UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 13-cv-03891-EMC

ORDER DENYING DEFENDANTS' MOTION TO DISMISS UNITED STATES' FIRST AMENDED COMPLAINT

Docket No. 249

This litigation covers claims brought against various Kaiser entities pursuant to the False Claims Act ("FCA"). Currently, there are complaints filed by three sets of Plaintiffs: (1) the United States; (2) Dr. James Taylor; and (3) Gloryanne Bryant and Victoria M. Hernandez. This order addresses a motion to dismiss challenging the United States' operative complaint. For convenience, the Court refers to the Kaiser entities moving for dismissal as "Kaiser." The specific Kaiser entities that have been sued by the United States are: (1) the California health plan and two related physician medical groups (Kaiser Foundation Health Plan, Inc.; the Permanente Medical Group; and the Southern California Permanente Medical Group) and (2) the Colorado health plan and the related physician medical group (Kaiser Foundation Health Plan of Colorado and the Colorado Permanente Medical Group, P.C.).

Having considered the parties' briefs, as well as the oral argument of counsel, the Court hereby **DENIES** Kaiser's motion to dismiss.

I. FACTUAL & PROCEDURAL BACKGROUND

The government's operative complaint is the first amended complaint ("FAC"). Before the government filed the FAC, the Court granted in part and denied in part Kaiser's motion to dismiss

the government's original complaint. In that order, the Court noted that the gist of the United States' complaint was as follows: in conjunction with the Medicare Advantage program, "Kaiser submitted false claims for payment because it 'alter[ed] patient medical records [via addenda] to add diagnoses that either [1] did not exist or [2] were unrelated to the patient's visit with the Kaiser physician.'" Docket No. 223 (Order at 10). The Court noted that the government's first theory was predicated on factual falsity: "If a diagnosis of a medical condition was claimed but that medical condition did not exist (*i.e.*, the diagnosis was 'clinically inaccurate'), then a claim for payment based on that diagnosis is literally false." Docket No. 223 (Order at 10). The second theory was primarily predicated on legal falsity but also could be construed as being predicated on factual falsity. *See* Docket No. 223 (Order at 16-17) (explaining that "[a] legally false claim for payment involves an assertion (either express or implied) that there is compliance with a statute, regulation, or contract" and, here, "the government argues that both the CMS/Kaiser contract and federal regulations required Kaiser to comply with ICD Guidelines"; adding, however, that there was also factual falsity because "[Kaiser] incorrectly described the valid ICD codes for the patient visit").

The Court concluded that the factual falsity theory was problematic because the government was asserting that there was a *broad scheme* "to include nonexistent diagnoses in patients' medical records." Docket No. 223 (Order at 13). However, with one exception, the allegations were not sufficient to support a broad scheme. The Court acknowledged that the government's complaint identified three specific instances of clinically inaccurate diagnoses but noted that there was nothing to suggest that these three specific instances "were emblematic of a wider pattern of similar practices." Docket No. 223 (Order at 13). The one exception that the Court identified was with respect to a disease known as cachexia. For cachexia, there were sufficient allegations suggesting a scheme to overcode on that specific disease. *See* Docket No. 223 (Order at 13-14).

Although the Court dismissed the factual falsity theory, it gave the government leave to amend so that it could plead "a scheme by Kaiser to alter patient medical records by adding

clinically inaccurate diagnoses *on a general or systemic basis*."[1] Docket No. 223 (Order at 31) (emphasis added). The government has now filed its FAC, and Kaiser challenges that pleading, asserting that the factual falsity theory is still deficient.

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). "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). 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).

In its papers, Kaiser emphasizes that the *Iqbal* Court indicated a claim is not plausible if there is an "'obvious alternative explanation'" for a defendant's conduct. *Iqbal*, 556 U.S. at 669. But the Ninth Circuit subsequently pointed out that,

> [i]f there are two alternative explanations, one advanced by defendant and the other advanced by plaintiff, both of which are plausible, plaintiff's complaint survives a motion to dismiss under Rule 12(b)(6). Plaintiff's complaint may be dismissed only when defendant's plausible alternative explanation is so convincing that

[1] The Court allowed the government's causes of action based on a theory of legally false claims for payment to proceed.

> plaintiff's explanation is *implausible*.

