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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 GRANTING IN PART AND
DENYING IN PART DEFENDANTS’
MOTION TO DISMISS BRYANT AND
HERNANDEZ’S SECOND AMENDED
COMPLAINT**

Docket No. 251

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 Ms. Bryant and Ms. Hernandez’s operative complaint. For convenience, the Court refers to Ms. Bryant and Ms. Hernandez collectively as “Relators.” Relators have sued the following Kaiser entities:

- **Nationwide:** Kaiser Foundation Hospitals.¹
- **California:** Kaiser Foundation Health Plan, Inc.; The Permanente Medical Group, Inc.; and Southern California Permanent Medical Group.
- **Colorado:** Colorado Permanente Medical Group, P.C.; and Kaiser Foundation Health Plan of Colorado.
- **Georgia:** The Southeast Permanente Medical Group, Inc.; and Kaiser Foundation

¹ The pleading is not entirely clear but it appears that Kaiser Foundation Hospitals is nationwide in scope. See SAC ¶ 25 (“Kaiser owns and operates acute care hospitals in four regions (Northern California, Southern California, Northwest and Hawaii), and provides care in other settings through its non-profit Kaiser Foundation Hospitals (‘KFH’).”).

1 Health Plan of Georgia.

- 2 • **Hawaii:** Hawaii Permanente Medical Group, Inc.
- 3 • **Maryland, Virginia, and D.C.:** Mid-Atlantic Permanente Medical Group, P.C.;
- 4 and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
- 5 • **Oregon and Washington:** Northwest Permanente, P.C.; and Kaiser Foundation
- 6 Health Plan of the Northwest.
- 7 • **Washington:** Washington Permanente Medical Group, P.C.; and Kaiser
- 8 Foundation Health Plan of Washington.

9 The Court shall refer to these Kaiser entities collectively as “Kaiser.”

10 Having considered the parties’ briefs, as well as the oral argument of counsel, the Court
 11 hereby **GRANTS** in part and **DENIES** in part Kaiser’s motion to dismiss.

12 **I. FACTUAL & PROCEDURAL BACKGROUND**

13 Relators’ operative complaint is the second amended complaint (“SAC”). Before Relators
 14 filed the SAC, the Court addressed Kaiser’s challenge to their first amended complaint (“FAC”).
 15 In its order addressing the FAC, the Court allowed Ms. Hernandez’s retaliation claims to proceed
 16 but dismissed Relators’ FCA claims based on the Affordable Care Act (“ACA”) program.² The
 17 Court found several deficiencies with Relators’ FCA claims based on the ACA program:

- 18 • First, Relators failed to plead false claims for payment that were made to “HHS,
- 19 which is the relevant government agency with respect to the ACA program (as
- 20 opposed to CMS, which is the relevant government agency with respect to the
- 21 [Medicare Advantage] program).” Docket No. 226 (Order at 7). To the extent
- 22 Kaiser argued that there could not “have been a false claim for payment because
- 23 risk adjustment under the ACA program simply involves the transfer of funds
- 24 among health plans,” the Court did not address the issue “because it may turn on
- 25 how Relators will plead that false claims for payment were made to HHS.” Docket

26
 27 _____
 28 ² Like the government and other relators, Relators also asserted claims based on the Medicare Advantage program. However, the Court dismissed Relators’ claims based on the Medicare Advantage program, thus leaving Relators with claims based on the ACA program alone.

1 No. 226 (Order at 7-8).

- 2 • Second, Relators did not successfully plead falsity to the extent they claimed that
3 “the scope of their case extends to upcoding a number of diagnoses made under the
4 ACA program beyond the AA [aortic atherosclerosis] and vent dependence codes
5 described in the complaint.” Docket No. 226 (Order at 8) (emphasis added).
- 6 • Third, Relators did not sufficiently plead allegations to support materiality –
7 “largely because Relators . . . glossed over the fact that they must make out a
8 plausible case that HHS, and not CMS, would have found the false claims
9 material.” Docket No. 226 (Order at 8).
- 10 • Fourth, Relators did not include adequate allegations as to how Kaiser entities other
11 than The Permanente Medical Group (“TPMG”) had engaged in misconduct.
12 Relators had largely made conclusory allegations.
- 13 • Finally, with respect to the Relators’ conspiracy claim, the Court did not rule on
14 Kaiser’s contention that the claim was too conclusory because “Relators’
15 amendment – which should include allegations as to each specific defendant – will
16 likely affect the conspiracy claim.” Docket No. 226 (Order at 10). The Court
17 noted, however, that Relators should clarify whether they were “claiming one
18 overarching conspiracy involving all Kaiser entities or rather multiple bilateral
19 conspiracies (*i.e.*, between a health plan and its affiliated medical group).” Docket
20 No. 226 (Order at 10). The Court was “somewhat skeptical as to whether an
21 overarching conspiracy can be plausibly pled – *e.g.*, even if other regions followed
22 what TPMG was doing with coding of AA and vent dependence, that does not
23 mean that those regions entered into an agreement with TPMG to defraud the
24 government. This would be particularly true if each region was financially
25 independent – *i.e.*, what benefited TPMG would not benefit any other region.”
26 Docket No. 226 (Order at 10).

27 Subsequently, Relators filed their SAC, geared toward addressing the deficiencies
28 identified above. Some of the new allegations in the pleading provide background on the ACA.

1 For example:

- 2 • Under the ACA, “Exchanges” consisting of private insurers offering health
3 insurance plans are created in the states. *See* SAC ¶ 52; *see also*
4 [https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces)
5 [Marketplaces](https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces) (last visited 5/8/2023) (“The Affordable Care Act helps create a
6 competitive private health insurance market through the creation of Health
7 Insurance Marketplaces [also known as Exchanges]. These State-based,
8 competitive marketplaces provide millions of Americans and small businesses with
9 ‘one-stop shopping’ for affordable coverage.”).
- 10 • Notably, private insurers participating in the Exchanges cannot set premiums based
11 on the health status of prospective enrollees. *See* SAC ¶ 51.
- 12 • To get private insurers to participate and stay in the Exchanges (*i.e.*, to prevent
13 them from fleeing “due to fears of unhealthy individuals rushing to sign-up,
14 coupled with the general uncertainty of what kind of risk pool would develop when
15 prices did not depend on existing health conditions”), the ACA provides for risk
16 adjustment. SAC ¶ 54. The risk adjustment program “‘is intended to provide
17 increased payments to health insurance issuers that attract higher-risk populations
18 (such as those with chronic conditions) and reduce the incentives for issuers to
19 avoid higher-risk enrollees. Under this program, funds are transferred from issuers
20 with lower-risk enrollees to issuers with higher-risk enrollees.’” SAC ¶ 55 (quoting
21 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012)); *see also* SAC ¶ 59 5 (alleging that the
22 program “balances out the overall risks taken on by insurers in a given market, by
23 shifting funds from insurers with less risky (less expensive, more healthy) patients
24 to insurers with more risky (more expensive, less healthy) patients”); 42 U.S.C. §
25 18063(a) (providing that “each State shall assess a charge on health plans and
26 health insurance issuers (with respect to health insurance coverage) . . . if the
27 actuarial risk of the enrollees of such plans or coverage for a year is less than the
28 average actuarial risk of all enrollees in all plans or coverage in such State” and that

1 “each State shall provide a payment to health plans and health insurance issuers
2 (with respect to health insurance coverage) . . . if the actuarial risk of the enrollees
3 of such plans or coverage for a year is greater than the average actuarial risk of all
4 enrollees in all plans and coverage in such State”) (emphasis added).

