.S. Compl. ¶ 1 (“Beginning sometime prior to 2009 and continuing through at least 2018, Kaiser engaged in a coordinated scheme to unlawfully obtain payments from the Medicare Part C program, also called Medicare Advantage.”).

Kaiser acknowledges that the FCA contains a relation back provision in § 3731(c). It also recognizes – implicitly – the government’s contention that, under § 3731(c), it can claim relation back to the *Osinek* complaint (filed in 2013) or the *Taylor* complaint (filed in 2014), and then, because *Osinek* was filed in 2013 and *Taylor* in 2014, § 3731(b)(1) would allow the government to wrap in conduct six years earlier – *i.e.*, from 2007 and 2008. But Kaiser contends that the government rely on § 3731(c) because that provision in the FCA only mentions relation back and the statute of limitations, not the statute of repose. In support of this argument, Kaiser relies on *United States v. Scan Health Plan*, No. CV 09-5013-JFW (JEMx), 2017 U.S. Dist. LEXIS 174308 (C.D. Cal. Oct. 5, 2017) [hereinafter *Swoben II*]. There, the court held as follows:

[T]he Government[] cannot rely on the relation back doctrine contained in Section 3731(c) because Section 3731(c) is specifically limited to “statute of limitations purposes.” In fact, Congress added the relation-back provision [to the FCA] in 2009, as part of the same legislation in which it considered consolidating the separate statutes of limitations and repose into a single ten-year statute of limitations before rejecting that consolidation as insufficiently protective of defendants’ interests in repose. As one False Claims Act expert testified during the Senate’s consideration of those changes, without a repose period, the relation-back provision would have forced defendants “to defend themselves for actions that occurred 12, 15 or even 20 years ago, depending on how long a qui tam case remains under seal.”

Id. at *27-28.

But at least one court has expressly disagreed with the analysis in *Swoben II*. Its reasoning was that “subsection (c)’s relation-back provision does not distinguish between ‘statutes of limitation’ and the ‘statute of repose,’” and so “the Court concludes that subsection (c) refers to the various timing restrictions contained in subsection (b), the statute of repose included.” *United States ex rel. Ling v. City of L.A.*, No. CV 11-974 PSG (JCx), 2018 U.S. Dist. LEXIS 136589, at

*70-71 (C.D. Cal. July 25, 2018).

Arguably, both the analysis in *Ling* and that in *Swoben II* are problematic in that they rely on terminology used in § 3731(c) but neither Congress nor the Supreme Court has been precise in their use of the term “statute of limitations” or “statute of repose.” Given the ambiguity of the terms as they appear in this statute, the more fundamental question is whether as a matter of principle it would be improper to apply relation back where there is a statute of repose (as opposed to a statute of limitations). On this question, the government correctly argues that it would not because relation back does not alter a limitations period or repose period, nor does it even toll one. Rather relation back simply pinpoints *when a claim is filed*. See Opp’n at 25. This was the basic point that the Third Circuit made when considering whether the FCA’s statute of repose prevented relation back under Federal Rule of Civil Procedure 15(c) (*i.e.*, instead of relation back under § 3731(c) of the FCA): “[T]olling extends the repose period, while relation back *keeps the repose period intact*.” *SEPTA v. Orrstown Fin. Servs.*, 12 F.4th 337, 351 (3d Cir. 2021) (emphasis added). The Third Circuit’s analysis is convincing.

Accordingly, the Court reject Kaiser’s argument that the government’s claims cannot reach back to conduct from 2009 given the application of relation back.

6. Summary

For the foregoing reasons, the government’s FCA claims largely survive Kaiser’s 12(b)(6) challenge. The FCA claims are not viable only to the extent the government has argued factual falsity on a systemic basis because diagnoses were made for nonexistent conditions. The government has not pled enough to support this factual falsity claim with one exception – *i.e.*, that there was a scheme to amend patient records to add a clinically inaccurate diagnosis of cachexia. The government has leave to amend its complaint for this factual falsity theory. Any amended complaint shall be filed by December 12, 2022. Kaiser shall then have until January 3, 2023 to file a response, whether an answer or a motion.