Starr v. Baca, 652 F.3d 1202, 1216 (9th Cir. 2011) (emphasis in original); *see also Waln v. Dysart Sch. Dist.*, 54 F.4th 1152, 1159-60 (9th Cir. 2022) (articulating the same standard); *Patton v. Ind. Univ. Bd. of Trs.*, No. 1:20-cv-00699-TWP-MJD, 2022 U.S. Dist. LEXIS 154900, at *44 (S.D. Ind. Aug. 29, 2022) (finding defendant's "'obvious alternative explanation' argument . . . unsuccessful" because (1) plaintiff "has not alleged 'so fantastic a story that it could be easily debunked by a non-illicit "obvious alternative explanation"'" and (2) "the alleged non-illicit explanations for [defendant's] actions are not so patently obvious as to make Patton's causation allegations implausible").

In addition to Rules 8 and 12, Federal Rule of Civil Procedure 9 is also implicated in the instant case because the government is making a claim for fraud. Under Rule 9(b), a plaintiff who alleges fraud "must state with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b). The Ninth Circuit has noted that,

> [t]o state an FCA claim, a relator is not required to identify actual examples of submitted false claims; instead, "it is sufficient to allege 'particular details of a *scheme* to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted.'" *Ebeid ex rel. U.S. v. Lungwitz*, 616 F.3d 993, 998-99 (9th Cir. 2010) (quoting *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009)). A relator is not required to identify representative examples of false claims to support every allegation, although the use of representative examples is one means of meeting the pleading obligation. *Id.* at 998.

Godecke ex rel. United States v. Kinetic Concepts, Inc., 937 F.3d 1201, 1209 (9th Cir. 2019) (emphasis added); *see also United States ex rel. Chorches v. Am. Med. Response, Inc.*, 865 F.3d 71, 89 (2d Cir. 2017) (noting that the majority of circuits follow this approach based on the Fifth Circuit's decision in *Grubbs*; citing cases from the Fifth, Tenth, Ninth, Third, D.C., and Seventh Circuits).

B. Elements of False Claim Act

"[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). In the instant case, Kaiser argues that the government's

factual falsity theory must be dismissed because the government has failed to plead falsity, scienter, and materiality.

C. Falsity

1. "Contradiction"

As an initial matter, Kaiser argues that the government has failed to plead falsity because the government no longer alleges that Kaiser diagnosed medical conditions that patients did not actually have – and instead simply alleges that the diagnoses made were "contradicted" by the patients' medical records. According to Kaiser,

> [t]hese theories are distinct. When a member does not have the diagnosed medical condition, the associated diagnosis code is false on its face, regardless of what the medical record shows. Even if the diagnosis does not contradict any information in the medical record, it is still false because the member does not have the medical condition described by the diagnosis. Conversely, a contradiction between the diagnosis and information in the medical record does not on its own establish falsity. Where the medical record contradicts the diagnosis, the contradiction could suggest any number of innocuous things – for example, there may have been a change of medical circumstances or a simple typographical error in the record. Indeed, contradictory information in the medical record may be the best reason to query a healthcare provider to clarify which of the contradictory indicators should be credited for purposes of diagnosis coding.

Mot. at 8. Kaiser contends that the government's position is predicated on "the faulty premise that a diagnosis must necessarily be false when the patient's medical record contains information that conflicts with the diagnosis." Mot. at 8; *see also* Mot. at 10 (asserting that "it is not reasonable to infer that a 'contradiction' between a diagnosis and information in the medical record necessarily supports the conclusion that the patient does not have the diagnosed condition").

The Court rejects Kaiser's position. First, contrary to what Kaiser suggests, the government makes clear that, by alleging that a condition is contradicted by the medical record, it means that the condition did not actually exist. *See, e.g.*, FAC ¶ 2 ("Kaiser falsely submitted diagnosis codes for conditions that the patient did not actually have at the time of the visit, as the existence of the conditions was contradicted by the medical record."). Notably, Kaiser itself

admits that "contradictions in medical records *can* serve as *evidence* of a nonexistent diagnosis."[2] Reply at 4 (emphasis in original).

Second, even if, as Kaiser maintains, a contradiction in the medical record does not *necessarily* mean that the diagnosed condition did not exist, the question at 12(b)(6) is whether it is *plausible* that the diagnosed condition did not exist. If the medical record does not support a condition, then it is reasonable to infer that the condition did not exist.