- 5 • Specifically, the risk adjustment program “takes patient data provided by insurers,
6 evaluates each insurer's risk in a given market, and shifts money from insurers who
7 ended up with healthier populations to insurers who ended up with sicker
8 populations. After completion of the risk adjustment process for a given benefit
9 year, the Government shifts funds by issuing invoices to those insurers who owe
10 risk adjustment payments (and those insurers then submit the due funds *directly to*
11 *the Government*), and issues payments *from the Treasury* to those insurers who are
12 due risk adjustment payments.” SAC ¶ 56 (emphasis added).
- 13 • Another benefit of the ACA is that it makes insurance less expensive for insureds.
14 See SAC ¶ 51. Specifically, “[u]nder the ACA, private insurers offer different tiers
15 of plans; Bronze, Silver, Gold, or Platinum. Consumers select the tier of coverage
16 they want from among the insurers offering plans in their area, and pay the
17 corresponding monthly premium, with the Government providing tax credits to
18 fully or partially offset the monthly premiums for those consumers that qualify.”
19 SAC ¶ 53. Thus, in essence, “the Government pays a portion of premiums to
20 insurers offering ACA plans.” SAC ¶ 79.
- 21 • The amount of a tax credit “depends on two things: the cost of the ‘benchmark
22 plan’ for an individual, and the individual’s expected contribution (based on a
23 percentage of the individual’s income). Essentially, the Government, using federal
24 funds, pays those portions of the ACA premiums that exceed an individual’s
25 expected contributions to the cost of the benchmark plan in the individual’s area.”
26 SAC ¶ 80. “The ‘benchmark plan’ is the ‘second lowest cost silver plan . . . offered
27 through the Exchange for the rating area where the taxpayer resides.” SAC ¶ 81
28 (quoting 26 C.F.R. § 1.36B-3(f)).

- 1 • Insurers set the premiums they charge based in part on “payments that [they]
2 expect[] to either make or receive through the Risk Adjustment Program.” SAC ¶
3 77.

4 In the SAC, Relators allege that Kaiser engaged in a fraudulent upcoding scheme with
5 respect to the ACA program, similar to the fraudulent upcoding scheme used for the Medicare
6 Advantage program. *See* SAC ¶ 11(b); *see also* SAC ¶ 65 (alleging that “[t]he ACA utilizes a
7 hierarchical condition category (‘HCC’) model [which is] modeled after the Medicare risk
8 adjustment model”); SAC ¶ 67 (alleging that the ACA requires that insurers follow the ICD
9 Guidelines). That is, Kaiser upcoded

10 by manipulating the documentation and submitting claims and codes
11 . . . for diagnoses that the member does not have or for which the
12 member was not treated in the relevant year, or by claiming that a
13 member was treated for a more serious condition that the member
14 actually has, or by documenting and submitting a diagnosis that was
15 labeled significant when it was not.

16 SAC ¶ 11(a)(i). Relators assert that Kaiser engaged in a systematic fraud, discussing, in particular,
17 the following medical conditions: aortic atherosclerosis; vent dependence; malnutrition;
18 arrhythmia; and major depression.

19 According to Relators, Kaiser benefited from the upcoding scheme in two ways:

20 **First**, because of the upcoding fraud, Kaiser’s patients “appear[ed] more risky and
21 expensive to insure than they actually [were]. . . . [S]ince its patient base appears more risky,
22 Kaiser either pays less in risk adjustments than it should have (when HHS determines that it owes
23 money into the risk pool), or it receives more in risk adjustment payments than it should (when
24 HHS determine that it is owed money from the risk pool).” SAC ¶ 206. Relators admit that,
25 “between 2014 and 2021, Kaiser has made, in the aggregate, nearly \$6.13 billion in risk
26 adjustment payments into the pool under the ACA.” SAC ¶ 208. However, Relators maintain
27 that, if “Kaiser [had] accurately coded its patient encounters, HHS would have determined that
28 Kaiser owed substantially more money to the risk pools than Kaiser actually paid.” SAC ¶ 209
(emphasis in original).

Second, risk adjustment factors into the premiums that Kaiser and other insurers set. *See*

1 SAC ¶ 213. Because Kaiser has paid less into the risk pool than it should have, “it is able to lower
 2 [the] premiums [it charges its members]” – *i.e.*, it “uses those ‘savings’ to charge lower
 3 premiums.” SAC ¶ 213 (emphasis added). Kaiser’s competitors, in turn, have had to charge
 4 higher premiums because they have had to pay more into the risk pool than they should have (as a
 5 result of Kaiser’s conduct). *See* SAC ¶ 214. The government is affected because it covers part of
 6 the cost of monthly premiums (for qualifying individuals at least) – specifically, through tax
 7 credits. As noted above, the amount of a tax credit depends in part on the cost of a benchmark
 8 plan. When the cost of Kaiser’s plan is lower than the cost of the benchmark plan (*i.e.*, a
 9 competitor’s plan is the benchmark plan), *see* SAC ¶ 217 (alleging that “Kaiser plans have served
 10 as the benchmark plan in California’s ratings areas (marketplaces) less than 30 percent of the time
 11 since 2014”), that effectively means that the government is contributing more to cover the cost of
 12 the monthly premiums than it should.

13 As a hypothetical and simplified example, assume that there are
 14 three insurers in a particular market. Insurer A charges \$140 for a
 15 silver plan, Insurer B charges \$130, and Kaiser charges \$80. As the
 16 second-lowest priced plan, Insurer B's premium of \$130 would serve
 17 as the benchmark, and all premium tax credits would be tied [to] the
 18 \$130 price. For qualifying individuals, the Government would pay
 19 up to \$130 of the premium cost, using taxpayer dollars. However,
 20 due to Kaiser's upcoding fraud (and the resulting lower share of risk
 21 adjustment payments received by Insurers A and B), the premiums
 22 charged by Insurers A and B are artificially inflated. If Kaiser
 23 submitted accurate risk adjustment data, Insurers A and B would
 24 each charge \$15 less (anticipating higher risk adjustment pool
 25 payments by Kaiser), and Kaiser would charge \$30 more (to recover
 26 more from consumers in anticipation of the need to pay more into
 27 the pool). In other words, if Kaiser were behaving lawfully, Insurer
 28 A would charge \$125, Insurer B would charge \$115, and Kaiser
 would charge \$110. With accurate data, the benchmark in the area
 would now be \$115, instead of \$130. As a result of Kaiser's fraud,
 the maximum premium tax credit – and amount paid by the
 Government towards all premium payments in the area by qualified
 individuals – would be up to \$15 higher than it should have been.
 Due to Kaiser's over-documentation and upcoding, the Government
 is overpaying by up to \$15 per month for each and every plan
 purchased in that area due to Kaiser's over-documentation and
 upcoding fraud.

26 SAC ¶ 216.

27 In short, Relators assert that

28 Defendants overdocumented and upcoded risk adjustment claims

1 relevant to individuals covered by the ACA in the same manner and
 2 pursuant to the same schemes as relevant to the Medicare Advantage
 3 program, and similarly refused to correct or reimburse HHS for
 4 overpayments caused by this conduct, in a deliberate scheme to
 overcharge the ACA program, receive more in insurance premiums
 funded through government tax credits, and receive more of, or
 contribute less into, the ACA insurance pool.

5 SAC ¶ 11(b); *see also* SAC ¶ 16.

6 Kaiser now moves to dismiss the ACA-based claims as repled by Relators in the SAC.

7 **II. DISCUSSION**

8 A. Legal Standard

9 Federal Rule of Civil Procedure 8(a)(2) requires a complaint to include “a short and plain
 10 statement of the claim showing that the pleader is entitled to relief.” Fed. R. Civ. P. 8(a)(2). A
 11 complaint that fails to meet this standard may be dismissed pursuant to Federal Rule of Civil
 12 Procedure 12(b)(6). *See* Fed. R. Civ. P. 12(b)(6).

13 To overcome a Rule 12(b)(6) motion to dismiss after the Supreme Court’s decisions in
 14 *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007),
 15 a plaintiff’s “factual allegations [in the complaint] ‘must . . . suggest that the claim has at least a
 16 plausible chance of success.’” *Levitt v. Yelp! Inc.*, 765 F.3d 1123, 1135 (9th Cir. 2014). “A claim
 17 has facial plausibility when the plaintiff pleads factual content that allows the court to draw the
 18 reasonable inference that the defendant is liable for the misconduct alleged.” *Iqbal*, 556 U.S. at
 19 678. “The plausibility standard is not akin to a probability requirement, but it asks for more than a
 20 sheer possibility that a defendant has acted unlawfully.” *Id.* (internal quotation marks omitted).
 21 The court “accept[s] factual allegations in the complaint as true and construe[s] the pleadings in
 22 the light most favorable to the nonmoving party.” *Manzarek v. St. Paul Fire & Marine Ins. Co.*,
 23 519 F.3d 1025, 1031 (9th Cir. 2008).