C. Claims for Payment by Mistake and Unjust Enrichment

Aside from the FCA claims, the government has also asserted the following causes of action: payment by mistake and unjust enrichment. According to Kaiser, these are common law

claims that should be dismissed for two reasons: (1) the claims are “derivative of the flawed FCA claims”⁹ and (2) with respect to the Health Plans (who contracted with CMS to provide the MA plans), “quasi-contractual claims are unavailable” because of the express contract between the Health Plans and CMS. Mot. at 24. Kaiser adds that, even as to the Permanente Medical Groups (who contracted with the Health Plans to provide services to patients), “it is not clear how the government could have quasi-contract claims” because the government alleges that the Permanente Medical Groups “must ‘comply with’ the Health Plan Defendants’ ‘contractual obligations to CMS.’” Mot. at 25.

The Court rejects Kaiser’s first argument because, as discussed above, the FCA claims largely survive.

Kaiser’s second argument presents a closer call. Kaiser does have authority to support its position. For example, in *United States v. First Choice Armor & Equipment*, 808 F. Supp. 2d 68, (D.D.C. 2011), the district court noted as follows:

The defendants argue that the government cannot simultaneously proceed on its FCA claims and its claims of payment by mistake and unjust enrichment. Rule 8(d)(2) allows a plaintiff to plead alternative theories of liability. Accordingly, “at the motion-to-dismiss stage, courts in this district . . . have permitted the government to proceed with claims alleging FCA violations as well as claims for unjust enrichment or payment by mistake.” However, “it does not appear that the D.C. Circuit has [wavered] from the rule that ‘there can be no claim for unjust enrichment when an express contract exists between the parties.’” Allegations in a complaint that an express contract existed between the parties, therefore, preclude a plaintiff from proceeding on alternative theories of FCA liability and unjust enrichment or payment by mistake.

Id. at 77-78; *see also United States ex rel. Doughty v. Or. Health & Scis. Univ.*, No. 3:13-CV-01306-BR, 2017 U.S. Dist. LEXIS 55083, at *18 (D. Or. Apr. 11, 2017) (“[T]he basis for Plaintiff-Relators’ claims for payment by mistake and unjust enrichment arise from the express contracts the government alleged in its Complaint. In fact, Defendant could only have been

⁹ In its reply, Kaiser acknowledges that a FCA claim requires a knowing false representation, while payment by mistake and unjust enrichment do not. However, it argues that, if there is no falsity, then there can be FCA claim, not a cause of action for payment by mistake or unjust enrichment.

enriched unjustly and payments to Defendant could only have been mistaken if the express contracts did not set out specific rates and methods for charging costs. . . . The Court, therefore, concludes Plaintiff-Relators have not stated claims for unjust enrichment or payment by mistake.”).

Nevertheless, Kaiser’s position is problematic given that the government has not simply alleged the violation of the CMS/Kaiser contract but also the violation of federal regulations. In other words, if the Court or the trier of fact were to find that Kaiser’s failure to comply with the ICD Guidelines was not a violation of the CMS/Kaiser contract, then why should the government not be able to proceed with a quasi-contractual theory at that point? *Cf. United States ex rel. Costa v. Baker & Taylor, Inc.*, No C-95-1825-VRW, 1998 U.S. Dist. LEXIS 23509, at *36 (N.D. Cal. Mar. 20, 1998) (“In the present case, plaintiffs believe that their contracts with defendants are valid. In the unlikely event that the court should find these contracts invalid, however, plaintiffs have included claims for unjust enrichment and payment by mistake.”).

More important, the government persuasively argues that, even if a quasi-contract claim might ordinarily be barred where an express contract exists, its claim is unique precisely because the government is involved.

