

United States District Court  
Northern District of California

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UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
San Francisco Division

UNITED STATES OF AMERICA ex rel.  
KATHY ORMSBY,

Plaintiff,

v.

SUTTER HEALTH, et al.,  
Defendants.

Case No. 15-cv-01062-LB

**ORDER DENYING DEFENDANTS’  
MOTIONS TO DISMISS**

Re: ECF Nos. 66, 68, 81

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1 **INTRODUCTION**

2 The government and relator Kathy Ormsby sued Sutter Health and its affiliate Palo Alto  
3 Medical Foundation (“PAMF”) for violations of the False Claims Act (“FCA”), 31 U.S.C.  
4 §§ 3729–3733, and for common-law claims of payment by mistake and unjust enrichment. Sutter  
5 and PAMF control hospitals and physician foundations throughout California. The plaintiffs allege  
6 that Sutter and PAMF knowingly submitted thousands of false claims relating to the Medicare  
7 Part C Program, known as Medicare Advantage, and knowingly concealed and avoided their  
8 obligations to return Medicare Advantage overpayments that they received.

9 Under the Medicare Advantage program, the federal agency that administers the Medicare  
10 program — the Centers for Medicare and Medicaid Services (“CMS”) — contracts with private  
11 health-insurance companies (known as “Medicare Advantage Organizations” or “MA  
12 Organizations”) that operate health-insurance plans (known as “Medicare Advantage Plans” or  
13 “MA Plans”) that cover Medicare beneficiaries. MA Organizations in turn contract with medical  
14 providers such as Sutter and PAMF for healthcare services (e.g., doctor’s visits, hospitalizations,  
15 etc.) for the beneficiaries enrolled in the MA Plan. CMS pays MA Organizations a capitated  
16 (fixed) amount for each beneficiary enrolled in their MA Plans. MA Organizations share those  
17 payments with their contracted medical providers.

18 The amount that CMS pays for a given beneficiary depends in large part on the beneficiary’s  
19 health status. Broadly speaking, CMS pays higher rates for sicker beneficiaries and lower rates for  
20 healthier beneficiaries, out of a recognition that sicker beneficiaries likely will need more care.

21 CMS relies on “diagnosis codes” to calculate beneficiaries’ health statuses. Every disease,  
22 injury, infection, and symptom has its own diagnosis code. Medical providers such as Sutter and  
23 PAMF enter diagnosis codes into beneficiaries’ medical records after “physician-patient  
24 encounters” (a doctor’s physical examination of a patient). Medical providers submit the diagnosis  
25 codes to MA Organizations, which submit them to CMS. CMS uses some of the diagnosis codes  
26 (such as codes for major, severe, or chronic illnesses) — referred to as “risk-adjusting diagnosis  
27 codes” — in a risk-adjustment model to calculate a risk score for each beneficiary. The diagnosis  
28 codes that medical providers submit are the only factors that CMS uses to determine a

1 beneficiary's health status to calculate the beneficiary's risk score and thus to calculate how much  
2 CMS will pay for that beneficiary.

3 As the Ninth Circuit has recognized, participants in the Medicare Advantage program (MA  
4 Organizations and medical providers) (collectively, "MA Participants") have an incentive to over-  
5 report diagnosis codes in order to raise beneficiary risk scores and, in turn, increase the amount  
6 that CMS pays them. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir.  
7 2018); *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1168 (9th Cir. 2016) (*Swoben*).

8 The government alleges that Sutter and PAMF maximized the number of risk-adjusting  
9 diagnosis codes that they reported (through MA Organizations to CMS) in order to increase the  
10 payments that CMS paid to the MA Organizations and, ultimately, to Sutter and PAMF. Among  
11 other things, Sutter and PAMF (1) pre-populated Medicare Advantage beneficiaries' medical  
12 records with diagnosis codes before physicians saw or diagnosed the beneficiaries, (2) had non-  
13 physician "coders" review Medicare Advantage beneficiaries' medical records and retroactively  
14 add codes that the physicians supposedly "missed" or change the physicians' codes to codes for  
15 more severe conditions, and (3) knowingly submitted unsupported diagnosis codes to CMS and  
16 prohibited their internal coders/auditors from deleting unsupported diagnosis codes. Relator Kathy  
17 Ormsby, who worked as PAMF's Risk-Adjustment Project Manager from 2013 to 2015,  
18 conducted internal reviews and audits, found that large percentages of the risk-adjusting diagnosis  
19 codes that Sutter and PAMF submitted were false, and reported her findings to Sutter and PAMF  
20 management. The government alleges Sutter and PAMF were deliberately ignorant or reckless  
21 about their submitting false diagnosis codes and retaining payments predicated on false diagnosis  
22 codes and did nothing to fix the problem. The government alleges that Sutter and PAMF violated  
23 the FCA by (1) submitting false risk-adjusting diagnosis codes to CMS and (2) failing to return  
24 payments predicated on false diagnosis codes. These allegations also are the predicates for the  
25 government's common-law claims for payment by mistake and unjust enrichment.

26 Ms. Ormsby's complaint is broader than the government's complaint. The government's  
27 complaint is limited to PAMF (and Sutter's actions in connection with PAMF). Ms. Ormsby  
28 alleges that Sutter committed similar violations of the FCA through its other affiliates.

1 Sutter and PAMF move to dismiss both complaints under Federal Rules of Civil Procedure  
 2 12(b)(6) and 9(b). Sutter’s and PAMF’s main argument is that the FCA claims fail because the  
 3 plaintiffs have not alleged a sufficient threshold diagnosis-code error rate. The argument is  
 4 predicated on a statute — 42 U.S.C. § 1395w-23(a)(1)(C)(i) — that provides that CMS must  
 5 adjust Medicare Advantage payments to ensure “actuarial equivalence” with traditional Medicare.  
 6 Sutter and PAMF maintain that (1) traditional Medicare providers also submit false or  
 7 unsupported diagnosis codes and (2) under the principle of “actuarial equivalence,” Medicare  
 8 Advantage providers that submit false or unsupported diagnosis codes are not overpaid unless  
 9 their diagnosis-code “error rate” exceeds the “error rate” of traditional Medicare providers. Sutter  
 10 and PAMF contend that because the plaintiffs have not alleged that their “error rate” exceeds the  
 11 traditional-Medicare “error rate,” they have not sufficiently pleaded a claim. Sutter also argues  
 12 that where, as here, the government has intervened in an FCA case, a relator like Ms. Ormsby  
 13 cannot independently pursue claims that exceed the scope of the government’s intervention and  
 14 that the court therefore should dismiss her claims regarding Sutter’s non-PAMF affiliates. Sutter  
 15 and PAMF also move to dismiss the claims on the ground that the plaintiffs did not sufficiently  
 16 allege facts establishing their knowing failure to return overpayments or their knowing submission  
 17 of false claims.

18 The court denies the motions to dismiss. First, the “actuarial equivalence” provision in  
 19 42 U.S.C. § 1395w-23(a)(1)(C)(i) is not a defense to an FCA claim, does not entitle MA  
 20 Participants to submit unsupported diagnosis codes (or to keep and not return and report payments  
 21 predicated on unsupported diagnosis codes), and does not require an FCA plaintiff to allege that  
 22 an MA Participant’s “error rate” exceeds the traditional-Medicare “error rate” to plead a claim.<sup>1</sup>  
 23 Second, the government’s intervention with respect to Sutter and PAMF does not bar Ms. Ormsby  
 24  
 25

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26  
 27 <sup>1</sup> As explained below, traditional Medicare providers are paid under a fee-for-service model and are  
 28 not paid based on the diagnosis codes they submit. A traditional Medicare provider that submits an  
 unsupported diagnosis code does not cause CMS to pay out any additional money, whereas a Medicare  
 Advantage provider that submits an unsupported diagnosis code does.

1 from pursuing her claims regarding Sutter’s non-PAMF affiliates. Third, Sutter’s and PAMF’s  
 2 other challenges to the sufficiency of the plaintiffs’ pleadings fail.

## 3 4 STATEMENT

### 5 1. Medicare Advantage Generally

6 In recent cases, the Ninth Circuit has discussed the Medicare Advantage program in the  
 7 context of FCA claims. *Silingo*, 904 F.3d 667; *Swoben*, 848 F.3d 1161.

8 “Medicare Advantage is a modern adaptation of the momentous 1960s-era [Medicare]  
 9 program.” *Silingo*, 904 F.3d at 672. “Traditional Medicare uses a fee-for-service payment model,  
 10 whereby the more services physicians perform, the more money they earn.” *Id.*<sup>2</sup> “After Medicare  
 11 was enacted, however, experts came to realize that this payment structure encourages healthcare  
 12 providers to order more tests and procedures than medically necessary.” *Id.* (citing Thomas L.  
 13 Greaney, *Medicare Advantage, Accountable Care Organizations, and Traditional Medicare:  
 14 Synchronization or Collision?*, 15 Yale J. Health Pol’y, L. & Ethics 37, 38, 41 (2015)). “Medicare  
 15 Advantage seeks to improve the quality of care while safeguarding the public fisc by employing a  
 16 ‘capitation’ payment system.” *Id.*<sup>3</sup>

17 “Medicare beneficiaries have the option of receiving benefits through private health plans as  
 18 an alternative to the traditional fee-for-service Medicare program.” *Swoben*, 848 F.3d at 1167.<sup>4</sup>  
 19 “Under this option, known as Medicare Advantage or Medicare Part C, the government pays  
 20 Medicare Advantage organizations a capitated (per enrollee) amount to provide medical benefits.”  
 21 *Id.*<sup>5</sup> “Capitation means an amount is paid per person.” *Silingo*, 904 F.3d at 672 (citing Capitation,  
 22 Black’s Law Dictionary (10th ed. 2014)).<sup>6</sup> “Under Medicare Advantage’s capitation system,  
 23

24  
 25 <sup>2</sup> *Accord* Gov’t Compl. – ECF No. 41 at 2 (¶ 1), 10 (¶ 27). Citations refer to material in the Electronic  
 Case File (“ECF”); pinpoint citations are to the ECF-generated page numbers at the top of documents.

26 <sup>3</sup> *Accord id.* at 3 (¶ 3), 11 (¶ 30).

27 <sup>4</sup> *Accord id.* at 2 (¶ 1), 10 (¶ 28).

28 <sup>5</sup> *Accord id.* at 3 (¶ 3), 11 (¶ 30).

<sup>6</sup> *Accord id.* at 11 (¶ 30).

1 private health insurance organizations provide Medicare benefits in exchange for a fixed monthly  
 2 fee per person enrolled in the program — regardless of actual healthcare usage.” *Id.*<sup>7</sup> “These  
 3 organizations pocket for themselves or pay out to their enrollees’ providers the difference between  
 4 their capitation revenue and their enrollees’ medical expenses, creating an incentive for the  
 5 organizations to rein in costs.” *Id.* (citing Patricia A. Davis et al., Cong. Research Serv., R40425,  
 6 *Medicare Primer 20* (2017), <https://fas.org/sgp/crs/misc/R40425.pdf> (last visited Mar. 16, 2020)).

7 “The government adjusts the monthly payments to Medicare Advantage organizations to  
 8 reflect the health status of their enrollees.” *Swoben*, 848 F.3d at 1167 (citing 42 U.S.C. § 1395w-  
 9 23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2)).<sup>8</sup> “This ensures Medicare Advantage  
 10 ‘organizations are paid appropriately for their plan enrollees (that is, less for healthier enrollees  
 11 and more for less healthy enrollees).’” *Id.* (quoting *Establishment of the Medicare Advantage*  
 12 *Program*, 70 Fed. Reg. 4588, 4657 (Jan. 28, 2005)).<sup>9</sup>

13 “Medicare Advantage organizations obtain diagnosis codes from healthcare providers after  
 14 these providers have had medical visits with plan enrollees.” *Silingo*, 904 F.3d at 672 (citing Ctrs.  
 15 for Medicare and Medicaid Servs., Pub. No. 100-16, *Medicare Managed Care Manual*, ch. 7, § 40  
 16 (2014), [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/  
 17 mc86c07.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf) (last visited Mar. 16, 2020)).<sup>10</sup> “Physicians and other health care providers submit  
 18 diagnosis codes to the Medicare Advantage organizations[.]” *Swoben*, 848 F.3d at 1167 (citing  
 19 *Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare*  
 20 *Prescription Drug Benefit Programs*, 74 Fed. Reg. 54,634, 54,674 (Oct. 22, 2009)).<sup>11</sup> “In turn,  
 21 Medicare Advantage organizations report the diagnosis codes that they receive to the Centers for  
 22 Medicare and Medicaid Services (‘CMS’) for use in the risk adjustment model that is the key to  
 23 calculation of capitation rates.” *Silingo*, 904 F.3d at 672 (citing *Medicare Managed Care Manual*,

24  
 25 <sup>7</sup> *Accord id.*

26 <sup>8</sup> *Accord id.* at 3 (¶ 4), 11 (¶ 30).

27 <sup>9</sup> *Accord id.*

28 <sup>10</sup> *Accord id.* at 3–4 (¶¶ 4–5), 11–13 (¶¶ 30–35).

<sup>11</sup> *Accord id.* at 3–4 (¶¶ 4–5), 13 (¶ 35).



1 ch. 7, § 40); *accord Swoben*, 848 F.3d at 1167.<sup>12</sup> “The risk adjustment model deems a Medicare  
2 Advantage enrollee to be as healthy as the average Medicare beneficiary unless CMS receives  
3 updated diagnosis codes for the enrollee every year.” *Silingo*, 904 F.3d at 672 (citing *Medicare*  
4 *Managed Care Manual*, ch. 7, §§ 20, 70, 70.2.5, 120.2.4).<sup>13</sup> “These diagnosis codes contribute to  
5 an enrollee’s risk score, which is used to adjust a base payment rate.” *Swoben*, 848 F.3d at 1167–  
6 68 (citing 74 Fed. Reg. at 54,674).<sup>14</sup>

7 “Unfortunately, human nature being what it is, Medicare Advantage organizations also have  
8 some incentive to improperly inflate their enrollees’ capitation rates, if these organizations fall  
9 prey to greed.” *Silingo*, 904 F.3d at 672.<sup>15</sup> “[T]here is an incentive for Medicare Advantage  
10 organizations to potentially over-report diagnoses so that they can increase their payment[.]”  
11 *Swoben*, 848 F.3d at 1168 (internal brackets omitted).<sup>16</sup>

12 “With data for millions of people being submitted each year, CMS is unable to confirm  
13 diagnoses before calculating capitation rates.” *Silingo*, 904 F.3d at 672. “Instead, the agency  
14 accepts the diagnoses as submitted, and then audits some of the self-reported data a few years later  
15 to ensure that they are adequately supported by medical documentation.” *Id.* at 672–73 (citing  
16 42 C.F.R. §§ 422.310(e), 422.311; *Contract Year 2015 Policy and Technical Changes to the*  
17 *Medicare Advantage and the Medicare Prescription Drug Benefit Programs*, 79 Fed. Reg. 1918,  
18 2001 (Jan. 10, 2014)). “These audits have revealed excess payments for unsupported diagnoses  
19 steadily increasing over the last decade, reaching an estimated \$16.2 billion — nearly ten cents of  
20 every dollar paid to Medicare Advantage organizations — in 2016 alone.” *Id.* at 673 (emphasis in  
21 original) (citing James Cosgrove, U.S. Gov’t Accountability Office, GAO-17-761T, *Medicare*  
22 *Advantage Program Integrity: CMS’s Efforts to Ensure Proper Payments and Identify and*  
23 *Recover Improper Payments* 1 (2017), <https://www.gao.gov/assets/690/685934.pdf> (last visited  
24

25 <sup>12</sup> *Accord id.* at 3–4 (¶¶ 4–5), 13 (¶¶ 34–35).

26 <sup>13</sup> *Accord id.* at 13 (¶ 34).

27 <sup>14</sup> *Accord id.* at 3–4 (¶¶ 4–5), 11–13 (¶¶ 30–35).

28 <sup>15</sup> *Accord id.* at 4–5 (¶ 6).

<sup>16</sup> *Accord id.*

1 Mar. 16, 2020); James Cosgrove, U.S. Gov’t Accountability Office, GAO-13-206, *Medicare*  
 2 *Advantage: Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk*  
 3 *Score Adjustments* 9–10 (2013), <https://www.gao.gov/assets/660/651712.pdf> (last visited Mar. 16,  
 4 2020)).

5 “To combat the ‘incentive for Medicare Advantage organizations to potentially over-report  
 6 diagnoses,’ Medicare regulations require risk adjustment data to be produced according to certain  
 7 best practices.” *Id.* (internal brackets omitted) (citing 79 Fed. Reg. at 2001).<sup>17</sup> “Every diagnosis  
 8 code submitted to CMS must be based on a ‘face-to-face’ visit that is documented in the medical  
 9 record.” *Id.* (citing *Medicare Managed Care Manual*, ch. 7, §§ 40, 120.1.1).<sup>18</sup> “Medical records  
 10 must be validated by qualifying ‘physician/practitioner signatures and credentials.’” *Id.* (citing  
 11 *Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug*  
 12 *Benefit Programs*, 75 Fed. Reg. 19,678, 19,743 (Apr. 15, 2010)).<sup>19</sup> “Further, electronic medical  
 13 records must meet special signature requirements and use software that is ‘protected against  
 14 modification.’” *Id.* (citing Ctrs. for Medicare and Medicaid Servs., Pub. No. 100-08, *Medicare*  
 15 *Program Integrity Manual*, ch. 3, § 3.3.2.4 (2018), [https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf)  
 16 [Guidance/Guidance/Manuals/downloads/PIM83c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf) (last visited Mar. 16, 2020)).

17 “As a further bulwark against fraud, Medicare Advantage organizations must certify the  
 18 accuracy, completeness and truthfulness of the data they provide to CMS, including risk  
 19 adjustment data, as a condition to receiving payment[.]” *Swoben*, 848 F.3d at 1168 (citing  
 20 42 C.F.R. § 422.504(*I*)); *accord Silingo*, 904 F.3d at 673 (“[I]t is an express condition of payment  
 21 that a Medicare Advantage organization ‘certify (based on best knowledge, information, and  
 22 belief) that the [risk adjustment] data it submits . . . are accurate, complete, and truthful.’”)  
 23 (brackets and ellipsis in original) (quoting 42 C.F.R. § 422.504(*I*)(2)).<sup>20</sup> “The organization also is  
 24 required to ‘adopt and implement an effective compliance program, which must include measures

25 \_\_\_\_\_  
 26 <sup>17</sup> *Accord id.* at 10–11 (¶ 29).

27 <sup>18</sup> *Accord id.* at 12 (¶ 32).

28 <sup>19</sup> *Accord id.*

<sup>20</sup> *Accord id.* at 10–11 (¶ 29).

1 that prevent, detect, and correct non-compliance with CMS'[s] program requirements,' such as  
 2 written standards of conduct, the designation of a compliance officer, and other listed minimum  
 3 requirements." *Silingo*, 904 F.3d at 673 (internal brackets omitted) (quoting 42 C.F.R.  
 4 § 422.503(b)(4)(vi)).<sup>21</sup> Among other things, the compliance programs must "includ[e] 'procedures  
 5 for internal monitoring and auditing' and for 'ensuring prompt responses to detected offenses.'" *Swoben*,  
 6 848 F.3d at 1174 (internal brackets omitted) (quoting 42 C.F.R. § 422.503(b)(4)(vi),  
 7 (vi)(F), (vi)(G)).<sup>22</sup> Similarly, medical providers such as Sutter and PAMF that contract with MA  
 8 Organizations must certify that the data (including diagnosis codes) they submit are "accurate,  
 9 complete, and truthful." 42 C.F.R. § 422.504(l)(3).<sup>23</sup> They also are subject to the MA  
 10 Organization's compliance and training requirements, 42 C.F.R. § 422.503(b)(4)(vi)(C), and must  
 11 "comply with all Medicare laws, regulations and CMS instructions," 42 C.F.R.  
 12 § 422.504(i)(4)(v).<sup>24</sup> "The importance of accurate data certifications and effective compliance  
 13 programs is obvious: if enrollee diagnoses are overstated, then the capitation payments to  
 14 Medicare Advantage organizations will be improperly inflated." *Silingo*, 904 F.3d at 673.<sup>25</sup>

15 "The Medicare Advantage capitation payment system is subject to the False Claims Act." *Id.*<sup>26</sup>

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19 <sup>21</sup> *Accord id.*

20 <sup>22</sup> *Accord id.*

21 <sup>23</sup> *Accord id.*

22 <sup>24</sup> *Accord id.* More specifically, Medicare regulations define the concepts of "first tier entities," which  
 23 "means any party that enters into a written arrangement, acceptable to CMS, with an MA organization  
 24 or applicant to provide administrative services or health care services for a Medicare eligible  
 25 individual under the MA program," and "related entities," which "means any entity that is related to  
 26 the MA organization by common ownership or control and (1) Performs some of the MA  
 27 organization's management functions under contract or delegation; (2) Furnishes services to Medicare  
 28 enrollees under an oral or written agreement; or (3) Leases real property or sells materials to the MA  
 organization at a cost of more than \$2,500 during a contract period." 42 C.F.R. §§ 422.2, 422.500.  
 Medicare regulations impose various requirements with respect to "first tier entities" and "related  
 entities." *See, e.g.*, 42 C.F.R. §§ 422.503(b)(4)(vi)(C), 422.504(i)(4)(v), (l)(3). The government alleges  
 (and, for the purposes of their motions to dismiss, Sutter and PAMF do not deny) that Sutter and  
 PAMF are "first tier entities" and "related entities." Gov't Compl. – ECF No. 41 at 10 (¶ 29).

<sup>25</sup> *Accord id.* at 5 (¶ 6).

<sup>26</sup> *Accord id.* at 8 (¶ 19).

1 **2. The Government’s Allegations Regarding Diagnosis Codes**

2 In its complaint, the government alleges the following about diagnosis codes and their role in  
3 the Medicare Advantage program.

4 Under Medicare Advantage, CMS pays each MA Organization a monthly fixed, capitated, per-  
5 beneficiary amount, adjusted by the expected risk of each beneficiary.<sup>27</sup> The baseline payment is  
6 set each year through a bidding process.<sup>28</sup> Each MA Plan, through an MA Organization, submits a  
7 bid amount.<sup>29</sup> CMS compares these bid amounts to a benchmark that it sets through a statutory  
8 formula.<sup>30</sup> CMS then adjusts the baseline payment for each beneficiary based on that beneficiary’s  
9 (1) demographic factors, such as age and gender, and (2) health status.<sup>31</sup> Specifically, CMS uses a  
10 risk-adjustment model called the Hierarchical Conditions Category (“HCC”) model that takes into  
11 account a beneficiary’s demographic factors and health status and generates a numerical risk  
12 score, sometimes referred to as the “Risk-Adjustment Factor” (“RAF”), for the beneficiary.<sup>32</sup> This  
13 risk score is a multiplier that is applied to the baseline payment to the MA Organization (e.g., a  
14 beneficiary’s risk score of 1.2 means that CMS pays out 1.2 times the baseline payment for that  
15 beneficiary’s care).<sup>33</sup>

16 With respect to health status, CMS’s HCC model relies on diagnosis codes documented by  
17 treating physicians during office visits and hospital outpatient and inpatient stays.<sup>34</sup> Medical  
18 providers (e.g., physicians, or organizations that employ physicians such as Sutter and PAMF)  
19 submit the diagnosis codes to CMS, which uses the codes to determine a beneficiary’s health  
20 status in order to calculate the beneficiary’s risk score.<sup>35</sup> These diagnosis codes, as reported by  
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22 <sup>27</sup> *Id.* at 11 (¶ 30).

23 <sup>28</sup> *Id.*

24 <sup>29</sup> *Id.*

25 <sup>30</sup> *Id.*

26 <sup>31</sup> *Id.* (citing 42 U.S.C. § 1395w-23(a)(1)(C)).

27 <sup>32</sup> *Id.* at 11–12 (¶¶ 30–31) (citing 42 U.S.C. § 1395w-23(a)(1)(G); 42 C.F.R. § 422.308(e)).

28 <sup>33</sup> *Id.* at 11 (¶ 30).

<sup>34</sup> *Id.* at 11–12 (¶ 31).

<sup>35</sup> *Id.*

1 medical providers, are the only factors that CMS uses to determine a beneficiary's health status.<sup>36</sup>  
 2 Medicare regulations and guidance are clear that CMS relies on these diagnosis codes to make  
 3 accurate payments for each beneficiary enrolled in the Medicare Advantage program.<sup>37</sup>

4 The higher a beneficiary's risk score, the higher the payments that CMS makes to MA  
 5 Organizations for that beneficiary.<sup>38</sup> When medical providers submit more risk-adjusting diagnosis  
 6 codes, they increase the amount that CMS pays.<sup>39</sup> Conversely, when providers delete risk-  
 7 adjusting diagnosis codes (such as erroneous, invalid, unsupported, or otherwise false codes), they  
 8 reduce the amount that CMS pays.<sup>40</sup>

9 Given the importance of accurate information, CMS requires MA Organization executives to  
 10 certify that the diagnosis codes (and other patient data) that they submit to CMS are true and  
 11 accurate.<sup>41</sup> CMS requires these signed certifications as a condition of payment.<sup>42</sup> If a subcontractor  
 12 or related entity (such as a medical provider operating under a contract with the MA Organization)  
 13 generates the data, the subcontractor or related entity also must certify that its diagnosis codes and  
 14 data are true and accurate.<sup>43</sup> Additionally, CMS audits MA Organizations, and MA Organizations  
 15 in turn audit medical providers, regarding the accuracy of their diagnosis coding.<sup>44</sup> If a medical  
 16 provider submits erroneous risk-adjusting diagnosis codes (whether manually, through an  
 17 automated "sweep" system, or otherwise), then CMS requires the return of any overpayments  
 18 predicated on those codes.<sup>45</sup>

19 \_\_\_\_\_  
 20 <sup>36</sup> *Id.* at 12 (¶ 31).

21 <sup>37</sup> *Id.* at 13–14 (¶ 36) (“Accurate risk-adjusted payments rely on the diagnosis coding derived from the  
 22 member's medical record.”) (quoting Ctrs. for Medicare and Medicaid Servs., *2013 National  
 23 Technical Assistance Risk Adjustment 101 Participant Guide* § 4.2 (2013) and citing 42 C.F.R.  
 24 § 422.504(l)(3)).

25 <sup>38</sup> *Id.* at 13 (¶ 34).

26 <sup>39</sup> *Id.* at 5 (¶ 6), 13 (¶ 34).

27 <sup>40</sup> *Id.* at 14 (¶ 37).

28 <sup>41</sup> *Id.* at 44 (¶ 126).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* (citing 42 C.F.R. § 422.504(l)(3)).

<sup>44</sup> *Id.* (¶ 127).

<sup>45</sup> *Id.* (citing *Medicare Managed Care Manual*, ch. 7, § 40; *Swoben*, 848 F.3d at 1176–77 & n.8).

1 MA Organizations and medical providers are able to delete diagnosis codes previously  
 2 submitted to CMS that are erroneous, invalid, unsupported, or otherwise false.<sup>46</sup> If an MA  
 3 Organization or medical provider deletes or withdraws a diagnosis code, CMS’s electronic-  
 4 processing system automatically recalculates the respective payment amount, which is the first  
 5 step in CMS’s process to recoup the payment associated with the deleted or withdrawn diagnosis  
 6 code.<sup>47</sup>

### 8 **3. The Government’s Allegations Against Sutter and PAMF**

9 Sutter, through its provider affiliates, including PAMF, furnishes healthcare services to  
 10 thousands of Medicare Advantage beneficiaries under at least 10 MA Plans managed by three MA  
 11 Organizations: UnitedHealth, Health Net, and Humana.<sup>48</sup> Under their agreements with the MA  
 12 Organizations, Sutter and PAMF submit patient-encounter data, including diagnosis codes, to the  
 13 MA Organizations for their MA Plan beneficiaries.<sup>49</sup> The MA Organizations then submit these  
 14 diagnosis codes to CMS.<sup>50</sup>

15 The MA Organizations’ agreements with Sutter and PAMF provide that they will pay Sutter  
 16 and PAMF a set percentage of the payments they receive from CMS.<sup>51</sup> Additionally, Sutter and  
 17 PAMF have “gainsharing” agreements with the MA Organizations whereby Sutter and PAMF  
 18 receive incentive payments based in whole or in part on the total revenues that the MA  
 19 Organizations receive for beneficiaries that Sutter and PAMF treat.<sup>52</sup> Consequently, when Sutter

21 \_\_\_\_\_  
 22 <sup>46</sup> *Id.* at 14 (¶ 37).

23 <sup>47</sup> *Id.* at 9 (¶ 23), 14 (¶ 37).

24 <sup>48</sup> *Id.* at 3–4 (¶ 5). The government refers to the UnitedHealth entity as “United Healthcare Group” in  
 25 one paragraph of its complaint, *id.*, but otherwise refers to it as “United Health Group,” *see, e.g., id.* at  
 26 22 (¶ 59). Ms. Ormsby refers to it in her complaint as “UnitedHealth Group Inc.” Relator First Amend.  
 27 Compl. (“FAC”) – ECF No. 52 at 12 (¶ 39). This order refers to it as “UnitedHealth.”

28 <sup>49</sup> Gov’t Compl. – ECF No. 41 at 4 (¶ 5), 13 (¶ 35).

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 4–5 (¶ 6), 13 (¶ 34).

<sup>52</sup> *Id.* at 4–5 (¶ 6).