24 B. False Claims for Payment: Relators’ Three Theories

25 Based on the SAC, Relators have three theories in support of their FCA claims:

- 26 (1) “Kaiser submits false claims when it certifies its risk adjustment data as being
 27 accurate when it is not, as that false data is used to determine risk adjustment
 28 payments made from or to the Government.” SAC ¶ 16; *see also* SAC ¶ 209

1 (alleging that, if “Kaiser accurately coded its patient encounters, HHS would have
2 determined that Kaiser owed substantially *more* money to the risk pools than
3 Kaiser actually paid”) (emphasis in original).

4 (2) “Kaiser . . . causes false claims to be submitted via premium tax credits, due to
5 Kaiser’s manipulation of the data it presents to the Government with its risk
6 adjustment submissions.” SAC ¶ 16; *see also* SAC ¶ 211 (alleging that “Kaiser’s
7 systemic practice of over-documenting and upcoding also has caused the
8 Government to overpay via ACA premium tax credits”).

9 (3) “[E]very payment to, from, or through the Government in connection with the ACA
10 is a false claim, because Kaiser should be ineligible to participate in the ACA
11 exchanges due to its manipulation of risk adjustment data.” SAC ¶ 16.

12 C. Third Theory: Eligibility to Participate

13 As a preliminary matter, the Court notes that Kaiser’s papers do not clearly address the
14 third theory described above. The Court therefore makes no concrete ruling on the third theory,
15 although it does note that this theory seems problematic for several reasons. First, the theory
16 seems to cover *any* payment under the ACA program, whether or not Kaiser is directly involved
17 (*i.e.*, whether a payment is made to or from Kaiser). If so, that would cover the entire ACA
18 program.

19 Second, even if Relators intended to plead a narrower theory – limited to Kaiser’s direct
20 involvement in a payment, *see* SAC ¶ 218 – there are still serious questions as to whether such a
21 theory would be viable. Admittedly, the ACA provide that “[c]ompliance with the requirements
22 of this Act concerning eligibility for a health insurance issuer to participate in the Exchange shall
23 be a material condition of an issuer’s entitlement to receive payments, including payments of
24 premium tax credits and cost-sharing reductions, through the Exchange.” 42 U.S.C. §
25 18033(a)(6)(A). Based on this provision, there is room for Relators to argue that, if Kaiser
26 certified to HHS that it was eligible to participate in an Exchange, and in fact it was not eligible,
27 then Kaiser would be making a false claim for payment. The question, however, is what is
28 required in order for an insurer to be considered eligible to participate in an Exchange in the first

1 place. Relators have not clearly pointed to authority suggesting that an insurer is not *eligible* to
 2 participate in the ACA program simply because *it does not do risk adjustment correctly* (i.e., if the
 3 insurer ends up not complying with the ICD Guidelines when it comes to diagnosis coding).
 4 Relators have simply noted that participants in the ACA program must comply with 45 CFR part
 5 153. *See* 45 C.F.R. § 156.200(b). Included among the standards in Part 153 are standards related
 6 to the risk adjustment program. *See, e.g.*, 45 C.F.R. § 153.620 (providing that an issuer must
 7 comply with data validation requests made by a state or HHS, maintain documents and records
 8 “sufficient to enable the evaluation of the issuer’s compliance with applicable risk adjustment
 9 standards,” and submit to audits by HHS). But these standards do not appear to expressly require
 10 as a condition for participation accurate risk adjustments.

11 If the ultimate issue here is whether Kaiser did its risk adjustment correctly, then that is
 12 essentially the same theory raised in (1) above. The Court now turns to that theory.

13 D. First Theory: Risk Adjustment Payments

14 In the first theory, Relators’ basic claim is that Kaiser certified that its risk adjustment data
 15 was accurate when, in fact, it was not because diagnoses were not coded in compliance with
 16 coding guidelines. Relators maintain that, if “Kaiser accurately coded its patient encounters, HHS
 17 would have determined that Kaiser owed substantially *more* money to the risk pools than Kaiser
 18 actually paid.” SAC ¶ 209 (emphasis in original).

19 1. Claim for Payment

20 Kaiser makes multiple challenges to Relators’ first theory. First, Kaiser argues that the
 21 theory is fundamentally flawed because no *claim* for payment is being made – i.e., a risk
 22 adjustment attestation cannot be deemed a claim for payment. Kaiser points out that, “while the
 23 Medicare Advantage program attestation certifies data for the express purpose of requesting
 24 payment, the ACA program attestation [simply] confirms that data generated in HHS’s report
 25 matches data made available separately to HHS.” Mot. at 12. *Compare, e.g.*, 42 C.F.R. §
 26 422.504(l) (for Medicare Advantage program, providing that, “[a]s a condition for receiving a
 27 monthly payment . . . , the MA organization agrees that its chief executive officer (CEO), chief
 28 financial officer (CFO), or an individual delegated the authority to sign . . . must request payment

1 under the contract on a document that certifies . . . the accuracy, completeness, and truthfulness of
 2 relevant data that CMS requests”), with 45 C.F.R. § 153.710(d) (for ACA program, providing that
 3 “the issuer must, in a format specified by HHS, either: (1) Confirm to HHS that the information in
 4 the final report accurately reflects the data to which the issuer has provided access to HHS . . . ;
 5 or (2) Describe to HHS any discrepancy it identifies in the final dedicated distributed data
 6 environment report”).

7 Kaiser’s argument is overly formalistic. Under the FCA, a “claim” for payment is defined
 8 as follows: “any request or demand, whether under a contract or otherwise, for money or property
 9 and whether or not the United States has title to the money or property, that – (i) is presented to an
 10 officer, employee, or agent of the United States.” 31 U.S.C. § 3729(b)(1)(A). In short, a claim for
 11 payment is a request for money presented to the United States. By participating in the ACA
 12 program which involves risk adjustment, an insurer implicitly makes a request for money which is
 13 presented to the United States. This is substantiated by the following allegation in the SAC:
 14 “After completion of the risk adjustment process for a given benefit year, the Government shifts
 15 funds by issuing invoices to those insurers who owe risk adjustment payments (and those insurers
 16 then submit the due funds *directly to the Government*), and issues payments *from the Treasury* to
 17 those insurers who are due risk adjustment payments.” SAC ¶ 56 (emphasis added).

18 Furthermore, the ACA contains the following provision (which was quoted above in part):

19 Payments made by, through, or in connection with an Exchange *are*
 20 *subject to the False Claims Act* (31 U.S.C. 3729 et seq.) if those
 21 payments include any Federal funds. Compliance with the
 22 requirements of this Act concerning eligibility for a health insurance
 23 issuer to participate in the Exchange shall be a material condition of
 an issuer’s entitlement to receive payments, including payments of
 premium tax credits and cost-sharing reductions, through the
 Exchange.

24 42 U.S.C. § 18033(a)(6)(A) (emphasis added). Here, Relators have alleged in their pleading that
 25 “Federal funds” are at issue because payments are made to or from the U.S. Treasury even if the
 26 United States does not have some kind of possessory interest in those payments as it ultimately
 27 transfers money among insurers through the U.S. Treasury.

28 Finally, the Court underscores that, in the case at bar, Relators’ theory is that Kaiser should

1 have paid more into the risk pool than it actually did, and therefore, Relators are not really
 2 asserting that Kaiser made false claims for payment; rather, Relators are asserting a cause of action
 3 for a reverse false claim, a claim within the ambit of the FCA. *See* 31 U.S.C. § 3729(a)(1)(G)
 4 (providing for liability with respect to any person who “knowingly conceals or knowingly and
 5 improperly avoids or decreases an obligation to pay or transmit money or property to the
 6 Government”). *See, e.g., United States ex rel. Foreman v. AECOM*, 19 F.4th 85, 119 (2d Cir.
 7 2021) (stating that “[s]ubsection (a)(1)(G) is referred to as the reverse false claims provision
 8 because it covers claims of money *owed* to the government, rather than payments *made* by the
 9 government”) (emphasis in original); *United States ex rel. Barrick v. Parker-Migliorini Int'l,*
 10 *LLC*, 878 F.3d 1224, 1230 (10th Cir. 2017) (stating that “the reverse-false-claims provision, 31
 11 U.S.C. §3729(a)(1)(G), reverses the typical claim under the False Claims Act: instead of creating
 12 liability for wrongfully *obtaining* money from the government, the reverse-false-claims provision
 13 creates liability for wrongfully *avoiding* payments that should have been made to the
 14 government”) (emphasis in original).