In its reply brief, Kaiser suggests that it is only *possible*, not plausible, that a diagnosis did not exist if there is a contradiction in the medical record. *See* Reply at 4 (arguing that "the United States fails to articulate why this inference is plausible rather than merely possible"; "[i]n a medical record, 'contradictions' are routine and even expected, such as where a healthcare provider determines a member has a medical condition despite the existence of a clinical indicator that might suggest otherwise, or where the provider concludes that a medical condition that previously receded has returned"). Although Kaiser's position is not baseless, it is not convincing for several reasons. First, Kaiser is making plausibility a more demanding standard than it actually is. As noted above, plausible does not mean probable; plausible simply means that there is more than a sheer possibility that a defendant acted unlawfully. Second, Kaiser's alternative explanation is not so convincing that Plaintiffs' explanation is thereby rendered implausible. For example, at this juncture, it is not clear that contradictions in medical records are routine and expected, as Kaiser asserts. Moreover, if as discussed below, there is a sufficient allegation of a widespread pattern of contradictions, that further supports the inference of purposeful falsity.

2. Systemic Scheme to Defraud

Kaiser argues that, even if the Court is not persuaded by its arguments above, there is another reason why the Court should reject the government's claim of factual falsity – specifically, because the government has failed to plead facts supporting a "systemic *scheme* by thousands of healthcare providers to falsely diagnose their patients with medical conditions that do not actually

[2] Kaiser has also argued a failure to plead materiality based on the government's "mere" pleading of a "contradiction." Mot. at 20-21. Because the government has in fact alleged the submission of clinically inaccurate diagnoses, Kaiser's materiality argument also lacks merit.

exist." Mot. at 10 (emphasis in original).

The Court does not agree. The United States has in its FAC pointed to specific examples of clinically inaccurate diagnoses. *See, e.g.*, FAC ¶¶ 175-76 (alleging that, as a result of Kaiser's refresh program, two patients were diagnosed via addenda with malnutrition even though, at the time of the visit, they were obese); FAC ¶ 375 (alleging that three patients were diagnosed via addenda with conditions even though their medical records, at the time of the visit, contradicted those diagnoses).

In addition, the United States has made allegations indicating that there were more than just isolated instances of clinically inaccurate diagnosing, *i.e.*, that these problems were systemic. *See, e.g.*, FAC ¶ 103 (alleging that, in "hundreds of thousands" of instances, diagnoses were made that "violated the ICD Guidelines requirement that a diagnosis 'require or affect patient care, treatment, or management' at a patient visit[,] [a]nd many times, contradictory information in patient medical records indicated the patient did not even have the condition at the time of the visit"); FAC ¶¶ 334, 337 (alleging that an audit of addenda in 2015 "identified significant evidence that Kaiser physicians were regularly making . . . errors [of diagnosing a condition where the medical record contradicted the existence of the condition], including in particular adding morbid-obesity diagnoses when the patient had a BMI at the time of the visit that was inconsistent with the diagnosis"); FAC ¶ 338 (alleging that an audit of addenda in 2016 "identified hundreds of instances in Northern California alone where Kaiser physicians added diagnoses via addenda where the existence of the condition was contradicted by information in the encounter note"); *see also* FAC ¶ 142 (alleging that Kaiser "often generate[d] after-visit queries [to doctors] based on previously run algorithms that relied upon outdated information"; "[i]nternally, Kaiser identified these data lag issues as a threat and weakness of their data-mining and refresh programs"); FAC ¶ 178 (alleging that "[i]nternal documents indicate that Kaiser was aware that its risk-adjustment initiatives were generating inaccurate diagnoses, including identifying, for example, that refresh reports would ask for a diagnosis to be refreshed even though it was only captured as a history of the condition"); FAC ¶ 323 (alleging that "one internal document identified as a weakness of the program that '[s]ome clinicians refresh the diagnosis without proper and detailed review of the

medical record, and as a result incorrect diagnoses keep being reported'").