1 and PAMF submit more risk-adjusting diagnosis codes, Sutter and PAMF cause CMS to make  
2 higher payments to Sutter and PAMF.<sup>53</sup>

### 3 **3.1 Sutter’s and PAMF’s “RAF Campaign”**

4 “Beginning no later than 2010, Sutter and PAMF began a campaign to increase the number of  
5 risk-adjusting diagnosis codes for its MA patients, in order to generate revenue and maximize  
6 reimbursement from CMS. This effort became known as the RAF Campaign.”<sup>54</sup>

7 In February 2012, Dr. Jeffrey Burnich (a Sutter Senior Vice President and Executive Officer)  
8 told Suzy Cliff (PAMF’s Vice President of Revenue Cycle) and other members of management  
9 that PAMF was “leaving millions of dollars on the table” from “sub-par coding.”<sup>55</sup> A couple of  
10 days later, a member of Sutter leadership told PAMF to “identify a PAMF operational director to  
11 work with them in improving our RAF scoring/coding on our Medicare Advantage patients.”<sup>56</sup>  
12 Sutter and PAMF tasked Nancy McGinnis (Sutter’s RAF Director) “to lead the efforts to improve  
13 Sutter Health’s RAF scores.”<sup>57</sup>

14 By November 2012, Sutter and PAMF formalized the RAF Campaign, calling it the “Risk  
15 Adjusted Factor Project.”<sup>58</sup> The Project’s goal was “to reach a 28% improvement in the HCC  
16 performance” for its MA Plan patients.<sup>59</sup> By late 2012, Sutter and PAMF outlined new steps in the  
17 Project, including approving the hiring of a “Project Manager” to coordinate the Project and a  
18 “Database Analyst” to track the diagnosis-coding performance of network physicians.<sup>60</sup>

19 As part of the RAF Campaign, Sutter and PAMF identified so-called “Physician Champions”  
20 to “act as a liaison between the coding team and the physicians” on the theory that physicians  
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23 <sup>53</sup> *Id.* at 5 (¶ 6), 13 (¶ 34).

24 <sup>54</sup> *Id.* at 16 (¶ 44).

25 <sup>55</sup> *Id.* at 17 (¶ 46).

26 <sup>56</sup> *Id.*

27 <sup>57</sup> *Id.* (¶ 44).

28 <sup>58</sup> *Id.* at 18 (¶ 48).

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*



1 would be more likely to accept diagnosis-coding guidance from other physicians.<sup>61</sup> Dr. Veko  
 2 Vahamaki, PAMF’s Lead RAF Physician Champion, supervised the champions at PAMF’s four  
 3 divisions in Alameda (Dr. Amy Lin), Camino (Dr. Graham Dresden), Palo Alto (Dr. Anita Gupta),  
 4 and Santa Cruz (Dr. Susan Schaefer).<sup>62</sup>

5 Sutter and PAMF engaged in activities to increase the risk-adjusting diagnosis codes they  
 6 reported to the MA Organizations and CMS — and thereby increase their revenue — including the  
 7 following.

### 8 **3.1.1 Characterizing conditions as “chronic”**

9 A medical provider’s labeling certain diagnoses “chronic” (as opposed to “acute”) allows the  
 10 provider to add risk-adjusting diagnosis codes to a Medicare Advantage beneficiary’s medical  
 11 record and thereby increase the money that CMS pays for the beneficiary.<sup>63</sup>

12 In January 2012, Dr. Steven Lane (a physician in PAMF’s network and PAMF’s Electronic  
 13 Health Record Ambulatory Physician Director) wrote an email with the subject line “HCC codes:  
 14 more to consider as chronic?”<sup>64</sup> Dr. Lane wrote, “Over the past year or two . . . increasing  
 15 attention has been focused on the importance of appropriately identifying and coding HCC  
 16 diagnoses to improve RAF scores and Medicare managed care reimbursement . . . .”<sup>65</sup>

17 In early February 2012, Greta Fees (Sutter’s Director of Coding, Documentation, and Data  
 18 Quality) expressed concern about “the added descriptive of chronic to the diagnosis code  
 19 descriptions” for leukemia, bronchitis, and asthma, among other conditions.<sup>66</sup> Ms. Fees believed  
 20 that these diagnoses clinically related to “acute” rather than “chronic conditions” and explained  
 21 that her research did “not support adding the descriptive term of chronic . . . as that would change  
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24 <sup>61</sup> *Id.* at 17 (¶ 45).

25 <sup>62</sup> *Id.*

26 <sup>63</sup> *Id.* at 32 (¶ 93).

27 <sup>64</sup> *Id.* at 17 (¶ 44).

28 <sup>65</sup> *Id.* (ellipsis in complaint).

<sup>66</sup> *Id.* at 32 (¶ 93).



1 the definition, intent and possibly use of the code.”<sup>67</sup> Ms. Fees related these concerns to Dr. Lane  
 2 and to Dr. Meg Durbin (a PAMF Regional Medical Director, Managed Care), who both wanted to  
 3 add the “chronic” label to these diagnoses.<sup>68</sup> Drs. Lane and Durbin pushed back in support of the  
 4 “chronic” designation, tried to pressure Ms. Fees to accept their analyses, and claimed that they  
 5 were “approaching a consensus” with Ms. Fees despite her continued disagreement with them.<sup>69</sup>

### 6 **3.1.2 Using a “pit crew” to add diagnosis codes to patient medical records**

7 Sutter and PAMF maintained a team of non-physician “coders” whose function, among others,  
 8 was to audit the accuracy of PAMF’s diagnosis coding and medical-record documentation.<sup>70</sup>

9 In November 2012, Dr. Jeffrey Brown (PAMF’s Associate Director for Managed Care)  
 10 approved coders adding risk-adjusting diagnosis codes to patient medical records that physicians  
 11 missed during their patient visits.<sup>71</sup> Dr. Veko Vahamaki (PAMF’s Lead RAF Physician  
 12 Champion) called this a “pit crew plan” and believed that it “would significantly help with the  
 13 RAF efforts.”<sup>72</sup>

14 Dr. Christopher Jaeger (a Sutter Vice President and Sutter’s Chief Medical Informatics  
 15 Officer) expressed concern that “having a coder change an entry that I purposefully enter that has  
 16 clinical meaning to me/others . . . seems like a dangerous step.”<sup>73</sup> In response, Dr. Vahamaki  
 17 defended the coder approach and forwarded his exchange with Dr. Jaeger to Julie Cheung  
 18 (Sutter’s RAF Program Manager).<sup>74</sup>

19 Another doctor, Dr. Douglas Tucker, complained to Dr. Vahamaki and others in PAMF’s  
 20 management about a coder changing a patient’s diagnosis, stating that “changing a diagnosis from  
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22  
 23 <sup>67</sup> *Id.* (ellipsis in complaint).

24 <sup>68</sup> *Id.*

25 <sup>69</sup> *Id.*

26 <sup>70</sup> *Id.* at 7 (¶ 13).

27 <sup>71</sup> *Id.* at 18 (¶ 49).

28 <sup>72</sup> *Id.*

<sup>73</sup> *Id.* (ellipsis in complaint).

<sup>74</sup> *Id.*

1 acute bronchitis to pneumonia is not a simple or unimportant change” and “it is so obviously  
2 unethical.”<sup>75</sup>

### 3 **3.1.3 Pressuring physicians to add diagnosis codes to patient medical records**

4 By late 2012, Sutter asked coders in all of its affiliates, including PAMF, to schedule annual  
5 “Medicare Wellness Exams” for Medicare Advantage patients lacking any risk-adjusting diagnosis  
6 codes.<sup>76</sup> The government alleges that Sutter scheduled these exams “to ensure the capture of every  
7 possible code that could increase CMS’s payments.”<sup>77</sup> Sutter tracked the success of each affiliate,  
8 including PAMF, in scheduling the Medicare Wellness Exams and rewarded meeting a goal of  
9 75% annual wellness visits with a 1% upside bonus at the group level.<sup>78</sup> The government alleges  
10 that “Sutter and PAMF understood that ‘capturing more wellness exams’ increased the capture of  
11 risk-adjusting diagnosis codes and thus increased revenue.”<sup>79</sup> One doctor, Dr. Heather Linebarger,  
12 complained to Dr. Vahamaki and others that “I have serious questions about the new policy of  
13 booking in Medicare Advantage patients to review all HCC codes . . . This represents a waste of  
14 time for the patient and a loss of appointment and worsening of access for me.”<sup>80</sup>

15 Also in late 2012, some PAMF physicians began to receive “HCC/RAF cheat sheets” that  
16 identified risk-adjusting diagnosis codes that purportedly were common to many Medicare  
17 Advantage patients (such as diabetes).<sup>81</sup> “The cheat sheets were used to pressure physicians to add  
18 these codes into the patient’s electronic medical records even during encounters focusing on other  
19 patient healthcare problems.”<sup>82</sup>

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23 <sup>75</sup> *Id.* at 33 (¶ 96).

24 <sup>76</sup> *Id.* at 18 (¶ 48).

25 <sup>77</sup> *Id.*

26 <sup>78</sup> *Id.*

27 <sup>79</sup> *Id.*

28 <sup>80</sup> *Id.* at 34 (¶ 96) (ellipsis in complaint).

<sup>81</sup> *Id.* at 19 (¶ 50).

<sup>82</sup> *Id.*

1 Sutter-affiliated physicians, including those at PAMF, received (through Sutter’s electronic-  
2 medical-record system) a customized “Problem List” for their MA Plan patients.<sup>83</sup> A “Problem  
3 List” is a list of health problems with corresponding diagnosis codes and can be used as a high-  
4 level summary of a patient’s past health problems.<sup>84</sup> At Sutter and PAMF management’s direction,  
5 coders or Physician Champions pre-populated the Problem Lists with “lucrative” diagnosis codes  
6 and had the Problem Lists auto-flag these codes with “a red pushpin icon” that served as a “visual  
7 reminder” for physicians to examine patients with those codes in mind.<sup>85</sup> To document a diagnosis  
8 code, the physician needed only to electronically move the diagnosis code from the Problem List  
9 to the patient-encounter part of the patient’s electronic medical record.<sup>86</sup> Sometimes, disputes  
10 arose over the pre-population of the Problem Lists. An example is when physicians or PAMF  
11 employees did not believe that patient diagnoses qualified as “chronic” (a label that permits the  
12 addition of risk-adjusting diagnosis codes and increases the amount that CMS pays), and  
13 management disagreed and often “err[ed] on the side of including the [diagnoses] as chronic.”<sup>87</sup>

14 In early 2013, Dr. Jeffrey Brown (PAMF’s Associate Director for Managed Care) sent letters  
15 to physicians with more than 20 Medicare Advantage patients “asking those with higher than  
16 PAMF average HCC scores what they thought helped them in HCC coding and ask[ing] those  
17 with lower than PAMF average scores what the barriers to HCC coding were.”<sup>88</sup> Dr. Brown  
18 compiled the results in a survey distributed in March 2013 to Sutter and PAMF executives,  
19 including Julie Cheung (Sutter’s RAF Program Manager), Nancy McGinnis (Sutter’s RAF  
20 Director), Roger Larsen (PAMF’s Chief Financial Officer and a Sutter Regional Vice President of  
21 Finance), Suzy Cliff (PAMF’s Vice President of Revenue Cycle), and Kris Anne Crow (PAMF’s  
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24 <sup>83</sup> *Id.* (¶ 51).

25 <sup>84</sup> *Id.*

26 <sup>85</sup> *Id.*

27 <sup>86</sup> *Id.*

28 <sup>87</sup> *Id.* at 19 (¶ 51) (brackets in complaint), 32 (¶ 93).

<sup>88</sup> *Id.* at 20 (¶ 53) (brackets in complaint).

1 Director of Coding and Education).<sup>89</sup> The survey found that for the above-average-coding  
 2 physicians, auto-flagging of diagnosis codes in the Problem Lists and the HCC/RAF cheat sheets  
 3 (called the “HCC code tip sheet” in the survey) especially helped increase coding.<sup>90</sup> By contrast,  
 4 the below-average-coding physicians focused on patient care and treatment rather than on coding  
 5 as exemplified by this statement: “I do not address longstanding stable or prior conditions when  
 6 that is not important to the care being delivered at the moment.”<sup>91</sup> In the survey, Dr. Brown  
 7 classified that statement as among the “Barriers to Better Coding.”<sup>92</sup>

8 Using data mining, Sutter and PAMF “pushed” their physicians through messages in the  
 9 electronic medical record to find and refresh especially high-paying risk-adjusting diagnosis codes  
 10 to increase patients’ risk scores.<sup>93</sup> Similarly, PAMF physicians received “queries” in the electronic  
 11 medical record from coders reminding the physicians to ensure that all such diagnosis codes were  
 12 captured.<sup>94</sup> Numerous physicians disliked this practice and felt “pressured” to add diagnosis codes  
 13 that they did not believe to be clinically accurate or relevant.<sup>95</sup> Furthermore, PAMF coders met  
 14 one-on-one with physicians to discuss their diagnosis coding.<sup>96</sup> During these meetings, the  
 15 auditors at times encouraged the physicians to add addendums to their patient records to add risk-  
 16 adjusting diagnosis codes.<sup>97</sup> (An addendum to a medical record is a note drafted by a physician or  
 17 other medical professional that clarifies or amends a previous note made by the same professional,  
 18 typically within 30 days of the encounter.<sup>98</sup>) At least two doctors, Dr. Williams and Dr. Wong,  
 19 were prompted to add addendums to records from a prior year and thought that it was unethical to  
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21 <sup>89</sup> *Id.*

22 <sup>90</sup> *Id.*

23 <sup>91</sup> *Id.*

24 <sup>92</sup> *Id.*

25 <sup>93</sup> *Id.* (¶ 54).

26 <sup>94</sup> *Id.*

27 <sup>95</sup> *Id.*

28 <sup>96</sup> *Id.*

<sup>97</sup> *Id.*

<sup>98</sup> *Id.* at 20–21 (¶ 54).

1 add addendums to old face-to-face encounters.<sup>99</sup> The coders also laid out a plan to address with  
 2 PAMF physicians other risk-adjusting diagnosis codes that were viewed as “high potential missed  
 3 opportunity [to] increase RAF score,” including for major depression, cachexia, protein-calorie  
 4 malnutrition, morbid obesity, and chronic obstructive pulmonary disease.<sup>100</sup>

5 In August 2013, physicians in PAMF’s network began receiving “daily alert” forms for the  
 6 MA Plan patients on each physician’s schedule that day.<sup>101</sup> The daily alerts identified “what HCC  
 7 codes have not yet been captured this year for the patient[s].”<sup>102</sup> Those codes included not just  
 8 previously diagnosed conditions but also conditions that data-mining software, using an algorithm,  
 9 “suspect[ed]” the patient might have.<sup>103</sup> “[T]he focus of the daily alerts was on pressuring  
 10 physicians to increase RAF scores rather than on improving coding accuracy or meeting the  
 11 clinical needs of patients.”<sup>104</sup>

12 In addition to the daily alerts, each physician received a weekly list of MA Plan patients  
 13 scheduled for appointments that week and a monthly report of MA Plan patients needing to  
 14 schedule “Medicare Wellness Exams” by year’s end.<sup>105</sup> The purpose of the forms was to “aid in  
 15 your capturing of chronic conditions.”<sup>106</sup> In response, physicians raised concerns about this  
 16 pressure and asked that the messages from RAF coders be “nicer.”<sup>107</sup> Multiple physicians  
 17 complained to Dr. Graham Dresden (a PAMF Physician Champion) about the “harshness of the  
 18 messages” on the daily alerts and about how “they were offended by the messages and . . . felt like  
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22 <sup>99</sup> *Id.* at 21 (¶ 54).

23 <sup>100</sup> *Id.* (first brackets in complaint).

24 <sup>101</sup> *Id.* (¶ 55).

25 <sup>102</sup> *Id.*

26 <sup>103</sup> *Id.*

27 <sup>104</sup> *Id.*

28 <sup>105</sup> *Id.* (¶ 56).

<sup>106</sup> *Id.*

<sup>107</sup> *Id.*

1 the message was either confusing, fraudulent, excessive, etc.”<sup>108</sup> Dr. Dresden relayed this  
2 complaint to PAMF management.<sup>109</sup>

3 Also by August 2013, PAMF executives, including Suzy Cliff (PAMF’s Vice President of  
4 Revenue Cycle) and Dr. Veko Vahamaki (PAMF’s Lead RAF Physician Champion), received  
5 these daily alerts, the weekly lists, and the monthly reports in order to interact with and, if  
6 necessary, pressure PAMF physicians to increase diagnosis coding during the MA patient  
7 encounters.<sup>110</sup> One approach was that a coder would review a physician’s documentation after a  
8 patient encounter and identify any overlooked risk-adjusting diagnosis codes.<sup>111</sup> The coder would  
9 tell the physician to confirm that the codes should be added to the patient’s medical record.<sup>112</sup> For  
10 example, in August 2013, Dr. Vahamaki developed “Dr. V’s PCP [primary care physician] Audit  
11 Letter Template” to send to physicians with the message that “[t]he diagnostic coding team has  
12 added this code to your visit as an addendum . . . Please email back to confirm that this patient has  
13 this diagnosis.”<sup>113</sup>

#### 14 **3.1.4 Pre-populating patient medical records with diagnosis codes**

15 Over time, Sutter and PAMF began to pre-populate medical records of physician-patient  
16 encounters with risk-adjusting diagnosis codes before physicians saw their patients.<sup>114</sup> Sutter and  
17 PAMF pre-populated these codes regardless of the health conditions that the physicians managed,  
18 evaluated, assessed, or treated during their actual patient encounters.<sup>115</sup>

19 Physicians expressed concern that risk-adjusting diagnoses appeared in patient medical records  
20 before they saw their patients.<sup>116</sup> For example, Dr. Thomas Deetz told a PAMF auditor that “pre-

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21  
22 <sup>108</sup> *Id.* at 34 (¶ 96) (ellipsis in complaint).

23 <sup>109</sup> *Id.*

24 <sup>110</sup> *Id.* at 21 (¶ 57).

25 <sup>111</sup> *Id.*

26 <sup>112</sup> *Id.*

27 <sup>113</sup> *Id.* (ellipsis and first brackets in complaint).

28 <sup>114</sup> *Id.* at 19 (¶ 52).

<sup>115</sup> *Id.* at 19–20 (¶ 52).

<sup>116</sup> *Id.* at 19 (¶ 52).

1 populating diagnoses into his visit encounter is possibly fraud . . . Does CMS know about what  
 2 you all are doing?”<sup>117</sup> Physicians also expressed concern that they did not know how to delete  
 3 incorrect diagnoses from their patients’ documentation.<sup>118</sup> For example, Dr. Lisa Gervin told a  
 4 PAMF auditor that she did not know how to delete an incorrect diagnosis code that a coder entered  
 5 after her visit with a patient.<sup>119</sup>

### 6 **3.1.5 Adding diagnosis codes as addendums to patient medical records**

7 Sutter and PAMF used data mining to identify and send messages to physicians to find and  
 8 refresh high-paying risk-adjusting diagnosis codes.<sup>120</sup> Similarly, coders sent “queries” to remind  
 9 physicians to ensure that all diagnosis codes were captured.<sup>121</sup> Numerous physicians disliked this  
 10 practice and felt “pressured” to add diagnosis codes that they did not believe were clinically  
 11 accurate or relevant.<sup>122</sup> For example, Dr. Joann Falkenburg expressed discomfort several times to  
 12 Physician Champions Drs. Lin and Vahamaki, including (1) “I got two new HCC [daily] alerts  
 13 today and have concerns about both of them,” (2) “they [coders] suggested [a patient] get  
 14 diagnosed with COPD [asthma] based on a diagnosis in UC a year and a half ago . . . I don’t feel it  
 15 is legitimate to code this,” (3) “with my patient on hospice, there is something that seems  
 16 unseemly about pursuing a new diagnosis of PVD [pulmonary vascular disease] when she has  
 17 weeks to live,” (4) “it makes me feel a little fraudulent to be considering it,” and (5) “I try to be  
 18 pretty legitimate about how I diagnose, document and chart and want to avoid any possibility that  
 19 it looks like I am working someone up just for the financial upside.”<sup>123</sup>

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24 <sup>117</sup> *Id.* at 34 (¶ 96) (ellipsis in complaint).

25 <sup>118</sup> *Id.* at 20 (¶ 52).

26 <sup>119</sup> *Id.* at 34 (¶ 96).

27 <sup>120</sup> *Id.* at 20 (¶ 54).

28 <sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.* at 33 (¶ 96) (brackets and ellipsis in complaint).





1 and Humana contractually require Sutter and its affiliates, including PAMF, to participate and  
2 cooperate in medical-chart reviews and audits.<sup>132</sup>

3 In October 2012, UnitedHealth conducted an audit focusing on so-called “outlier” risk-  
4 adjusting diagnosis codes that certain medical providers submitted much more frequently than the  
5 industry average among other large providers.<sup>133</sup> UnitedHealth identified that Sutter and PAMF  
6 were outliers with respect to diagnosis codes mapping to the HCC model’s code for heart attack  
7 (HCC 82).<sup>134</sup> UnitedHealth reviewed the underlying medical charts and found that 27 of 30 of the  
8 patient records (90%) containing heart-attack diagnosis codes were erroneous, invalid,  
9 unsupported, or otherwise false.<sup>135</sup> UnitedHealth conducted a subsequent audit and found that six  
10 of seven patient records (86%) containing heart-attack diagnosis codes similarly were false.<sup>136</sup>

11 At a December 2012 “PAMF Coding and Compliance Committee” meeting that included  
12 Roger Larsen (PAMF’s Chief Financial Officer and a Sutter Regional Vice President of Finance),  
13 Dr. Jeffrey Brown (PAMF’s Associate Director for Managed Care), and Kris Anne Crow  
14 (PAMF’s Director of Coding and Education), Mr. Larsen said that deleting unsupported codes in  
15 patient medical records based on the October 2012 audit results would have a “negative impact to  
16 our reimbursement.”<sup>137</sup> The Coding and Compliance Committee decided not to perform any  
17 follow-up audits to determine whether other medical records similarly contained false diagnosis  
18 codes.<sup>138</sup> At the December 2012 meeting, Ms. Crow said that Sutter’s and PAMF’s coding  
19 department “presently does not have the bandwidth to support such an effort [to perform follow-  
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23 <sup>132</sup> Gov’t Compl. – ECF No. 41 at 22 (¶ 59).

24 <sup>133</sup> *Id.* (¶¶ 59–60).

25 <sup>134</sup> *Id.* (¶ 60).

26 <sup>135</sup> *Id.*

27 <sup>136</sup> *Id.*

27 <sup>137</sup> *Id.* at 23 (¶ 61).

28 <sup>138</sup> *Id.*

1 up audits].”<sup>139</sup> Sutter and PAMF did not assign any coders or auditors to perform follow-up  
2 audits.<sup>140</sup>

3 In or shortly after April 2014, UnitedHealth and Health Net hired a consultant to review dates  
4 of service in 2012 and 2013.<sup>141</sup> The review identified over 8,000 false diagnosis codes for MA  
5 Plan patients that Sutter and its affiliates needed to delete based on “overcod[ing]” and diagnoses  
6 “not supported in documentation.”<sup>142</sup> Sutter and PAMF executives learned of these results but did  
7 not direct any auditors to take remedial action to identify other false diagnosis codes.<sup>143</sup>

8 UnitedHealth conducted additional audits for heart-attack diagnosis codes for dates of service  
9 in 2013, 2014, and 2015.<sup>144</sup> At one PAMF location (Camino), UnitedHealth found that 28 of 30  
10 patient records (93%) containing heart-attack diagnosis codes were erroneous, invalid,  
11 unsupported, or otherwise false.<sup>145</sup> At another PAMF location (Mills-Peninsula), UnitedHealth  
12 found that three of four patient records (75%) containing heart-attack diagnosis codes were  
13 erroneous, invalid, unsupported, or otherwise false.<sup>146</sup> Sutter and PAMF deleted the specific  
14 diagnosis codes that UnitedHealth’s audits identified but refused to expand auditing of diagnosis  
15 codes (either of heart-attack diagnosis codes specifically or other risk-adjusting diagnosis codes  
16 more generally) beyond the specific codes that UnitedHealth reviewed.<sup>147</sup>

### 17 **3.2.2 Lack of compliance and training programs**

18 The government alleges that:

19 Sutter and PAMF lacked any effective compliance or training program related to  
20 diagnostic coding for its Medicare Part C program. While there was a PAMF

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21  
22 <sup>139</sup> *Id.* (brackets in complaint).

23 <sup>140</sup> *Id.*

24 <sup>141</sup> *Id.* at 28 (¶ 78).

25 <sup>142</sup> *Id.* (brackets in complaint).

26 <sup>143</sup> *Id.*

27 <sup>144</sup> *Id.* at 23 (¶ 62).

28 <sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.*

1 coding and compliance committee, as noted above its members focused primarily  
2 on Sutter's RAF Campaign and little on audits examining the validity of the coding  
or other compliance efforts.<sup>148</sup>

3 In March 2013, Kris Anne Crow (PAMF's Director of Coding and Education) told Katie  
4 Borgstrom (PAMF's Interim Chief Operating Officer) that one of PAMF's divisions, Mills-  
5 Peninsula, "has never been audited and we have no idea what is going on there."<sup>149</sup> Ms. Crow said  
6 that PAMF's coding and training group "had no credibility" with physicians and that  
7 "[h]istorically, the coding department has had no structure, no policies and really no accountability  
8 in terms of education provided and timely feedback" to the physicians in PAMF's network.<sup>150</sup> Ms.  
9 Crow discussed these problems with Richard Slavin (PAMF's Chief Executive Officer), who  
10 agreed that PAMF must improve in these areas.<sup>151</sup>

11 On May 6, 2013, Sutter hired relator Kathy Ormsby as PAMF's Risk-Adjustment Project  
12 Manager.<sup>152</sup> In this position, Ms. Ormsby served as "the primary liaison between [the] coding,  
13 revenue cycle, quality & clinical departments with regards to the Medicare Advantage RAF/HCC  
14 coding initiative."<sup>153</sup> Ms. Ormsby initially reported to Ms. Crow and at times to Suzy Cliff  
15 (PAMF's Vice President of Revenue Cycle).<sup>154</sup>

16 Ms. Ormsby previously had earned a coding certification from the American Academy of  
17 Professional Coders.<sup>155</sup> Ms. Ormsby also had experience with HCC codes, risk-adjusting diagnosis  
18 codes, diagnosis-coding standards, and Medicare Advantage compliance and training through her  
19 previous six-year employment at an MA Organization, where her responsibilities included training  
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23 <sup>148</sup> *Id.* (¶ 63).

24 <sup>149</sup> *Id.* at 23–24 (¶ 64).

25 <sup>150</sup> *Id.* at 24 (¶ 64).

26 <sup>151</sup> *Id.*

27 <sup>152</sup> *Id.* (¶ 65).

28 <sup>153</sup> *Id.* (brackets in complaint).

<sup>154</sup> *Id.*

<sup>155</sup> *Id.* (¶ 66).

1 physicians on accurate coding, supervising risk-adjustment auditors, and helping to ensure  
2 compliance with Medicare rules and regulations relating to the Medicare Advantage program.<sup>156</sup>

3 Within her first few days on the job, Ms. Ormsby became aware that PAMF lacked a coding  
4 compliance or training program relating to Medicare Advantage.<sup>157</sup> As she explained, “I was sent  
5 to a cube with nothing in it but an empty desk,” “with absolutely no support, tools or guidance.”<sup>158</sup>  
6 Ms. Crow (Ms. Ormsby’s supervisor) acknowledged that PAMF had no coding compliance or  
7 training program when Ms. Ormsby started at PAMF.<sup>159</sup>

8 Ms. Ormsby realized that the same problems existed systemwide at Sutter: there were no  
9 Sutter coding compliance manuals or training guides on diagnosis coding for physicians.<sup>160</sup> Ms.  
10 Ormsby discussed the situation with Julie Cheung (Sutter’s RAF Program Manager), who  
11 confirmed that Sutter had no compliance program regarding risk-adjustment diagnosis coding.<sup>161</sup>

### 12 **3.2.3 Internal reviews and audits by Sutter and PAMF**

13 Concerned about the lack of coding compliance and training, Ms. Ormsby personally  
14 conducted, within a few weeks of her hiring, a random diagnosis-coding audit of 42 patient  
15 encounters at PAMF occurring in the first two quarters of 2013.<sup>162</sup> (The type of audit that Ms.  
16 Ormsby conducted was an “Encounter Audit” that evaluates one physician-patient encounter in a  
17 given year.<sup>163</sup> Encounter Audits are useful to establish a baseline for coding accuracy.<sup>164</sup> An  
18 Encounter Audit alone does not determine the extent of overpayments from CMS.<sup>165</sup>)

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21 <sup>156</sup> *Id.*

22 <sup>157</sup> *Id.* (¶ 67).

23 <sup>158</sup> *Id.*

24 <sup>159</sup> *Id.*

25 <sup>160</sup> *Id.* (¶ 68).

26 <sup>161</sup> *Id.*

27 <sup>162</sup> *Id.* at 26 (¶ 71).

28 <sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

1 Ms. Ormsby completed this audit in early June 2013.<sup>166</sup> Ms. Ormsby found that 53 of 62 risk-  
2 adjustment diagnosis codes (85%) from these patient encounters were false.<sup>167</sup> Sutter and PAMF  
3 had submitted all of these codes for reimbursement, which raised the prospect of overpayments  
4 from CMS with respect to these patients.<sup>168</sup>

5 One month later, in July 2013, UnitedHealth sent Nancy McGinnis (Sutter’s RAF Director) a  
6 letter “identif[ying] your practice as having submitted one or more HCCs at significantly higher  
7 rates than your peers,” requesting supporting documentation, and noting UnitedHealth’s  
8 engagement of a consulting firm to conduct a medical-chart review.<sup>169</sup> Julie Cheung (Sutter’s RAF  
9 Program Manager) forwarded the letter to Ms. Ormsby, among others.<sup>170</sup> Ms. Ormsby responded  
10 to Sutter and PAMF executives that the letter “identifies [PAMF] as having some red flags and I  
11 want us to be compliant.”<sup>171</sup> Ms. Ormsby began lobbying for auditing support, saying that “[w]e  
12 really need to get on the ball with our potential HCC auditor[s].”<sup>172</sup>

13 In light of her audit results, in August 2013, Ms. Ormsby created a “Corrective Action  
14 Plan.”<sup>173</sup> Her Plan called for hiring certified coders to perform audits and developing a compliance  
15 and training program to improve coding accuracy.<sup>174</sup> Ms. Ormsby cited the 85% diagnosis-coding  
16 failure rate in her June 2013 audit and identified the “root cause” as PAMF’s ineffective  
17 compliance and training.<sup>175</sup> Her Plan explained that the June 2013 audit “confirmed that proper  
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21 <sup>166</sup> *Id.* (¶ 72).