15 2. Falsity

16 a. Conclusory

17 Kaiser contends that, even if a risk adjustment attestation could be deemed a claim for
 18 payment, Relators’ FCA claim still founders because Relators have failed to adequately plead
 19 falsity. According to Kaiser, Relators have simply offered “threadbare recitals of fraud For
 20 example, even though the relevant ACA regulations require an annual audit by an independent
 21 validator and a subsequent HHS audit, 45 C.F.R. § 153.630, Relators say nothing about these
 22 audits, what the results were, and whether any actions were taken in response to the audits.” *Mot.*
 23 *at* 12-13. This argument is not persuasive. Even if Relators did not specifically describe these
 24 audits and the results thereof, that does not render their falsity claims conclusory. A claim of
 25 falsity can be made without making reference to an audit.

26 b. Identified Medical Conditions

27 Kaiser asserts that, even if the Court evaluates the specific medical conditions described in
 28 the Relators’ SAC, Relators have still failed to plead falsity (whether a factually false submission

1 or a legally false one). Relators' complaint refers to the following medical conditions: aortic
2 atherosclerosis; vent dependence; malnutrition; arrhythmia; and major depression.

3 i. Aortic Atherosclerosis

4 Aortic atherosclerosis ("AA") is the "'hardening of the arteries.' It describes a thickening
5 and loss of elasticity in the arterial wall." SAC ¶ 91. According to Kaiser, Relators are no longer
6 bringing an ACA-based claim predicated on a false claim for payment related to AA. *See* Mot. at
7 6. In support, Kaiser points to ¶ 93 of the SAC where Relators concede that, while there is an
8 HCC code for AA under the Medicare Advantage program, there is not an HCC code for the
9 disease under the ACA program. *See* SAC ¶ 93 ("The AA diagnosis is assigned to HCC 108; in
10 2016, Kaiser received approximately \$2,260 for each HCC 108 code under Medicare Advantage.
11 There is no corresponding HHS-HCC for AA in the ACA program."); *see also* SAC ¶ 114
12 ("[Kaiser's] efforts to mine for AA succeeded in capturing and submitting an enormous increase
13 of AA codes to Medicare . . .").

14 In their opposition, Relators do not take issue with Kaiser's position. This is true even
15 though there are multiple paragraphs pled in the SAC related to AA. *See* SAC ¶¶ 91-117.
16 Accordingly, the Court concludes that there is no viable ACA-based claim predicated on Kaiser's
17 conduct with respect to coding of AA.³

18 ii. Vent Dependence

19 As pled in the SAC, dependence on a respirator (or ventilator) is an appropriate diagnosis
20 "when a patient requires *long-term, continued* ventilator support to breathe beyond the acute care
21 phase." SAC ¶ 118 (emphasis in original). Relators have two theories related to diagnoses of vent
22 dependence. First, Relators allege that, in response to an inquiry from Kaiser (initiated by Ms.
23 Bryant), the American Hospital Association's Coding Clinic – "the official clearing house for
24 [ICD] coding guidance" – stated that "'this code should be reported when the patient requires
25 continued ventilator support for an unexpected period of time and not for the short-term acute
26

27 ³ Relators may have continued to plead allegations related to AA as a preservation technique – *i.e.*,
28 to preserve the right to appeal the Court's dismissal of their Medicare Advantage-based claims.
See Docket No. 226 (Order at 6) (noting that Relators' claims based on the Medicare Advantage
program were dismissed because they were covered by the earlier-filed cases *Osinek* and *Taylor*).

1 phase of a condition.’ [The] Coding Clinic further stated ‘there is *no time frame set* on what
 2 constitutes ventilator dependency.’” SAC ¶¶ 92, 119 (emphasis added). According to Relators,
 3 “Kaiser’s directives on vent dependence documentation and coding differ region by region, but
 4 were all similarly invalid, with regions establishing a ‘time frame’-based criteria for documenting
 5 vent dependence status after which the specific code assignment is permitted.” SAC ¶ 121. For
 6 example, in the Northern California region, the time period was 30 days or more. In the Southern
 7 California region, the time period was 21 days. *See* SAC ¶ 121. “These directives contravened
 8 AHA Coding Clinic’s caution that there is no ‘set time frame’ and that vent dependence should not
 9 be reported for the short-term acute phase of a condition.” SAC ¶ 122.

10 Second, Relators allege that Kaiser “ignored its own improper directives by coding for
 11 vent dependence status even when patients were on vents for just a few days, then discharged
 12 without the vent.” SAC ¶ 123 (emphasis added). Relators “were first made aware of Kaiser’s vent
 13 dependence status documentation and coding practices in the context of newborns that are placed
 14 on ventilators temporarily in Kaiser Foundation Hospitals before being discharged home.” SAC ¶
 15 124. “The coding data includes a high volume of cases in which patients were successfully weaned
 16 from ventilation and routinely discharged home or to self-care, including after just a day or two in
 17 the hospital. In a December 2013 validation audit, Ms. Hernandez and her NCAL audit team
 18 concluded that 100% of a sample of TPMG vent dependence cases were invalid.” SAC ¶ 138.

19 In its motion, Kaiser challenges the vent dependence allegations on two grounds: (1) the
 20 AHA’s Coding Clinic is a nongovernmental organization and thus its guidance cannot be binding
 21 as a legal matter; and (2) “much of the conduct” identified in the allegations “predate the
 22 implementation of the ACA risk-adjustment program, meaning that it could not have resulted in
 23 the submission of false diagnosis codes for ACA members.” Mot. at 14.

24 Kaiser’s first argument has merit. Relators point out that the AHA’s Coding Clinic is the
 25 “official clearinghouse for ICD coding guidance.” Opp’n at 15. But it is not clear what it means
 26 for the Coding Clinic to be the official clearing house for ICD coding guidance, and, if the Coding
 27 Clinic was simply giving its own interpretation of the ICD coding guidance, that is not legally
 28 binding in the absence of evidence to the contrary. Relators also suggest that what they really

1 meant in their allegations was that Kaiser was violating ICD Guidelines (*i.e.*, by coding vent
2 dependence based on a timeframe). *See* Opp’n at 15. However, Relators have not sufficiently
3 explained how the ICD Guidelines were violated just because Kaiser was coding vent dependence
4 based on a timeframe of 30 or 21 days. In other words, coding on a timeframe of 30 or 21 days is
5 not inherently contradictory to vent dependence involving long-term, continued ventilator support.

6 Kaiser’s second argument, however, lacks merit. Coding vent dependence based on just a
7 few days of ventilator support (as alleged with the newborns) appears contrary to the notion of
8 long-term, continued ventilator support – at least plausibly so. Kaiser’s timing argument is not
9 persuasive. There is no dispute that the ACA program was not implemented until 2014. That
10 being said, just because Relators identified conduct that took place in 2013, see SAC ¶¶ 124-36
11 (discussing events in November and December 2013); SAC ¶ 138 (referring to a validation audit
12 in December 2013, where “Ms. Hernandez and her NCAL audit team concluded that 100% of a
13 sample of TPMG vent dependence cases were invalid”), does not mean that Kaiser’s alleged
14 practice of improper coding of vent dependence (*i.e.*, for a patient who was on a vent for just a few
15 days) did not go beyond that period. In fact, as Relators point out, Exhibit 28 to the SAC is a chart
16 that suggests vent dependence coding started to increase in 2013 and that pattern continued past
17 that date and through 2016 at least. *See* SAC, Ex. 28 (chart titled “ALL REGIONS: 2010-2016
18 Volumes – Vent Dependence Code”).

19 iii. Malnutrition

20 Relators’ allegations related to malnutrition – specifically, protein-calorie malnutrition
21 (“PCM”) – are not entirely clear. Relators seem to take the position that Kaiser had a practice of
22 querying doctors about a diagnosis of PCM simply because there was a dietitian comment of PCM
23 in “dietary notes”; in essence, doctors diagnosed PCM only because they were queried in a leading
24 manner. According to Relators, this was not sufficient documentation to support a diagnosis of
25 PCM. *See* SAC ¶ 143 (“Kaiser’s CDI querying activities improperly led physicians to diagnose
26 protein-calorie malnutrition, including the use of ‘SMARTPHRASE’ acknowledgments of
27 dietitian diagnoses of PCM with a co-signature of dietary notes for all risk-based payers,
28 including both the [Medicare Advantage] program and the ACA program. . . . [T]he co-signature

1 of a physician on dietary notes is not sufficient documentation for a PCM diagnosis.”).