Finally, the United States has alleged a plausible reason why there was, in effect, a *practice* of clinically inaccurate diagnosing – one not limited to specific medical conditions. As the government notes in its opposition brief:

> The false claims arose from the design of Kaiser's risk-adjustment programs . . . . These issues were not specific to any particular [medical] condition [e.g., cachexia] but were *programmatic*. By *design*, Kaiser's risk-adjustment programs [*e.g.*, data mining and chart review] generated voluminous queries to physicians after visits, but the programs would often fail to account for what actually occurred at the visit, ignoring both whether [1] the condition had any relevance to the visit and [2] contradictory information in a patient's medical record showing the patient did not have the condition. Consequently, even if the medical record for the visit contradicted the existence of the condition, Kaiser would still regularly query the physician after a visit to create an addendum to add the diagnosis.

Opp'n at 10 (emphasis added).

Kaiser's "refresh" program provides the clearest example of how there was, effectively, a practice of submitting clinically inaccurate diagnoses. Under the refresh program, "Kaiser created algorithms that mined patients' electronic medical records for any diagnoses that had been made in any setting during the past several (typically three) years." FAC ¶ 161. "[I]f a physician failed to re-diagnose these conditions at a patient visit," Kaiser would send a query to the physician about those diagnoses and "systematically pressure the physician to add the diagnoses via addenda." FAC ¶ 162. But this approach disregarded the fact that an old diagnosis – precisely because it was old – might no longer accurate. For example, the medical condition diagnosed several years earlier could have resolved; or at least the medical condition was now a historical condition instead of an active one. *See* FAC ¶ 161. The patient visit therefore could have "clinical indicators . . . contradict[ing] the actual existence of the condition" that was diagnosed years earlier but, even so, Kaiser would still send query the doctor about the old diagnosis and pressure the doctor to add the diagnosis via an addendum. FAC ¶ 161; *see also* FAC ¶ 134 (alleging that "Kaiser generated these lists [of missed opportunities] without accounting for contradictory information in the medical record of the visit"); FAC ¶ 228 (alleging that clinically inaccurate diagnosing was an "inevitable result[] of Kaiser's flawed programs, given the way that the

diagnoses were generated and the pressure on physicians to add them").

In its papers, Kaiser argues that the refresh program allegations do not demonstrate falsity because, as alleged, all that Kaiser did was send queries to doctors; it was then up to the doctors to use their independent judgment to determine whether the old diagnoses should be "refreshed." *See* Reply at 6 ("Even if this Court accepts that Defendants sent healthcare providers queries that had incomplete or inaccurate information, to show a widespread scheme based on those purportedly flawed queries, the United States must also allege with specific facts a widespread failure by thousands of healthcare providers to exercise their professional judgment, adequately review members' medical records, or diagnose medical conditions that they knew their patients did not have."). While Kaiser's position is not entirely without basis, the government has not relied solely on the fact that queries were sent to doctors. Rather, the government has expressly alleged that doctors were *pressured* to add the old diagnoses. This pressure took various forms – *e.g.*, doctors were subjected to multiple queries, were required to justify their refusals to add old diagnoses, and were offered financial incentives (both positive and negative) to generate addenda. *See* FAC ¶ 201 *et seq.* To the extent Kaiser suggests it is implausible that doctors would succumb to such pressure, *cf.* Reply at 8 (arguing that the government has lodged "a serious charge of misconduct against Defendants" and further "call[ed] into question the professional conduct of the thousands of healthcare providers who work for Defendants and who actually recorded these challenged diagnoses in the members' medical records"), there is enough here to give rise to a reasonable and plausible inference that the pressure had effect. This is especially true given that, under the refresh program, doctors were being asked to diagnose conditions that had, in fact, been previously diagnosed – *i.e.*, this was not a situation in which diagnoses were being made up out of whole cloth; hence, it took less of a stretch to succumb to pressure from Kaiser.