22 <sup>167</sup> *Id.*

23 <sup>168</sup> *Id.*

24 <sup>169</sup> *Id.* (¶ 73).

25 <sup>170</sup> *Id.*

26 <sup>171</sup> *Id.* (brackets in complaint).

27 <sup>172</sup> *Id.* (brackets in complaint).

28 <sup>173</sup> *Id.* (¶ 74).

<sup>174</sup> *Id.*

<sup>175</sup> *Id.*

1 instruction for documentation requirements had not been communicated clearly to providers” and  
2 that PAMF “currently lacks a clearly defined procedure for auditing and provider feedback.”<sup>176</sup>

3 Ms. Ormsby’s Plan called for two types of audits: (1) “Encounter Audits” and (2) “FOCUS  
4 Audits” that examine the error rates of several key HCCs (cancer, stroke, and fractures) that Ms.  
5 Ormsby understood from her prior experience are often miscoded and result in higher CMS  
6 payments.<sup>177</sup> (Unlike Encounter Audits, FOCUS Audits examine diagnosis codes in PAMF patient  
7 medical records covering an entire calendar year and thus could be used in determining  
8 overpayments from CMS.<sup>178</sup>)

9 Ms. Ormsby gave Ms. Crow (her supervisor) a copy of her Plan.<sup>179</sup> PAMF management above  
10 Ms. Crow approved the hiring of five certified coders to work as auditors.<sup>180</sup> But PAMF  
11 management viewed audits as a tool to increase diagnosis coding— i.e., to submit more risk-  
12 adjusting diagnosis codes to CMS — rather than a tool for compliance.<sup>181</sup>

13 In January 2014, Dr. Anita Gupta (a PAMF Physician Champion) identified “thousands” of  
14 “old, outdated and incorrect” diagnoses on the Problem Lists that place “[us] at risk of incorrectly  
15 coding them in a given year.”<sup>182</sup> Ms. Ormsby, Ms. Crow, and other PAMF executives, including  
16 Dr. Veko Vahamaki (PAMF’s Lead RAF Physician Champion) and Drs. Amy Lin, Graham  
17 Dresden, Anita Gupta, and Susan Schaefer (PAMF’s remaining Physician Champions), all learned  
18 of this problem.<sup>183</sup>

19 By April 2014, Ms. Ormsby identified 185 risk-adjusting diagnosis codes that had been  
20 “incorrectly captured by providers and submitted for reimbursement” in the first quarter of  
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23 <sup>176</sup> *Id.* at 26–27 (¶ 74).

24 <sup>177</sup> *Id.* at 27 (¶ 75).

25 <sup>178</sup> *Id.*

26 <sup>179</sup> *Id.*

27 <sup>180</sup> *Id.*

28 <sup>181</sup> *Id.*

<sup>182</sup> *Id.* (¶ 76) (brackets in complaint).

<sup>183</sup> *Id.*

1 2013.<sup>184</sup> Ms. Ormsby proposed to Ms. Crow and Ms. Cliff that they hire five more full-time coders  
 2 to augment her team, explaining that with these additional coders, “[d]ocumentation across all of  
 3 PAMF would be better supported to reach the requirements identified by CMS (Center for  
 4 Medicare and Medicaid Services) and show a marked increase in compliance.”<sup>185</sup> Shortly after  
 5 Ms. Ormsby made this proposal, Sutter and PAMF executives learned that the audit conducted by  
 6 UnitedHealth’s and Health Net’s consultant (described above) had identified over 8,000 false  
 7 diagnosis codes that Sutter and its affiliates needed to delete based on “overcod[ing]” and  
 8 diagnoses “not supported in documentation.”<sup>186</sup>

9 On June 3, 2014, Ms. Ormsby informed PAMF management that the preliminary results of her  
 10 2013 Encounter Audits found 1,082 false risk-adjusting diagnosis codes in 2,226 patient  
 11 encounters audited.<sup>187</sup>

12 A few weeks later, on June 27, 2014, Ms. Ormsby informed Ms. Crow that the Physician  
 13 Champions “have been training our providers on aortic atherosclerosis and morbid obesity  
 14 incorrectly.”<sup>188</sup> Ms. Ormsby suggested an audit to uncover the extent of the problem.<sup>189</sup> PAMF did  
 15 not authorize any audit.<sup>190</sup>

16 In late July 2014, Ms. Ormsby identified (to PAMF management) false diagnosis codes  
 17 relating to a specific Medicare Advantage beneficiary (identified as “Patient A”) dating back to  
 18 2010.<sup>191</sup> In 2010, PAMF had submitted a risk-adjusting diagnosis code for prostate cancer for  
 19 Patient A.<sup>192</sup> UnitedHealth asked for medical records that supported that diagnosis code.<sup>193</sup> Ms.

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21 <sup>184</sup> *Id.* (¶ 77).

22 <sup>185</sup> *Id.* (brackets in complaint).

23 <sup>186</sup> *See supra* notes 141–143.

24 <sup>187</sup> Gov’t Compl. – ECF No. 41 at 28 (¶ 79).

25 <sup>188</sup> *Id.* (¶ 80).

26 <sup>189</sup> *Id.*

27 <sup>190</sup> *Id.*

28 <sup>191</sup> *Id.* (¶ 81).

<sup>192</sup> *Id.*

<sup>193</sup> *Id.*

1 Ormsby pulled Patient A’s medical records and found nothing in them to support the prostate-  
 2 cancer code for 2010.<sup>194</sup> Ms. Ormsby gave Patient A’s medical records to UnitedHealth and  
 3 brought the issue to the attention of Ms. Crow (her supervisor) and Ms. Cheung (Sutter’s RAF  
 4 Program Manager).<sup>195</sup> Ms. Crow asked Ms. Ormsby to calculate the potential reimbursements to  
 5 CMS from the false coding related to Patient A, in light of UnitedHealth’s understanding that  
 6 CMS took the position that “if one HCC failed in audit, [CMS] could assume that for every patient  
 7 in the plan that submitted the same HCC, [CMS] can ask for the payment back.”<sup>196</sup> Ms. Ormsby  
 8 identified 484 codes for prostate cancer submitted for payment in 2010 and estimated the potential  
 9 reimbursement at \$1.936 million, which she said was “probably low.”<sup>197</sup> Ms. Cheung reprimanded  
 10 Ms. Ormsby for giving Patient A’s medical records to UnitedHealth and told her to never do that  
 11 again and instead to send patient medical records to her.<sup>198</sup>

12 In July 2014, Ms. Ormsby performed another Encounter Audit like the one she conducted in  
 13 June 2013.<sup>199</sup> Ms. Ormsby reviewed 20 physician-patient encounters covering March 2013.<sup>200</sup> She  
 14 found false risk-adjusting diagnosis codes in 18 of 20 encounters (90%).<sup>201</sup>

15 Throughout 2014, Ms. Ormsby circulated to Sutter and PAMF management — including  
 16 Roger Larsen (PAMF’s Chief Financial Officer and a Sutter Regional Vice President of Finance),  
 17 Suzy Cliff (PAMF’s Vice President of Revenue Cycle), and Ms. Cheung — a “RAF Dashboard”  
 18 summarizing various data metrics, including (1) Sutter’s and PAMF’s Medicare Advantage patient  
 19 population and how their average risk scores compared to state and national benchmarks, (2) a  
 20 “prevalence” rate identifying the percentage of MA Plan patients assigned certain lucrative  
 21 diagnosis codes, and (3) the “HCC Recapture Rate” and “HCC Score Comparison” designed to

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22  
 23 <sup>194</sup> *Id.*

24 <sup>195</sup> *Id.*

25 <sup>196</sup> *Id.* at 29 (¶ 82) (brackets in complaint).

26 <sup>197</sup> *Id.*

27 <sup>198</sup> *Id.* at 28 (¶ 81).

28 <sup>199</sup> *Id.* at 29 (¶ 83).

<sup>200</sup> *Id.*

<sup>201</sup> *Id.*



1 track the performance of “acuity capture and reporting” by PAMF physicians.<sup>202</sup> The RAF  
 2 Dashboard detailed hundreds of erroneous, invalid, unsupported, or otherwise false diagnosis  
 3 codes identified during Ms. Ormsby’s Encounter and FOCUS Audits.<sup>203</sup>

4 In December 2014, Ms. Ormsby and her audit team memorialized the final tally of the 2013  
 5 FOCUS Audit of risk-adjusting diagnosis codes for cancer, stroke, and fracture.<sup>204</sup> For cancer, 164  
 6 of 182 patient records (90%) were erroneous, invalid, unsupported, or otherwise false.<sup>205</sup> For  
 7 stroke, 162 of 169 patient records (96%) were erroneous, invalid, unsupported, or otherwise  
 8 false.<sup>206</sup> For fracture, 57 of 86 patient records (66%) were erroneous, invalid, unsupported, or  
 9 otherwise false.<sup>207</sup>

10 On December 16, 2014, Ms. Ormsby met with Marcella Alaniz (a PAMF Compliance  
 11 Analyst) to discuss the results of the 2013 FOCUS Audit.<sup>208</sup> Ms. Ormsby also discussed the results  
 12 with Jessica Driver-Zuniga (Sutter’s lead RAF/HCC coder).<sup>209</sup> Three days later, on December 19,  
 13 2014, Ms. Ormsby widely distributed the results of the 2013 FOCUS audit to PAMF senior  
 14 management, flagging the failure rates of 90% for cancer, 96% for stroke, and 64% for fracture.<sup>210</sup>

15 Also on December 19, 2014, Ms. Ormsby notified PAMF senior management that there were  
 16 additional false risk-adjusting diagnosis codes that had been submitted to CMS and that required  
 17 returning overpayments to CMS.<sup>211</sup> Ms. Ormsby wrote, “[w]e have identified 94 encounters that  
 18 have been submitted to CMS without supporting documentation for HCC conditions billed” from  
 19

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20  
 21 <sup>202</sup> *Id.* at 15 (¶ 40), 30 (¶ 88).

22 <sup>203</sup> *Id.* at 30 (¶ 88).

23 <sup>204</sup> *Id.* at 29 (¶ 84).

24 <sup>205</sup> *Id.*

25 <sup>206</sup> *Id.*

26 <sup>207</sup> *Id.*

27 <sup>208</sup> *Id.* (¶ 85).

28 <sup>209</sup> *Id.* at 29–30 (¶ 85).

<sup>210</sup> *Id.* at 30 (¶ 86). While 57 of 86 is approximately 66%, the complaint alleges that Ms. Ormsby  
 flagged for PAMF senior management a failure rate for fracture of 64%. *Id.*

<sup>211</sup> *Id.*

1 PAMF physicians and that she “expect[ed] this number to increase daily until a resolution can be  
2 implemented.”<sup>212</sup>

3 The 2013 FOCUS Audit further showed that over 3,500 physician-patient encounters from  
4 2013 remained unreviewed.<sup>213</sup> Ms. Ormsby identified the 2013 FOCUS Audit as a high-priority  
5 compliance issue that encompassed over 7,500 physician-patient encounters in one year of  
6 service.<sup>214</sup> Ms. Ormsby’s auditing team had the capacity to review only a small percentage of the  
7 physician-patient encounters with cancer, stroke, or fracture diagnosis codes for dates of service in  
8 2013.<sup>215</sup> Ms. Ormsby raised (in writing to Ms. Cliff) her concern that no other dates of service had  
9 been reviewed.<sup>216</sup>

10 In early January 2015, Ms. Ormsby raised with Sutter and PAMF management, including  
11 Mses. Cheung and Cliff, an issue concerning “misleading labels” for stroke in Sutter’s electronic  
12 medical-record system.<sup>217</sup> Ms. Ormsby said (and attached a screenshot showing) that Sutter’s  
13 labels stated that various types of stroke were considered acute and carried an HCC label as long  
14 as the stroke took place within eight weeks of the physician-patient encounter.<sup>218</sup> Ms. Ormsby  
15 explained that this diagnosis code should not be captured after a patient is discharged from the  
16 hospital in an inpatient setting (much less eight weeks after discharge) and that “[t]he labels are  
17 causing providers to capture the incorrect ICD-9 [diagnosis] codes and we are being reimbursed  
18 inappropriately.”<sup>219</sup> Ms. Ormsby asked to remove the words “8 weeks” from the label.<sup>220</sup> Ms.  
19 Cheung responded that “[t]he Compliance Reimbursement Team hasn’t yet weighed in.”<sup>221</sup> Ms.

21 <sup>212</sup> *Id.* (second brackets in complaint).

22 <sup>213</sup> *Id.* (¶ 87).

23 <sup>214</sup> *Id.* (¶ 86).

24 <sup>215</sup> *Id.* (¶ 87).

25 <sup>216</sup> *Id.*

26 <sup>217</sup> *Id.* (¶ 89).

27 <sup>218</sup> *Id.*

28 <sup>219</sup> *Id.* at 30–31 (¶ 89) (first brackets in complaint).

<sup>220</sup> *Id.* at 31 (¶ 89).

<sup>221</sup> *Id.* (brackets in complaint).

1 Cheung stated that these misleading electronic medical-record labels were a systemwide problem  
 2 at all of Sutter’s affiliates, not just PAMF, and that a change in labeling “won’t be made for just  
 3 one organization.”<sup>222</sup>

4 On January 21, 2015, Ms. Ormsby met with Ms. Cliff, and on January 22, 2015, Ms. Ormsby  
 5 sent a follow-up email to PAMF management — including Ms. Cliff, Dr. Veko Vahamaki,  
 6 (PAMF’s Lead RAF Physician Champion), Debbie Troklus (PAMF’s Compliance Director),  
 7 Marcella Alaniz (a PAMF Compliance Analyst), and Dr. Criss Morikawa (a PAMF executive) —  
 8 “reiterat[ing her] concerns” regarding five key HCC-coding compliance problems:

- 9 1. Accuracy rates of cancer, fracture and stroke (2013 dates of service and  
 10 beyond);
- 11 2. Concerns regarding the payments received without supporting documentation  
 (60 day window);
- 12 3. Encounters by providers who are no longer at PAMF and have unsupported  
 13 HCC submissions;
- 14 4. Providers who are not responding to staff messages regarding specificity and  
 clarification for HCC’s submitted to CMS;
- 15 5. Discontinued use of the auditing billing notes/corrections to rectify unsupported  
 16 ICD-9 [diagnosis codes].<sup>223</sup>

17 Ms. Ormsby also notified management that the monthly electronic medical-record “sweeps” of  
 18 risk-adjusting diagnosis codes from physician-patient encounters would lead to Sutter’s and  
 19 PAMF’s submitting many false codes to the MA Organizations and then to CMS.<sup>224</sup> Jessica  
 20 Driver-Zuniga (Sutter’s lead RAF/HCC coder) acknowledged in a February 24, 2015 memo that  
 21 unsupported diagnosis codes that Sutter and PAMF knew were invalid were being “swept” into  
 22 their reimbursement system.<sup>225</sup>

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26 <sup>222</sup> *Id.*

27 <sup>223</sup> *Id.* at 39 (¶ 113).

28 <sup>224</sup> *Id.* at 39–40 (¶ 114).

<sup>225</sup> *Id.* at 40 (¶ 114).

1 In March 2015, Ms. Ormsby updated her Encounter and FOCUS Audit results.<sup>226</sup> The updated  
 2 2013 FOCUS Audit results showed Ms. Ormsby's and her auditing team's deletion of 1,001 false  
 3 diagnosis codes that had been submitted to CMS for reimbursement.<sup>227</sup> The 2013 and 2014  
 4 Encounter Audit results showed deletion of 777 false diagnosis codes in 2013 and 517 false  
 5 diagnosis codes in 2014.<sup>228</sup> Ms. Ormsby's new supervisor, Christian Gabriel (hired by Sutter and  
 6 PAMF in 2015<sup>229</sup>) reviewed Ms. Ormsby's data and asked Ms. Ormsby to calculate how much  
 7 CMS overpaid Sutter and PAMF for these false codes.<sup>230</sup> Ms. Ormsby estimated overpayments at  
 8 approximately \$4.2 million.<sup>231</sup> She explained that this likely was the tip of the iceberg: 3,844  
 9 physician-patient encounters remained unaudited for dates of service in 2013 alone, and thousands  
 10 of later physician-patient encounters were never audited.<sup>232</sup>

### 11 **3.3 Knowingly Ignoring Red Flags and Actual Notice of False Claims**

12 The government alleges that:

13 Sutter and PAMF management knew about the ineffective compliance and  
 14 training that would inevitably result in substantial false coding. They also knew  
 15 about the internal and external audits highlighting years of substantial false coding  
 16 at PAMF. Instead of addressing these problems, Sutter and PAMF management  
 17 continued to engage in the RAF Campaign and encouraged aggressive diagnosis  
 18 coding, resulting in the submission of false codes and inflated Medicare  
 19 reimbursements.

20 Before Ormsby's arrival at PAMF in May 2013, Sutter and PAMF management  
 21 recklessly disregarded and were deliberately indifferent to problems of false  
 22 diagnosis coding, with few attempts made to audit or otherwise identify such  
 23 problems even in the face of the high failure results of audits and chart reviews by  
 24 UHG [UnitedHealth], Peak [UnitedHealth's consultant] and Optum  
 25 [UnitedHealth's affiliate]. Indeed, the RAF Campaign itself, with the goal of

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26 <sup>226</sup> *Id.* at 31 (¶ 90).

27 <sup>227</sup> *Id.*

28 <sup>228</sup> *Id.*

<sup>229</sup> *Id.* at 25 (¶ 70), 31 (¶ 90), 40 (¶ 117).

<sup>230</sup> *Id.* at 31 (¶ 90).

<sup>231</sup> *Id.*

<sup>232</sup> *Id.*

1 increasing lucrative diagnosis coding, highlighted Sutter and PAMF’s focus on Part  
2 C profits over compliance. . . .

3 In addition to the frequent complaints from physicians, after Ormsby’s arrival  
4 Sutter and PAMF management received actual notice from Ormsby and her audit  
5 team about rampant false diagnosis coding and ineffective compliance and training.  
6 Initially, Sutter and PAMF management ignored her and continued the RAF  
7 Campaign unabated. However, as Ormsby and her auditing team deleted false  
8 diagnosis codes that mapped to HCCs and negatively impacted the reimbursement  
9 from CMS, Sutter and PAMF management took steps to impede her efforts and  
10 stop her ability to delete false codes.<sup>233</sup>

11 For example, on September 19, 2014, Ms. Ormsby attended a PAMF executive meeting with  
12 Roger Larsen (PAMF’s Chief Financial Officer and a Sutter Regional Vice President of Finance),  
13 Suzy Cliff (PAMF’s Vice President of Revenue Cycle), Dr. Veko Vahamaki (PAMF’s Lead RAF  
14 Physician Champion), and many others.<sup>234</sup> Ms. Ormsby delivered a PowerPoint presentation  
15 summarizing the results, to date, of the Encounter and FOCUS Audits.<sup>235</sup> The results identified  
16 6,082 false risk-adjusting diagnosis codes in 12,220 physician-patient encounters.<sup>236</sup> Ms. Ormsby  
17 made compliance and training recommendations at the meeting, including proposing “Diagnosis  
18 Champions” to work alongside the Physician Champions and to train physicians in PAMF’s  
19 network about proper coding and other compliance issues.<sup>237</sup> Several days after this meeting, Mr.  
20 Larsen wrote an email to Dr. Vahamaki, Ms. Cliff, and Dr. Michael Conroy (PAMF’s Chief  
21 Medical Officer) discussing increasing reimbursements from CMS.<sup>238</sup> Among other things, Mr.  
22 Larsen wrote, “We are now over a year into the HCC improvement effort [i.e., the formal RAF  
23 Campaign] and I see that we are making some limited progress but are behind where we could be  
24 and will likely not achieve more than a modest improvement if we continue as is. Given our  
25 existing efforts and the general mindset of the physicians[,] I predict we will achieve at most a

26 \_\_\_\_\_  
27 <sup>233</sup> *Id.* at 32 (¶¶ 91–92), 34 (¶ 97).

28 <sup>234</sup> *Id.* at 35 (¶ 103).

<sup>235</sup> *Id.*

<sup>236</sup> *Id.*

<sup>237</sup> *Id.* at 35–36 (¶ 103).

<sup>238</sup> *Id.* at 36 (¶ 104).

1 10% improvement” and that “I think we may need to ask the Board to reconsider implementing a  
2 physician compensation incentive along with a refocus on the other key parts of the plan to  
3 effectively change the PCP [primary-care physician] culture necessary for HCC success.”<sup>239</sup> Dr.  
4 Vahamaki forwarded Mr. Larsen’s email to Julie Cheung (Sutter’s RAF Program Manager) and  
5 Nancy McGinnis (Sutter’s RAF Director) and agreed with Mr. Larsen’s “strategic” focus on  
6 profits.<sup>240</sup> Dr. Vahamaki identified one barrier as Ms. Ormsby’s and the coding department’s focus  
7 on compliance.<sup>241</sup>

8 On October 15, 2014, Ms. Cliff wrote an email to Ms. Ormsby titled “HCC Coding  
9 Corrections” instructing Ms. Ormsby: “[p]er our conversation this morning, please remind your  
10 team to stop performing any charge corrections on accounts until we can map out the downstream  
11 [e]ffects.”<sup>242</sup>

12 On November 12, 2014, Dr. Criss Morikawa (a PAMF executive) distributed to PAMF  
13 management and Ms. Ormsby’s auditing team an email describing PAMF’s new policy  
14 prohibiting “submitting charge corrections to payors (esp. Medicare) more than 30 days after date  
15 of service.”<sup>243</sup> Dr. Edward Yu (PAMF’s Medical Director) asked, “What happens if the incorrect  
16 diagnosis code puts us at risk of [M]edicare fines for inaccurate coding?”<sup>244</sup> Dr. Morikawa  
17 responded that due to the “close to a million charge transactions” that PAMF submits every  
18 month, “it is not scalable to hold and review every encounter — even on say all [M]edicare.”<sup>245</sup>

19 On November 26, 2014, Ms. Ormsby attended a meeting with Marcella Alaniz and Jessica Lin  
20 (PAMF Compliance Analysts), among others.<sup>246</sup> Ms. Alaniz said that Ms. Ormsby lacked  
21 authority to delete false diagnosis codes from physician-patient encounters in the electronic  
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23 <sup>239</sup> *Id.* (first brackets in complaint).

24 <sup>240</sup> *Id.* at 36–37 (¶ 105).

25 <sup>241</sup> *Id.* at 37 (¶ 105).

26 <sup>242</sup> *Id.* (¶ 106) (brackets in complaint).

27 <sup>243</sup> *Id.* (¶ 107).

28 <sup>244</sup> *Id.* (brackets in complaint).

<sup>245</sup> *Id.* (brackets in complaint).

<sup>246</sup> *Id.* at 38 (¶ 108).

1 medical records that were submitted to MA Organizations and, in turn, to CMS.<sup>247</sup> Ms. Ormsby  
 2 tried to reverse the directive to stop her auditing team from deleting false diagnosis codes.<sup>248</sup> On  
 3 December 1, 2014, Ms. Ormsby warned PAMF management — including Ms. Alaniz, Ms. Cliff,  
 4 Dr. Morikawa, and Debbie Troklus (PAMF’s Compliance Director) — that “I don’t think this  
 5 recommendation is a compliant solution.”<sup>249</sup> The next day, on December 2, 2014, Ms. Ormsby  
 6 warned PAMF management about the importance to Medicare of proper diagnosis coding and  
 7 Medicare’s upcoming focus on coding compliance.<sup>250</sup> On December 10, 2014, Ms. Ormsby wrote  
 8 an email to Dr. Conroy, Dr. Vahamaki, and Ms. Cliff stating, “I am very concerned about the large  
 9 number of non-compliant chronic HCC conditions that have been submitted to the health plans for  
 10 reimbursement.”<sup>251</sup> Ms. Ormsby emphasized that MA Organizations would be auditing diagnosis  
 11 coding.<sup>252</sup> Ms. Ormsby also discussed her concerns about Sutter’s and PAMF’s requiring  
 12 physicians (as opposed to coders) to delete unsupported codes: she explained that, based on her  
 13 experience, most physicians will not delete unsupported codes due to time pressure and inattention  
 14 (and that some physicians had left PAMF and thus could not delete unsupported codes in any  
 15 event).<sup>253</sup> Ms. Cliff subsequently chastised Ms. Ormsby for escalating the issue to Dr. Conroy.<sup>254</sup>

16 Sutter and PAMF continued the RAF Campaign without implementing any of Ms. Ormsby’s  
 17 recommendations.<sup>255</sup> In December 2014, Dr. Susan Schaefer (Sutter’s Regional Physician  
 18 Champion for Diagnostic Coding) allegedly increased coding pressure on physicians because “as

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 21 <sup>247</sup> *Id.* More specifically, Ms. Ormsby had authority to make changes on the “billing side” of the  
 22 electronic medical record (which does not affect claims to or payments from CMS) but was told that  
 she did not have authority to delete diagnosis codes from the “encounter side” of the electronic record  
 (the “side” that is submitted to CMS for payment). *Id.*

23 <sup>248</sup> *Id.* (¶ 109).

24 <sup>249</sup> *Id.*

25 <sup>250</sup> *Id.*

26 <sup>251</sup> *Id.* (¶ 110).

27 <sup>252</sup> *Id.*

28 <sup>253</sup> *Id.*

<sup>254</sup> *Id.*

<sup>255</sup> *Id.* at 39 (¶ 111).



1 we approach end of year [we] are trying to maximize capture of HCC's.”<sup>256</sup> In another widely  
 2 distributed email in December 2014 discussing a coding issue, Dr. Schaefer wrote, “I am not  
 3 sending this to Kathy [Ormsby] as we know what happens.”<sup>257</sup>

4 As noted above, in February 2015, Sutter and PAMF hired a new supervisor, Christian  
 5 Gabriel, to oversee Ms. Ormsby.<sup>258</sup> Initially, Ms. Ormsby emphasized to Mr. Gabriel the  
 6 importance of coding-compliance issues.<sup>259</sup> Ms. Ormsby presented him with a recent CMS  
 7 presentation highlighting the importance of appropriate HCC coding and documentation and  
 8 identifying the Medicare rules that related to coding and documentation.<sup>260</sup> Ms. Ormsby also gave  
 9 Mr. Gabriel a self-assessment (relating to PAMF's MA Plan program) describing the need for  
 10 more auditors and compliance.<sup>261</sup>

11 When Ms. Ormsby tried to raise compliance issues, Mr. Gabriel told her to discuss any  
 12 “differences in private” with him rather than via emails that included the auditing team.<sup>262</sup> On  
 13 March 9, 2015, Mr. Gabriel issued a “verbal warning” to Ms. Ormsby based on misgivings that  
 14 Ms. Ormsby had expressed to him and her auditing team about the RAF Campaign.<sup>263</sup>

15 Mr. Gabriel told Ms. Ormsby that the audit “team, structure and process is my #1 focus,”  
 16 “[g]iven the lack of progress in improving our RAF/HCC scores.”<sup>264</sup> Similarly, at a “Strategy  
 17 Meeting” in mid-March 2015, Mr. Gabriel stressed that the new focus of Ms. Ormsby's auditing  
 18 was to “rais[e] the RAF score.”<sup>265</sup> A few days later, on March 18, 2015, Mr. Gabriel stressed this  
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21 <sup>256</sup> *Id.* (brackets in complaint).

22 <sup>257</sup> *Id.* (¶ 112).

23 <sup>258</sup> *See supra* note 229.

24 <sup>259</sup> Gov't Compl. – ECF No. 41 at 40 (¶ 117).

25 <sup>260</sup> *Id.*

26 <sup>261</sup> *Id.*

27 <sup>262</sup> *Id.* (¶ 118).

28 <sup>263</sup> *Id.*

<sup>264</sup> *Id.* (brackets in complaint).

<sup>265</sup> *Id.* at 41 (¶ 119).



1 new focus in a three-hour meeting (with the auditing team) that Ms. Ormsby could not attend.<sup>266</sup>  
 2 Mr. Gabriel wrote in a follow-up email to the auditing team that he had “dropped a ‘bomb’ on you  
 3 in terms of a new initiative . . . .”<sup>267</sup> Ellie Kamkar (Manager of Coding, Training, and Auditing at  
 4 PAMF) reported to Ms. Ormsby that Mr. Gabriel had directed the auditing team “to take off the  
 5 compliance hat and put on the revenue hat” based on directives from senior management.<sup>268</sup> Ms.  
 6 Kamkar also believed that Mr. Gabriel “was asking her to teach physicians how to up code.”<sup>269</sup>

7 A week later, on March 25, 2015, Mr. Gabriel had a meeting with Ms. Ormsby where he told  
 8 her that “[w]e need to audit to raise [RAF] score[s].”<sup>270</sup> Mr. Gabriel directed Ms. Ormsby and the  
 9 auditing team to conduct more data-mining audits that would “support leadership’s directives for  
 10 this year” for the RAF Campaign.<sup>271</sup> On March 26, 2015, Mr. Gabriel wrote an email to Ms.  
 11 Ormsby and the auditing team where he explained that the goal of the audits was to increase  
 12 Medicare reimbursement.<sup>272</sup> Mr. Gabriel identified “our overall goals” as:

- 13 • Identification of new HCC’s
- 14 • Decreasing the # of patients without HCC’s
- 15 • Maintain/improve HCC capture rate for 2015
- 16 • Improve RAF/HCC scores through several techniques
  - 17 ○ Data-mining for HCC pockets of opportunities
  - 18 ○ Focus on providers that have a large volume of HCC eligible patients and  
 19 target for review<sup>273</sup>

20 The audits targeted certain conditions (diabetes with manifestations, thrombocytopenia,  
 21 pulmonary vascular disease, chronic kidney disease, major depressive disorder, and pathological

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 23 <sup>266</sup> *Id.*

24 <sup>267</sup> *Id.* (ellipsis in complaint).