2 In addition to the above, Relators make allegations about PCM that are specific to the
3 Northwest Region and its coding related to newborns. According to Relators, Sharon Beausoleil,
4 the HIM Coding Manager for the Northwest Region’s medical group, emailed Ms. Bryant in late
5 2014 “about documentation and coding of protein-calorie malnutrition on HHS-HCC’s for
6 newborns. In particular, she was concerned with the query language being utilized by the CDI
7 staff in the NW Region, which appeared to not be supported by clinical indicators and to be
8 leading.” SAC ¶ 144. “Ms. Beausoleil provided Ms. Bryant with a short list of inpatient medical
9 record accounts,” which Ms. Bryant then had one of her staff review. SAC ¶ 145. The staff
10 member concluded that “there was no supporting documentation or clinical indicators for a
11 newborn malnutrition diagnosis for these records,” and Ms. Bryant agreed. See SAC ¶ 145. Later,
12 the Northwest Region’s medical director questioned Ms. Bryant’s “authority to audit region’s
13 medical records, notwithstanding Ms. Bryant’s position with Kaiser’s National Revenue Cycle
14 group.” SAC ¶ 146.

15 Kaiser fairly challenges Relators’ allegations related to the Northwest Region and its
16 coding related to newborns. A “short list of [deficient] inpatient medical record accounts” is not
17 enough to support there being a practice of improper coding by Kaiser. SAC ¶ 145.

18 However, Relators’ allegation that Kaiser had a practice of having doctors co-sign
19 dietitians’ notes passes muster. Contrary to what Kaiser argues, Relators are asserting more here
20 than just improper queries to doctors. Compare *Integra Med Analytics LLC v. Provident Health &*
21 *Services*, 854 F. App’x 840, 844 (9th Cir. 2021) (indicating that leading queries, by themselves,
22 are not enough to support a conclusion that doctors thereby “recorded unsupported medical
23 conditions”). Relators have alleged that doctors did in fact respond to queries by co-signing
24 dietitians’ notes. The ICD Guidelines require medical documentation for a condition; a dietitian
25 note is not sufficient. Nor is it sufficient (at least plausibly so) for a doctor just to co-sign a
26 dietitian note.

27 Kaiser’s contention that there is no indication that the diagnoses were for ACA members
28 or were submitted to HHS lacks merit. All reasonable inferences are to be made in Relators’ favor

1 at this point. Notably, Relators have alleged that “Kaiser data compiled by Ms. Bryant through
 2 her national coding quality monitoring work establishes that malnutrition continued to have a high
 3 frequency of being coded in Kaiser’s MA and ACA populations.” SAC ¶ 149. Finally, to the
 4 extent Kaiser makes a timing argument again – *i.e.*, that any problems related to PCM predated the
 5 implementation of the ACA in 2014 – the Court rejects that argument as well. *See, e.g.*, SAC ¶
 6 147 (alleging that, “[i]n late 2016, Kaiser’s TPMG CDI Director Emily Emmons contacted Ms.
 7 Bryant about a possible compliance issue regarding PCM diagnosis, documentation, and coding[;]
 8 Ms. Emmons was concerned with dietary documentation of PCS wherein physicians appeared to
 9 be queried in a leading manner”).

10 iv. Arrhythmia

11 Relators have also pled upcoding with respect to the medical condition of arrhythmia.
 12 According to Relators, “Kaiser’s coders would code heart arrhythmia for members even after the
 13 members receive pacemakers to correct their arrhythmia for all risk-based payers, including both
 14 the MA and the ACA program.” SAC ¶ 150. Relators further assert that, “[i]n addition to cardiac
 15 arrhythmia, diagnoses for ventricular fibrillation and ventricular flutter (HCC 84 and HHS-HCC
 16 142) were also overdocumented,” presumably based on the same pacemaker issue. SAC ¶ 150.

17 Kaiser attacks the arrhythmia allegations on various bases. Most of the attacks are not
 18 particularly significant, with the exception of one – *i.e.*, that, because Kaiser submitted both the
 19 pacemaker status code and the arrhythmia code, *see* SAC ¶ 150, then there was no fraud because
 20 “HHS and the independent validator could readily observe that both diagnoses were submitted.”
 21 Mot. at 16. This argument is meritorious. Furthermore, having a pacemaker does not necessarily
 22 mean that the patient does not have the underlying condition. Notably, Relators have failed to
 23 respond to this specific argument in their opposition.

24 v. Major Depression

25 Finally, Relators address the medical condition of major depression in their SAC.
 26 According to Relators, “Kaiser manipulated its electronic system for picking diagnoses to ‘gray
 27 out’ the diagnosis of ‘major depression unspecified,’ which is not linked to an HCC, so that Kaiser
 28 doctors would not pick that diagnosis but would instead select a major depression diagnosis

1 category that is linked to a high-paying HCC. Ms. Hernandez believes that this practice also took
 2 place within TPMG.” SAC ¶ 152. Although this practice does seem dubious, without more
 3 allegations, it is not plausible that the practice would plausibly result in fraud – *i.e.*, a patient not
 4 having the kind of major depression identified by the doctor. Kaiser essentially makes this point
 5 in its motion. *See* Mot. at 16 (“Relators do not allege that a single healthcare provider diagnosed
 6 major depression in a member who did not have major depression. Nor do they allege that any
 7 such inaccurate diagnoses were submitted to HHS or falsely confirmed as accurate in any
 8 attestation.”). Relators do not do much to address this problem in their opposition. *See* Opp’n at
 9 16 (simply making a general argument that Kaiser coded for depression when it was not supported
 10 by the patient’s status and condition).

11 vi. Summary

12 For the reasons stated above, Relators have not pled enough to establish a fraudulent
 13 scheme to upcode for all of the medical conditions specifically identified in the SAC. At best,
 14 Relators have pled a fraudulent scheme to upcode for (1) vent dependence and (2) malnutrition –
 15 but only to the extent discussed above.

16 c. Scheme to Defraud

17 Although Relators have alleged schemes to defraud for specific medical conditions, they
 18 have also suggested that there was a broader scheme to defraud – one not tied to any given
 19 medical condition (although perhaps limited to high-value HCCs). *See, e.g.*, Opp’n at 15
 20 (asserting that “the SAC alleges an upcoding scheme and provides *illustrative* examples including
 21 ventilator dependence, malnutrition, arrhythmia, and depression”) (emphasis added); SAC ¶ 88
 22 (alleging that there was “over-coding and upcoding of certain high value HCCs”). Based on the
 23 allegations in the SAC, the Court does not find such a broad scheme to defraud plausible.

24 To be sure, the Court did conclude that, with respect to the Medicare Advantage program,
 25 the federal government adequately pled a broad scheme to defraud not tied to a specific medical
 26 condition. In particular, the Court took note of allegations related to the refresh program.
 27 However, Relators here have made much more scattershot allegations. *See, e.g.*, SAC ¶ 167
 28 (alleging that Kaiser used “leading query templates” for a number of conditions – *e.g.*,

1 “obesity/extreme or morbid obesity; protein calorie malnutrition (mild/moderate/severe); pressure
2 ulcer; neoplasm (history versus current); emphysema; depression; adrenal mass; aortic
3 atherosclerosis; diabetes manifestations; neutropenia; sepsis/SIRS with organ dysfunction, and
4 others”); SAC ¶ 168 (alleging that Kaiser did not include as options for diagnosis “unknown,”
5 “other,” “clinically undetermined,” or “unspecified”); SAC ¶¶ 180-81, 197 (alleging that Kaiser
6 used old encounters to query doctors, with no face-to-face visit); SAC ¶ 191 (alleging that Kaiser
7 used data mining to find ““missed opportunities”” which would be covered through addenda);
8 SAC ¶¶ 198-99 (alleging that Kaiser used a natural language processing tool that had a poor
9 accuracy rate – 60% or less). And notably, although Relators address the pressure that *they* were
10 subjected to (as coding employees), *see* SAC ¶ 158 (alleging that “[t]he culture at Kaiser
11 perpetuates a superiority, manipulation, and intimidation by physician medical group leaders and
12 medical group management, resulting in an inability to challenge or present a different
13 perspective, even when backed by express, unambiguous coding guidelines, standards, or HIM
14 coding expertise, without being chastised, threatened and ridiculed”), they largely fail to make
15 allegations about the pressure that *doctors* (the ultimate party responsible for making a diagnosis)
16 were subjected to with respect to upcoding; this stands in contrast to the allegations made by the
17 federal government in its operative complaint.