To the extent Kaiser relies on the Ninth Circuit's decision in *Integra Med Analytics LLC v. Provident Health & Services*, 854 F. App'x 840 (9th Cir. 2021), to support its position, that case is not binding since it is not a published decision. Furthermore, *Integra* is distinguishable from the case at hand. In *Integra*, the plaintiff did claim that the defendant, which operated numerous hospitals and clinics across multiple states, gave its doctors leading queries. *See id.* at 842. The

plaintiff also claimed that the defendant "incentivized doctors to use language conducive to coding higher-paying . . . diagnoses though [its] documentation tips and queries." *Id.* at 844; *see also id.* at 842 (referring to "'leading queries'"). The Ninth Circuit held that these allegations *on their own* were not enough to support the conclusion that doctors thereby "recorded unsupported medical conditions." *Id.* at 844. In the instant case, the government has made allegations beyond those made in *Integra* – *e.g.*, alleging that doctors were subjected to significant pressure beyond the mere fact of the queries (*e.g.*, there were positive and negative financial incentives to upcode, and doctors were required to justify their refusals to add diagnoses) and that audits *confirmed* that there was incorrect diagnosing.

Furthermore, it appears that, in *Integra*, the plaintiff simply alleged queries "'would *sometimes* result in the creation of contradictory medical records,' such as an initial documentation of 'delirium' with the later addition of 'encephalopathy.'" *Id.* at 842 (emphasis added). Here, the government has alleged that, based on audits, there was more than just sporadic incorrect diagnosing.

Finally, the focus of the Ninth Circuit in *Integra* was the plaintiff's use of statistics to support its claim of falsity. According to the plaintiff, there must have been the false recording of medical conditions because the defendant "submitted proportionally *more* claims with higher-paying diagnosis codes than comparable institutions." *Id.* at 841 (emphasis added). But data cited in the complaint actually showed that, over time, other comparable institutions were also coding more for major complications or comorbidities. "By 2017, [other] entities generally coded claims with encephalopathy, respiratory failure, and severe malnutrition at similar rates to [defendant's] in 2011 to 2012." *Id.* at 843. Moreover, even if the defendant had at one point submitted proportionally more claims, the Ninth Circuit said that the plaintiff had simply offered a "*possible* explanation – that doctors lied about underlying medical conditions – to explain" the statistics; the "statistical trend [was also] consistent with a plausible alternative (and legal explanation)" – *i.e.*, that the defendant, "one of the largest health care systems in the country, which specifically hired consultants to improve its Medicare billing, would be at the forefront of a national trend toward coding these relevant MCCs at a higher rate." *Id.* at 844 (emphasis in original). Unlike the

plaintiff in *Integra*, the government is not relying on similar statistics to prove falsity; rather, the government is claiming falsity based on, *e.g.*, audits that confirmed more than sporadic incorrect diagnosing.

In any event, even if Kaiser's reading of *Integra* is the correct one, the Court also takes note of an additional allegation made by the government with respect to the refresh program. According to the government,

> Kaiser physicians who were requested to add diagnoses through addenda many times would comply with Kaiser's request by creating addenda documenting that the patient [only] had a *history* of the condition. . . . However, instead of using *historical* condition codes, as required by the ICD Guidelines, Kaiser would submit an *active* condition code with the condition, even though the physicians documented the condition as historical. This regularly occurred with respect to conditions that may be temporary or resolve over time with treatment, such as cancers, stroke, irregular heart rhythms, blood disorders, malnutrition, obesity-related conditions, and numerous others.

FAC ¶ 177 (emphasis in original and added). In other words, here, the government is not only alleging that Kaiser successfully pressured doctors to add incorrect diagnoses via addenda. Here, the government is alleging that in addition to erroneous diagnoses, doctors sometimes added correct diagnoses but, because these diagnoses would not result in risk adjustment (because they were historical conditions and not active ones), Kaiser then *changed* the diagnoses.

Accordingly, for the reasons stated above, the Court rejects Kaiser's contention that the government has not adequately pled falsity.

D. Knowledge

Kaiser argues that, even if falsity is sufficiently pled, knowledge of falsity is not. The Court rejects this argument as well.

For purposes of the False Claims Act, 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). *See, e.g.*, *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1175-76 (9th Cir. 2016) (addressing "when a Medicare Advantage organization undertakes comprehensive blind coding but then runs a unidirectional comparison with the

previously submitted codes to reveal only *under-reporting* errors"; "where 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") (emphasis added).