25 <sup>268</sup> *Id.*

26 <sup>269</sup> *Id.*

27 <sup>270</sup> *Id.* (¶ 120) (brackets in complaint).

28 <sup>271</sup> *Id.*

<sup>272</sup> *Id.*

<sup>273</sup> *Id.* (bullet points in original email).

1 fractures) that the government alleges are all “lucrative” risk-adjusting diagnosis codes that drive  
2 up the reimbursement amounts that CMS pays out.<sup>274</sup>

3 Mr. Gabriel thereafter instituted additional policies to increase RAF scores.<sup>275</sup> He required that  
4 — before physicians actually saw their patients — coders pre-populate patients’ medical records  
5 with risk-adjusting diagnosis codes that the coders suspected (but did not know) might be  
6 applicable to the patient.<sup>276</sup> Sutter’s and PAMF’s systems swept these pre-populated codes into the  
7 electronic medical record and submitted them through MA Organizations to CMS for payment  
8 unless the physician affirmatively deleted the codes.<sup>277</sup> (Sutter’s and PAMF’s policies prevented  
9 coders from deleting codes: only physicians could do so.<sup>278</sup>)

10 The government alleges that by prohibiting coders from deleting false risk-adjusting diagnosis  
11 codes and having coders add diagnosis codes that physicians had not reported or verified in the  
12 electronic medical record, Sutter and PAMF knowingly pursued policies designed to yield inflated  
13 reimbursements through the over-reporting of diagnosis codes.<sup>279</sup> At a March 27, 2015 strategy  
14 meeting involving Arvin Magusara (a Sutter Senior Analyst), Mr. Gabriel, and Ms. Ormsby, Julie  
15 Cheung (Sutter’s RAF Program Manager) stated that increasing MA Plan patient risk scores “had  
16 been a concern for several years” among the RAF Steering Committee, which included Dr. Jeffrey  
17 Burnich (a Sutter Senior Vice President and Executive Officer), Nancy McGinnis (Sutter’s RAF  
18 Director), Dr. Veko Vahamaki (PAMF’s Lead RAF Physician Champion), and Ms. Cheung.<sup>280</sup>  
19 Ms. Cheung said that false-coding problems remained and that “CMS is still receiving HCC’s that  
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22 <sup>274</sup> *Id.* at 41–42 (¶ 120).

23 <sup>275</sup> *Id.* at 42 (¶ 121).

24 <sup>276</sup> *Id.*

25 <sup>277</sup> *Id.*

26 <sup>278</sup> *Id.* As discussed above, coders could delete diagnosis codes from the “billing side” of the electronic  
27 medical records, but this would not prevent the codes from being swept to CMS for payment. *See*  
*supra* note 247; *accord* Gov’t Compl. – ECF No. 41 at 42 (¶ 121).

28 <sup>279</sup> Gov’t Compl. – ECF No. 41 at 42 (¶ 121).

<sup>280</sup> *Id.* (¶ 122).

1 we know are not correct.”<sup>281</sup> No follow-up discussions took place at the meeting, and no efforts  
2 were taken to correct this problem.<sup>282</sup>

3 Several days later, at a March 31, 2015 “Champions Meeting” that included Drs. Vahamaki,  
4 Graham Dresden, Anita Gupta, Amy Lin (PAMF’s Physician Champions), Mr. Gabriel, and Ms.  
5 Ormsby, Mr. Gabriel explained that each PAMF division had met the prior week and (according to  
6 the notes of the March 31 meeting) discussed “[h]ow both the physician and the auditor could  
7 work together to identify areas to increase the RAF scores for each division.”<sup>283</sup> During the  
8 meeting, Ms. Ormsby told management, “I want to go on the record saying that I do not agree with  
9 any auditor reviewing/auditing in search of reimbursement. I don’t believe that this is a compliant  
10 practice.”<sup>284</sup> Ms. Ormsby also complained about management stopping the Encounter and FOCUS  
11 Audits.<sup>285</sup> Mr. Gabriel “interrupted” her and said that (1) “we are not doing any encounter audits  
12 this year,” (2) PAMF’s compliance department (not the coding department) would focus on  
13 compliance, and (3) “[u]nfortunately our compliance department does not have the bandwidth to  
14 investigate compliance concerns” related to coding.<sup>286</sup>

15 On May 7, 2015, Ms. Ormsby left PAMF for another position.<sup>287</sup>

16 Sutter did not resume using internal auditing to find and delete erroneous, invalid,  
17 unsupported, or otherwise false diagnosis codes until the second quarter of 2016.<sup>288</sup> At that time,  
18 the Office of Patient Experience began an audit to attempt to establish an accuracy baseline for  
19 physician-patient encounters for dates of service in 2015 that resulted in diagnoses of stroke and  
20 heart attack.<sup>289</sup> The audit randomly selected a sample of Medicare Advantage beneficiaries from  
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22 <sup>281</sup> *Id.*

23 <sup>282</sup> *Id.*

24 <sup>283</sup> *Id.* at 42–43 (¶ 123) (brackets in complaint).

25 <sup>284</sup> *Id.* at 43 (¶ 123).

26 <sup>285</sup> *Id.*

27 <sup>286</sup> *Id.* (brackets in complaint).

28 <sup>287</sup> *Id.* at 7 (¶ 13).

<sup>288</sup> *Id.* at 43 (¶ 124).

<sup>289</sup> *Id.*

1 each Sutter affiliate, including PAMF, and reviewed patient encounters by primary-care  
 2 physicians and specialists.<sup>290</sup> The audit reviewed the medical records for 38 beneficiaries and  
 3 found that the accuracy rate at PAMF for heart-attack diagnosis codes was 39.29% and the  
 4 accuracy rate for stroke diagnosis codes was 22.22%.<sup>291</sup> The accuracy rate at PAMF, when  
 5 combined with the Mills Peninsula Division of PAMF and the Mills Peninsula Medical Group (a  
 6 provider affiliated with PAMF), for stroke diagnosis codes was 10.87%.<sup>292</sup> A similar review of  
 7 206 Medicare Advantage beneficiaries throughout Sutter system-wide showed that the accuracy  
 8 rate for heart-attack diagnosis codes was 53.7%, and the accuracy rate for stroke diagnosis codes  
 9 was 22.8%.<sup>293</sup>

10 Sutter and PAMF knew that they had to report and return overpayments to CMS.<sup>294</sup> Sutter’s  
 11 written policies stated, “**Overpayment Refund, 13-540 . . . POLICY[:]** Sutter Health and its  
 12 Affiliates will report and refund overpayments from state and federal health care programs within  
 13 60 days of identification, or the due date for any applicable reconciliation” and required that “[a]s  
 14 appropriate, Sutter Health and its affiliates will take remedial steps to prevent identified  
 15 overpayments from recurring.”<sup>295</sup> Sutter’s policy defined “**Overpayment**” to include “incorrect  
 16 code or modifier assignment resulting in a higher level of reimbursement, insufficient or lack of  
 17 documentation to support billed services[,] . . . lack of medical necessity, . . . or any other finding  
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24 <sup>290</sup> *Id.*

25 <sup>291</sup> *Id.*

26 <sup>292</sup> *Id.*

27 <sup>293</sup> *Id.*

28 <sup>294</sup> *Id.* at 15 (¶ 42).

<sup>295</sup> *Id.* at 15–16 (¶ 42) (emphasis in policy, brackets and ellipsis in complaint).

1 that reflects [that] an overpayment was received as a result of inaccurate or improper coding or  
2 reporting of healthcare items or services.”<sup>296</sup>

### 3 **3.4 Examples of False Diagnosis Codes and Estimate of Total Overpayments**

4 The government alleges:

5 During the period from January 2010 through December 31, 2016, Sutter and  
6 PAMF, through their unlawful conduct discussed . . . above, knowingly caused the  
7 submission of thousands of erroneous, invalid, unsupported or otherwise false risk-  
8 adjusting diagnosis codes to CMS for tens of thousands of Medicare Advantage  
9 beneficiaries at PAMF. The MA beneficiary population at PAMF Mills Peninsula  
tallied approximately 28,000 over those six years, while PAMF served  
approximately 74,000 MA beneficiaries during that period. These false claims  
inflated CMS’s reimbursements by tens of millions of dollars.

10 Sutter and PAMF knew that they were required to submit accurate diagnosis  
11 data to the MA Plans and delete erroneous, invalid, unsupported or otherwise false  
12 diagnoses. Sutter and PAMF were also on notice from Ormsby and her audit team,  
13 as well as from other audits and chart reviews, of thousands of such coding  
14 problems. Yet, Sutter and PAMF knowingly disregarded that information and  
failed to investigate the prevalence of this miscoding or delete these codes. Instead,  
they knowingly retained the resulting overpayments.<sup>297</sup>

15 The government cites ten examples of false claims that Sutter and PAMF submitted through  
16 MA Organizations to CMS:

- 17 1. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient A” for prostate  
18 cancer dating back to a physician-patient encounter in 2010.<sup>298</sup> Nothing in Patient A’s  
19 medical record supported the prostate-cancer code for that year.<sup>299</sup>
- 20 2. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient B” for  
21 “malignant neoplasm of thyroid gland” for a date of service in 2012.<sup>300</sup> Sutter’s and  
22 PAMF’s submission of this diagnosis code caused CMS to pay out more money for  
23

24  
25 <sup>296</sup> *Id.* at 16 (¶ 42) (emphasis in policy, ellipsis in complaint).

26 <sup>297</sup> *Id.* at 45–46 (¶¶ 131–32).

27 <sup>298</sup> *Id.* at 28 (¶ 81).

28 <sup>299</sup> *Id.*

<sup>300</sup> *Id.* at 46 (¶ 133).

1 Patient B’s Medicare Advantage coverage.<sup>301</sup> Patient B’s medical records show that  
2 this diagnosis code was false because (1) Patient B’s thyroid cancer was treated by  
3 thyroidectomy in 2007, (2) the cancer had not recurred, and (3) there was no evidence  
4 of treatment, evaluation, or management of thyroid cancer in 2012 in Patient B’s  
5 medical records.<sup>302</sup>

6 3. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient C” for  
7 “malignant melanoma of skin of scalp and neck” for a date of service in 2012.<sup>303</sup>  
8 Sutter’s and PAMF’s submission of this diagnosis code caused CMS to pay out more  
9 money for Patient C’s Medicare Advantage coverage.<sup>304</sup> Patient C’s medical records  
10 show that this diagnosis code was false because (1) Patient C had last been treated for  
11 malignant skin cancer in 2006 and (2) there was no evidence of treatment, evaluation,  
12 or management of skin cancer in 2012 in Patient C’s medical records.<sup>305</sup>

13 4. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient D” for stroke  
14 (specifically, “cerebral artery occlusion, unspecified, with cerebral infarction”) for a  
15 date of service in 2014.<sup>306</sup> Sutter’s and PAMF’s submission of this diagnosis code  
16 caused CMS to pay out more money for Patient D’s Medicare Advantage coverage.<sup>307</sup>  
17 Patient D’s medical records show that this diagnosis code was false because (1) Patient  
18 D’s past medical history reflected a cerebellar infarction, a transient rather than a  
19 chronic medical condition that does not map to any HCC code, (2) the cerebellar  
20 infarction took place in 1990 without further recurrence, and (3) no stroke or  
21 cerebrovascular-accident event was noted in 2014 in Patient D’s medical records.<sup>308</sup>

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22  
23 <sup>301</sup> *Id.*

24 <sup>302</sup> *Id.*

25 <sup>303</sup> *Id.*

26 <sup>304</sup> *Id.*

27 <sup>305</sup> *Id.*

28 <sup>306</sup> *Id.*

<sup>307</sup> *Id.* at 46–47 (¶ 133).

<sup>308</sup> *Id.* at 47 (¶ 133).

- 1           5. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient E” for stroke  
2           (specifically, “cerebral artery occlusion, unspecified, with cerebral infarction”) for a  
3           date of service in 2014.<sup>309</sup> Sutter’s and PAMF’s submission of this diagnosis code  
4           caused CMS to pay out more money for Patient E’s Medicare Advantage coverage.<sup>310</sup>  
5           Patient E’s medical records show that this diagnosis code was false because (1) Patient  
6           E’s diagnostic test of magnetic resonance angiography reflected normal results without  
7           signs of a stroke and (2) no stroke or cerebrovascular-accident event was noted in 2014  
8           in Patient E’s medical records.<sup>311</sup> A billing note said that the diagnosis code should be  
9           corrected to a “history of cerebrovascular accident” but said that the physician’s  
10          original code is “associated with an order and cannot be removed.”<sup>312</sup>  
11          6. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient F” for stroke  
12          (specifically, “cerebral artery occlusion, unspecified, with cerebral infarction”) for a  
13          date of service in 2013.<sup>313</sup> Sutter’s and PAMF’s submission of this diagnosis code  
14          caused CMS to pay out more money for Patient F’s Medicare Advantage coverage.<sup>314</sup>  
15          Patient F’s medical records show that this diagnosis code was false because (1) Patient  
16          F was admitted in 2011 for a stroke, (2) no stroke had recurred, (3) Patient F had been  
17          on an anticoagulant long-term since her stroke in 2011, and (4) there was no evidence  
18          of treatment, evaluation, or management of a stroke event or cerebrovascular accident  
19          in 2013 in Patient F’s medical records.<sup>315</sup>  
20          7. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient G” for  
21          “cerebral embolism with cerebral infarction; cerebral artery occlusion, unspecified,  
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23           <sup>309</sup> *Id.*

24           <sup>310</sup> *Id.*

25           <sup>311</sup> *Id.*

26           <sup>312</sup> *Id.*

27           <sup>313</sup> *Id.*

28           <sup>314</sup> *Id.*

<sup>315</sup> *Id.* at 47–48 (¶ 133).

1 with cerebral infarction” for a date of service in 2013.<sup>316</sup> Sutter’s and PAMF’s  
 2 submission of this diagnosis code caused CMS to pay out more money for Patient G’s  
 3 Medicare Advantage coverage.<sup>317</sup> Patient G’s medical records show that this diagnosis  
 4 code was false because (1) no stroke or cerebrovascular-accident event was noted in  
 5 2014 [sic] in Patient G’s medical records, (2) Patient G’s medical records show a  
 6 history of a cerebrovascular accident taking place in 2004 for which the patient  
 7 subsequently underwent rehabilitation, and (3) there was no evidence of treatment,  
 8 evaluation, or management of a cerebrovascular accident in 2012 [sic] in Patient G’s  
 9 medical records.<sup>318</sup>

10 8. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient H” for hip/  
 11 femur fracture, specifically, “traumatic fracture of the mid-cervical section and  
 12 unspecified part of the neck of the femur” for a date of service in 2014.<sup>319</sup> Sutter’s and  
 13 PAMF’s submission of this diagnosis code caused CMS to pay out more money for  
 14 Patient H’s Medicare Advantage coverage.<sup>320</sup> Patient H’s medical records show that  
 15 this diagnosis code was false because (1) there was no evidence of treatment,  
 16 evaluation, or management of an acute hip or femur fracture in 2014 in Patient H’s  
 17 medical records, (2) Patient H was last treated for fracture of the right hip in 2011, and  
 18 (3) Patient H received a total hip replacement in December 2011.<sup>321</sup>

19 9. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient I” for hip/  
 20 femur fracture, specifically, “traumatic fracture of the pelvis” for a date of service in  
 21 2014.<sup>322</sup> Sutter’s and PAMF’s submission of this diagnosis code caused CMS to pay  
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23 <sup>316</sup> *Id.* at 48 (¶ 133).

24 <sup>317</sup> *Id.*

25 <sup>318</sup> *Id.*

26 <sup>319</sup> *Id.*

27 <sup>320</sup> *Id.*

27 <sup>321</sup> *Id.*

28 <sup>322</sup> *Id.*



1 out more money for Patient I’s Medicare Advantage coverage.<sup>323</sup> Patient I’s medical  
2 records show that this diagnosis code was false because (1) there was no evidence of  
3 treatment, evaluation, or management of an acute hip or femur fracture in 2014 in  
4 Patient I’s medical records, (2) Patient I’s fracture occurred in 2013, and (3) Patient I’s  
5 medical records document only a history of pelvic fracture (as opposed to actual  
6 fracture) for 2014.<sup>324</sup>

7 10. Sutter and PAMF submitted a risk-adjusting diagnosis code for “Patient J” for “benign  
8 neoplasm of the brain for cerebral meninges” for a date of service in 2014.<sup>325</sup> Sutter’s  
9 and PAMF’s submission of this diagnosis code caused CMS to pay out more money  
10 for Patient J’s Medicare Advantage coverage.<sup>326</sup> Patient J’s medical records show that  
11 this diagnosis code was false because (1) Patient J’s last brain MRI was in 2012, (2) a  
12 2014 physician-patient encounter noted a history of a “small meningioma” and did not  
13 note any recurrence of a brain neoplasm, and (3) there was no evidence of treatment,  
14 evaluation, or management of brain cancer in 2014 in Patient J’s medical records.<sup>327</sup>

#### 16 **4. The Relator’s Allegations Against Sutter Regarding Its Non-PAMF Affiliates**

17 Ms. Ormsby’s First Amended Complaint is similar to the government’s complaint regarding  
18 PAMF but includes additional allegations about Sutter and its affiliates other than PAMF.

19 Sutter has two operating units (consolidated from a former five-region structure): a Bay Area  
20 operating unit and a Valley operating unit.<sup>328</sup> Sutter’s Bay Area operating unit includes one  
21 medical-foundation corporation: Sutter Bay Medical Foundation (“Sutter Bay”).<sup>329</sup> Sutter Bay  
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23 <sup>323</sup> *Id.*

24 <sup>324</sup> *Id.* at 48–49 (¶ 133).

25 <sup>325</sup> *Id.* at 49 (¶ 133).

26 <sup>326</sup> *Id.*

27 <sup>327</sup> *Id.*

28 <sup>328</sup> Relator FAC – ECF No. 52 at 5 (¶ 11).

<sup>329</sup> *Id.*

1 does business as PAMF, Sutter East Bay Medical Foundation, and Sutter Pacific Medical  
2 Foundation.<sup>330</sup> Sutter’s Valley operating unit includes one medical-foundation corporation: Sutter  
3 Valley Medical Foundation (“Sutter Valley”).<sup>331</sup> Sutter Valley does business as Sutter Medical  
4 Foundation and Sutter Gould Medical Foundation.<sup>332</sup> Sutter is the sole member of Sutter Bay and  
5 Sutter Valley.<sup>333</sup>

6 Sutter has two other affiliates, Sutter Connect, LLC, and Sutter Medical Network.<sup>334</sup> Sutter  
7 Connect does business as Sutter Physician Services and supports Sutter’s various medical  
8 foundations with services such as administration, billing, managed-care management, financial-  
9 management reporting, and provider relations.<sup>335</sup> Sutter Medical Network is the network of the  
10 approximately 5,500 physicians at Sutter’s affiliated hospitals and foundations.<sup>336</sup>

11 Sutter’s medical foundations all use an electronic-medical-record system called EpicCare, and  
12 Sutter Physician Services sends out the diagnosis-code records in this system to the MA  
13 Organizations, which submit the codes to CMS.<sup>337</sup>

14 When Ms. Ormsby started working at PAMF in May 2013, she searched on Sutter’s intranet  
15 for relevant RAF (Risk Adjustment Factor, i.e., risk score) policies and procedures at Sutter’s  
16 other affiliates.<sup>338</sup> Other than Sutter’s Overpayment Policy,<sup>339</sup> Ms. Ormsby found no policies or  
17 procedures relevant to a RAF program.<sup>340</sup> Ms. Ormsby asked her peers at Sutter’s other affiliates  
18

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20 <sup>330</sup> *Id.* at 5–6 (¶ 11).

21 <sup>331</sup> *Id.* at 6 (¶ 11).

22 <sup>332</sup> *Id.*

23 <sup>333</sup> *Id.*

24 <sup>334</sup> *Id.* (¶¶ 12–13).

25 <sup>335</sup> *Id.* (¶ 12).

26 <sup>336</sup> *Id.* (¶ 13).

27 <sup>337</sup> *Id.* at 16 (¶ 45), 47 (¶ 149); *see also id.* at 31 (¶ 99) (one individual at Sutter Physician Services  
28 performed Medicare Advantage submissions Sutter-wide).

<sup>338</sup> *Id.* at 33 (¶ 104).

<sup>339</sup> *Id.* at 19–20 (¶ 60); *see also supra* notes 294–296.

<sup>340</sup> Relator FAC – ECF No. 52 at 33 (¶ 104).

1 and the Physician Champions, but none could point her to any relevant materials.<sup>341</sup> Thus, Ms.  
2 Ormsby alleges, as of May 2013, there was no formalized support at Sutter for the Medicare  
3 Advantage program (which had approximately 48,000 patients Sutter-wide).<sup>342</sup>

4 While she was at PAMF, Ms. Ormsby participated in Sutter’s RAF Coder User Group, which  
5 was made up of individuals at all Sutter affiliates doing jobs similar to Ms. Ormsby’s at PAMF,  
6 i.e., supporting Sutter’s RAF program.<sup>343</sup> The RAF Coder User Group held monthly calls over  
7 WebEx and met in person quarterly.<sup>344</sup> The purpose of the calls and meetings was to keep  
8 employees across Sutter’s affiliates up to date on Sutter’s systemwide effort to increase  
9 beneficiary RAFs (i.e., beneficiary risk scores).<sup>345</sup> For example, each meeting included time for a  
10 “Round Robin” discussion, where Physician Champions or RAF employees from each affiliate  
11 would share what they were doing to increase RAF scores.<sup>346</sup> At one meeting, the Round Robin  
12 was subtitled “Proactive Coding Strategies.”<sup>347</sup> Before the meeting, Sutter had collected objections  
13 from physicians to Sutter’s RAF Campaign, such as “I don’t see the purpose of doing annual  
14 wellness visits. I know it doesn’t extend life” and “I know what RAF means — Revenue for Sutter  
15 at My Expense!”<sup>348</sup> At the meeting, Dr. Veko Vahamaki (PAMF’s Lead RAF Physician  
16 Champion) coached coders on how to overcome objections from physicians.<sup>349</sup> Following these  
17 types of exchanges, Sutter circulated strategies through the RAF portal so that anyone supporting  
18 the RAF Campaign had access to the tools that affiliates used to raise RAF scores.<sup>350</sup>

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20  
21 <sup>341</sup> *Id.* at 33 (¶ 104), 35 (¶¶ 109–10).

22 <sup>342</sup> *Id.* at 33 (¶ 104), 35–36 (¶ 111).

23 <sup>343</sup> *Id.* at 25 (¶ 75).

24 <sup>344</sup> *Id.* (¶ 76).

25 <sup>345</sup> *Id.* at 26 (¶ 76).

26 <sup>346</sup> *Id.* (¶ 78).

27 <sup>347</sup> *Id.*

28 <sup>348</sup> *Id.* (¶ 79).

<sup>349</sup> *Id.*

<sup>350</sup> *Id.* (¶ 78).

1 From January 2013 to January 2015, Sutter increased its average HCC coding by 21% across  
2 all affiliates.<sup>351</sup> From January 2014 to January 2015, Sutter had a systemwide increase of 25% in  
3 its RAF scores.<sup>352</sup> When Sutter circulated the preliminary numbers reporting the 2014–2015  
4 increase, Dr. Vahamaki forwarded them to Ms. Ormsby with his observation that Sutter’s RAF  
5 Campaign to increase RAF scores was producing results.<sup>353</sup>

6 Ms. Ormsby repeatedly urged Sutter management, the Physician Champions, and members of  
7 the RAF Coders User Group to understand that Medicare required compliance and that Sutter’s  
8 focus on raising RAF scores was not proper.<sup>354</sup> Sutter did not implement Ms. Ormsby’s  
9 suggestions.<sup>355</sup> Julie Cheung (Sutter’s RAF Program Manager) repeatedly confirmed that Ms.  
10 Ormsby was the only person at Sutter conducting audits to evaluate whether Sutter’s RAF  
11 Campaign was generating unsupported diagnosis codes that resulted in overpayments from  
12 CMS.<sup>356</sup>

13 As noted above, PAMF management agreed to hire five additional coders to audit risk-  
14 adjustment data in PAMF’s Medicare Advantage program.<sup>357</sup> Sutter did not authorize additional  
15 resources to expand audits Sutter-wide, even though Sutter’s other affiliates needed help training  
16 their physicians on accurate coding.<sup>358</sup>

17 In February 2014, following UnitedHealth’s request for medical records for Patient A in  
18 connection with an audit of diagnosis codes,<sup>359</sup> Ms. Ormsby spoke with Ms. Cheung to tell her that

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21 <sup>351</sup> *Id.* at 28 (¶ 85).

22 <sup>352</sup> *Id.*

23 <sup>353</sup> *Id.*

24 <sup>354</sup> *Id.* at 27 (¶ 83).

25 <sup>355</sup> *Id.*

26 <sup>356</sup> *Id.* (¶ 84).

27 <sup>357</sup> *Id.* at 34 (¶ 107); *see also supra* note 180.

28 <sup>358</sup> Relator FAC – ECF No. 52 at 34–35 (¶ 107). For example, in 2015, a coder from Sutter Gould  
“[a]cknowledged that they need to get out of the office to support the clinicians, but this is a challenge  
with just two of them to support 100 physicians.” *Id.* at 35 (¶ 107).

<sup>359</sup> *Id.* at 28–29 (¶¶ 88–89); *see also supra* note 193.

1 Sutter’s coding issues were not limited to PAMF and instead affected Sutter systemwide.<sup>360</sup> Ms.  
 2 Cheung responded that there was invalid and unsupported diagnosis coding at Sutter systemwide  
 3 and that PAMF was not “unique.”<sup>361</sup> Ms. Ormsby explained to Ms. Cheung what the potential  
 4 liability could be if audit failures were extrapolated across Sutter’s patient population.<sup>362</sup> Ms.  
 5 Cheung expressed concern about the amount of money (millions of dollars) that Sutter could be  
 6 made to repay.<sup>363</sup> Ms. Ormsby told Ms. Cheung that she had forwarded to UnitedHealth the  
 7 medical records of audited patients, as United Health had requested.<sup>364</sup> Several days later, Sutter  
 8 had a mandatory RAF Coder User Group call with Ms. Cheung and coders from all of Sutter’s  
 9 affiliates, including Ms. Ormsby.<sup>365</sup> Ms. Ormsby and other coders from other Sutter affiliates  
 10 reported that Sutter had badly failed the audit, particularly in the areas of cancer, stroke, and  
 11 myocardial infarction (heart attack).<sup>366</sup> Ms. Ormsby and coders from other Sutter affiliates had  
 12 forwarded medical records to UnitedHealth, as UnitedHealth had requested.<sup>367</sup> Ms. Cheung  
 13 directed all RAF Coder User Group members to not, under any circumstances, submit medical  
 14 records as they had done and, in the future, to instead forward the medical records solely to her.<sup>368</sup>

15 On March 31, 2014, Ms. Ormsby met with Ms. Cheung, Jessica Driver-Zuniga (Sutter’s lead  
 16 RAF/HCC coder), Dr. Veko Vahamaki (PAMF’s Lead RAF Physician Champion), Arvin  
 17 Magusara (a Sutter Senior Analyst), and Michelle Tulier from Optum, a UnitedHealth affiliate.<sup>369</sup>  
 18 The purpose of the meeting was to strategize about further improving RAF scores.<sup>370</sup> On April 4,

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20 <sup>360</sup> Relator FAC – ECF No. 52 at 29 (¶ 91).

21 <sup>361</sup> *Id.*

22 <sup>362</sup> *Id.* at 30 (¶ 92).

23 <sup>363</sup> *Id.*

24 <sup>364</sup> *Id.* (¶ 93).

25 <sup>365</sup> *Id.* (¶ 94).

26 <sup>366</sup> *Id.*

27 <sup>367</sup> *Id.*

28 <sup>368</sup> *Id.*

<sup>369</sup> *Id.* (¶ 95).

<sup>370</sup> *Id.*

1 2014, Ms. Tulier sent an email to the meeting’s participants, copying Nancy McGinnis (Sutter’s  
2 RAF Director), and referenced training the physicians whose patients were audited to improve  
3 their coding and documentation.<sup>371</sup> Ms. Tulier did not discuss expanding physician training on  
4 accurate coding Sutter-wide or expanding the auditing to remove known improper diagnosis codes  
5 beyond the specific codes reviewed in the audit.<sup>372</sup>

6 In July 2014, Ms. Cheung invited Ms. Ormsby to participate in a “Peak Audit” (undertaken at  
7 Optum’s request), which was a medical-record review by an outside vendor for dates of service  
8 from 2013 to July 2014 across all Sutter affiliates.<sup>373</sup> Ms. Ormsby responded that “it might be a  
9 better investment to hire our own (additional) auditors” to “improve[] documentation and increase  
10 ‘compliant’ capture of HCC in the future.”<sup>374</sup> Ms. Cheung responded that “one vocal leader  
11 believes that it’s worthwhile as long as the \$ earned exceeds \$ spent.”<sup>375</sup> Ms. Cheung expressed  
12 frustration that Sutter was not taking the necessary steps to prevent coding errors from recurring,  
13 writing that “[w]e keep spending money to find the same issues, but we’re not preventing it from  
14 happening again.”<sup>376</sup>

15 The Peak Audit revealed widespread false coding across Sutter’s affiliates, requiring Sutter to  
16 delete thousands of unsupported diagnosis codes.<sup>377</sup> In December 2014, Ms. Ormsby exchanged  
17 emails with Michael Aguilar (a member of Sutter Physicians Services), the person performing  
18 Medicare Advantage submissions Sutter-wide.<sup>378</sup> Mr. Aguilar confirmed that, except for the Peak  
19 Audit, Sutter had no process in place to submit “deletes” for unsupported diagnosis codes.<sup>379</sup>

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22 <sup>371</sup> *Id.*

23 <sup>372</sup> *Id.*

24 <sup>373</sup> *Id.* at 31 (¶ 98).