When a payment is erroneously or illegally made, as is alleged here, “it is in direct violation of . . . the Constitution.” To correct for this violation, the United States may exercise its “[well]-established right to sue for money wrongfully or erroneously paid from the public treasury,” *a right arising separate and apart from statute, regulation, or contract.*

Agility Public Warehousing Co. K.S.C.P. v. United States, 969 F.3d 1355, 1365 (Fed. Cir. 2020); *see also United States v. Wurts*, 303 U.S. 414, 415 (1938) (“The Government by appropriate action can recover funds which its agents have wrongfully, erroneously, or illegally paid. ‘No statute is necessary to authorize the United States to sue in such a case. The right to sue is independent of statute, ...’”); *id.* at 416 (“The Government’s right to recover funds, from a person who received them by mistake and without right, is not barred unless Congress has ‘clearly manifested its intention’ to raise a statutory barrier.”); *United States ex rel. Robinson-Hill v. Nurses’ Registry & Home Health Corp.*, No. 5:08-145-KKC, 2015 U.S. Dist. LEXIS 68222, at *8

(E.D. Ky. May 27, 2015) (“The United States’ common law claims for fraud, unjust enrichment, and payment by mistake also survive Mr. House’s death. ‘The Government by appropriate action can recover funds which its agents have wrongfully, erroneously, or illegally paid.’”).

III. CONCLUSION

For the foregoing reasons, the Court grants in part and denies in part Kaiser’s motion to dismiss the government’s complaint. The Court grants the motion only to the extent that the government has failed to plead a FCA claim based on a scheme by Kaiser to alter patient medical records by adding clinically inaccurate diagnoses on a general or systemic basis. The government, however, has adequately alleged a general scheme to add clinically inaccurate diagnoses for cachexia (specifically). It has also adequately alleged a FCA violation based on Kaiser adding clinically accurate diagnoses but for which no treatment was provided at the time of the doctors’ visits. The FCA claims are not time barred. As for the claims for payment by mistake and unjust enrichment, they are allowed to proceed.

The government has leave to file an amended complaint by December 12, 2022. If the government files an amended complaint, then Kaiser shall file a response by January 3, 2023. If no amended complaint is filed by December 12, 2022, then Kaiser shall answer the original complaint in intervention by January 3, 2023.

This order disposes of Docket No. 178.

IT IS SO ORDERED.

Dated: November 14, 2022



EDWARD M. CHEN
United States District Judge

EXHIBIT 10

Choe, Shiwon (USACAN)

From: Choe, Shiwon (USACAN)
Sent: Friday, May 26, 2023 4:47 PM
To: 'Sullivan, Stephen M.'
Cc: Blalack II, K. Lee; Deaton, David; Bair, Caitlin M.; Portnoi, Dimitri D.; Beard, Jenn; Girolamo, Becky; Jenkins, Brooke D.; Syed, Khadija; Oberembt, Laurie (CIV); Dyal, Gary R. (CIV); Thrope, Jonathan T (CIV); Moskowitz, David (USACO); DeVito, David M. (USACAN); Fishman, Michael (CIV); Civins, Braden (CIV)
Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

Dear Stephen:

Our response was not intended “manufacture confusion” but rather to understand, given your prior explanations about these requests, if there might be information that you need for discovery where we could discuss ways for us to provide you with that information. Your response makes clear that there is not any such information that you need and that we have not already provided.

Re a joint letter, your proposal that Defendants take close to a week for their portion and then leave us with less than a day for ours is wholly inappropriate. We can provide our portion within two business days of receiving yours (accounting for the time to prepare our portion and for the necessary reviews and approvals). If you can get us your portion by COB Wednesday, we can provide our portion for joint submission to the Court by Friday.

Best regards,
 Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>
Sent: Friday, May 26, 2023 3:38 PM
To: Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>
Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>
Subject: [EXTERNAL] RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Thank you for your email. Your questions posed below suggest to us that you are attempting to manufacture confusion and questions where there are none. These questions do not seek any new information from Defendants. And Defendants have addressed each of these questions, in detail and supported by relevant authorities, throughout the course of our months of correspondence and discussions on this issue. See, e.g., Apr. 18, 2023 Letter from Defendants to DOJ; May 9, 2023 Letter from Defendants to DOJ; and May 19, 2023 Letter from Defendants to DOJ. Again, as explained in our May 19, 2023 Letter, Defendants are entitled to formal responses to the RFAs, which, unlike informal meet-and-confer correspondence, are admissible evidence at trial and impose an affirmative obligation upon the responding party “to supplement or correct its disclosure or response...if the party learns that in some material respect the disclosure or response is incomplete or incorrect.” Fed. R. Civ. P. 26(e).