In the case at bar, the government has alleged, at the very least, reckless disregard and deliberate ignorance because audits revealed more than just isolated instances where clinically inaccurate diagnoses were being submitted. *See, e.g.*, FAC ¶ 347 ("[A] 2015 N. California Medical Group internal analysis of stop prompts identified that Kaiser's programs were prompting physicians to add diagnoses for conditions that patients never had or did not have at the time."); FAC ¶ 345 ("[National Compliance Office] audits consistently showed that Kaiser's California and Colorado regions erroneously submitted active condition diagnosis codes to CMS for payment when the medical records indicated that the patient had only a history of the condition."); FAC ¶ 337 ("While [a 2015] audit [that focused on addenda] did not expressly categorize diagnoses where the medical record contradicted the existence of the condition, auditors nevertheless identified significant evidence that Kaiser physicians were regularly making such errors, including in particular adding morbid-obesity diagnoses when the patient had a BMI at the time of the visit that was inconsistent with the diagnosis."). In other words, the audits put Kaiser on notice of systemic problems and, if Kaiser did not do anything thereafter, then, at least plausibly, it acted in reckless disregard on in deliberate indifference.

Other allegations in the government's FAC further support plausibility of the claim that Kaiser acted with the requisite state of mind. For example, the government has alleged that "[i]nternal documents indicate . . . Kaiser was aware that its risk-adjustment initiatives were generating inaccurate diagnoses, including identifying, for example, that refresh reports would ask for a diagnosis to be refreshed even though it was only captured as a history of the condition." FAC ¶ 178; *see also* FAC ¶ 179 (noting that some "internal documents identified this as a key problem area for cancer and stroke in particular"); FAC ¶ 142 (alleging that Kaiser "often generate[d] after-visit queries [to doctors] based on previously run algorithms that relied upon outdated information"; "[i]nternally, Kaiser identified these data lag issues as a threat and weakness of their data-mining and refresh programs"); FAC ¶ 323 (alleging that "one internal

document identified as a weakness of the program that '[s]ome clinicians refresh the diagnoses without proper and detailed review of the medical record, and as a result incorrect diagnoses keep being reported'"). Furthermore, the FAC alleges that numerous doctors warned Kaiser that there was a problem with the submission of clinically inaccurate diagnoses. *See* FAC ¶ 307 *et seq.* Finally, as noted above, the government's allegation that Kaiser *pressured* doctors to add further diagnoses implies Kaiser acted with scienter, as pressure could plausibly lead to incorrect diagnosing.

Collectively, these allegations substantiate the government's position that Kaiser was, at the very least, acting in reckless disregard or deliberate ignorance of the truth or falsity of the diagnoses, if not knowingly so, through submission of addenda.

E. Conspiracy

Kaiser contends that, even if the government has adequately pled the elements of falsity and knowledge, the specific cause of action for conspiracy to violate the False Claims Act should be dismissed – at least to the extent it is based on a factual falsity theory. According to Kaiser, the allegation of conspiracy is pled in too conclusory a fashion – *i.e.*, there are no "specific facts that would support a plausible inference that the health plan Defendants and medical group Defendants had an agreement to submit diagnosis codes to CMS for medical conditions *that did not exist*." Mot. at 21 (emphasis added).

To a certain extent, Kaiser's position here is a variant of one of its arguments above: namely, that it is implausible that a doctor would diagnose a condition that did not actually exist. The Court rejected that argument above; likewise, it rejects the argument that Kaiser now makes here.

To be sure, Kaiser's position is not entirely lacking in merit. "'The essence of a conspiracy under the [FCA] is an agreement between two or more persons to commit a fraud.'" *United States ex rel. Atkinson v. Pa. Shipbuilding Co.*, No. 94-7316, 2000 U.S. Dist. LEXIS 12081, at *41 (E.D. Pa. Aug. 24, 2000). Thus, "to prove a False Claims Act conspiracy, a relator must show '(1) the existence of an unlawful agreement between defendants to get a false or fraudulent claim allowed or paid by [the Government] and (2) at least one act performed in furtherance of that agreement.'"

United States ex rel. Grubbs v. Ravikumar Kanneganti, 565 F.3d 180, 193 (5th Cir. 2009); *see also United States v. St. Luke's Subacute Hosp. & Nursing Ctr., Inc.*, No. C 00-1976 MHP, 2004 U.S. Dist. LEXIS 25380, at *18-19 (N.D. Cal. Dec. 15, 2004) ("[T]o establish a claim for civil conspiracy under the FCA, the United States need only prove (1) that the defendant conspired with one or more persons to get a false or fraudulent claim allowed or paid by the United State and (2) that one or more conspirators performed an act to effect the object of the conspiracy."); *cf. United States ex rel. Durcholz v. FKW Inc.*, 189 F.3d 542, 545 n.3 (7th Cir. 1999) ("The FCA provides for conspiracy claims, and general civil conspiracy principles apply.").