25 <sup>374</sup> *Id.* (brackets in complaint).

26 <sup>375</sup> *Id.*

27 <sup>376</sup> *Id.*

28 <sup>377</sup> *Id.* (¶ 99).

<sup>378</sup> *Id.*

<sup>379</sup> *Id.* at 32 (¶ 99).

1 Ms. Ormsby was aware of two other discrete auditing “projects” at PAMF and Sutter Gould  
2 during her time at PAMF: a project to find unsupported diagnosis codes for 2012 dates of service  
3 and a project to find diagnosis codes for physician visits for immunizations or therapeutic  
4 injections when a medical assistant (as opposed to a physician) administered an injection.<sup>380</sup> Other  
5 than those projects and her own efforts to perform audits at PAMF, Ms. Ormsby is unaware of any  
6 other audits that Sutter performed to address the issue of unsupported diagnosis codes being  
7 submitted to CMS.<sup>381</sup> Ms. Ormsby alleges that she would have known about any other audits  
8 through her participation in the RAF Coder User Group and her interactions with Physician  
9 Champions.<sup>382</sup> Instead, at these meetings and in interactions with the RAF Coder User Group and  
10 Physician Champions, Ms. Ormsby heard that no Sutter affiliates were conducting audits to  
11 remove or prevent unsupported codes and that Sutter management resisted any such auditing.<sup>383</sup>

12 As discussed above, Ms. Ormsby began auditing diagnosis codes at PAMF and implementing  
13 a “Corrective Action Plan.”<sup>384</sup> Ms. Ormsby urged Ms. Cheung, Jessica Driver-Zuniga (Sutter’s  
14 lead RAF/HCC coder), and her peers at Sutter’s other affiliates to conduct similar audits.<sup>385</sup> In the  
15 fall of 2013, at a RAF Coder User Group meeting, Ms. Ormsby said that she was conducting  
16 encounter audits to establish accuracy baselines for PAMF and would soon start FOCUS audits for  
17 cancer, fracture, and stroke.<sup>386</sup> Ms. Ormsby impressed on the group the need to focus on improper  
18 coding for cancer, fracture, and stroke because if these diagnosis codes for “active” cancer,  
19 fracture, or stroke were left in patient medical records when the conditions were no longer active,  
20 CMS would pay Sutter higher amounts for conditions that patients did not have and that Sutter  
21 was not treating.<sup>387</sup> The payment for these conditions could be thousands of dollars per patient per  
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23 <sup>380</sup> *Id.* (¶ 100).

24 <sup>381</sup> *Id.* (¶ 101).

25 <sup>382</sup> *Id.*

26 <sup>383</sup> *Id.* at 32–33 (¶ 101).

27 <sup>384</sup> *Id.* at 37–38 (¶¶ 116–19); *see also supra* notes 162–178.

28 <sup>385</sup> Relator FAC – ECF No. 52 at 39 (¶ 124).

<sup>386</sup> *Id.*

<sup>387</sup> *Id.* at 40 (¶ 125).

1 year.<sup>388</sup> As of the time that Ms. Ormsby left Sutter in May 2015, however, none of Sutter’s other  
 2 affiliates undertook the baseline-accuracy testing that Ms. Ormsby had initiated at PAMF or  
 3 conducted any subsequent comparisons or auditing.<sup>389</sup> (By contrast, Sutter conducted audits to  
 4 identify HCCs that CMS had rejected in order to resubmit them to CMS for payment.<sup>390</sup>)

5 At all of its affiliates, Sutter limited its auditors to removing unsupported diagnosis codes only  
 6 from the “billing” side of electronic medical records, not from the “encounter data” that was  
 7 submitted to CMS for payment.<sup>391</sup> In February 2015, Ms. Cheung admitted that Sutter knew that  
 8 unsupported diagnosis codes (caught by the auditors and removed from the “billing” file)  
 9 nonetheless were being submitted to CMS for payment when the “encounter data” was swept  
 10 (automatically pushed) to CMS.<sup>392</sup> This caused CMS to pay Sutter based on false diagnosis  
 11 codes.<sup>393</sup> Ms. Cheung shared Ms. Ormsby’s concern that this Sutter practice did not comply with  
 12 Medicare Advantage program requirements and that this was a Sutter-wide problem.<sup>394</sup> Ms.  
 13 Cheung told Ms. Ormsby that they needed to “brainstorm” how to fix it because she (Ms. Cheung)  
 14 did not know how.<sup>395</sup> In a February 24, 2015 “Meeting Preparation Memo” to the RAF Coder  
 15 User Group, Ms. Driver-Zuniga confirmed that Sutter had a systemwide problem that caused it to  
 16 submit false diagnosis codes and retain overpayments predicated on those codes:

17 Due to limitations with the current preformatted electronic claim form in the Sutter  
 18 E[lectronic]H[ealth]R[ecord], only 12 diagnosis codes can be submitted per  
 19 encounter. To overcome this limitation, a monthly “data sweep” was implemented  
 20 several years back. While *the [data] sweep supports the capture and reporting of*  
 21 *diagnostic information for RAF reporting, [Sutter Medical Network] has learned of*  
 22 *an unintended consequence — the inclusion of HCC diagnosis codes removed from*  
 23 *claims, but remaining in the Sutter E[lectronic]H[ealth]R[ecord]. To improve*

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23 <sup>388</sup> *Id.*

24 <sup>389</sup> *Id.* at 38 (¶¶ 120–21).

25 <sup>390</sup> *Id.* at 43–44 (¶ 138).

26 <sup>391</sup> *Id.* at 47–48 (¶¶ 148–51).

27 <sup>392</sup> *Id.* at 48 (¶ 151).

28 <sup>393</sup> *Id.*

<sup>394</sup> *Id.*

<sup>395</sup> *Id.*



1 quality control, [Sutter Medical Network] would like for you to brainstorm with  
2 your affiliate, the pros and cons of potential solutions that can be used system-  
wide.<sup>396</sup>

3 At a strategy meeting to raise RAF scores a month later, Ms. Cheung confirmed that Sutter  
4 still did not have a plan to stop the submission of false diagnosis codes or to return  
5 overpayments.<sup>397</sup> Ms. Cheung confirmed that CMS was still receiving HCCs that Sutter knew  
6 were false.<sup>398</sup> Ms. Ormsby had suggested allowing coders to delete unsupported codes from the  
7 “encounter data” of patient medical records, but Sutter management allegedly shut down those  
8 mechanisms in order to increase RAF scores and would not consider them as a “potential  
9 solution.”<sup>399</sup>

10 At all of its affiliates, Sutter employed a strategy of using patients’ “problem lists” and a daily  
11 alert form to encourage physicians to capture new HCCs and recapture old HCCs that had not  
12 been documented for the year.<sup>400</sup> At some point, Sutter modified the process at its affiliates to pre-  
13 populate diagnosis codes into patients’ encounter data before physicians met with their patients.<sup>401</sup>  
14 Christian Gabriel (PAMF’s Director of Education and Coding) described this practice as  
15 “aggressive,” and Dr. Veko Vahamaki (PAMF’s Lead RAF Physician Champion) questioned  
16 whether pre-populating diagnosis codes into patients’ actual encounter data was proper.<sup>402</sup> After  
17 Ms. Ormsby left PAMF in May 2015, PAMF joined Sutter’s other affiliates in this pre-population  
18 practice, which effectively captured HCCs regardless of whether physicians actually diagnosed  
19 patients with the medical conditions that had been pre-populated.<sup>403</sup>

21 \_\_\_\_\_  
22 <sup>396</sup> *Id.* at 48–49 (¶ 152) (emphasis and brackets in complaint). Ms. Ormsby alleges that this monthly  
23 “data sweep” (as an end run around the 12-diagnosis claim-form limit) was a red flag because it is  
implausible that Sutter physicians routinely were treating patients for 12 or more conditions in a  
standard office visit (that typically was less than 30 minutes). *Id.* at 48 (¶ 152 n.4).

24 <sup>397</sup> *Id.* at 49 (¶ 153).

25 <sup>398</sup> *Id.*

26 <sup>399</sup> *Id.*

27 <sup>400</sup> *Id.* at 50–51 (¶ 157).

28 <sup>401</sup> *Id.* at 51 (¶ 157).

<sup>402</sup> *Id.*

<sup>403</sup> *Id.*

1 On April 19, 2019, Sutter, including all of its affiliates with Medicare Advantage patients other  
 2 than PAMF, signed a settlement agreement to refund \$30 million to CMS to resolve allegations by  
 3 the government and CMS that it submitted improper payment data that inflated the payments it  
 4 received.<sup>404</sup> The settlement covered improper billing for medical conditions, including cancer, hip  
 5 and vertebral fractures, strokes, and myocardial infarction (heart attack), involving six HCCs  
 6 between 2010 and 2012 and seven HCCs between 2013 and 2016.<sup>405</sup> The settlement expressly  
 7 reserved and did not release any liability arising under the FCA.<sup>406</sup>

### 8 **THE FALSE CLAIMS ACT**

9  
 10 The plaintiffs each bring claims under (1) 31 U.S.C. § 3729(a)(1)(A)–(B) (the “direct-FCA  
 11 provision”) and (2) 31 U.S.C. § 3729(a)(1)(G) (the “reverse-FCA provision”).<sup>407</sup>

12 Broadly speaking, (1) the direct-FCA provision imposes liability on a party that fraudulently  
 13 presents a claim for the government to pay it money, and (2) the reverse-FCA provision imposes  
 14 liability on a party that fraudulently avoids an obligation for it to pay money to the government.  
 15 The plaintiffs allege that Sutter and PAMF committed direct-FCA violations by knowingly  
 16 submitting false diagnosis codes to CMS, which caused CMS to pay Sutter and PAMF more  
 17 money than it otherwise would have paid. They allege that Sutter and PAMF committed reverse-  
 18 FCA violations by knowingly failing to delete false diagnosis codes that they had submitted and  
 19 knowingly failing to return payments from CMS that were predicated on those false codes.

#### 20 **1. Direct-FCA Claims**

21  
 22 The direct-FCA provision makes liable anyone who “[1)] knowingly presents, or causes to be  
 23 presented, a false or fraudulent claim for payment or approval; [or 2)] knowingly makes, uses, or

24  
 25 <sup>404</sup> *Id.* at 53 (¶ 166).

26 <sup>405</sup> *Id.*

27 <sup>406</sup> Relator Req. for Judicial Notice Ex. B (Settlement Agreement) – ECF No. 81 at 14 (¶ 3.b). The  
 court grants the unopposed request for judicial notice.

28 <sup>407</sup> The government additionally brings common-law claims for payment by mistake and unjust  
 enrichment.

1 causes to be made or used, a false record or statement material to a false or fraudulent claim[.]”  
2 31 U.S.C. § 3729(a)(1)(A)–(B). The direct-FCA provision “requires a showing of: ‘(1) a false  
3 statement or fraudulent course of conduct, (2) made with scienter, (3) that was material,  
4 (4) causing the government to pay out money or forfeit moneys due.’” *Godecke ex rel. United*  
5 *States v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1208 (9th Cir. 2019) (quoting *United States ex rel.*  
6 *Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 899 (9th Cir. 2017)).

7 Regarding the false-statement element, “[t]o state an FCA claim, a [plaintiff] is not required to  
8 identify actual examples of submitted false claims; instead, ‘it is sufficient to allege particular  
9 details of a scheme to submit false claims paired with reliable indicia that lead to a strong  
10 inference that claims were actually submitted.’” *Id.* at 1209 (some internal quotation marks  
11 omitted) (quoting *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998–99 (9th Cir. 2010)).  
12 “A [plaintiff] is not required to identify representative examples of false claims to support every  
13 allegation, although the use of representative examples is one means of meeting the pleading  
14 obligation.” *Id.* (citing *Ebeid*, 616 F.3d at 998).

15 Regarding the scienter element, “[l]iability under the FCA is established only when the  
16 defendant ‘knowingly’ presents a false or fraudulent claim for payment.” *Id.* at 1211 (citing  
17 31 U.S.C. § 3729(a)(1)(A)). “‘Knowingly’ is defined as having: (1) actual knowledge of the  
18 information; (2) deliberate ignorance of the truth or falsity of the information; or (3) reckless  
19 disregard of the truth or falsity of the information.” *Id.* (citing 31 U.S.C. § 3729(b)(1)(A)). “The  
20 FCA’s ‘knowingly’ requirement ‘requires no proof of specific intent to defraud.’” *Id.* (internal  
21 brackets omitted) (quoting 31 U.S.C. § 3729(b)(1)(B)). “Instead of pleading specific intent to  
22 defraud, it is sufficient to plead that the defendant knowingly filed false claims, or that the  
23 defendant submitted false claims with reckless disregard or deliberate ignorance as to the truth or  
24 falsity of its representations.” *Id.* (citing *United States v. Bourseau*, 531 F.3d 1159, 1167 (9th Cir.  
25 2008)). “The deliberate ignorance standard can cover ‘the ostrich type situation where an  
26 individual has buried his head in the sand and failed to make simple inquiries which would alert  
27 him that false claims are being submitted.’” *Id.* (quoting *Swoben*, 848 F.3d at 1174). “‘Congress  
28 adopted the concept that individuals and contractors receiving public funds have some duty to

1 make a limited inquiry so as to be reasonably certain they are entitled to the money they seek.” *Id.*  
2 (quoting *Swoben*, 848 F.3d at 1174).

3 Regarding the materiality element, the FCA defines materiality as “‘having a natural tendency  
4 to influence, or be capable of influencing, the payment or receipt of money or property.’” *Id.* at  
5 1213 (quoting 31 U.S.C. § 3729(b)(4)). “Although the requirement is ‘demanding,’ the Supreme  
6 Court has held that there is not a bright-line test for determining whether the FCA’s materiality  
7 requirement has been met.” *Id.* (citing *Universal Health Servs., Inc. v. United States ex rel.*  
8 *Escobar*, 136 S. Ct. 1989, 2003 (2016)). “Instead, the Supreme Court has given a list of relevant,  
9 but not necessarily dispositive, factors in determining whether the false claims were material, such  
10 as whether the government decided ‘to expressly identify a provision as a condition of payment.’”  
11 *Id.* (quoting *Escobar*, 136 S. Ct. at 2003). “Likewise, proof of materiality can include, but is not  
12 necessarily limited to, evidence that the defendant knows that the government consistently refuses  
13 to pay claims in the mine run of cases based on noncompliance with the particular statutory,  
14 regulatory, or contractual requirement.” *Id.* (quoting *Escobar*, 136 S. Ct. at 2003). “Conversely,  
15 if the government pays a particular claim in full despite its actual knowledge that certain  
16 requirements were violated, that is very strong evidence that those requirements are not material.”  
17 *Id.* (quoting *Escobar*, 136 S. Ct. at 2003). “Or, if the government regularly pays a particular type  
18 of claim in full despite actual knowledge that certain requirements were violated, and has signaled  
19 no change in position, that is strong evidence that the requirements are not material.” *Id.* (quoting  
20 *Escobar*, 136 S. Ct. at 2003–04). “Materiality, in addition, cannot be found where noncompliance  
21 is minor or insubstantial.” *Id.* (quoting *Escobar*, 136 S. Ct. at 2003).

## 22 23 **2. Reverse-FCA Claims**

24 The reverse-FCA provision makes liable anyone who “[1] knowingly makes, uses, or causes  
25 to be made or used, a false record or statement material to an obligation to pay or transmit money  
26 or property to the Government, or [2] knowingly conceals or knowingly and improperly avoids  
27 or decreases an obligation to pay or transmit money or property to the Government.” 31 U.S.C.  
28 § 3729(a)(1)(G).

1 The elements of a violation under the first prong of the reverse-FCA provision are that (1) a  
2 record or statement was false, (2) the defendant had knowledge of the falsity, (3) the defendant  
3 made or used (or caused to be made or used) the false record or statement, (4) the defendant’s  
4 purpose was to conceal, avoid, or decrease an obligation to pay the government, and (5) the false  
5 record or statement was material. *Bourseau*, 531 F.3d at 1164–71.

6 The elements of a violation under the second prong of the reverse-FCA provision are that the  
7 defendant (1) concealed or improperly avoided or decreased an obligation to pay the government  
8 and (2) did so knowingly. *United States ex rel. Customs Fraud Investigations, LLC v. Victaulic*  
9 *Co.*, 839 F.3d 242, 255 (3d Cir. 2016) (citing 31 U.S.C. § 3729(a)(1)(G)); *accord United States v.*  
10 *Vandewater Int’l, Inc.*, No. 2:17-cv-04393RGK-KS, 2019 WL 6917927, at \*4 n.1 (C.D. Cal. Sept.  
11 3, 2019) (citing *Victaulic*, 839 F.3d at 255). There is no requirement under the second prong to  
12 show that the defendant used a false record or statement or that a record or statement was material.  
13 *Victaulic*, 839 F.3d at 255; *Vandewater*, 2019 WL 6917927, at \*4 n.1.<sup>408</sup>

14 Regarding the obligation-to-pay-the-government element, in 2010, as part of the Patient  
15 Protection and Affordable Care Act (“ACA”), Congress promulgated “Enhanced Medicare and  
16 Medicaid Program Integrity Provisions,” including provisions codified at 42 U.S.C. § 1320a-7k.  
17 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402, 124 Stat. 119, 753–56  
18 (2010). Section 1320a-7k provides that a person (including a medical provider)<sup>409</sup> who has  
19 received a Medicare or Medicaid overpayment must report and return the overpayment within 60

20 \_\_\_\_\_  
21 <sup>408</sup> As first enacted in 1986, the reverse-FCA provision contained only the first prong. False Claims  
22 Amendment Act of 1986, Pub. L. No. 99-562, § 2, 100 Stat. 3153, 3153 (1986). “The plain language  
23 of this statute require[d] that a defendant make or use a false record or statement in order to conceal,  
24 avoid or decrease an obligation to the government.” *Bourseau*, 531 F.3d at 1169. In 2009, Congress  
25 amended the reverse-FCA provision to additionally make liable anyone who “knowingly conceals or  
26 knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to  
27 the government.” Fraud Enforcement and Recovery Act of 2009 (FERA), Pub. L. No. 111-21, § 4, 123  
28 Stat. 1617, 1622 (2009). “A false statement is no longer a required element, since the post-FERA FCA  
specifies that mere knowledge and avoidance of an obligation is sufficient, without the submission of a  
false record, to give rise to liability.” *Victaulic*, 839 F.3d at 255.

<sup>409</sup> “The term ‘person’ means a provider of services, supplier, [M]edicaid managed care organization  
(as defined in section 1396b(m)(1)(A) of this title), Medicare Advantage organization (as defined in  
section 1395w-28(a)(1) of this title), or PDP sponsor (as defined in section 1395w-151(a)(13) of this  
title). Such term does not include a beneficiary.” 42 U.S.C. § 1320a-7k(d)(4)(C) (internal headings  
omitted).

1 days after the overpayment is identified. 42 U.S.C. § 1320a-7k(d)(2)(A).<sup>410</sup> Any overpayment  
 2 retained for more than 60 days becomes an “obligation” for purposes of the reverse-FCA  
 3 provision. 42 U.S.C. § 1320a-7k(d)(3).<sup>411</sup>

4 Regarding the scienter element and (with respect to the first prong only) the false-statement  
 5 and materiality elements, the standards for these elements are the same for the reverse-FCA  
 6 provision and the direct-FCA provision. 31 U.S.C. § 3729(b)(1), (4); *Bourseau*, 531 F.3d at 1164–  
 7 68, 1170–71.

### 8 9 STANDARD OF REVIEW

10 A complaint must contain a “short and plain statement of the claim showing that the pleader is  
 11 entitled to relief” to give the defendant “fair notice” of what the claims are and the grounds upon  
 12 which they rest. Fed. R. Civ. P. 8(a)(2); *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). A  
 13 complaint does not need detailed factual allegations, but “a plaintiff’s obligation to provide the  
 14 ‘grounds’ of his ‘entitlement to relief’ requires more than labels and conclusions, and a formulaic  
 15 recitation of the elements of a cause of action will not do. Factual allegations must be enough to  
 16 raise a claim for relief above the speculative level[.]” *Twombly*, 550 U.S. at 555 (internal citations  
 17 omitted).

18 To survive a motion to dismiss, a complaint must contain sufficient factual allegations, which  
 19 when accepted as true, “state a claim to relief that is plausible on its face.” *Ashcroft v. Iqbal*, 556  
 20 U.S. 662, 678 (2009) (quoting *Twombly*, 550 U.S. at 570). “A claim has facial plausibility when  
 21 the plaintiff pleads factual content that allows the court to draw the reasonable inference that the  
 22 defendant is liable for the misconduct alleged.” *Id.* “The plausibility standard is not akin to a  
 23

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24 <sup>410</sup> More specifically, § 1320a-7k(d)(2) provides that a person must report and return an overpayment  
 25 “by the later of — (A) the date which is 60 days after the date on which the overpayment was  
 26 identified; or (B) the date any corresponding cost report is due, if applicable.” The “corresponding cost  
 27 report” condition is inapplicable in the Medicare Advantage program because, in general, CMS makes  
 28 payments to MA Organizations based on their bids and not based on their actual incurred costs.  
*Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and Medicare  
 Prescription Drug Benefit Programs*, 79 Fed. Reg. 29,844, 29,920 (May 23, 2014).

<sup>411</sup> As discussed below, § 1320a-7k does not expressly delineate the scope of “overpayment” and does  
 not define “identified.” A central issue in the case is how to define these terms.



1 ‘probability requirement,’ but it asks for more than a sheer possibility that a defendant has acted  
 2 unlawfully.” *Id.* (citing *Twombly*, 550 U.S. at 557). “Where a complaint pleads facts that are  
 3 merely consistent with a defendant’s liability, it stops short of the line between possibility and  
 4 plausibility of ‘entitlement to relief.’” *Id.* (some internal quotation marks omitted) (quoting  
 5 *Twombly*, 550 U.S. at 557).

6 FCA claims also are subject to the heightened pleading requirements of Federal Rule of Civil  
 7 Procedure 9(b). *Swoben*, 848 F.3d at 1180. Under Rule 9(b), “the plaintiff must allege ‘the who,  
 8 what, when, where, and how of the misconduct charged,’ including what is false or misleading  
 9 about a statement, and why it is false.” *Id.* (quoting *Ebeid*, 616 F.3d at 998). “Knowledge,  
 10 however, may be pled generally.” *Id.* (citing *United States v. Corinthian Colls.*, 655 F.3d 984, 996  
 11 (9th Cir. 2011)).

12 Under Rule 9(b), “‘mere conclusory allegations of fraud are insufficient.’” *Id.* (citing *Wool v.*  
 13 *Tandem Computers Inc.*, 818 F.2d 1433, 1439 (9th Cir. 1987), *overruled as stated in Flood v.*  
 14 *Miller*, 35 F. App’x 701, 703 n.3 (9th Cir. 2002)). “Broad allegations that include no particularized  
 15 supporting detail do not suffice[.]” *Id.* (citing *Bly-Magee v. California*, 236 F.3d 1014, 1018 (9th  
 16 Cir. 2001)). “[B]ut ‘statements of the time, place and nature of the alleged fraudulent activities are  
 17 sufficient[.]’” *Id.* (quoting *Wool*, 818 F.2d at 1439). “Because this standard ‘does not require  
 18 absolute particularity or a recital of the evidence,’ a complaint need not allege ‘a precise time  
 19 frame,’ ‘describe in detail a single specific transaction’ or identify the ‘precise method’ used to  
 20 carry out the fraud.” *Id.* (quoting Charles Alan Wright & Arthur R. Miller, *Federal Practice and*  
 21 *Procedure* § 1298 (3d ed. 2016); *Cooper v. Pickett*, 137 F.3d 616, 627 (9th Cir. 1997)).

## 22 ANALYSIS

23  
 24 Sutter and PAMF move to dismiss the complaints on the following grounds: (1) a statutory  
 25 requirement — that CMS ensure “actuarial equivalence” between traditional Medicare and  
 26 Medicare Advantage, 42 U.S.C. § 1395w-23(a)(1)(C)(i) — means that to state an FCA claim, the  
 27 plaintiffs must allege that an MA Participant’s rate of unsupported diagnosis codes exceeds the  
 28 rate of unsupported diagnosis codes in the traditional Medicare data CMS uses in its Medicare

1 Advantage risk model (and the plaintiffs have not alleged this);<sup>412</sup> (2) Ms. Ormsby cannot pursue  
 2 her claims against Sutter’s non-PAMF affiliates because the claims exceed the scope of the  
 3 government’s intervention;<sup>413</sup> and (3) the complaints fail to allege facts showing that Sutter and  
 4 PAMF knowingly failed to return overpayments (for a reverse-FCA claim) or knowingly  
 5 submitted false claims (for a direct-FCA claim).<sup>414</sup>

6 The court denies the motions to dismiss. “Actuarial equivalence” is not a defense to an FCA  
 7 claim (and nothing in 42 U.S.C. § 1395w-23(a)(1)(C)(i) imposes the pleading standard that Sutter  
 8 and PAMF assert here), the clear weight of authority establishes that Ms. Ormsby may pursue her  
 9 claims, and the plaintiffs otherwise sufficiently plead their claims.

#### 11 **1. The “Actuarial Equivalence” Argument Is Not a Valid Defense**

12 Sutter’s and PAMF’s main argument is that MA Participants are not overpaid merely because  
 13 they submit unsupported diagnosis codes.<sup>415</sup> Instead, they argue, MA Participants are overpaid  
 14 only if they have a rate of unsupported codes that is higher than the error rate in the traditional  
 15 Medicare fee-for-service program.<sup>416</sup> They move to dismiss the FCA claims on the ground that the  
 16 plaintiffs did not allege any facts about this foundational requirement for false claims.<sup>417</sup>

17 This argument is predicated on 42 U.S.C. § 1395w-23(a)(1)(C)(i), which provides that CMS  
 18 must pay MA Organizations in a manner that ensures “actuarial equivalence” between payments  
 19 for healthcare under traditional Medicare and payments for health care under MA Plans:

20 [CMS] shall adjust [Medicare Advantage payments] for such risk factors as age,  
 21 disability status, gender, institutional status, and such other factors as [CMS]  
 22 determines to be appropriate, including adjustment for health status . . . , so as to

23 \_\_\_\_\_  
 24 <sup>412</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 7–21.

25 <sup>413</sup> Defs. Mot. to Dismiss Relator FAC – ECF No. 68 at 5–10.

26 <sup>414</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 9, 21–28; Defs. Mot. to Dismiss Relator FAC  
 – ECF No. 68 at 6, 10–13.

27 <sup>415</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 14, 17–18.

28 <sup>416</sup> *Id.*

<sup>417</sup> *Id.* at 17–18.



1 ensure actuarial equivalence. [CMS] may add to, modify, or substitute for such  
2 adjustment factors if such changes will improve the determination of actuarial  
equivalence.

3 To support their argument that payments to an MA Participant predicated on false diagnosis  
4 codes are not “overpayments” unless the MA Participant’s diagnosis-code “error rate” exceeds the  
5 “error rate” for traditional Medicare, Sutter and PAMF cite a District of Columbia decision (now  
6 on appeal to the D.C. Circuit) that addressed a challenge by the MA Organization UnitedHealth  
7 (and its affiliates) under the Administrative Procedures Act (“APA”) to CMS’s Medicare  
8 Advantage payment practices. *UnitedHealth Insurance Co. v. Azar*, 330 F. Supp. 3d 173 (D.D.C.  
9 2018) (*UnitedHealthcare II*), *recons. denied*, No. 16-157 (RMC), 2020 WL 417867 (D.D.C. Jan.  
10 27, 2020) (*UnitedHealthcare III*), *appeal docketed*, No. 18-5326 (D.C. Cir. filed Nov. 18, 2018).  
11 In 2014, CMS issued guidance that said, among other things, that “a risk adjustment diagnosis that  
12 has been submitted for payment but is found to be invalid because it does not have supporting  
13 medical record documentation would result in an overpayment.” *Medicare Program; Contract*  
14 *Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare*  
15 *Prescription Drug Benefit Programs*, 79 Fed. Reg. 29,844, 29,921 (May 23, 2014). The  
16 *UnitedHealthcare* court held that this guidance (which it called the “2014 Overpayment Rule”<sup>418</sup>)  
17 violated the statutory mandate of actuarial equivalence. *UnitedHealthcare II*, 330 F. Supp. 3d at  
18 176. The court found that CMS uses unaudited records of the payments it makes in the traditional  
19 Medicare program in the risk model it uses to set payment rates for the Medicare Advantage  
20 program. *Id.* at 176, 179. Because the traditional-Medicare data are unaudited, they necessarily  
21 contain errors. *Id.* at 179. The court held that using traditional Medicare data with errors to set  
22 payment rates — and then requiring MA Participants to return payments predicated on erroneous  
23 or unsupported diagnosis codes — imposed higher scrutiny on Medicare Advantage than  
24 traditional Medicare and thus violated actuarial equivalence. *Id.* at 176, 186–87.

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26  
27 <sup>418</sup> As discussed below, CMS disputes that its 2014 guidance was a new rule because it has long  
28 required (since well before 2014) that diagnosis codes be supported by medical-record documentation.  
*See infra* note 424. The court uses the *UnitedHealthcare* court’s term “2014 Overpayment Rule” for  
convenience, and the use of that term is not an opinion that it was a new rule.