18 Accordingly, the Court concludes that Relators have not adequately alleged a broad
19 scheme to defraud, not tied to any specific medical condition, with respect to the ACA program.
20 However, the Court shall give Relators leave to amend, particularly since, as noted above, the
21 government was able to adequately plead a broad scheme to defraud with respect to the Medicare
22 Advantage program.

23 d. Summary

24 For the reasons stated above, the Court concludes that Relators have adequately pled
25 falsity with respect to two identified medical conditions: vent dependence and malnutrition (to the
26 extent recognized above). Relators have leave to amend to plead a broader scheme to defraud.

27 3. Materiality

28 Kaiser challenges next Relators’ allegations on materiality. The Court agrees with Kaiser

1 that Relators cannot base materiality on the following provision from the ACA: “[c]ompliance
2 with the requirements of this Act concerning eligibility for a health insurance issuer to participate
3 in the Exchange shall be a material condition of an issuer’s entitlement to receive payments,
4 including payments of premium tax credits and cost-sharing reductions, through the Exchange.”
5 42 U.S.C. § 18033(a)(6)(A). This statute does make clear that an insurer must be eligible to
6 participate in the ACA program in order to get payment and a misrepresentation about eligibility
7 would be material. However, as discussed above, Relators seem to assert that that an insurer is not
8 eligible to participate in the ACA program simply because it does not do the risk adjustment
9 correctly – and that position is problematic. The Court also notes that it previously rejected
10 Relators’ attempt to claim materiality based on § 18033(a)(6)(A). *See* Docket No. 226 (Order at
11 8-9) (noting that Relators claimed materiality based on § 18033(a)(6)(A) but rejecting that position
12 because eligibility to participate in an Exchange “is not at issue in this case”).

13 That being said, the Court finds that Relators have adequately pled materiality, even if
14 limited to just the medical conditions of vent dependence and malnutrition. First, consistent with
15 the Court’s order addressing the operative complaint in *Taylor*, materiality may be inferred based
16 on allegations that risk adjustment is tied directly to diagnosis codes submitted by health plans.
17 *See, e.g.*, SAC ¶ 55 (“The ACA’s Risk Adjustment Program . . . ‘is intended to provide increased
18 payments to health insurance issuers that attract higher-risk populations (such as those with
19 chronic conditions) and reduce the incentives for issuers to avoid higher-risk enrollees.’”).
20 Second, materiality is supported by Relators’ allegation that, when an insurer validates the data it
21 submits to the government as part of the risk adjustment process, it submits an attestation, and the
22 attestation form requires an insurer to check a box that states: “I acknowledge that the data
23 submitted to the EDGE server and made available for the permanent risk adjustment program
24 established under Section 1343 of the Affordable Care Act, upon which final risk adjustment
25 transfers are calculated, may be subject to the False Claims Act.” SAC ¶¶ 7, 73; *see also* 42 U.S.C.
26 § 18033(a)(6)(A) (providing that “[p]ayments made by, through, or in connection with an
27 Exchange are subject to the False Claims Act (31 U.S.C. 3729 et seq.) if those payments include
28 any Federal funds”). Finally, the size of the alleged fraud – even if limited to fraud with respect to

1 vent dependence and malnutrition – likely weighs in favor of materiality. *See* SAC ¶ 226 (alleging
 2 that Kaiser “managed to increase its overall ACA risk score most every year by at least one
 3 percent annually, often much more than that[;] [g]iven the amount of premium revenue and the
 4 size of the insurance pool, this level of risk adjustment fraud benefited Kaiser’s ACA plans by at
 5 least tens of million dollars in federal risk pool adjustments each year”).

6 4. Summary

7 For the foregoing reasons, Relators have successfully pled part of their first theory – *i.e.*,
 8 that Kaiser had schemes to defraud tied to vent dependence and malnutrition and that Kaiser’s
 9 fraud was material. Relators have leave to amend to plead a scheme to defraud not tied to a
 10 specific medical condition.

11 E. Second Theory: Tax Credits

12 The Court now turns to Relators’ second theory for relief – *i.e.*, that Kaiser “causes false
 13 claims to be submitted via premium tax credits, due to Kaiser’s manipulation of the data it
 14 presents to the Government with its risk adjustment submissions.” SAC ¶ 16. As indicated in the
 15 factual and procedural background, this is a somewhat complicated theory. The theory goes as
 16 follows.

17 Risk adjustment factors into the premiums that Kaiser and other insurers set. *See* SAC ¶¶
 18 77, 213. Because Kaiser has paid less into the risk pool than it should have, “it is able to *lower*
 19 [the] premiums [it charges its members]” – *i.e.*, it “uses those ‘savings’ to charge lower
 20 premiums.” SAC ¶ 213 (emphasis added). Kaiser’s competitors, in turn, have had to charge
 21 *higher* premiums because they have had to pay more into the risk pool than they should have (as a
 22 result of Kaiser’s conduct). *See* SAC ¶ 214. The government is affected because it covers part of
 23 the cost of monthly premiums (for qualifying individuals at least) – specifically, through tax
 24 credits. As noted above, the amount of a tax credit depends in part on the cost of a benchmark
 25 plan. When the cost of Kaiser’s plan is *lower* than the cost of the benchmark plan (*i.e.*, a
 26 competitor’s plan is the benchmark plan), *see* SAC ¶ 217 (alleging that “Kaiser plans have served
 27 as the benchmark plan in California’s ratings areas (marketplaces) less than 30 percent of the time
 28 since 2014”), the fact that other insurers have to raise the premiums elevates the benchmark and

1 hence increases the government's premium subsidy; this effectively requires the government to
2 contribute more to cover the cost of the monthly premiums than it should. To reiterate the
3 illustration alleged in the SAC:

4 As a hypothetical and simplified example, assume that there are
5 three insurers in a particular market. Insurer A charges \$140 for a
6 silver plan, Insurer B charges \$130, and Kaiser charges \$80. As the
7 second-lowest priced plan, Insurer B's premium of \$130 would serve
8 as the benchmark, and all premium tax credits would be tied [to] the
9 \$130 price. For qualifying individuals, the Government would pay
10 up to \$130 of the premium cost, using taxpayer dollars. However,
11 due to Kaiser's upcoding fraud (and the resulting lower share of risk
12 adjustment payments received by Insurers A and B), the premiums
13 charged by Insurers A and B are artificially inflated. If Kaiser
14 submitted accurate risk adjustment data, Insurers A and B would
15 each charge \$15 less (anticipating higher risk adjustment pool
16 payments by Kaiser), and Kaiser would charge \$30 more (to recover
17 more from consumers in anticipation of the need to pay more into
18 the pool). In other words, if Kaiser were behaving lawfully, Insurer
19 A would charge \$125, Insurer B would charge \$115, and Kaiser
20 would charge \$110. With accurate data, the benchmark in the area
21 would now be \$115, instead of \$130. As a result of Kaiser's fraud,
22 the maximum premium tax credit – and amount paid by the
23 Government towards all premium payments in the area by qualified
24 individuals – would be up to \$15 higher than it should have been.
25 Due to Kaiser's over-documentation and upcoding, the Government
26 is overpaying by up to \$15 per month for each and every plan
27 purchased in that area due to Kaiser's over-documentation and
28 upcoding fraud.

17 SAC ¶ 216.

18 As an initial matter, Kaiser argues that this second theory of relief is beyond the scope of
19 the amendment permitted by the Court. The Court rejects this argument. The Court's prior order
20 recognized that Relators made reference to the federal government contributing to premiums for
21 the ACA program via tax credits. *See, e.g.*, Docket No. 226 (Order at 3).