Here, if the government had simply alleged reckless disregard, then arguably, a finder of fact would have to conclude that there was not an *agreement* among the Kaiser entities to submit clinically inaccurate diagnoses. A California district court made a similar point in *United States ex rel. Integra Med Analytics LLC v. Providence Health & Servs.*, No. CV 17-1694 PSG (SSx), 2019 U.S. Dist. LEXIS 125352, at *66 (C.D. Cal. July 16, 2019), *overruled on other grounds by Integra*, 854 F. App'x at 840:

> The FCA claims described above provide for liability if the defendant acts "knowingly," which is defined as having actual knowledge or acting in deliberate ignorance or with reckless disregard. However, the FCA's reference to conspiracy claims does not have this "knowingly" requirement. Accordingly, most courts have concluded that general civil conspiracy principles apply to the conspiracy provision of the FCA. Under these principles, Relator "must show that the conspiring parties reached a unity of purpose or a common design and understanding, or a meeting of the minds in an unlawful agreement." As the alleged object of this conspiracy was to submit false claims to Medicare, Relator must show that Defendants jointly intended to do so. *For conspiracy, reckless disregard is not enough.*

Id. at *66 (emphasis added).

But in the instant case, the government has plausibly pled more than just reckless disregard, or even deliberate ignorance. Notably, a conspiracy can be based on an express agreement or an implied one. *Cf. United States v. Hernandez*, 876 F.2d 774, 777 (9th Cir. 1989) (in a criminal matter, noting that, for purposes of a conspiracy, an agreement does not have to be explicit; "'[a]n implicit agreement may be inferred from the facts and circumstances of the case'"). Given the collective allegations that Kaiser internally recognized a problem with clinically

inaccurate diagnosing, as supported by, *e.g.*, audits, but continued to pressure doctors to add diagnoses through the addenda process, it is plausible that the Kaiser entities implicitly agreed to submit factually false claims for payment to the United States. Although arguably a close call – *i.e.*, the evidence more easily supports a finding of reckless disregard – the government has sufficiently alleged enough from which knowledge and agreement may reasonably be inferred, at least for 12(b)(6) purposes.[3]

F. "Lumping" Defendants

Finally, Kaiser argues that, at the very least, some of the Kaiser entities sued should be dismissed. The government has sued the following five entities (two health plans and three physicians groups):

- Kaiser Foundation Health Plan, Inc. ("KFHP"), a health plan that has contracted with CMS to provide Medicare Advantage plans in California (both the Northern California and Southern California regions), *see* FAC ¶ 23;
- Kaiser Foundation Health Plan of Colorado ("Colorado Health Plan"), a health plan that has contracted with CMS to provide Medicare Advantage plans in Colorado, *see* FAC ¶ 24;
- The Permanente Medical Group, Inc. ("TPMG"), a physicians group that provides medical services for the Northern California region, *see* FAC ¶ 26;
- The Southern California Permanente Medical Group ("SoCal Medical Group"), a physicians group that provides medical services for the Southern California region, *see* FAC ¶ 27; and

[3] At the hearing, the Court asked some questions regarding the scope of the alleged conspiracy – *i.e.*, did the conspiracy consist of two bilateral conspiracies (*i.e.*, a conspiracy involving the California entities and a separate conspiracy involving the Colorado entities), or instead a single overarching conspiracy involving all of the California and Colorado entities. The government indicated the latter. Although that position may be questionable, *cf. United States v. Singh*, 979 F.3d 697, 721-22 (9th Cir. 2020) (stating that "[a] single conspiracy can only be demonstrated by proof that an overall agreement existed among the conspirators" and "the evidence must show that each defendant knew, or had reason to know, that his benefits were probably dependent upon the success of the entire operation"), the Court need not delve into that issue here because Kaiser did not expressly make a challenge based on the scope of the conspiracy in its motion to dismiss. *See* FAC ¶¶ 122, 149, 153 (allegations suggesting a single nationwide conspiracy).