1 Relying on *UnitedHealthcare*, Sutter and PAMF assert that requiring MA Participants to  
 2 return payments predicated on false diagnosis codes leads to the “inevitable” result that CMS will  
 3 pay less for beneficiaries enrolled in MA Plans than it would pay for those beneficiaries if they  
 4 were enrolled in traditional Medicare, thereby violating “actuarial equivalence.”<sup>419</sup> Sutter and  
 5 PAMF thus contend that they must return overpayments (predicated on false diagnosis codes) only  
 6 if “the error rate for a Medicare Advantage contract is greater than the CMS error rate” for  
 7 traditional fee-for-service Medicare.<sup>420</sup> They contend that the plaintiffs did not plead FCA claims  
 8 because they did not allege (1) the rate of unsupported diagnosis codes for traditional Medicare  
 9 providers, (2) Sutter’s and PAMF’s “overall rate of unsupported diagnosis codes,” and (3) a  
 10 comparison of those rates showing that Sutter’s and PAMF’s “error rate” (in the form of the  
 11 unsupported diagnosis codes) exceeded the traditional Medicare “error rate.”<sup>421</sup> They also argue  
 12 that at minimum, this argument shows that their position was reasonable, thereby defeating the  
 13 plaintiffs’ allegations about the scienter needed for FCA claims.<sup>422</sup>

14 The “actuarial equivalence” argument is not a ground to dismiss the complaints. First, Sutter  
 15 and PAMF have not established that their premise — CMS’s using unaudited traditional-Medicare  
 16 data in its Medicare Advantage risk model and requiring MA Participants to return payments  
 17 predicated on false diagnosis codes inevitably leads to CMS’s paying less for Medicare Advantage  
 18 than for traditional Medicare — is sound. Second, even if it were, it is not a defense to an FCA  
 19 claim. CMS’s possibly underpaying MA Participants does not entitle the MA Participants to  
 20 correct that supposed wrong by submitting false diagnosis codes and failing to report or return  
 21 payments predicated on the codes. Additionally, nothing in the “actuarial equivalence” provision  
 22 imposes the pleading standard Sutter and PAMF seek to impose here. Third, Sutter’s and PAMF’s  
 23  
 24

25 \_\_\_\_\_  
 26 <sup>419</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 15 (quoting *UnitedHealthcare II*, 330  
 F. Supp. 3d at 176, 187).

27 <sup>420</sup> *Id.* at 8, 15 (quoting *UnitedHealthcare II*, 330 F. Supp. 3d at 186).

28 <sup>421</sup> *Id.* at 21 (emphasis in original).

<sup>422</sup> Defs. Reply in Supp. of Mot. to Dismiss Gov’t Compl. – ECF No. 86 at 6.

1 position — which, at its core, is that MA Participants do not have to report or return payments  
2 predicated on false codes — is not objectively reasonable and does not defeat scienter.

### 3 **1.1 The Premise — That CMS Is Violating “Actuarial Equivalence” — Is Not Sound**

4 In the next sections, the court examines (1) CMS’s historical audit process and its  
5 promulgation of the 2014 Overpayment Rule, (2) the *UnitedHealthcare* court’s invalidation of the  
6 Rule, and (3) whether Sutter’s and PAMF’s contention — that the return of payments predicated  
7 on false diagnosis codes inevitably violates “actuarial equivalence” — is sound.

#### 8 **1.1.1 CMS’s Medicare Advantage audit process and the “2014 Overpayment Rule”**

9 Understanding how the actuarial-equivalence analysis in *UnitedHealthcare* applies to this case  
10 begins with the consideration of CMS’s historical audit process for MA Organizations and its  
11 promulgation of the 2014 Overpayment Rule.

##### 12 **1.1.1.1 Audits of MA Organizations**

13 Historically, CMS conducted “Risk Adjustment Data Validation” (“RADV”) audits of a subset  
14 of MA Organizations, comparing their submitted diagnosis codes to underlying patient medical  
15 records to verify that the records supported the diagnosis codes. *UnitedHealthcare II*, 330  
16 F. Supp. 3d at 180; *accord Silingo*, 904 F.3d at 672–73 (“With data for millions of people being  
17 submitted each year, CMS is unable to confirm diagnoses before calculating capitation rates.  
18 Instead, the agency accepts the diagnoses as submitted, and then audits some of the self-reported  
19 data a few years later to ensure that they are adequately supported by medical documentation.”)  
20 (citing 42 C.F.R. §§ 422.310(e), 422.311; 79 Fed. Reg. at 2001). CMS required MA Organizations  
21 to return any payments predicated on unsupported diagnosis codes. *UnitedHealthcare II*, 330  
22 F. Supp. 3d at 180.

23 In 2008, CMS announced that it would apply the RADV error rate from the audited samples to  
24 the entire MA Plan for the MA Organization. *Id.* More specifically, previously MA Organizations  
25 returned only payments for the specific unsupported diagnosis codes identified in the audit. The  
26 new proposal meant that MA Organizations also would return an extrapolated payment for  
27 diagnosis-code submissions that CMS did not audit, essentially on the presumption that the other  
28 submissions would include similar unsupported codes. *Id.*

1 In response to CMS’s request for comments, MA Organizations objected that the proposed  
 2 methodology would violate the “actuarial equivalence” provision in 42 U.S.C. § 1395w-  
 3 23(a)(1)(C)(i) because CMS (1) sets the payment rates for Medicare Advantage based on  
 4 diagnosis codes from traditional Medicare providers that are not audited or verified in any way  
 5 and (2) requires MA Organizations to make repayments based on audited results. *Id.* As a result of  
 6 the comments, in 2012, CMS announced that it would apply a “Fee-for-Service Adjuster” or “FFS  
 7 Adjuster” — essentially, according to the *UnitedHealthcare* court, CMS’s own estimate of the  
 8 error rate in risk factors and diagnosis codes submitted in traditional Medicare — to the results of  
 9 RADV audits of the MA Organizations (meaning, to its extrapolation of the RADV audit results to  
 10 the entire MA Plan). *Id.*

11 The *UnitedHealthcare* court described the outcome from CMS’s application of the FFS  
 12 Adjuster: “Medicare Advantage providers must return to CMS any audited ‘overpayments’ to the  
 13 extent that the insurer’s errors exceed the estimated error rate in CMS payments under traditional  
 14 Medicare.” *Id.* at 180–81 (citing Ctrs. For Medicare and Medicaid Servs., *Notice of Final Payment*  
 15 *Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation*  
 16 *Contract-Level Audits* 1–5 (Feb. 24, 2012), available at [https://www.cms.gov/Research-Statistics-](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf)  
 17 [Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf)  
 18 [Types/RADV-Docs/RADV-Methodology.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf) (last visited Mar. 16, 2020)). CMS’s announcement  
 19 of the FFS Adjuster puts it differently, saying that CMS would conduct a review to calculate the  
 20 actual amount of the FFS Adjuster without forecasting the amount or linking it to “error rates.”  
 21 *See Notice of Final Payment Error Calculation Methodology* 4–5.<sup>423</sup>

22  
 23  
 24  
 25  
 26 \_\_\_\_\_  
 27 <sup>423</sup> CMS’s announcement stated that “[t]he FFS adjuster accounts for the fact that the documentation  
 28 standard in RADV audits to determine a contract’s payment error (medical records) is different from  
 the documentation standard used to develop the Part C risk-adjustment model (FFS claims). The actual  
 amount of the adjuster will be calculated by CMS based on a RADV-like review of records submitted  
 to support FFS claims data.” *Notice of Final Payment Error Calculation Methodology* 4–5.

### 1.1.1.2 The “2014 Overpayment Rule”

1 In 2010, as part of the ACA (as discussed above), Congress promulgated “Enhanced Medicare  
2 and Medicaid Program Integrity Provisions” that require MA Participants to return Medicare  
3 “overpayments” within 60 days after the overpayments are “identified.” 42 U.S.C. § 1320a-  
4 7k(d)(2)(A). “The term ‘overpayment’ means any funds that a person receives or retains under  
5 [Medicare or Medicaid] to which the person, after applicable reconciliation, is not entitled.”  
6 42 U.S.C. § 1320a-7k(d)(4)(B). An overpayment that is not returned within 60 days of when it is  
7 identified becomes an “obligation” under the reverse-FCA provision. 42 U.S.C. § 1320a-7k(d)(3).

8  
9 In January 2014, CMS issued a notice of proposed rulemaking, including a rule to clarify for  
10 § 1320a-7k’s statutory definition of “overpayment” by defining the terms “funds” and “applicable  
11 reconciliation.” 79 Fed. Reg. at 1996. The proposed definition of “funds” was “payments an MA  
12 organization . . . has received that are based on data that these organizations submitted to CMS for  
13 payment purposes and for which they have responsibility for the accuracy, completeness, and  
14 truthfulness of such data under existing [42 C.F.R.] § 422.504(l) and § 423.505(k). For Part C  
15 [Medicare Advantage], the data submitted by the MA organization to CMS includes § 422.308(f)  
16 (enrollment data) and § 422.310 (risk adjustment data).” *Id.* The proposed definition of “applicable  
17 reconciliation” was that it “occurs on the date that CMS announces as the final deadline for risk  
18 adjustment data submission.” *Id.*

19 CMS also stated that “[i]t is our expectation that MA organizations . . . must be continuously  
20 diligent regarding the accuracy and completeness of payment-related data they submit to CMS for  
21 a payment year, whether during or after that payment year, and whether before or after applicable  
22 reconciliation dates.” *Id.* at 1997. It disclaimed that this was a new requirement, explaining that  
23 “[t]his expectation is based on existing requirements at [42 C.F.R.] § 422.310, § 422.504(l),  
24 § 423.329(b)(3)(ii), and § 423.505(k), and our proposed amendments that clarify and strengthen  
25 these requirements.” *Id.*

26 In May 2014, CMS published its final rules. 79 Fed. Reg. 29,844. It said in its notice that it  
27 “did not receive any comments on the proposed definitions of the terms ‘funds’ or ‘overpayment’”  
28 and finalized (in 42 C.F.R. § 422.326(a)) its proposed definitions for those terms. *Id.* at 29,920,

1 29,958. Additionally, CMS “reminded all stakeholders that even in the absence of a final  
 2 regulation on these statutory provisions, MA organizations . . . are subject to the statutory  
 3 requirements found in [42 U.S.C. § 1320a-7k] and could face potential False Claims Act liability,  
 4 Civil Monetary Penalties (CMP) Law liability, and exclusion from Federal health care programs  
 5 for failure to report and return an overpayment.” *Id.* at 29,919. It reaffirmed that an “overpayment”  
 6 occurs when “the MA organization . . . has submitted erroneous data to CMS that caused CMS to  
 7 overpay the organization.” *Id.* at 29,921 (“identification of an overpayment means knowing that  
 8 the MA organization . . . has submitted erroneous data to CMS that caused CMS to overpay the  
 9 organization”). “For example, a risk adjustment diagnosis that has been submitted for payment but  
 10 is found to be invalid because it does not have supporting medical record documentation would  
 11 result in an overpayment.” *Id.* (The *UnitedHealthcare* court refers to CMS’s May 2014  
 12 announcement as the “2014 Overpayment Rule.” *UnitedHealthcare II*, 330 F. Supp. 3d at 182.<sup>424</sup>)

13 CMS addressed a commenter’s contention that (given CMS’s announcement that it would use  
 14 an FFS Adjuster in its RADV audits in the context of extrapolating error rates from an RADV  
 15 audit to the entire MA Plan), an overpayment cannot exist for a particular Medicare Advantage  
 16 contract unless CMS applied an FFS Adjuster to the entire contract. 79 Fed. Reg. at 29,921. CMS  
 17 disagreed:

18 Our RADV methodology does not change our existing contractual requirement that  
 19 MA organizations must certify (based on best knowledge, information, and belief)  
 20 the accuracy, completeness, and truthfulness of the risk adjustment data they  
 21 submit to CMS. Further, this decision does not change the long-standing risk  
 22 adjustment data requirement that a diagnosis submitted to CMS by an MA

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23 <sup>424</sup> CMS did not describe its guidance about “overpayments” — including its guidance that  
 24 submissions of unsupported diagnosis codes result in overpayments — as a new rule. Instead, it  
 25 characterized its guidance as in keeping with its longstanding requirements that providers submit  
 26 accurate diagnosis codes and return overpayments arising from inaccurate diagnosis codes. *See* 79 Fed.  
 27 Reg. at 29,921; *see also id.* at 29,919 (“MA organizations . . . continue to be obliged to comply with  
 28 our current procedures for handling inaccurate payments. . . . MA organizations . . . have responsibility  
 for the accuracy, completeness, and truthfulness of data they submit under existing [42 C.F.R.]  
 §§ 422.504(l) and 423.505(k). For Part C, the data submitted by the MA organization to CMS includes  
 §§ 422.308(f) (enrollment data) and 422.310 (risk adjustment data).”); *accord UnitedHealthcare II*,  
 330 F. Supp. 3d at 180 (noting that for years before CMS proposed its 2014 rules, it had “required  
 repayment to CMS of any costs that were based on unsupported diagnosis codes”).



1 organization for payment purposes must be supported by medical record  
2 documentation.

3 *Id.* at 29,921–22.

#### 4 **1.1.2 *UnitedHealthcare’s* invalidation of the 2014 Overpayment Rule**

5 The genesis of the *UnitedHealthcare* lawsuit was FCA lawsuits against UnitedHealth,  
6 including the *Swoben* lawsuit, charging that UnitedHealth submitted false risk-adjusting diagnosis  
7 codes (and false certifications that its codes were accurate, complete, and truthful) to CMS.  
8 *UnitedHealthcare Ins. Co. v. Price*, 255 F. Supp. 3d 208, 209–10 (D.D.C. 2017)  
9 (*UnitedHealthcare I*).<sup>425</sup> UnitedHealth and its affiliates then sued CMS in *UnitedHealthcare*,  
10 claiming, in part, that CMS’s May 2014 notice implemented a new rule that any payment for an  
11 unsupported diagnosis code constituted an “overpayment” and that this violated the “actuarial  
12 equivalence” provision in 42 U.S.C. § 1395w-23(a)(1)(C)(i) and the APA.<sup>426</sup>

13 CMS moved to stay the *UnitedHealthcare* lawsuit in light of the FCA lawsuits. The court  
14 denied the motion, holding that “[t]his APA case is limited to whether CMS acted beyond its  
15 authority when promulgating its 2014 Overpayment Rule.” *Id.* at 211. It explained:

16 [A]ny decision in this matter will not answer the most relevant questions in the  
17 FCA Cases. Whether a government contractor knowingly engaged in fraud, and  
18 whether a government agency appropriately promulgated a rule several years later,  
19 are simply too different from one another to warrant a stay, even if such lawsuits  
20 may touch upon similar questions of statutory interpretation.

21 *Id.*

22 UnitedHealth moved for summary judgment in the *UnitedHealthcare* lawsuit. The court  
23 granted the motion on the ground that the 2014 Overpayment Rule — that “any diagnostic code  
24 that is inadequately documented in a patient’s medical chart results in an ‘overpayment,’”

25 <sup>425</sup> The *UnitedHealthcare* lawsuit was filed when Sylvia Burwell was Secretary of Health and Human  
26 Services and originally was captioned *UnitedHealthcare Insurance Co. v. Burwell*. It was recaptioned  
27 as *UnitedHealthcare Insurance Co. v. Price* and *UnitedHealthcare Insurance Co. v. Azar* as Tom Price  
and Alex Azar, respectively, were appointed as Secretary.

28 <sup>426</sup> Complaint, *UnitedHealthcare Ins. Co. v. Burwell*, No. 1:16-cv-00157-RMC (D.D.C. Jan. 29, 2016)  
– ECF No. 1 at 9–13 (¶¶ 9–15), 33 (¶ 71), 39–40 (¶¶ 91–94).

1 *UnitedHealthcare II*, 330 F. Supp. 3d at 182 (emphasis in original) (citing 79 Fed. Reg. at 29,921)  
 2 — established a system where actuarial equivalence purportedly cannot be achieved. *Id.* at 187. It  
 3 concluded that (1) CMS’s using unaudited data from traditional Medicare (which contain errors)  
 4 in the risk model it uses to set Medicare Advantage payment while (2) requiring MA Participants  
 5 to return payments predicated on erroneous diagnosis codes, led to CMS’s paying less to MA  
 6 Participants to provide healthcare coverage than it pays for the coverage of comparable  
 7 beneficiaries in traditional Medicare, thereby violating “actuarial equivalence.” *Id.* at 184–85.

8 More specifically (and based solely on the administrative record<sup>427</sup>), the *UnitedHealthcare*  
 9 court made the following findings and conclusions.

10 For traditional Medicare Part B, physicians bill for services and identify the reasons for the  
 11 services with diagnosis codes. *Id.* at 177, 184. Payment depends only on the services; the  
 12 diagnosis codes — while required — are irrelevant to payment. *Id.* at 177, 184. This means that  
 13 “physicians are essentially indifferent to the diagnosis. . . . There’s no financial incentive to be  
 14 particularly careful” with diagnosis coding. *Id.* at 179 (ellipsis in original) (quoting hearing). As a  
 15 result, “diagnosis reports for Medicare Part B are considered much less reliable[.]” *Id.* Also,  
 16 because diagnosis codes do not affect what CMS pays for Part B, CMS purportedly does not audit  
 17 “traditional Medicare patient records; to the contrary, it accepts their diagnosis codes as given.” *Id.*  
 18 at 184.

19 CMS uses the traditional Medicare data (as discussed above) as inputs in its HCC model for  
 20 calculating risk scores for (and thus payments under) Medicare Advantage. *Id.* at 178. But because  
 21 CMS and medical providers are not careful about diagnosis codes in Part B (because they do not  
 22 matter for payment), the Part B diagnosis codes have errors. *Id.* (citing UnitedHealth’s claim that  
 23 the error rate “can be as high as 20%.”). “In consequence, the rates at which CMS pays Medicare  
 24 Advantage insurers are based on flawed data across the millions of people in traditional Medicare.  
 25 Yet the 2014 Overpayment Rule ignores those flaws when defining an ‘overpayment.’” *Id.* at 184.

26  
 27 \_\_\_\_\_  
 28 <sup>427</sup> See *UnitedHealthcare I*, 255 F. Supp. 3d at 211 (“[A]ny analysis by the Court would be limited to  
 the administrative record behind the 2014 Overpayment Rule and the statute.”).



1 The *UnitedHealthcare* court concluded, “the effect of the 2014 Rule, without some kind of  
2 adjustment, is that Medicare Advantage insurers will be paid less to provide the same healthcare  
3 coverage to their beneficiaries than CMS itself pays [to physicians under Medicare Part B] for  
4 comparable patients.” *Id.* at 184–85.

5 The problem with the Rule, said the court, was that it had no such adjustment. *Id.* at 187.  
6 According to the court, CMS recognized (in the context of RADV audits) the actuarial need to  
7 apply an FFS Adjuster. *Id.* But “the fly in the ointment” was that CMS did not implement a similar  
8 adjuster in the 2014 Overpayment Rule.” *Id.* “The consequence is inevitable: while CMS pays for  
9 all diagnostic codes, erroneous or not, submitted to traditional Medicare, it will pay less for  
10 Medicare Advantage coverage because essentially no errors would be reimbursed.” *Id.* The court  
11 thus invalidated the Rule under the APA because it “establishes a system where ‘actuarial  
12 equivalence’ cannot be achieved.”<sup>428</sup>

13 **1.1.3 *UnitedHealthcare* does not compel the conclusion that there is no actuarial**  
14 **equivalence here**

15 Sutter and PAMF contend that — under the analysis in *UnitedHealthcare* — requiring MA  
16 Participants to return payments predicated on false diagnosis codes also leads to the “inevitable”  
17 result that CMS will pay less for beneficiaries enrolled in MA Plans than for beneficiaries enrolled  
18 in traditional Medicare, thereby violating the “actuarial equivalence” provision in 42 U.S.C.  
19 § 1395w-23(a)(1)(C)(i).<sup>429</sup> The court does not reach that conclusion for several reasons.

20 First, the *UnitedHealthcare* court predicated its decision — that CMS inevitably pays less for  
21 beneficiaries in MA plans — on CMS’s application of an FFS Adjuster when extrapolating RADV  
22 audit results to the entire MA Plan. *UnitedHealthcare II*, 330 F. Supp. 3d at 180–81 (citing *Notice*  
23 *of Final Payment Error Calculation Methodology* 1–5). But as discussed above, CMS’s 2012  
24 announcement of the FFS Adjuster says only that CMS would conduct a review to calculate the

25 \_\_\_\_\_  
26 <sup>428</sup> The *UnitedHealthcare* court also held that the putative 2014 Overpayment Rule should be set aside  
27 because it (1) purportedly violated a separate statutory provision, 42 U.S.C. § 1395w-23(b)(4)(D), and  
(2) was arbitrary and capricious. *UnitedHealthcare II*, 330 F. Supp. 3d at 187–90.

28 <sup>429</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 15 (citing *UnitedHealthcare II*, 330  
F. Supp. 3d at 176, 187).

1 actual amount of the FFS Adjuster. *See Notice of Final Payment Error Calculation Methodology*  
 2 4–5. It does not identify the amount or state that CMS is paying less for Medicare Advantage  
 3 coverage.<sup>430</sup> Thus, the court cannot conclude from CMS’s 2012 announcement that CMS  
 4 inevitably pays less for beneficiaries in MA plans.

5 Second, Sutter and PAMF advance a hypothetical to demonstrate that CMS inevitably pays  
 6 less. The hypothetical does not demonstrate this point. The following is a simplified version of the  
 7 hypothetical. Assume that CMS used traditional Medicare data from 2011 as inputs in its HCC  
 8 model to determine risk scores in 2014.<sup>431</sup> Assume that in 2011, there were 1,000 beneficiaries in  
 9 traditional Medicare with a diagnosis code for diabetes (with a resulting \$1 million in bills to  
 10 CMS), and 500 of the 1,000 diagnosis codes were unsupported.<sup>432</sup> Because CMS allegedly does  
 11 not audit the traditional Medicare data it uses in its HCC model,<sup>433</sup> it would assume that the 1,000

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13 <sup>430</sup> In 2018, CMS completed its FFS Adjuster review and concluded that while there is a significant  
 14 error rate in traditional Medicare diagnosis codes, the overall impact of those errors on Medicare  
 15 Advantage payments is less than 1% and results in a 1% overpayment to MA Organizations (i.e., CMS  
 16 pays more, not less, for Medicare Advantage coverage). Ctrs. for Medicare and Medicaid Servs., *Fee*  
 17 *for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation*  
 18 *Audits 5* (Oct. 26, 2018), available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/  
 19 Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/  
 20 RADV-Docs/FFS-Adjuster-Executive-Summary.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Risk-Adjustment-Data-Validation-Program/Other-Content-Types/RADV-Docs/FFS-Adjuster-Executive-Summary.pdf) (last visited Mar. 16, 2020). The  
 21 *UnitedHealthcare* court found CMS’s FFS Adjuster review to be unpersuasive, *UnitedHealthcare III*,  
 22 2020 WL 417867, at \*5, but CMS’s FFS Adjuster review shows that CMS had not concluded in 2012  
 23 that it was paying less for Medicare Advantage coverage, much less that it was inevitably doing so.

19 <sup>431</sup> *Cf.* Ctrs. for Medicare and Medicaid Servs., *Announcement of Calendar Year (CY) 2014 Medicare*  
 20 *Advantage and Part D Payment Policies and Final Call Letter 3* (Apr. 1, 2013), available at  
 21 [https://www.cms.gov/medicare/health-plans/medicareadvtspeccratestats/downloads/  
 22 announcement2014.pdf](https://www.cms.gov/medicare/health-plans/medicareadvtspeccratestats/downloads/announcement2014.pdf) (last visited Mar. 16, 2020) (“We will rebase the FFS capitation rates for 2014,  
 23 using historical claims data for 2007 through 2011.”).

22 <sup>432</sup> *Cf.* Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 13. Sutter and PAMF propose a  
 23 hypothetical where 1,000 beneficiaries have 3,000 different diagnosis codes (i.e., the average  
 24 beneficiary has multiple diagnosis codes), and 1,500 codes are unsupported. *Id.* The court begins with  
 25 a hypothetical that assumes one diagnosis code per beneficiary and then addresses below the more  
 26 complicated issues that may arise when beneficiaries have multiple diagnosis codes.

25 <sup>433</sup> This is not to say that CMS does not audit traditional Medicare data at all. CMS audits traditional  
 26 Medicare data, just as it audits Medicare Advantage data. What Sutter and PAMF claim is that CMS  
 27 does not audit traditional Medicare data before using the data as inputs in its HCC model. *Id.* (“CMS  
 28 does not audit fee-for-service data before calculating the incremental costs associated with diagnosis  
 codes”). The government agrees that “[t]he claim dataset used to calibrate the HCC model reflects a  
 snapshot in time” and that “[c]ertain claims and diagnoses could have been corrected by the  
 [traditional Medicare] providers that submitted them or rejected by CMS before or after the claims  
 dataset was generated to calibrate the HCC model.” Gov’t Opp’n – ECF No. 82 at 28.

1 diabetes diagnosis codes all are valid and would calculate (and pay MA Participants) an average  
 2 cost per code of \$1,000. Now assume that in 2014, the beneficiaries enrolled in either traditional  
 3 Medicare or Medicare Advantage and had the same costs and codes that they had in 2011. For  
 4 enrollees in traditional Medicare, CMS would pay \$1 million.<sup>434</sup> For enrollees in MA plans, CMS  
 5 requires MA Participants to delete unsupported codes (and return the related payments), which  
 6 means that after deleting the 500 false diagnosis codes, CMS would pay the MA Participant  
 7 \$500,000. Sutter and PAMF contend that by paying less for Medicare Advantage coverage  
 8 (\$500,000) than traditional Medicare coverage (\$1 million), CMS violates “actuarial equivalence.”  
 9 Sutter and PAMF contend that CMS therefore cannot require the MA Participant to return  
 10 payments for false diagnosis codes (unless the MA Participant’s submission rate of false codes  
 11 exceeds the error rate for traditional Medicare providers).

12 But the hypothetical captures only part of the story. If CMS really does not audit the traditional  
 13 Medicare data that it uses as inputs in its HCC model, then the traditional Medicare data likely  
 14 contain not only unsupported diagnosis codes but also, unsupported costs.<sup>435</sup> In this hypothetical  
 15 involving data from traditional Medicare in 2011, Sutter and PAMF posit that half of the diagnosis  
 16 codes were unsupported, but it might be that half of the costs were unsupported too (based on bills  
 17 for services that were medically unnecessary or not performed), and CMS did not catch the  
 18 misbilling because it purportedly does not audit traditional Medicare data.<sup>436</sup> CMS would assume

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19  
 20 <sup>434</sup> Of course, CMS would not pay exactly \$1 million for traditional-Medicare coverage of these  
 21 beneficiaries in 2014. Traditional Medicare uses a fee-for-services model, and the beneficiaries likely  
 22 would require different services in 2014 than in 2011. A beneficiary in perfect health on Monday  
 23 might suffer an accident on Tuesday, incurring additional medical costs. But the relevant issue here is  
 24 actuarial predictions, not actual costs, and this hypothetical therefore assumes that actuarial predictions  
 25 accurately predict actual costs.

26 <sup>435</sup> The Ninth Circuit in *Silingo* cited a GAO report that found that in 2016, \$16.2 billion — nearly  
 27 10% — of all Medicare Advantage payments were improper. *Silingo*, 904 F.3d at 673 (citing *Medicare*  
 28 *Advantage Program Integrity* 1). The same report found that 11% of traditional Medicare payments  
 also were improper, in part, because reviewers could not conclude that the traditional Medicare  
 provider actually provided the billed services, that it provided services for the amounts billed, or that  
 the billed services were medically necessary. *Medicare Advantage Program Integrity* 3–4 & n.8.

<sup>436</sup> The *UnitedHealthcare* court observed that traditional Medicare providers do not have an incentive  
 to be careful about their diagnosis coding because coding does not affect what they are paid.  
*UnitedHealthcare II*, 330 F. Supp. 3d at 179. Traditional Medicare providers do have an incentive to  
 bill as many services as possible to increase payments to them.

1 that the \$1 million in costs were valid and pay MA Participants \$1,000 for a diabetes diagnosis  
2 code. Now assume that in 2014, the beneficiaries enrolled in either traditional Medicare or  
3 Medicare Advantage and had the same costs and codes that they had in 2011. For enrollees in  
4 traditional Medicare (with providers who billed only for legitimate services instead of overbilling,  
5 as they did in 2011), CMS would pay \$500,000 (which means that it would not pay less for  
6 Medicare Advantage beneficiaries than for traditional Medicare beneficiaries).<sup>437</sup>

7 The actuarial-equivalence argument is even less persuasive for patients with multiple  
8 diagnoses. An example is patients who fracture their tibia (the front bone in the lower leg) or their  
9 fibula (the rear bone in the lower leg). Assume that in 2011, there were 1,000 traditional Medicare  
10 beneficiaries, 200 with a diagnosis code for a tibia fracture, 200 with a diagnosis code for a fibula  
11 fracture, and 600 erroneously coded for both (when they broke only one bone). All patients need  
12 an X-ray of their leg at an assumed cost (say, \$100). Sutter and PAMF assume that CMS's HCC  
13 model divides the total cost ( $\$100 \times 1,000$  patients = \$100,000) by the total number of diagnosis  
14 codes ( $200 + 200 + (600 \times 2) = 1600$ ) for a cost of \$62.50 per diagnosis code.<sup>438</sup> But CMS's HCC  
15 model is a regression model, not a cost averager. *UnitedHealthcare II*, 330 F. Supp. 3d at 178.<sup>439</sup>  
16 Sutter and PAMF provide no support for their assumption that CMS's HCC model divides total  
17 costs by total diagnosis codes (as opposed to using a regression model that correctly identifies that

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19 <sup>437</sup> Cf. Gov't Opp'n – ECF No. 82 at 28 (“If both the traditional Medicare provider and the MA  
20 provider comply with their obligation to correct their data, they continue to receive comparable  
21 payments.”). And, of course, if the traditional Medicare providers knowingly overbilled and received  
22 \$1 million in payment for \$500,000 in legitimate services, they would be subject to FCA liability, like  
23 Medicare Advantage providers that knowingly overcoded. *See, e.g., United States ex rel. Martinez v.*  
*KPC Healthcare Inc.*, No. 8:15-cv-01521-JLS-DFM, 2017 WL 10439030, at \*6 (C.D. Cal. June 8,  
2017) (“[U]nder [42 U.S.C. § 1320a-7k]’s plain meaning, a Medicare fee-for-service payment  
24 recipient has violated 31 U.S.C. § 3729(a)(1)(G) if it fraudulently bills the government and then  
25 knowingly fails to return the overpayment within sixty days of the identification of the overpayment.”)  
(citing cases).