Given your position, Defendants will prepare a joint letter to Magistrate Judge Spero. We expect to share our portion with you by COB Wednesday or Thursday morning so that you can input your portion in time for Defendants to complete the filing by Thursday evening.

Best,

Stephen

Stephen M. Sullivan
O: +1-213-430-6221
M: +1-213-703-3622
ssullivan@omm.com

From: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>
Sent: Friday, May 26, 2023 10:31 AM
To: Sullivan, Stephen M. <ssullivan@omm.com>
Cc: Blalack II, K. Lee <lblack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>
Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

[EXTERNAL MESSAGE]

Dear Stephen:

We remain confused regarding Defendants' views regarding the RFAs. The clear weight of the case law holds that Defendants' RFAs are improper, and Defendants have provided no contrary authorities.

In your May 19 letter, you claim that Defendants need to know the United States' contentions "to pursue targeted discovery and prepare their defenses" and further claim that our May 16 letter, which responded regarding our contentions, is insufficient. Can Defendants explain specifically what this "targeted discovery" is that Defendants believe they cannot pursue without having our contentions, and why our May 16 letter is insufficient for them to pursue that discovery? If Defendants are willing to explain, we would be happy to schedule a further meet and confer to hear your explanation and to try to see if there is a way we might be able to further address those issues. If Defendants are unwilling to explain, however, then I think our respective positions are what they are. If Defendants plan to escalate this issue to Judge Spero and want to submit a joint letter by next Thursday, kindly confirm today that you will send us your portion by COB Tuesday so that we have sufficient time to add our portion.

Best regards,
Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>
Sent: Thursday, May 25, 2023 4:02 PM
To: Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>
Cc: Blalack II, K. Lee <lblack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV)

<Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>

Subject: [EXTERNAL] RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Given that your May 24, 2023 letter, after a lengthy meet and confer process, simply reiterates the United States' refusal to respond to Defendants' First Set of Requests for Admission and provides no counter proposal to Defendants' latest offer of compromise as outlined in our May 19, 2023 letter, Defendants are inclined to proceed with submitting a joint letter to Judge Spero by next Thursday, June 1, 2023. However, Defendants are willing to schedule a final meet-and-confer with lead trial counsel early next week if the United States has a new counter offer in response to Defendants' latest offer of compromise. If not, we think it makes sense to simply proceed with the joint letter to Judge Spero.

To allow for sufficient time to prepare the parties' joint letter, please let us know by tomorrow, May 26, 2023 if the United States would like to schedule another meet-and-confer with lead trial counsel to discuss further.

Best,

Stephen

Stephen M. Sullivan
O: +1-213-430-6221
M: +1-213-703-3622
ssullivan@omm.com

From: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>

Sent: Wednesday, May 24, 2023 8:28 PM

To: Sullivan, Stephen M. <ssullivan@omm.com>

Cc: Blalack II, K. Lee <kblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>

Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

[EXTERNAL MESSAGE]

Dear Stephen:

Please see the attached response to your letter of May 19.

Best regards,
Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>

Sent: Friday, May 19, 2023 6:05 PM

To: Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>

Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>

Subject: [EXTERNAL] RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Attached please find Defendants' response to your May 16, 2023 letter.

Best,

Stephen

Stephen M. Sullivan
O: +1-213-430-6221
M: +1-213-703-3622
ssullivan@omm.com

From: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>

Sent: Tuesday, May 16, 2023 4:00 PM

To: Sullivan, Stephen M. <ssullivan@omm.com>

Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>

Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

[EXTERNAL MESSAGE]

Dear Stephen,

Please see the attached letter regarding Defendants' First Set of Requests for Admission.