- The Colorado Permanente Medical Group, P.C. ("Colorado Medical Group"), a physicians group that provides medical services for the Colorado region. *See* FAC ¶ 28.

According to Kaiser, the government has improperly lumped Defendants together and, at most, made allegations that support KFHP and TPMG being defendants, but not the remaining Kaiser entities (*i.e.*, the SoCal Medical Group, the Colorado Health Plan, and the Colorado Medical Group). *See generally Karkanen v. Cal.*, No. 17-cv-06967-YGR, 2018 U.S. Dist. LEXIS 135536, at *18 (N.D. Cal. Aug. 10, 2018) ("Courts consistently conclude that a complaint which 'lump[s] together . . . multiple defendants in one broad allegation fails to satisfy [the] notice requirement of Rule 8(a)(2).'"); *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 677 (9th Cir. 2018) ("To satisfy Rule 9(b), a fraud suit against differently situated defendants must 'identify the role of each defendant in the alleged fraudulent scheme.' In other words, when defendants engage in different wrongful conduct, plaintiffs must likewise 'differentiate their allegations.'").

The government has the better position on this issue. First, there is no concern here that Kaiser does not have adequate notice as to the general roles played by the health plans and the physician medical groups with respect to risk adjustment. The FAC provides sufficient details in those regard.

Second, as the government points out, the Ninth Circuit has held that

> a complaint need not distinguish between defendants that had the exact same role in a fraud. . . . "There is no flaw in a pleading . . . where collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct." A good claim against one defendant did not become inadequate simply because a co-defendant was alleged to have committed the same wrongful acts.

Id. Here, the various Kaiser entities have allegedly engaged in the same basic conduct. This is substantiated by allegations that Kaiser's risk adjustment operations were integrated and/or involved collaboration. *See, e.g.*, FAC ¶ 30 *et seq.* (making allegations regarding Kaiser's "integrated and collaborative risk-adjustment operations"); *see also* FAC ¶¶ 164-65 (alleging that the refresh program was "nationwide . . . , with small adaptations in each region" and that "Kaiser's National Medicare Finance department identified and monitored unrefreshed diagnoses

on a regular basis and shared results with each region").

Finally, there are allegations that point to specific wrongdoing by the SoCal Medical Group, the Colorado Health Plan, and the Colorado Medical Group. For example:

- The Colorado Health Plan and the Colorado Medical Group. In FAC ¶¶ 154-55, the government makes allegations about how the Colorado entities responded when CMS removed the diagnosis of hypoxia (a below-normal level of oxygen) from the CMS-HCC model, and, as a result, "hypoxia (and several other common diagnoses for which patients may receive oxygen)" were no longer sufficient for reimbursement. FAC ¶¶ 155, 227. Specifically, in response, "the Colorado Health Plan identified [through data mining or chart review] patients on oxygen in an effort to generate other diagnoses that would result in risk-adjustment payment." FAC ¶ 155. In particular, the Colorado Health Plan would query a physician about adding diagnoses for (1) acute and/or chronic respiratory failure and (2) obesity hypoventilation syndrome. *See* FAC ¶ 155.
- The SoCal Medical Group. In FAC ¶¶ 261 and 278, the government alleges that Kaiser targeted the condition of AA for risk adjustment and that, "[i]n some years in Northern California and Southern California, AA accounted for as much as 30-40% of all addenda diagnoses." FAC ¶¶ 278. In ¶ 340, the government alleges that, in the Southern California region, a probe audit for the year 2011 "identified an 'addendum issue' as one of the classification of errors, and described the errors as there being 'no justification in [the] original note to support an addendum." FAC ¶ 340.

III. CONCLUSION

For the foregoing reasons, Kaiser's motion to dismiss is denied. The government has sufficiently pled a factual falsity theory, including as part of its conspiracy claim. In addition, the government has not improperly "lumped" the various Kaiser entities together.

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Because the Court is denying Kaiser's motion to dismiss, it orders Kaiser to file an answer to the government's complaint within forty-five (45) days of the date of this order.

This order disposes of Docket No. 249.

IT IS SO ORDERED.

Dated: June 15, 2023

EDWARD M. CHEN
United States District Judge

United States District Court
Northern District of California