26 <sup>438</sup> *See* Defs. Mot. to Dismiss Gov't Compl. – ECF No. 66 at 13.

27 <sup>439</sup> “A regression analysis is ‘a common statistical tool designed to isolate the influence of one  
28 particular factor — e.g., sex — on a dependent variable — e.g., salary.’” *EEOC v. Gen. Tel. Co. of*  
*Nw., Inc.*, 885 F.2d 575, 577 n.3 (9th Cir. 1989) (internal brackets and ellipses omitted) (quoting *Sobel*  
*v. Yeshiva Univ.*, 839 F.2d 18, 21–22 (2d Cir. 1988)). More specifically, a regression analysis is “[t]he  
use of an algebraic formula to express the influence of one or more independent variables (e.g., racial  
status) on the average level of a dependent variable (e.g., selection rate).” *Id.* (internal ellipses  
omitted) (quoting David Baldus and James Cole, *Statistical Proof of Discrimination* 357 (1980)).

1 diagnosis codes (for a tibia fracture, a fibula fracture, or both) all result in the same \$100 X-ray  
 2 cost). Assuming the regression model and the \$100 cost, CMS would pay an MA Participant \$100  
 3 (not \$62.50), and the alleged errors in the double-coded traditional Medicare patients would not  
 4 change those payment rates. Under this scenario, it is not inevitable that CMS pays less for MA  
 5 plan beneficiaries than for traditional Medicare beneficiaries.

6 In sum, the arguments do not persuade that CMS inevitably pays less for MA Plan  
 7 beneficiaries than for traditional Medicare beneficiaries, thereby violating the “actuarial  
 8 equivalence” provision in 42 U.S.C. § 1395w-23(a)(1)(C)(i).

### 9 **1.2 “Actuarial Equivalence” Is Not a Defense to an FCA Claim**

10 In any event, actuarial equivalence is not a defense to an FCA claim: it does not authorize MA  
 11 Participants to report false diagnosis codes or keep (and not report and return) overpayments  
 12 predicated on the false codes, and it does not vitiate scienter.

#### 13 **1.2.1 MA Participants cannot retain payments predicated on false diagnosis codes**

14 Even if CMS pays less for beneficiaries in MA plans than it pays for traditional Medicare  
 15 beneficiaries (thereby violating the “actuarial equivalence” requirement of 42 U.S.C. § 1395w-  
 16 23(a)(1)(C)(i)), controlling Ninth Circuit authority establishes that this is not a defense that  
 17 permits MA Participants such as Sutter and PAMF to submit false claims based on false diagnosis  
 18 codes and to keep (and not report and return) inflated payments predicated on the false claims.

19 42 U.S.C. § 1320a-7k requires an MA Participant to report and return “overpayments.”  
 20 “Overpayments” are “any funds that a person receives or retains under [Medicare or Medicaid] to  
 21 which the person, after applicable reconciliation, is not entitled.” 42 U.S.C. § 1320a-7k(d)(2)(A),  
 22 (d)(4)(B).<sup>440</sup> Necessarily, then, an MA Participant must be entitled to a payment to keep it. Ninth  
 23 Circuit precedent establishes the following. A properly documented medical record must support  
 24 each diagnosis code. *Swoben*, 848 F.3d at 1168 (citations omitted). An MA Participant should  
 25 withdraw unsupported diagnosis codes. *Id.* at 1177 n.8; *see id.* at 1174 (rejecting the argument that  
 26

27 \_\_\_\_\_  
 28 <sup>440</sup> Sutter and PAMF do not challenge the “applicable reconciliation” provision and do not contend that payments to them are not overpayments because “applicable reconciliation” had not taken place.



1 MA Participants are not obliged to withdraw unsupported diagnosis codes). Payments based on  
 2 unsupported diagnosis codes are “improperly inflated.” *Silingo*, 904 F.3d at 673. The  
 3 *UnitedHealthcare* court similarly noted that for more than a decade, CMS has “required  
 4 repayment to CMS of any costs that were based on unsupported diagnosis codes.”  
 5 *UnitedHealthcare II*, 330 F. Supp. 3d at 180.<sup>441</sup> These cases compel the conclusion that MA  
 6 Participants are not entitled to payments predicated on unsupported diagnosis codes. And if MA  
 7 Participants are not entitled to payments predicated on unsupported diagnosis codes, then the  
 8 payments are “overpayments” subject to the reporting-and-return requirements of § 1320a-7k.

9 A contrary conclusion would permit MA Participants to submit or not report false diagnosis  
 10 codes to adjust for a payment rate that is less than the rate for traditional Medicare beneficiaries.  
 11 That would defy the aphorism that “[m]en must turn square corners when they deal with the  
 12 government.” *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1217 (9th Cir. 2014) (quoting *Rock Island,*  
 13 *A. & L. R. Co. v. United States*, 254 U.S. 141, 143 (1920)). And “[i]f the [defendants] did indeed  
 14 knowingly submit false claims in order to receive payment . . . not covered under the [existing]  
 15 rule, the invalidity of the rule will be no defense.” *Cedars-Sinai Med. Ctr. v. Shalala*, 125 F.3d  
 16 765, 769 (9th Cir. 1997). In *Cedars-Sinai*, hospitals submitted claims to Medicare and Medicaid  
 17 for reimbursement of non-FDA-approved medical devices. *Id.* at 767. A Health Care Financing  
 18 Administration (“HCFA”) policy barred coverage. *Id.* In a separate qui tam FCA lawsuit, a relator  
 19 alleged that the hospitals knowingly submitted the false claims. *Id.* The hospitals challenged the  
 20 HCFA policy under the APA in a separate lawsuit. *Id.* In part, the district court held that the issues  
 21 in the qui tam case and the APA case were different. *Id.* at 769. On appeal, the Ninth Circuit  
 22 affirmed, holding that the invalidity of the policy was not a defense to the submission of false  
 23 claims: “One who elects fraud as a means of self-help may not escape the consequences by urging  
 24  
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26  
 27 <sup>441</sup> MA Participants dispute whether CMS should require them to return payments based on  
 28 extrapolating RADV-audit results across non-audited diagnosis codes, but there is no dispute that  
 CMS has long required MA Participants to return all payments based on the unsupported diagnosis  
 codes identified during audits. *UnitedHealthcare II*, 330 F. Supp. 3d at 180.

1 that his conduct be excused because the [rule] which he sought to evade is invalid.” *Id.* (internal  
2 brackets omitted) (quoting *Bryson v. United States*, 396 U.S. 64, 68 (1969)).

3 This precedent establishes that even if CMS’s payment methodology does not ensure  
4 “actuarial equivalence” between payments for healthcare under traditional Medicare and payments  
5 for health care under MA Plans, and “were declared invalid, . . . that will be no defense to the []  
6 claims under the False Claims Act.” *Id.* (citing *United States v. Weiss*, 914 F.2d 1514, 1522–23  
7 (2d Cir. 1990)); accord *UnitedHealthcare I*, 255 F. Supp. 3d at 211 (“[w]hether a government  
8 contractor knowingly engaged in fraud [an FCA claim], and whether a government agency  
9 appropriately promulgated a rule years later [an APA claim], are simply too different from one  
10 another” to warrant staying one action in lieu of the other).<sup>442</sup>

11 Also, the defendants’ proposed pleadings standard — requiring the government to allege facts  
12 establishing that the defendants’ “error rate” of unsupported codes is higher than the “error rate” in  
13 the traditional Medicare fee-for-service program<sup>443</sup> — is not obviously accomplishable at the  
14 pleadings stage and would make it unworkable for the government to pursue reverse-FCA claims  
15 against MA Participants. This is not what Congress intended. *Cf. Kane ex rel. United States v.*  
16 *Healthfirst, Inc.*, 120 F. Supp. 3d 370, 390 (S.D.N.Y. 2015) (rejecting the defendants’ narrow  
17 interpretation of 42 U.S.C. § 1320a-7k because it placed an unworkable burden on the plaintiffs at  
18 the pleadings stage).

19 Here, the defendants propose no workable methodology to define or compare an MA  
20 Participant’s “error rate” against the traditional-Medicare error rate. The error rate is not simply  
21 total unsupported diagnosis codes divided by total diagnosis codes, in part because some errors are  
22 serious and some are not. Put another way, the severity of the code and the magnitude of the error  
23 matter. For example, miscoding the wrong broken bone (e.g., coding a patient who broke his tibia

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25 <sup>442</sup> MA Participants know in advance what they will be paid: each year, CMS announces well in  
26 advance the annual Medicare Advantage capitation rate and the risk and other factors to be used in  
27 adjusting such rate. 42 U.S.C. § 1395w-23(b)(1)(B); see, e.g., *Announcement for Calendar Year (CY)*  
28 *2014 Medicare Advantage and Part D Payment Policies*. If MA Participants think that they should be  
paid more or that the “actuarial equivalence” provision in 42 U.S.C. § 1395w-23(a)(1)(C)(i) requires  
CMS to pay them more, they can raise that objection with CMS.

<sup>443</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 14, 17–18.

1 as having broken his fibula) is different than falsely coding a cancer diagnosis (e.g., coding a  
2 healthy patient as having lung cancer).

3 In addition, because it is impracticable to review every single diagnosis code that an MA  
4 Participant submits (much less every diagnosis code in CMS’s traditional Medicare data), any  
5 calculation of “error rates” necessarily must involve sampling and extrapolation — which in turn  
6 necessitates some mechanism to select appropriately representative samples and then give the  
7 samples their appropriate weight. Sutter and PAMF offer no mechanism for doing so.

8 Sutter’s and PAMF’s proposed pleading standard would mean that the government could not  
9 sue an MA Participant — even if it had proof that all of the MA Participant’s codes for, say,  
10 pneumonia were false, and the MA Participant refused to repay<sup>444</sup> — unless it (1) took an  
11 appropriate sample of all of the codes the MA Participant submitted across its contract with CMS,  
12 including codes unrelated to the fraudulent-pneumonia-coding scheme,<sup>445</sup> (2) obtained the  
13 underlying medical records, (3) compared the codes and the records to identify and weight the  
14 extent and seriousness of the errors, (4) extrapolated the errors over the MA Participant’s contract  
15 with CMS, (5) took an appropriate sample of all of its traditional Medicare data, (6) obtained the  
16 underlying medical records, which might require it to seek medical records from hundreds of  
17 separate third-party traditional Medicare providers, (7) compared the codes and the records to  
18 identify and weight the extent and seriousness of the errors, (8) extrapolated the errors over the  
19 MA Participant’s contract with CMS, and (9) compared the resulting error rates. Even after the  
20 pleadings stage, the case would get swallowed by disputes about sample sizes, extrapolation, and  
21 error-rate calculations, thereby preventing the government from litigating the underlying  
22 fraudulent-pneumonia-code scheme and frustrating Congress’s intent for robust FCA enforcement  
23 to prevent healthcare fraud. *Cf. Kane*, 120 F. Supp. 3d at 390.

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25 \_\_\_\_\_  
26 <sup>444</sup> *Cf. Gov’t Compl. – ECF No. 41 at 33 (¶ 96)* (PAMF physician complaining to PAMF Physician  
27 Champion and others in PAMF management that “changing a diagnosis from acute bronchitis to  
28 pneumonia is not a simple or unimportant change” and “it is so obviously unethical”).

<sup>445</sup> *Cf. Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 21* (arguing that the government must  
“make allegations about the *overall* rate of unsupported diagnosis codes in Defendants’ data” to plead  
an FCA claim) (emphasis in original).



1 As the Supreme Court has said, “Congress ‘does not alter the fundamental details of a  
2 regulatory scheme in vague terms or ancillary provisions — it does not, one might say, hide  
3 elephants in mouseholes.’” *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1626–27 (2018) (quoting  
4 *Whitman v. Am. Trucking Ass’ns, Inc.*, 531 U.S. 457, 468 (2001)).<sup>446</sup> Nothing suggests that the  
5 “actuarial equivalence” provision in 42 U.S.C. § 1395w-23(a)(1)(C)(i) — part of a statute that  
6 does not mention the FCA — imposes a pleading or proof standard for FCA cases. “It’s more than  
7 a little doubtful that Congress would have tucked into the mousehole of [42 U.S.C. § 1395w-  
8 23(a)(1)(C)(i)’s actuarial-equivalence provision] an elephant that tramples the work done by [the  
9 FCA].” *Cf. id.* at 1627. That conclusion is bolstered by Congress’s subsequent 2010 enactment, as  
10 part of the ACA, of “Enhanced Medicare and Medicaid Program Integrity Provisions” that  
11 expand, not contract, the scope of FCA liability. *Cf. Kane*, 120 F. Supp. 3d at 391 (“Each time  
12 Congress has weighed in on the purpose and power of the FCA, it has endorsed a reading of that  
13 statute as a robust, remedial measure aimed at combatting fraud against the federal government as  
14 firmly as possible.”).

15 *Swoben* also supports this result. In *Swoben*, the MA Organizations allegedly submitted  
16 certifications regarding unsupported diagnosis codes. 848 F.3d at 1166. CMS audits put them on  
17 notice that their submissions likely included a significant number of erroneous codes. *Id.* at 1167.  
18 Under the relevant regulations, MA Organizations may (but are not required to) conduct  
19 retrospective reviews of their enrollees’ medical records to ensure the accuracy of the diagnosis  
20 codes. *Id.* at 1169. According to the relator, the MA Organizations conducted one-sided reviews to  
21 capture under-reporting errors but not over-reporting errors, resulting in inflated capitation  
22 payments, and rendering their periodic certifications false, in violation of the FCA. *Id.* at 1170.  
23 The MA Organizations argued (in part) that they reasonably believed that they were not required  
24 to take affirmative steps to find unsupported diagnosis codes because (1) 42 C.F.R. § 422.310(d)

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27 <sup>446</sup> In *Epic Systems*, the Supreme Court upheld under the Federal Arbitration Act (“FAA”) an  
28 arbitration clause in an employment contract that waived the right to collective litigation against the  
employer and held that Section 7 of the National Labor Relations Act did not alter the FAA. *Epic Sys.*,  
138 S. Ct. at 1626–27.

1 provided only that MA Organizations must submit “data that conform to CMS’[s] requirements  
 2 for data equivalent to [traditional] Medicare fee-for-service data,” and (2) CMS does not verify  
 3 diagnosis codes from traditional Medicare providers, and the “data equivalent” requirement in the  
 4 regulation meant that MA Organizations did not have to verify their diagnosis codes either. *Id.* at  
 5 1179. The Ninth Circuit rejected the argument: “because nothing in § 422.310(d)[’s ‘data  
 6 equivalent’ requirement] speaks to a Medicare Advantage organization’s obligations to ensure the  
 7 accuracy of risk adjustment data, it does not modify a Medicare Advantage organization’s  
 8 obligations” to submit accurate diagnosis codes under the relevant regulations. *Id.* (citing  
 9 42 C.F.R. §§ 422.503(b)(4)(vi) & 422.504(l)).

10 Like the “data equivalent” regulation in *Swoben*, nothing in 42 U.S.C. § 1395w-  
 11 23(a)(1)(C)(i)’s “actuarial equivalence” provision speaks to an MA Participant’s obligation to  
 12 ensure the accuracy of its diagnosis codes, and thus nothing in the provision modifies an MA  
 13 Participant’s obligation to ensure that it is submitting accurate diagnosis codes or allows it to keep  
 14 (and not report and return) inflated payments predicated on false diagnosis codes.<sup>447</sup>

### 15 1.2.2 The “actuarial equivalence” requirement does not vitiate scienter

16 Sutter and PAMF — quoting *Safeco Insurance Co. of America v. Burr*, 551 U.S. 47, 70 n.20  
 17 (2007) — also contend that even if one rejects their actuarial-equivalence argument, their  
 18 interpretation of that requirement vitiates scienter because “‘Congress could not have intended’ to  
 19

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20 <sup>447</sup> Sutter and PAMF distinguish *Swoben* on the ground that it did not address the “actuarial  
 21 equivalence” provision in 42 U.S.C. § 1395w-23(a)(1)(C)(i). Defs. Reply in Supp. of Mot. to Dismiss  
 22 Gov’t Compl. – ECF No. 86 at 8–9 & n.3 (citing *United States ex rel. Poehling v. UnitedHealth Grp.,*  
 23 *Inc.*, No. CV 16-8697-MWF (SSx), 2019 WL 2353125 (C.D. Cal. Mar. 28, 2019) (*Poehling II*)). But  
 24 the reasoning for the holding in *Swoben* (a regulation requiring data equivalence reported does not  
 25 alter the obligation to report data accurately) applies here: the requirement of “actuarial equivalence”  
 26 between Medicare Advantage coverage and traditional Medicare coverage does not alter the accurate-  
 27 reporting obligation either. The failure to discuss “actuarial equivalence” does not distinguish *Swoben*.

28 Sutter and PAMF also contend that *Swoben* does not control because the direct-FCA claims there  
 were based on false certifications of accuracy, completeness, and truthfulness under 42 C.F.R.  
 § 422.504(l), and the direct-FCA claims here are based on false diagnosis codes, not certifications.  
 Defs. Reply in Supp. of Mot. to Dismiss Gov’t Compl. – ECF No. 86 at 8–9. This argument does not  
 change the outcome. The *Swoben* court did not limit its holding — that MA Participants must submit  
 accurate diagnosis codes and withdraw unsupported codes — to false certifications and compels the  
 conclusion that MA Participants cannot bill CMS for false diagnosis codes (and keep and not report  
 the resulting overpayments). *Swoben*, 848 F.3d at 1168, 1774, 1777 n.8; *accord Silingo*, 904 F.3d at  
 673 (submitting unsupported codes results in “improperly inflated” payments).

1 subject a defendant to liability under a knowing or reckless standard where the defendant  
 2 ‘followed an interpretation that could reasonably have found support in the courts, whatever their  
 3 subjective intent might have been.’<sup>448</sup> This argument fails.

4 In *Safeco*, the Supreme Court said, “[w]here . . . the statutory text and relevant court and  
 5 agency guidance allow for more than one reasonable interpretation, it would defy history and  
 6 current thinking to treat a defendant who merely adopts one such interpretation as a knowing or  
 7 reckless violator. Congress could not have intended such a result for those who followed an  
 8 interpretation that could reasonably have found support in the courts, whatever their subjective  
 9 intent may have been.” *Safeco*, 551 U.S. at 70 n.20. By contrast, “even if a regulated party adopts  
 10 a ‘reasonable’ interpretation of an ‘ambiguous’ statute, it can nonetheless be deemed liable for  
 11 knowingly making a false statement if it ‘had been warned away from that interpretation’ by  
 12 authoritative agency guidance.” *Ipsen Biopharmaceuticals, Inc. v. Azar*, 943 F.3d 953, 957–58  
 13 (D.C. Cir. 2019) (quoting *United States ex rel. Purcell v. MWI Corp.*, 807 F.3d 281, 288 (D.C. Cir.  
 14 2015)); accord *Swoben*, 848 F.3d at 1178 (rejecting MA Organizations’ argument that their  
 15 interpretation of the regulation in question was objectively reasonable in light of “CMS’[s] clear  
 16 statements in the [regulation’s] preamble,” which “resolved any ambiguity” against the MA  
 17 Organizations).

18 CMS regulations have long warned MA Participants that they must certify that the data they  
 19 submit is accurate, complete, and truthful, 42 C.F.R. § 422.504(l)(3), that they will be required to  
 20 submit a sample of medical records for data validation, 42 C.F.R. § 422.310(e), and that there may  
 21 be penalties for the submission of false data, *id.* Additionally, for more than a decade, CMS has  
 22 “required repayment to CMS of any costs that were based on unsupported diagnosis codes.”  
 23 *UnitedHealthcare II*, 330 F. Supp. 3d at 180. No court — including the *UnitedHealthcare* court —  
 24 has held that an MA Participant can keep and not report or return payments based on unsupported  
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28 <sup>448</sup> Defs. Reply in Supp. of Mot. to Dismiss Gov’t Compl. – ECF No. 86 at 6, 14–16.

1 codes. *Cf. id.* at 189 (“UnitedHealth does not contend that Medicare Advantage insurers should be  
2 permitted knowingly or recklessly to bill CMS for erroneous diagnosis codes.”).<sup>449</sup>

3 In sum, the actual-equivalence argument does not vitiate scienter.

4 \* \* \*

5 Sutter and PAMF complain that “the government . . . attempt[s] to impose a heightened  
6 standard on Medicare Advantage providers that it has never imposed in traditional Medicare.”<sup>450</sup> It  
7 does not. Traditional Medicare providers and Medicare Advantage providers both must submit  
8 accurate data to CMS. The government brings FCA claims against both if they submit false claims  
9 that result in overpayments or fail to return overpayments. Traditional Medicare providers — who  
10 submit claims based on medical services — are liable if they (with the requisite scienter) submit  
11 false bills for medical services (or fail to return overpayments). Medicare Advantage providers —  
12 who submit claims based on diagnosis codes — also are liable if they submit (with the requisite  
13 scienter) false or unsupported codes (or fail to return overpayments).<sup>451</sup>

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15 <sup>449</sup> The *UnitedHealthcare* decision issued in 2018, i.e., after the core time period of the defendants’  
16 alleged misconduct. *See* Gov’t Compl. – ECF No. 41 at 6 (¶ 10), 45 (¶ 131). Before 2018, agency  
17 guidance warned medical providers that they could not keep (and must report or return) overpayments  
18 based on false diagnosis codes. 42 C.F.R. §§ 422.310(e), 422.504(l)(3); *see also, e.g.*, 79 Fed. Reg. at  
19 29,921 (“For example, a risk adjustment diagnosis that has been submitted for payment but is found to  
20 be invalid because it does not have supporting medical record documentation would result in an  
21 overpayment.”). Sutter’s written policies and procedures acknowledge this: they state that Sutter  
22 would report and return any payment based on (among other things) an “incorrect code or modifier  
23 assignment resulting in a higher level of reimbursement” or “insufficient or lack of documentation to  
24 support billed services.” *See supra* notes 294–296. *Safeco* addresses circumstances where the statutes,  
25 regulations, and court decisions allow for more than one reasonable interpretation. *Safeco*, 551 U.S. at  
26 70 n.20. That is not the case here. The 2018 *UnitedHealthcare* decision does not vitiate the defendants’  
27 scienter at the time of their alleged misconduct. *See Halo Elecs., Inc. v. Pulse Elecs., Inc.*, 136 S. Ct.  
28 1923, 1933 (2016) (“Nothing in *Safeco* suggests that [courts] should look to facts that the defendant  
neither knew or had reason to know at the time he acted.”); *accord Cedars-Sinai*, 125 F.3d at 769  
 (“Even if the Hospitals succeed in having the rule [later] declared invalid, however, that will be no  
defense to the Relator’s claims under the False Claims Act.”) (citing *Weiss*, 914 F.2d at 1522–23). In  
any event, as discussed above, the *UnitedHealthcare* court did not hold that MA Participants could  
keep (and not report or return) overpayments based on false diagnosis codes. *Cf. UnitedHealthcare II*,  
330 F. Supp. 3d at 180, 189. To the contrary, it acknowledged that CMS requires repayment of any  
costs predicated on unsupported diagnosis codes. *Id.* at 180.

<sup>450</sup> Defs. Reply in Supp. of Mot. to Dismiss Gov’t Compl. – ECF No. 86 at 5.

<sup>451</sup> Sutter and PAMF argue if the court were to dismiss the FCA claims, the government would not  
lack resources: “[i]t is free to use administrative and other mechanisms to pursue reimbursement when  
it believes that it has overpaid a participant in the Medicare Advantage program.” Defs. Mot. to  
Dismiss Gov’t Compl. – ECF No. 66 at 24. But that approach shifts the burden for ascertaining the

1 The court denies the motion to dismiss on the ground that “actuarial equivalence” is not a  
2 defense to an FCA claim.<sup>452</sup>

## 3 4 **2. The Relator Can Pursue Her Sutter-Wide Claims**

5 The government’s complaint challenges PAMF’s unsupported diagnosis codes, but it did not  
6 allege FCA or other violations at Sutter affiliates other than PAMF.<sup>453</sup> Ms. Ormsby filed a First  
7 Amended Complaint after the government intervened in the action, adding additional allegations  
8 about Sutter affiliates other than PAMF (as described above in the Statement).<sup>454</sup> The government  
9 previously settled with Sutter and its non-PAMF affiliates for \$30 million in a non-FCA  
10 settlement.<sup>455</sup> It does not object to Ms. Ormsby’s expansion of the FCA claims to non-PAMF  
11 Sutter affiliates.<sup>456</sup> Sutter moves to dismiss Ms. Ormsby’s complaint on the ground that she cannot

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16 accuracy of diagnosis codes to CMS (presumably through its audits) and away from MA Participants.  
17 That is not what the statutory scheme requires. Instead, MA Participants must certify that their  
18 diagnosis codes and data are true and accurate, and MA Participants must report and return any  
19 overpayments. *See supra* notes 17–25, 41–47 and accompanying text. CMS audits MA participants to  
20 confirm the accuracy of the diagnosis coding. *See supra* note 44 and accompanying text. That audit  
21 process does not excuse MA Participants’ obligation to report diagnosis codes and overpayments  
22 accurately in the first instance.

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28 <sup>452</sup> This holding means that going forward (including through discovery, motions, or trial), this case is  
not about “actuarial equivalence” calculations or the overall error rates in CMS’s traditional Medicare  
data. Instead, and unlike the APA dispute in *UnitedHealthcare*, the case is about whether Sutter and  
PAMF submitted false diagnosis codes to CMS or failed to report and return overpayments predicated  
on the false codes. *Cf. Cedars-Sinai*, 125 F.3d at 769 (invalidity of applicable rule “will be no defense  
to . . . claims under the False Claims Act”); *UnitedHealthcare I*, 255 F. Supp. 3d at 211 (“any decision  
in this [APA] matter will not answer the most relevant questions in the FCA Cases[, namely, w]hether  
a government contractor knowingly engaged in fraud”).

<sup>453</sup> Gov’t Compl. – ECF No. 41; Hr’g Tr. – ECF No. 97 at 18 (“[THE GOVERNMENT:] If you look at  
the claims in the respective [latest] complaints and we’re dealing with, as you already noted, PAMF  
and Sutter as to PAMF[.]”).

<sup>454</sup> Relator FAC – ECF No. 52.

<sup>455</sup> *Id.* at 3–4 (¶ 7); *see* Relator Req. for Judicial Notice Ex. B (Settlement Agreement) – ECF No. 81 at  
10–22.

<sup>456</sup> Hr’g Tr. – ECF No. 97 at 18 (“[THE GOVERNMENT:] . . . [W]e think, just like Judge Donato  
did in [*United States ex rel. Jahr v. Tetra Tech EC, Inc.*, No. 3:13-cv-03835-JD (N.D. Cal. filed Aug.  
19, 2013)], that we don’t have a problem with [the relator] pursuing those claims.”).

1 maintain a broader FCA action than the government’s FCA action, and that her lawsuit thus is  
2 limited to PAMF (and cannot extend to Sutter’s non-PAMF affiliates).<sup>457</sup>

3 Practically, the government’s intervention means that it has the primary responsibility for  
4 prosecuting the action, *see* 31 U.S.C. § 3730(c)(1), and the litigation in intervened cases generally  
5 focuses initially on the government’s case (here, PAMF). That said, the government’s limit of its  
6 case to PAMF does not bar Ms. Ormsby’s claims regarding Sutter’s non-PAMF affiliates. The  
7 court thus denies Sutter’s motion to dismiss Ms. Ormsby’s claims.

8 Under the FCA, a relator may bring a civil FCA lawsuit on behalf of the government, and  
9 thereafter, the government may elect to intervene and proceed with the action. 31 U.S.C.  
10 § 3730(b)(1)–(2). If the government intervenes, it “shall — (A) proceed with the action, in which  
11 case the action shall be conducted by the government; or (B) notify the court that it declines to  
12 take over the action, in which case the person bringing the action shall have the right to conduct  
13 the action.” 31 U.S.C. § 3730(b)(4).

14 When the government intervenes in a case, it becomes a party to the lawsuit as a whole, not  
15 merely a party to particular claims:

16 [31 U.S.C. § 3730] states that “[t]he Government may elect to intervene and  
17 proceed with the action within 60 days after it receives both the complaint and the  
18 material evidence and information.” It does not state that the government may  
19 intervene in part of the action or as to certain counts or certain claims for relief.  
20 Neither does it state that the government declines party status in those claims it  
21 chooses not to prosecute or settle. . . . [T]he government becomes a “party” to the  
22 suit as a whole when it intervenes. It does not become a “party” to a particular  
23 claim or number of claims.”

24 *United States ex rel. Bennett v. Biotronik, Inc.*, 876 F.3d 1011, 1020–21 (9th Cir. 2017).

25 After the government intervenes, it has primary responsibility for prosecuting the action “and  
26 shall not be bound by an act of the person bringing the action,” meaning, the relator. 31 U.S.C.  
27 § 3730(c)(1). The relator has the right to continue as a party in the action. *Id.* But § 3730(c) limits  
28 the relator’s participation and essentially gives the government the authority to run the plaintiffs’

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<sup>457</sup> Defs. Mot. to Dismiss Relator FAC – ECF No. 68 at 5–7. Ms. Ormsby’s initial complaint focused on PAMF, but she alleged too that there was a system-wide failure at Sutter. Relator Compl. – ECF No. 1 at 4–5 (¶¶ 7–8) (system-wide failure), 15–32 (¶¶ 51–115) (PAMF).