22 Kaiser's stronger argument is its main merits argument – *i.e.*, that Relators' theory of relief
23 is too speculative. There is a complicated causal chain being claimed by Relators: (1) Kaiser is
24 claiming that its members are sicker than they are, which means that Kaiser does not have to
25 transfer as much as it should into the risk pool; (2) this enables Kaiser to offer cheaper premiums
26 since it does not have to pay as much as it should into the risk pool; (3) by extension, this leads
27 other insurers to raise their premiums since they are covering more than they should in the risk
28 pool; (4) Kaiser's plans end up costing less than the benchmark plan (which is the second-lowest,

1 silver plan); and (5) since the government contributes to the cost of the benchmark plan through
2 tax credits, the government is paying more than it should.

3 Moreover, even if the chain of causation here were plausible, the injury being claimed by
4 Relators here (*i.e.*, to the government) is derivative in nature. Nothing in the FCA nor its
5 legislative history suggests that the statute was intended to cover derivative harms that are not
6 direct. Case authority in analogous contexts, if anything, suggests the opposite. For example, in
7 *City of Oakland v. Wells Fargo & Co.*, 14 F.4th 1030 (9th Cir. 2021) (en banc), the Ninth Circuit
8 indicated that, in many common-law based statutes, proximate cause requires a direct relation
9 between the injury asserted and the allegedly injurious conduct. *See id.* at 1035 (citing Supreme
10 Court cases applying a direct relation standard for claims brought under the Lanham Act, RICO,
11 and the Clayton Act). In other words, anything beyond the first step of the causal chain is
12 attenuated. *See id.*; *see also Bank of Am. Corp. v. City of Miami*, 581 U.S. 189, 201 (2017) (“It is
13 a well established principle of [the common] law that in all cases of loss, we are to attribute it to
14 the proximate cause, and not to any remote cause. We assume Congress is familiar with the
15 common-law rule and does not mean to displace it sub silentio in federal causes of action.”)
16 (internal quotation marks omitted). In *Oakland*, the City of Oakland sued Wells Fargo for a
17 violation of the Federal Housing Act, which “prohibits ‘lending to minority borrowers on worse
18 terms than equally creditworthy nonminority borrowers and inducing defaults by failing to extend
19 refinancing and loan modifications to minority borrowers on fair terms.’” *Id.* at 1036. The City
20 argued that the bank had discriminatory lending practices that “caused higher default rates, which
21 in turn triggered higher foreclosure rates that drove down the assessed value of properties, and
22 which ultimately resulted in lost property tax revenue and increased municipal expenditures.” *Id.*
23 at 1032. The Ninth Circuit held that “[t]hese downstream ‘ripples of harm’ are too attenuated and
24 travel too ‘far beyond’ [the bank’s] alleged misconduct to establish proximate cause.” *Id.* It
25 explained as follows: “[t]he harm that the [FHA] guards against . . . is . . . situated at the first step:
26 the issuance of the discriminatory loan. The harm to the borrower has a clear direct relation to
27 conduct prohibited by the FHA.” *Id.* There was “no question that [the City’s] theory of harm
28 goes beyond the first step – the harm to minority borrowers who receive predatory loans.

1 Oakland’s theory of harm runs far beyond that – to depressed housing values, and ultimately to
 2 reduced tax revenue and increased municipal expenditures.” *Id.* at 1036. It thus rejected the
 3 City’s claim for relief.

4 Here, the conduct that the FCA prohibits is the submission of a false claim for payment to
 5 the United States. Relators’ first theory of relief, discussed above, covers the first step in the
 6 causal chain, *i.e.*, the submission of a risk adjustment certification to the United States. Their
 7 second theory of relief, however, goes well beyond that first step, looking into, *inter alia*, how risk
 8 adjustment affects premiums through a multi-step chain of causation.

9 Accordingly, the Court rejects Relators’ second theory for relief. It is futile and, therefore,
 10 any claim based on that theory is dismissed with prejudice.

11 F. Conspiracy

12 Kaiser argues next that Relators’ conspiracy claim should be dismissed because it is
 13 insufficiently pled. According to Kaiser, the conspiracy allegations are too conclusory in nature.

14 Although a close call, the Court concludes that there are sufficient allegations to support
 15 bilateral conspiracies. It is a reasonable inference that, for the scheme to defraud to work, a health
 16 plan and an affiliated physician medical group or hospital had to work together – *e.g.*, because the
 17 health plan submitted the risk adjustment attestations to HSS, while the physician group or
 18 hospital established the coding policies and practices. However, the Court holds that there are not
 19 enough allegations to support an overarching conspiracy involving *all* health plans, and *all*
 20 physician medical groups or hospitals. Relators point to allegations made about two Kaiser
 21 groups: (1) Kaiser’s Regional Reporting Group (“RRG”) and (2) Kaiser’s Coding Governance
 22 Group (“CGG”). These groups do appear (as alleged) to be comprised of employees from all of
 23 the various Kaiser regions. *See, e.g.*, SAC ¶ 185 (“In approximately 2008-2009, Kaiser formed
 24 Regional Reporting Group (‘RRG’), comprised of senior personnel from the Health Plan,
 25 Permanente Medical Groups and Revenue Cycle of each region with the focus of Medicare
 26 Advantage Finance Risk Adjustment, and later risk adjustment under the ACA program as well.”);
 27 SAC ¶ 170 (“Kaiser’s own Coding Governance Group (‘CGG’) . . . is composed of a majority of
 28 physicians and representatives from Kaiser’s Permanente Medical Groups rather than coding

1 professionals.”). But the fact that the groups involved employees from all of the various Kaiser
2 regions is not by itself enough to show an overarching agreement and conspiracy to defraud.

3 Indeed, for the RRG, Relators have simply alleged that risk adjustment best practices were
4 shared. *See* SAC ¶ 185 (“The RRG met regularly to share regional ‘best practices’ on how to
5 capture more HCC conditions, diagnoses, and codes, and thus to increase Kaiser revenue.”); SAC
6 ¶ 107 (“[A]t Kaiser's Regional Reporting Group (‘RRG’) meetings, Kaiser regional leaders
7 overseeing its Medicare Advantage programs presented on opportunities and techniques to capture
8 high-yield HCCs, including AA, emulating NCAL TPMG.”). An allegation of sharing may make
9 an overarching conspiracy (agreement to defraud) possible but is not enough to push the claim
10 across the line of plausibility. *See Twombly*, 550 U.S. at 556-57 (in § 1 conspiracy case, stating
11 that “allegations [must] plausibly suggest[] (not merely [be] consistent with) agreement”;
12 therefore, “when allegations of parallel conduct are set out in order to make a § 1 claim, they must
13 be placed in a context that raises a suggestion of a preceding agreement, not merely parallel
14 conduct that could just as well be independent action”).

15 The allegations for the CGG are not much better – simply indicating that the CGG was a
16 resource that Kaiser employees were told to use to get guidance on coding. *See* SAC ¶ 170 (“Ms.
17 Bryant was directed that any and all coding questions must go through Kaiser's own Coding
18 Governance Group (‘CGG’), a group that was and is composed of a majority of physicians and
19 representatives from Kaiser's Permanente Medical Groups rather than coding professionals. In
20 December 2013, Ms. Bryant was told by Kaiser TPMG's senior physician lead Dr. Bliss that she
21 was ‘putting the organization at risk’ by submitting questions directly to [the American Hospital
22 Association’s] Coding Clinic, a sentiment echoed by TPMG Director Anne Cadwell on a call that
23 also included many regional physicians and Revenue Cycle leaders.”).

24 Furthermore, it is worth noting that there are allegations in Relators’ pleading that weigh
25 against an overarching conspiracy nationwide in scope. For example, Relators allege that

26 Kaiser’s National Compliance Office is ineffective, apprehensive,
27 and slow in investigating and responding to documentation and
28 coding compliance issues. In addition, NCO coding leadership
openly admitted to Ms. Hernandez that the Permanente Medical
Groups have significant control over chart audit selection, accuracy

1 rates, documentation guidance, coding policy and practices, all to
 2 manipulate the capture of more HCC codes and to increase
 government payer reimbursement.