Best regards,
Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>

Sent: Tuesday, May 9, 2023 12:25 PM

To: Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>

Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV)

<Braden.Civins2@usdoj.gov>

Subject: [EXTERNAL] RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Please see the attached letter regarding yesterday's meet-and-confer concerning Defendants' First Set of Requests for Admission. Please let us know by tomorrow whether the United States agrees to the compromise proposal we offered yesterday, summarized again in this letter.

Best,

Stephen

Stephen M. Sullivan
O: +1-213-430-6221
M: +1-213-703-3622
ssullivan@omm.com

From: Sullivan, Stephen M. <ssullivan@omm.com>

Sent: Tuesday, May 2, 2023 9:40 AM

To: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>

Cc: Blalack II, K. Lee <kblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>

Subject: Re: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Yes, let's go with Monday, 5/8 at 9:00am Pacific. We will circulate a calendar invite shortly.

Best,

Stephen

Stephen M. Sullivan
O: [+1-213-430-6221](tel:+1-213-430-6221)
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ssullivan@omm.com

On May 2, 2023, at 8:42 AM, Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov> wrote:

[EXTERNAL MESSAGE]

Dear Stephen,

Would next Monday work for you? We could do Monday 9–10 or 11–1 PT / 12–1 or 2–4 ET.

Best,

Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>
Sent: Sunday, April 30, 2023 5:55 PM
To: Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>
Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>; Syed, Khadija <ksyed@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>; Civins, Braden (CIV) <Braden.Civins2@usdoj.gov>
Subject: [EXTERNAL] Re: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Thank you. We would like to arrange a meet-and-confer among lead trial counsel to discuss your letter. Please let us know the DOJ team's availability this week.

Best,

Stephen

Stephen M. Sullivan
O: [+1-213-430-6221](tel:+1-213-430-6221)
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ssullivan@omm.com

On Apr 28, 2023, at 4:51 PM, Choe, Shiwon (USACAN) <Shiwon.Choe@usdoj.gov> wrote:

[EXTERNAL MESSAGE]

Dear Stephen,

Please see the attached response to your April 18 letter regarding Defendants' First Set of Requests for Admission.

Best regards,
Shiwon

From: Syed, Khadija <ksyed@omm.com>
Sent: Tuesday, April 18, 2023 10:03 PM
To: Sullivan, Stephen M. <ssullivan@omm.com>; Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>;

Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>

Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>

Subject: [EXTERNAL] RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

On behalf of Stephen Sullivan, please see the attached letter regarding the United States' Responses and Objections to Defendants' First Set of Requests for Admission.

Best,
Khadija

Khadija Syed
O: +1-415-984-8794
ksyed@omm.com

From: Sullivan, Stephen M. <ssullivan@omm.com>

Sent: Wednesday, April 12, 2023 10:47 AM

To: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>

Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Syed, Khadija <ksyed@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>

Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

Yes, that date and time will work. We will circulate a calendar notice shortly.

Best,

Stephen

Stephen M. Sullivan
O: +1-213-430-6221
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ssullivan@omm.com

From: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>

Sent: Wednesday, April 12, 2023 9:08 AM

To: Sullivan, Stephen M. <ssullivan@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>

Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair,

Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Syed, Khadija <ksyed@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>
Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

[EXTERNAL MESSAGE]

Dear Stephen:

Some members of our team are traveling on Monday and Tuesday. Would Wednesday, April 19, between 10 and 11 PT / 1 and 2 ET work for you?

Best,
Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>
Sent: Tuesday, April 11, 2023 2:22 PM
To: Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>
Cc: Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Syed, Khadija <ksyed@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>
Subject: [EXTERNAL] RE: United States ex rel. Osinek v. Kaiser Permanente

Shiwon,

We received and have reviewed the United States' straight objections to all the requests in KFHP's three sets of discovery referenced below. Please let us know your availability next Monday 4/17 and Tuesday 4/18 to meet and confer regarding the objections.