3 SAC ¶ 157; *see also* SAC ¶ 190 (alleging that a statement was made by a Kaiser employee that
 4 “the National Compliance Office has no power over the Permanente Medical Groups”). Although
 5 the physician medical groups appear to have “a national leadership and consulting organization,
 6 the Permanente Federation,” SAC ¶ 39, the allegations related to the Federation are sparse.

7 The Court therefore shall allow Relators’ conspiracy claim to proceed but only to the
 8 extent they have alleged bilateral conspiracies. The Court’s ruling here, however, does not
 9 preclude Relators from moving for leave to amend should they find through discovery a good faith
 10 basis to allege an overarching conspiracy.

11 G. “Lumping” Defendants

12 Finally, Kaiser argues that Relators have failed to specify what is the alleged wrongdoing
 13 of each Kaiser entity that has been sued (other than TPMG, which is the Northern California
 14 medical group) – which is particularly significant given the number of entities that have been sued
 15 (in essence, each of the health plans, physician medical groups, and hospitals across the various
 16 Kaiser regions). A similar issue was raised in conjunction with Kaiser’s motion to dismiss the
 17 United States’ first amended complaint.

18 As an initial matter, the Court acknowledges that

19 a complaint need not distinguish between defendants that had the
 20 exact same role in a fraud. . . . “There is no flaw in a pleading . . .
 21 where collective allegations are used to describe the actions of
 22 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.

23 *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 677 (9th Cir. 2018).

24 That being said, Relators’ pleading differs from the government’s in that the government’s
 25 contained at least some allegations about specific wrongdoing by each Kaiser entity sued. In other
 26 words, the government’s pleading alleged not only that Kaiser’s risk adjustment operations were
 27 integrated and/or involved collaboration but also that the Kaiser entities at issue actually went
 28 ahead and implemented the risk adjustment approach being challenged. Here, Relators have made

1 specific allegations about only a handful of the Kaiser regions: Southern California, Northwest,
2 and Colorado. There do not appear to be any specific allegations about, *e.g.*, Southeast, Hawaii,
3 Mid-Atlantic, and Washington.

4 Moreover, the Court takes note that, to the extent allegations have been made about
5 Southern California, Northwest, and Colorado, some of the allegations may not support a viable
6 claim for reasons discussed above. For example:

- 7 • In ¶¶ 121-22 and 135 of the SAC, Relators make allegations about the Southern
8 California medical group’s approach to vent dependence – “requir[ing] 21 days as
9 its time-frame criteria for documenting and coding this status” even though the
10 ACA Coding Clinic has said “there is no ‘set time frame’ and that vent dependence
11 should not be reported for the short-term acute phase of a condition.” However, as
12 noted above, Relators have not sufficiently explained how the ICD Guidelines were
13 violated just because Kaiser was coding vent dependence based on a timeframe. In
14 other words, coding on a timeframe of 21 days is not inherently contradictory to
15 vent dependence involving long-term, continued ventilator support.
- 16 • In ¶ 144, Relators make allegations about the Northwest medical group’s approach
17 to malnutrition: the coding manager for the group had “concerns about
18 documentation and coding of protein-caloric malnutrition on HHS-HCC’s for
19 newborns[;] [i]n particular, she was concerned about the query language being
20 utilized by the CDI [clinical documentation integrity] staff in the NW Region,
21 which appeared to not be supported by clinical indicators and to be leading.”
22 However, as noted above, a “short list of [deficient] inpatient medical record
23 accounts,” SAC ¶ 145, is not enough to support there being a practice of improper
24 coding by Kaiser.
- 25 • In ¶ 150, Relators make allegations about the Colorado medical group’s approach
26 to arrhythmia: the medical group was “instructing doctors to diagnose and
27 document so that Kaiser’s coders would code heart arrhythmia for members even
28 after the members receive pacemakers to correct their arrhythmia for all risk-based

1 payers, including both the MA program and the ACA program”). But, as noted
2 above, because Kaiser submitted both the pacemaker status code and the
3 arrhythmia code, *see* SAC ¶ 150, it is not clear how there was fraud since “HHS
4 and the independent validator could readily observe that both diagnoses were
5 submitted.” Mot. at 16.

- 6 • In ¶ 152, Relators make allegations about the Southern California medical group’s
7 approach to major depression: the group “manipulated [the] electronic system for
8 picking diagnoses to ‘gray out’ the diagnosis of ‘major depression unspecified,’
9 which is not linked to an HCC, so that Kaiser doctors would not pick that diagnoses
10 but would instead select a major depression category that *is* linked to a high-paying
11 HCC” (emphasis in original). But, even though this practice does seem
12 questionable, it is not clear that this would thereby result in fraud – *i.e.*, a patient
13 not having the kind of major depression identified by the doctor.

14 The strongest allegation that Relators do make – which could potentially support a viable
15 claim – relate to Northwest. Relators allege that the Northwest medical group created leading
16 “CDI query templates.” SAC ¶ 165; *see also* SAC ¶¶ 159-60 (alleging that leading queries are
17 forbidden by third party AHIMA’s⁴ “Standards of Ethical Coding,” “Guidelines for Achieving a
18 Compliant Query Practice,” and “Managing an Effective Query Process Practice Brief”).
19 “Through the queries, CDI staff introduce clinical indicators for specific HCC diagnoses to the
20 providers, who in turn routinely follow the suggestion to add a reimbursable diagnoses where none
21 existed and should not have been added.” SAC ¶ 165. Examples of leading query templates
22 included the following: “obesity/extreme or morbid obesity; protein calorie malnutrition
23 (mild/moderate/severe); pressure ulcer; neoplasm (history versus current); emphysema;
24 depression; adrenal mass; aortic atherosclerosis; diabetes manifestations; neutropenia; sepsis/SIRS
25 with organ dysfunction, and others.” SAC ¶ 167. Relators also allege that “certain query
26 templates in Kaiser's Northwest Region developed by the Northwest PMG include leading
27

28 ⁴ AHIMA is American Health Information Management Association. According to Relators, it is
“a neutral organization that can be queried for guidance by coding professionals.” SAC ¶ 125.

1 language introducing a diagnosis to the physician, and *not* including options of ‘unknown,’
 2 ‘other,’ ‘clinically undetermined’ or ‘unspecified.’” SAC ¶ 168 (emphasis added; also alleging
 3 that this practice “contravene[s] AHIMA’s guidance).

4 In summary, at best, Relators have only made allegations about the following regions
 5 (other than Northern California): Southern California, Northwest, and Colorado. Of those
 6 allegations, many are problematic which would leave only allegations against Northwest. The
 7 Court, however, shall give Relators leave to amend here. That is, Relators have leave to amend to
 8 identify specific misconduct by Kaiser entities beyond those affiliated with the California and
 9 Northwest regions. The Court notes that, as stated above, it is already permitting Relators to
 10 amend their pleading if they can, in good faith, allege a broad scheme to defraud, not tied to any
 11 specific medical condition, with respect to the ACA program.

12 **III. CONCLUSION**

13 For the foregoing reasons, the Court grants in part and denies in part the motion to dismiss
 14 Relators’ SAC. Relators have sufficiently pled a FCA claim, with respect to the ACA program, to
 15 the extent predicated on the medical conditions of vent dependence and malnutrition (as limited
 16 above). Relators have also sufficiently pled wrongdoing by the Kaiser entities in California and
 17 Northwest, but not the other regions. In addition, Relators have sufficiently pled bilateral
 18 conspiracies, but not an overarching conspiracy involving all Kaiser entities.

19 Relators have leave to amend their pleading to the extent that they can, in good faith, allege
 20 a broad scheme to defraud not tied to any specific medical condition. Relators also have leave to
 21 amend to the extent that they can, in good faith, allege specific wrongdoing by Kaiser entities
 22 beyond those in the California and Northwest regions.

23 At this juncture, Relators do not have leave to amend an overarching conspiracy, but the
 24 Court’s order here does not preclude them from moving for leave to amend in the future.

25 The Court dismisses with prejudice Relators’ FCA claims to the extent they are based on
 26 the theory that the government was derivatively harmed by issuance of tax credits.

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Relators have forty-five (45) days to file an amended pleading, consistent with the above.
Kaiser shall thereafter have forty-five (45) days to respond to the amended pleading.

This order disposes of Docket No. 251.

IT IS SO ORDERED.

Dated: June 15, 2023



EDWARD M. CHEN
United States District Judge

United States District Court
Northern District of California