Best,

Stephen

Stephen M. Sullivan
O: +1-213-430-6221
M: +1-213-703-3622
ssullivan@omm.com

From: Choe, Shiwon (USACAN) <Shiwon.Cho@usdoj.gov>
Sent: Monday, April 10, 2023 9:22 PM
To: Sullivan, Stephen M. <ssullivan@omm.com>; Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; David.Moskowitz@usdoj.gov; DeVito, David M. (USACAN) <David.DeVito@usdoj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>

Cc: ehg@classlawgroup.com; amz@classlawgroup.com; dsh@classlawgroup.com; mronickher@constantinecannon.com; dan@loevy.com; ebaker@constantinecannon.com; minman@constantinecannon.com; mvoidman@constantinecannon.com; rvaldes@constantinecannon.com; prukin@rukinhyland.com; matthew.organ@goldbergkohn.com; roger.lewis@goldbergkohn.com; Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Syed, Khadija <ksyed@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>
Subject: RE: United States ex rel. Osinek v. Kaiser Permanente

[EXTERNAL MESSAGE]

Dear counsel:

Please see attached the United States' responses and objections to Defendants' First Set of Requests for Admission, Defendants' First Set (and KFHP's Second Set) of Interrogatories, and Defendants' First Set (and KFHP's Third Set) of Requests for Production.

Best regards,
Shiwon

From: Sullivan, Stephen M. <ssullivan@omm.com>
Sent: Friday, March 10, 2023 1:41 PM
To: Oberembt, Laurie (CIV) <Laurie.Oberembt@usdoj.gov>; Choe, Shiwon (USACAN) <SChoe@usa.doj.gov>; Dyal, Gary R. (CIV) <Gary.R.Dyal@usdoj.gov>; Thrope, Jonathan T (CIV) <Jonathan.T.Thrope@usdoj.gov>; Moskowitz, David (USACO) <Dmoskowitz@usa.doj.gov>; DeVito, David M. (USACAN) <DDeVito@usa.doj.gov>; Fishman, Michael (CIV) <Michael.Fishman@usdoj.gov>
Cc: ehg@classlawgroup.com; amz@classlawgroup.com; dsh@classlawgroup.com; mronickher@constantinecannon.com; dan@loevy.com; ebaker@constantinecannon.com; minman@constantinecannon.com; mvoidman@constantinecannon.com; rvaldes@constantinecannon.com; prukin@rukinhyland.com; matthew.organ@goldbergkohn.com; roger.lewis@goldbergkohn.com; Blalack II, K. Lee <lblalack@omm.com>; Deaton, David <ddeaton@omm.com>; Bair, Caitlin M. <cbair@omm.com>; Portnoi, Dimitri D. <dportnoi@omm.com>; Beard, Jenn <jbeard@omm.com>; Syed, Khadija <ksyed@omm.com>; Girolamo, Becky <bgirolamo@omm.com>; Jenkins, Brooke D. <brookejenkins@omm.com>
Subject: [EXTERNAL] United States ex rel. Osinek v. Kaiser Permanente

Counsel,

Attached are the following requests served in connection with *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-03891-EMC:

1. Defendants' First Set of Requests for Admission to Plaintiff, United States of America

2. Defendants' First Set of Interrogatories to Plaintiff, United States of America
3. Defendants' First Set of Requests for Production to Plaintiff, United States of America

Best,

Stephen

O'Melveny

Stephen M. Sullivan

ssullivan@omm.com

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<2023-04-28 - U.S. letter to Kaiser re 2023-04-18 letter and RFAs.pdf>

EXHIBIT 11



United States Department of Justice

*United States Attorney
Northern District of California*

9th Floor, Federal Building
450 Golden Gate Ave., Box 36055
San Francisco, CA 94102-3495

Phone (415) 436-6967
Facsimile (415) 436-6748
Email shiwon.choe@usdoj.gov

May 24, 2023

BY EMAIL

Stephen Sullivan, Esq.
O'Melveny & Myers LLP
400 South Hope Street
18th Floor
Los Angeles, CA 90071-2899

Re: *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC –
Defendants' First Set of Requests for Admission

Dear Mr. Sullivan:

I write on behalf of the United States in response to your letter of May 19, 2023 regarding Defendants' First Set of Requests for Admissions ("RFAs").

As we have previously discussed and set forth in detail in our letter of April 28, 2023, the relevant authorities both within and outside the Ninth Circuit—including the authorities that Defendants themselves have cited—hold that Defendants' contention RFAs are improper and do not comport with the requirements of Federal Rule of Civil Procedure 36. Defendants have provided no authority in response that supports their contrary position. *See* Kaiser May 9, 2023 Ltr. (citing no authority); Kaiser May 19, 2023 Ltr. (same). Despite the fact that Defendants' RFAs are improper, we nevertheless have tried to reach a compromise by addressing the substance of all of your RFAs. *See* U.S. May 16, 2023 Ltr.

Your May 19 letter claims that our response is insufficient because "it does not generate admissible evidence[.]" This is a non sequitur. The reason that Defendants' RFAs do not generate admissible evidence is because they ask for *contentions*, and contentions are not evidence. That Defendants are trying to use their RFAs to somehow transform contentions into "admissible evidence" only confirms how Defendants are misusing the Rule 36 RFA procedure. *See, e.g., Paramount Fin. Commc'ns v. Broadridge Inv. Commc'n Sols., Inc.*, No. 15-405, 2017 WL 495784, at *4 (E.D. Pa. Feb. 7, 2017) (RFAs for party's contentions are improper and "is not the purpose of Rule 36"); *SEC v. Nutmeg Grp., LLC*, 285 F.R.D. 403, 405–06 (N.D. Ill. 2012) (RFAs for plaintiff's current state of knowledge about facts of case are improper, because

plaintiff's current state of knowledge "is not admissible evidence," "is not relevant to or probative of anything," and "would not be a 'fact' admissible at trial"); *Crouch v. Teledyne Continental Motors, Inc.*, No. 10-00072-KD-N, 2011 WL 13135770, at *4 (S.D. Ala. Apr. 21, 2011) (defendant's RFAs to plaintiff about plaintiff's contentions are improper) (cited by Kaiser Apr. 18, 2023 Ltr. at 2). Your May 19 letter further claims that our response is insufficient because it "imposes no obligation on the United States to supplement or amend its responses if its position changes later in the litigation as required by the Federal Rules of Civil Procedure." This, again, is a non sequitur. The United States has no obligation to respond to requests like Defendants' RFAs that do not comply with the Federal Rules of Civil Procedure in the first place.

Defendants claim to need the United States' contentions to pursue targeted discovery and prepare their defenses, but we have already responded regarding our contentions. Defendants have those responses as they prepare their defenses. *See* U.S. May 16, 2023 Ltr. Further, Defendants already have direct access to their own doctors, their own medical records, and their own documents and reports (with such access not being dependent on the United States' contentions) and are fully capable of using their own access to their own doctors and documents to prepare their defenses. *See, e.g., Campbell v. Facebook Inc.*, No. 13-cv-05996-PJH (MEJ), 2015 WL 3533221, at *4–6 (N.D. Cal. June 3, 2015) (rejecting defendant's claim that plaintiffs' contentions were necessary for defendant to prepare its case where "defendant appears to have control over or adequate access to much of the evidence relevant to its alleged misconduct") (cited by Kaiser Apr. 18, 2023 Ltr. at 3). Should the United States become aware of other individuals not previously identified who are likely to have discoverable information that the United States may use to support its claims, it will provide Defendants with those individuals and the subjects of that information. *See* Fed. R. Civ. P. 26(a)(1)(A)(i).

Very truly yours,

ISMAIL J. RAMSEY
United States Attorney

By: s/Shiwon Choe
SHIWON CHOE
Assistant United States Attorney

CERTIFICATION

Pursuant to Civil L.R. 5-1(h)(3), the undersigned hereby attests that Shiwon Choe has concurred in the filing of this document.

DATED: June 5, 2023

O'MELVENY & MYERS LLP

By: /s/ Stephen M. Sullivan

Stephen M. Sullivan, Esq.
Attorney for Defendants