1 show. *Id.* In summary form, the limitations to the relator’s participation are as follows: (1) the  
2 government may dismiss the case over the relator’s objections (on the government’s motion and  
3 after the court provides the relator the opportunity for a hearing on the motion); (2) the  
4 government may settle the action over the relator’s objections (after the court determines, after a  
5 hearing, that the settlement is fair, adequate, and reasonable under all the circumstances); (3) the  
6 court — upon the government’s showing that the relator’s participation causes undue delay or is  
7 repetitious, irrelevant, and harassing — may impose limits on the relator’s participation (such as  
8 limiting the number of witnesses, limiting the length of testimony, limiting cross-examination, and  
9 otherwise limit participation); and (4) the court — upon a defendant’s showing that the relator’s  
10 conduct is harassing or would cause the defendant undue burden or expense — may limit the  
11 relator’s participation. 31 U.S.C. § 3730(c)(2).

12 Section 3730 demonstrates that the government is a party to the case and has primary  
13 responsibility for prosecuting it. But it does not address whether a relator may pursue claims when  
14 the government does not. That said, nothing in § 3730 suggests that the government’s intervention  
15 bars the relator from pursuing claims beyond those in the government’s complaint, and the weight  
16 of authority suggests that she can.

17 Section 3730 does not require the government — on intervention — to pursue all of the  
18 relator’s claims. *Bennett*, 876 F.3d at 1020 (after the government intervenes in an FCA case, the  
19 case may include “claims [the government] chooses not to prosecute or settle”). As then-Judge  
20 Samuel Alito wrote for the Third Circuit:

21 When a qui tam action is filed, the government may “proceed with *the action*,”  
22 §§ 3730(b)(2) and (4) (emphasis added) or “decline to take over *the action*,”  
23 § 3730(b)(4)(B) (emphasis added), but the government often decides to take over  
24 only certain claims in a multi-claim action, and we are aware of no decision  
holding that this is improper.

25 *United States ex rel. Merena v. SmithKline Beecham Corp.*, 205 F.3d 97, 102 (3d Cir. 2000)  
26 (emphasis in original). Indeed, the government need not intervene at all, and the relator can  
27 prosecute the case. 31 U.S.C. § 3730(b)(4)(B). The statute and case law thus contemplate that the  
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1 government can pursue some or all of the relator's claims, and the relator can pursue claims when  
2 the government does not.

3 In cases where the government intervenes in part, necessarily there are other claims that the  
4 relator has. Courts regularly allow relators to pursue their separate claims after the government's  
5 intervention. *See, e.g., United States ex rel. Ketroser v. Mayo Found.*, 729 F.3d 825, 826 (8th Cir.  
6 2013) (the relator filed an FCA case, the government intervened in part and settled the intervened  
7 claim, and the relator then filed an amended complaint asserting additional claims against the  
8 defendant); *United States ex rel. Fallon v. Accudyne Corp.*, 97 F.3d 937, 938 (7th Cir. 1996) ("The  
9 Attorney General took over the prosecution of Count I, *see* 31 U.S.C. § 3730(b)(4)(A), but left  
10 Count II in the hands of the relators."); *Fed. Recovery Servs., Inc. v. United States*, 72 F.3d 447,  
11 449 n.1 (5th Cir. 1995) ("The United States elected to intervene in that portion of the suit against  
12 [some] defendants but declined to intervene against [another defendant]. Although the United  
13 States' intervention vested it with control of the litigation against [the first group of defendants],  
14 [relator] retained the authority to proceed against [the other defendant] on its own.").

15 To the extent that Sutter argues that the government's intervention bars Ms. Ormsby's claims  
16 outright, courts also reject arguments to dismiss the complaints as a matter of course. *See, e.g.,*  
17 *United States ex rel. Dresser v. Qualium Corp.*, No. 5:12-cv-01745-BLF, 2016 WL 3880763, at  
18 \*10 (N.D. Cal. July 18, 2016) ("Defendants argue that if [relator] has any claims that overlap with  
19 the United States' claims, those claims should be dismissed because [relator] has no cause of  
20 action under the FCA once the United States intervenes . . . . Defendants' view of the FCA is  
21 contrary to the text of the statute, which gives relators the right to continue as a party to an FCA  
22 action even when the United States chooses to intervene."); *United States ex rel. Shemesh v. CA,*  
23 *Inc.*, 89 F. Supp. 3d 36, 55–56 (D.D.C. 2015) ("[D]ismissal [of the relator's complaint] is not  
24 automatically triggered by the government's intervention. '[T]here is no presumption under the  
25 statute against allowing both complaints to proceed.'" (quoting *United States ex rel. Landis v.*  
26 *Tailwind Sports Corp.*, 51 F. Supp. 3d 9, 28 (D.D.C. 2014)).

27 Courts also allow relators to amend their complaints after the government intervenes. *See, e.g.,*  
28 *Dresser*, 2016 WL 3880763, at \*1 ("After the United States intervened in part and filed an



1 Intervenor Complaint, [the relator] amended her complaint.”); *Shemesh*, 89 F. Supp. 3d at 43  
2 (noting that the government intervened in March 2014 and the relator amended his complaint in  
3 April 2014).

4 Sutter acknowledges the many cases that allow “relators to litigate individual claims for relief  
5 under the False Claims Act after the government intervenes.”<sup>458</sup> But it contends that the court  
6 should follow the only case — *United States ex rel. Brooks v. Stevens-Henager College, Inc.*, 359  
7 F. Supp. 3d 1088 (D. Utah) — where a district court held that relators have no right to maintain  
8 the non-intervened portion of an FCA case after the government intervenes. *Id.* at 1120 (“relators  
9 may not maintain the non-intervened portion of an action”) (capitalization removed). Sutter asserts  
10 that *Brooks* rightly identified the unique procedural context of a relator’s amendment after the  
11 government’s intervention<sup>459</sup> and appropriately held that a relator’s “limited right to continue as a  
12 party to the action . . . does not allow the relator to amend his or her complaint to add defendants  
13 and claims to the Government’s action” because “[t]hose rights necessarily belong to the party  
14 with the primary responsibility for conducting the action — in this case, the Government.” *Id.* at  
15 1116. “The Government’s complaint in intervention superseded the relators’ amended complaint,  
16 and any pleading subsequently filed by the relator lacked legal effect.” *Id.*

17 The *Brooks* court reached its decision in part because the FCA does not say that a relator can  
18 prosecute the non-intervened part of the complaint, and “Congress’[s] silence as to a relator’s right  
19 to prosecute the non-intervened claims leads to the conclusion that no such right exists.” *Id.* at  
20 1120. It examined the structure and legislative history of the FCA and found that the statute’s use  
21 of the word “action” meant “civil action” and not “cause of action.” *Id.* at 1118, 1121–26.

22 Other courts reach the contrary conclusion that the word “action” in the FCA means “cause of  
23 action” or claim. For example, in *Merena*, then-Judge Alito wrote that “the draftsmanship of the  
24 qui tam statute has its quirks, and one of those quirks is that the statute is based on the model of a  
25 single-claim complaint. . . . [T]he qui tam statute is phrased as if every qui tam complaint  
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<sup>458</sup> Defs. Mot. to Dismiss Relator FAC – ECF No. 68 at 8.

28 <sup>459</sup> *Id.*

1 contained only one claim.” *Merena*, 205 F.3d at 101–02 (citing *United States ex rel. Mistick v.*  
 2 *Hous. Auth.*, 186 F.3d 376, 387 (3d Cir. 1999)). He then examined the qui tam statute’s use of the  
 3 word “action” and concluded that the “each claim in a multi-claim [FCA] complaint must be  
 4 treated as if it stood alone.” *Id.* at 102; accord *United States ex rel. Schumann v. AstraZeneca*  
 5 *Pharm. L.P.*, 769 F.3d 837, 846 (3d Cir. 2014) (“FCA’s reference to ‘action’ may reasonably be  
 6 read to mean ‘claim’ because the statute envisions a single-claim complaint”) (citing *Merena*, 205  
 7 F.3d at 101–02); *United States ex rel. Rauch v. Oaktree Medical Centre, P.C.*, No. 6:15-cv-01589-  
 8 DCC, 2020 WL 1065955, at \*6–9 (D.S.C. Mar. 5, 2020) (declining to follow *Brooks*, applying  
 9 *Merena*, noting that the *Brooks* court (and not the defendants) sua sponte raised the issue,  
 10 determining that the word “action” meant “cause of action,” and holding that the FCA allowed  
 11 relators to pursue non-intervened claims) (citing *Merena*, 205 F.3d 101–02).<sup>460</sup>

12 Given the clear weight of authority that allows a relator to pursue non-intervened claims, the  
 13 court follows that approach (and not *Brooks*) as persuasive. The government can pursue some or  
 14 all of a relator’s claims, and a relator can pursue claims that government does not.

15 A contrary decision not only is inconsistent with the many decisions that allow relators to  
 16 pursue non-intervened claims but also is inconsistent with the FCA. The FCA allows the  
 17 government and private parties to pursue civil actions for false claims. 31 U.S.C. § 3730(a)–(b). It  
 18 allows the government to pursue some or all claims. *Bennett*, 876 F.3d at 1020. A relator can  
 19 pursue claims if the government does not intervene. 31 U.S.C. § 3730(c)(3). The government’s  
 20 failure to intervene on any or all claims does not mean that the claims lack merit (or that the  
 21 government thinks that they do). The decision to intervene can turn on “any number of reasons.

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 24 <sup>460</sup> The *Brooks* court held that the word “action” 31 U.S.C. § 3730 cannot mean “claim” or “cause of  
 25 action” because 31 U.S.C. § 3730(e)(4)(A) refers to “an action *or claim* under this section,” thereby  
 26 distinguishing the term “action” from a “claim.” *Brooks*, 359 F. Supp. 3d at 1118 (emphasis in  
 27 original). At the time that 31 U.S.C. § 3730 was amended, in 1986, to first allow relators to continue as  
 28 parties after the government intervened, it did not contain any reference to “an action or claim under  
 this section.” See Pub. L. No. 99-562, § 2, 100 Stat. at 3154–57. Instead, it appeared to use “action”  
 and “claim” somewhat interchangeably. See *id.* at 3156 (awarding relator “at least 15 percent but not  
 more than 25 percent of the proceeds of the action or settlement of the claim”). The reference to “an  
 action or claim under this section” in what is now 31 U.S.C. § 3730(e)(4)(A) was not added until 24  
 years later with the passage of the ACA. See Pub. L. No. 111-148, 124 Stat. at 901.

1 For example, a decision not to intervene may ‘not necessarily be an admission by the United  
 2 States that it has suffered no injury in fact, but rather the result of a cost-benefit analysis.’” *United*  
 3 *States ex rel. Williams v. Bell Helicopter Textron Inc.*, 417 F.3d 450, 455 (5th Cir. 2005) (internal  
 4 brackets omitted) (quoting *United States ex rel. Berge v. Bd. of Trs.*, 104 F.3d 1453, 1458 (4th Cir.  
 5 1997)). Also, for resource reasons, the government cannot pursue every meritorious claim. If  
 6 relators cannot pursue non-intervened claims, then there is no recourse at all. Surely the FCA does  
 7 not require that result.

### 9 **3. The Plaintiffs Sufficiently Plead Their Claims**

10 Sutter and PAMF move to dismiss the complaints on the grounds that (1) for the reverse-FCA  
 11 claims, the plaintiffs failed to allege (with the particularity that Rule 9(b) requires) that they  
 12 identified any overpayments or knowingly avoided repaying them and (2) for the direct-FCA  
 13 claims, the plaintiffs failed to plead that they knowingly submitted materially false claims or  
 14 statements.<sup>461</sup> The court denies the motions to dismiss because the plaintiffs sufficiently pleaded  
 15 these elements of the claims.

#### 16 **3.1 Reverse-FCA Claims**

17 The elements of the reverse-FCA claims are that Sutter and PAMF (1) concealed or  
 18 improperly avoided or decreased an obligation to pay the government and (2) did so knowingly.  
 19 31 U.S.C. § 3729(a)(1)(G).<sup>462</sup>

##### 20 **3.1.1 Concealing or avoiding an obligation to pay the government**

21 As discussed above, 42 U.S.C. § 1320a-7k requires MA Participants to return Medicare  
 22 overpayments within 60 days after the overpayments are “identified.” If they do not, the  
 23 overpayments become “obligations” under the reverse-FCA provision. 42 U.S.C. § 1320a-

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 25 <sup>461</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 9, 21–28; Defs. Mot. to Dismiss Relator FAC  
 – ECF No. 68 at 6, 10–13.

26 <sup>462</sup> Because the plaintiffs sufficiently plead a claim under the second prong of the reverse-FCA  
 27 provision, the court need not address whether they plead a claim under the first prong, i.e., whether  
 Sutter and PAMF made or used a material false statement to conceal or avoid an obligation to pay the  
 28 government. *Victaulic*, 839 F.3d at 255; *see also* Gov’t Opp’n – ECF No. 82 at 19–21 (addressing only  
 the sufficiency of the complaint under the second prong of the reverse-FCA statute).

1 7k(d)(2)(A). Payments based on false diagnosis codes are overpayments. Sutter and PAMF move  
2 to dismiss on the ground that the plaintiffs have not alleged that they “identified” any  
3 overpayments and failed to return them within 60 days.<sup>463</sup> Because the plaintiffs sufficiently allege  
4 that internal and external reviews of diagnosis codes put the defendants on notice of the potential  
5 overpayments, the court denies the motion to dismiss on this ground.

6 Section 1320a-7k uses the word “identified” but does not define it further. Another court — in  
7 the similar context of an employee’s identifying potential overpayments and telling his employer  
8 — conducted a comprehensive analysis of the statute and held that an overpayment is “identified”  
9 when the “provider is put on notice of a potential overpayment, rather than the moment when an  
10 overpayment is conclusively ascertained.” *Kane*, 120 F. Supp. 3d at 387–88 (analyzing the text,  
11 legislative history, and legislative purpose of § 1320a-7k and the FCA). *Kane* involved a software  
12 glitch that resulted in the submission of improper claims to Medicaid. *Id.* at 375. The New York  
13 State Comptroller alerted the defendants about the glitch and identified specific wrongful claims,  
14 and an employee then put them on notice of a set of claims likely to contain numerous  
15 overpayments. *Id.* at 388.<sup>464</sup> At this point, the defendants were on notice, the claims were  
16 identified, and the defendants had a duty to report and return wrongly collected money. *Id.* at 388,  
17 390.<sup>465</sup>

18 \_\_\_\_\_  
19 <sup>463</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 22–24.

20 <sup>464</sup> The employee’s list of claims was overinclusive and underinclusive: (1) roughly half of the claims  
21 on the list were not overpaid, and (2) the list omitted certain overpayments. *Kane*, 120 F. Supp. 3d at  
22 377 & n.7. The court held that the list “identified” overpayments for the employer. *Id.* at 390.

23 <sup>465</sup> The *Kane* court acknowledged that its holding — that an overpayment is “identified” when a party  
24 is put on notice of a potential overpayment — could be viewed as “unforgiving.” *Kane*, 120  
25 F. Supp. 3d at 389. Under such a rule, “an overpayment would technically qualify as an ‘obligation’  
26 even where a provider receives an email [putting it on notice], struggles to conduct an internal audit,  
27 and reports its efforts to the government within the sixty-day window, but has yet to isolate and return  
28 all overpayments sixty-one days after being put on notice of potential overpayments.” *Id.* The *Kane*  
court noted that the potential harshness of the rule was tempered by the fact that the FCA separately  
imposes a scienter requirement above and beyond § 1320a-7k’s “identified” requirement. As the *Kane*  
court explained, “while [‘identified’ overpayments] might qualify as ‘obligations,’ the mere existence  
of an ‘obligation’ does not establish a violation of the FCA. Rather, in the reverse false claims context,  
it is only when an obligation *is knowingly concealed* or *knowingly and improperly avoided or*  
*decreased* that a provider has violated the FCA.” *Id.* (emphasis in original). In the situation described  
above, where a medical provider is put on notice of a potential overpayment and makes a good-faith  
effort to investigate and to report and return any overpayment it finds, “the provider would not have

1 Other courts have followed this approach. *See United States ex rel. Strauser v. Stephen L.*  
 2 *LaFrance Holdings, Inc.*, No. 18-CV-673-GKF-FHM, 2019 WL 1086363, at \*16 (N.D. Okla.  
 3 Mar. 7, 2019) (allegation that defendant “had notice that the price-match program was unlawful  
 4 and failed to exercise reasonable diligence in investigating, reporting, and returning  
 5 overpayments” pleads a claim under § 1320a-7k and the reverse-FCA provision); *Graves v. Plaza*  
 6 *Med. Ctrs., Corp.*, 276 F. Supp. 3d 1335, 1347 (S.D. Fla. 2017) (“[T]he sixty day clock begins  
 7 ticking when the provider is put on notice of a potential overpayment, rather than the moment  
 8 when an overpayment is conclusively ascertained, which is compatible with the legislative history  
 9 of the FCA and the FERA [Fraud Enforcement Recovery Act].”) (quoting *Kane*, 120 F. Supp. 3d  
 10 at 388); *United States ex rel. Ortiz v. Mount Sinai Hosp.*, No. 13 Civ. 4735(RMB), 2015 WL  
 11 7076092, at \*13 (S.D.N.Y. Nov. 9, 2015) (allegation that defendants had received overpayments  
 12 and “had notice of those overpayments” but failed to return them pleads a claim under § 1320a-7k  
 13 and the reverse-FCA provision).

14 Sutter and PAMF argue that the plaintiffs must allege that they “*actually identified*”  
 15 unsupported diagnosis codes and failed to return the payments predicated on those codes within 60  
 16 days.<sup>466</sup> To the extent that Sutter and PAMF argue that § 1320a-7k requires the plaintiffs to plead  
 17 that they had actual knowledge of specific unsupported diagnosis codes and payments based on  
 18 those codes in order for the payments to be “identified” for purposes of triggering their 60-day-  
 19 return obligation, their argument fails. The defendants in the *Kane* action made a similar  
 20 argument, asserting that the government had to allege that they “classified with certainty”  
 21 overpayments in order for the overpayments to be “identified.” *Id.* at 384. The *Kane* court rejected  
 22 this argument, holding that:

23 Defendants’ interpretation . . . would make it all but impossible to enforce the  
 24 reverse false claims provision of the FCA in the arena of healthcare fraud. In the  
 25 Government’s words, “Permitting a healthcare provider that requests and receives

26 \_\_\_\_\_  
 27 acted with the reckless disregard, deliberate ignorance, or actual knowledge of an overpayment  
 required to support an FCA claim.” *Id.* at 389–90.

28 <sup>466</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 22 (emphasis in original).

1 an analysis showing over 900 likely overpayments to escape FCA liability by  
2 simply ignoring the analysis altogether and putting its head in the sand would  
3 subvert Congress’s intent in amending § 3729(a)(1)(G).” Doc. 59 at 19 (citing  
4 *United States v. Lakeshore Med. Clinic, Ltd.*, No. 11 Civ. 00892, 2013 WL  
5 1307013, at \*4 (E.D. Wis. Mar. 28, 2013)). Sure enough, the government’s  
6 Complaint in this action alleges that Defendants, upon receiving [employee]’s  
7 email and analysis, did nothing with the set of claims he pointed out as potentially  
8 overpaid and paid back hundreds of claims only after receiving the government’s  
9 CID. Gov’t’s Compl. ¶¶ 36, 38. If [employee]’s email did *not* “identify”  
10 overpayments within the meaning of the statute, there will be no recourse for the  
11 government when providers behave as [defendants] allegedly behaved here. It  
12 would be an absurd result to construe this robust anti-fraud scheme as permitting  
13 willful ignorance to delay the formation of an obligation to repay the government  
14 money that it is due.

15 . . . .

16 Congress expressly created FCA liability for the retention of Medicaid [and  
17 Medicare] overpayments in the ACA. By requiring providers to self-report  
18 overpayments and imposing a relatively short deadline for repayments, violation of  
19 which risks the severe liability of the FCA, Congress intentionally placed the onus  
20 on providers, rather than on the Government, to quickly address overpayments and  
21 return any wrongly collected money. This reading is in line with the legislative  
22 purpose of the FCA, the 1986 FCA amendments, and the FERA, which together  
23 reflect Congress’s more than 150-year commitment to deterring fraud against the  
24 federal government and ensuring that Government losses due to fraud are recouped  
25 in a timely fashion. Based on this understanding of legislative purpose, Defendants’  
26 proposed reading of the ACA would frustrate Congress’s intention to subject  
27 willful ignorance of Medicaid [and Medicare] overpayments to the FCA’s stringent  
28 penalty scheme.

19 *Id.* at 390–91 (emphasis in original).

20 Sutter and PAMF nonetheless argue that the standard is “actually identified” (rather than “put  
21 on notice and thus should have identified”) and — in support of that argument — cite the first  
22 version (introduced by the House of Representatives) of what ultimately became the ACA.<sup>467</sup> That  
23 version provided that parties had to return “known,” rather than “identified,” overpayments within  
24 60 days, and “known” was defined as it is in the FCA (i.e., including deliberate ignorance and  
25 recklessness, not just actual knowledge). H.R. 3200, 111th Cong. § 1641 (as introduced by House,  
26 July 14, 2009). Congress ultimately enacted the Senate version, which provided that overpayments

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28 <sup>467</sup> *Id.* at 24.



1 had to be reported and returned within 60 days of when they were “identified,” rather than  
 2 “known.” Pub. L. No. 111-148, § 6402(a), 124 Stat. at 755–56. Sutter and PAMF suggest (without  
 3 citing any supporting authority) that the change from “known” to “identified” reflects an intent to  
 4 impose a higher standard than the FCA’s “knowing” standard for triggering the 60-day-return  
 5 obligation.<sup>468</sup> The defendants in the *Kane* action made the same argument. *Kane*, 120 F. Supp. 3d  
 6 at 386. The *Kane* court rejected it, noting that the legislative history of the ACA was silent as to  
 7 why Congress made that change and holding that “[t]o define ‘identified’ such that the sixty day  
 8 clock begins ticking when a provider is put on notice of a potential overpayment, rather than the  
 9 moment when an overpayment is conclusively ascertained” better comported with the legislative  
 10 history of the FCA and “Congress[’s] inten[t] for FCA liability to attach in circumstances where,  
 11 as here, there is an established duty to pay money to the government, even if the precise amount  
 12 due has yet to be determined.” *Id.* at 387–88.

13 Sutter and PAMF argue that CMS in 2014 promulgated a regulatory definition for “identified”  
 14 and that the *UnitedHealthcare* court set aside that definition.<sup>469</sup> In the absence of a controlling  
 15 agency definition, the court still must construe the statutory term “identified,” and the court  
 16 follows as persuasive *Kane*, which construed the term without relying on agency interpretation.  
 17 *See id.* at 391–93. Following *Kane*, an overpayment is “identified” (as the word is used in  
 18 § 1320a-7k) when the “provider is put on notice of a potential overpayment, rather than the  
 19 moment when an overpayment is conclusively ascertained.” *Id.* at 387–88.

20 The plaintiffs alleged sufficient facts to show that Sutter and PAMF had notice that they had  
 21 submitted false diagnosis codes and had potential overpayments. By 2013 or 2014, internal  
 22 reviews by Ms. Ormsby and external reviews by UnitedHealth, HealthNet, and their consultant  
 23 confirmed that many of the risk-adjusting diagnosis codes they submitted were false.<sup>470</sup>

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<sup>468</sup> *Id.*

<sup>469</sup> *Id.* (citing *UnitedHealthcare II*, 330 F. Supp. 3d at 191).

<sup>470</sup> *See supra* notes 133–147, 162–236, 359–368, 373–379.



1 Sutter and PAMF recognized that “CMS is still receiving HCC’s that we know are not correct.”<sup>471</sup>  
 2 They were aware that they might have to return millions of dollars in overpayments predicated on  
 3 the false diagnosis codes.<sup>472</sup> Under *Kane*, the plaintiffs sufficiently pleaded that reviewers  
 4 “identified” overpayments to Sutter and PAMF and triggered their 60-day-return obligation under  
 5 § 1320a-7k(d)(2)(A). The plaintiffs also allege that Sutter and PAMF did not report or return the  
 6 overpayments within 60 days of their being identified,<sup>473</sup> and, thus, that the overpayments are  
 7 “obligations” under the reverse-FCA provision.

8 In sum, the plaintiffs have sufficiently pleaded that Sutter and PAMF concealed or avoided  
 9 obligations to pay the government.

### 10 3.1.2 Scienter

11 Sutter and PAMF also contend that — while Ms. Ormsby may believe that diagnosis codes  
 12 were unsupported and resulted in overpayments — they do not share that assessment based on  
 13 their assignment of review authority to physicians, who can evaluate diagnosis codes better.<sup>474</sup> At  
 14 the pleadings stage, the plaintiffs sufficiently allege that Sutter and PAMF knowingly concealed or  
 15 avoided their obligations to pay the government (i.e., that they had actual knowledge or were  
 16 deliberately ignorant or reckless as to whether they had an obligation to repay the government).<sup>475</sup>

17 Sutter and PAMF allegedly knew that about their potential liability for overpayments (totaling  
 18 millions of dollars) predicated on false diagnosis codes.<sup>476</sup> Sutter and PAMF point to their deletion

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21 <sup>471</sup> See *supra* notes 225, 281, 392, 398.

22 <sup>472</sup> See *supra* notes 137, 196–198, 230–232, 363, 387–388.

23 <sup>473</sup> See *supra* note 288; see also Relator FAC – ECF No. 52 at 4–5 (¶ 7), 46–47 (¶ 147) (Sutter and its  
 24 non-PAMF affiliates returned (pursuant to the settlement with the government) \$30 million in  
 25 overpayments for unsupported diagnosis codes only in 2019, i.e., at least five years after Ms. Ormsby  
 26 put it on notice, and only after Ms. Ormsby filed this FCA action). As Sutter acknowledges, a plaintiff  
 can base a reverse-FCA claim on an allegation that “the overpayments that Sutter did identify and  
 return . . . had been identified and improperly retained for more than 60 days before they were  
 returned.” Defs. Mot. to Dismiss Relator FAC – ECF No. 68 at 12. The plaintiffs have done so here.

27 <sup>474</sup> *Id.* at 23.

28 <sup>475</sup> See *supra* notes 133–147, 169–286, 356–403.

<sup>476</sup> See *supra* notes 137, 196–198, 230–232, 363, 387–388.

1 of codes identified in the internal and external audits.<sup>477</sup> But those audits addressed only limited  
 2 samples, and the plaintiffs allege that the defendants were deliberately ignorant or reckless by not  
 3 reviewing other risk-adjusting diagnosis codes. Allegations that a defendant ““has buried [its] head  
 4 in the sand and failed to make simple inquiries which would alert it that false claims are being  
 5 submitted”” plead scienter. *Godecke*, 937 F.3d at 1212 (internal brackets omitted) (quoting  
 6 *Swoben*, 848 F.3d at 1174); *see Bourseau*, 531 F.3d at 1168 (allegations that a defendant “has  
 7 buried [its] head in the sand” plead scienter with respect to reverse-FCA claims just like direct-  
 8 FCA claims).

9 The court cannot address Sutter’s fact challenges to the diagnosis codes on a motion to  
 10 dismiss. The plaintiffs have alleged sufficiently that the defendants had notice of the unsupported  
 11 diagnosis codes. On a motion to dismiss, the court accepts those allegations as true. *Godecke*, 937  
 12 F.3d at 1210 (“a motion to dismiss is too early a stage to render a judgment on the reliability of  
 13 [relator]’s recollections”). Also, while Sutter and PAMF contend that they appropriately assigned  
 14 the authority to delete codes to physicians,<sup>478</sup> the plaintiffs allege that Sutter and PAMF knew,  
 15 were deliberately ignorant, or were reckless about the physicians’ failure to delete codes for  
 16 reasons such as time pressure or inattention,<sup>479</sup> lack of knowledge about how to delete codes,<sup>480</sup>  
 17 and pressure by Sutter and PAMF to keep their coding levels high.<sup>481</sup> By assigning the authority to  
 18 delete codes to physicians who they knew would not actually delete codes, Sutter and PAMF  
 19 knowingly concealed and avoided their obligations to repay the government.

20 In sum, the plaintiffs have sufficiently pleaded Sutter’s and PAMF’s scienter.

### 21 **3.2 Direct-FCA Claims**

22 The elements of the direct-FCA claims are that (1) Sutter and PAMF submitted false claims  
 23 for payment or used false records or statements, (2) they did so knowingly, and (3) the false claims  
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25 <sup>477</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 22–23.

26 <sup>478</sup> *Id.*

27 <sup>479</sup> *See supra* note 253.

28 <sup>480</sup> *See supra* notes 118–119.

<sup>481</sup> *See supra* notes 76–113, 119–125.

1 were material and (4) caused the government to pay out money. 31 U.S.C. § 3729(a)(1)(A)–(B);  
 2 *Godecke*, 973 F.3d at 1208. Sutter and PAMF move to dismiss the direct-FCA claims on the  
 3 ground that the plaintiffs (1) do not identify any diagnosis code that Sutter and PAMF identified as  
 4 false when they submitted it and (2) instead rely on inadequate audits and red flags.<sup>482</sup> Because the  
 5 plaintiffs sufficiently plead false claims, scienter, and materiality (the elements at issue), the  
 6 argument fails.

### 7 **3.2.1 False claims, or false records and statements**

8 Sutter and PAMF do not meaningfully dispute that the government has sufficiently alleged that  
 9 they submitted false claims predicated on false records or statements, namely, the false diagnosis  
 10 codes submitted to CMS.<sup>483</sup> In any event, the government has alleged with the requisite  
 11 particularity that Sutter and PAMF submitted claims predicated on false diagnosis codes.

12 Sutter also contends that Ms. Ormsby’s claims against non-PAMF affiliates fail because she  
 13 does not identify any unsupported diagnosis code that a non-PAMF affiliate submitted to CMS.<sup>484</sup>  
 14 But “[t]o state an FCA claim, a [plaintiff] is not required to identify actual examples of submitted  
 15 false claims; instead, ‘it is sufficient to allege particular details of a scheme to submit false claims  
 16 paired with reliable indicia that lead to a strong inference that claims were actually submitted.’”  
 17 *Godecke*, 937 F.3d at 1209 (some internal quotation marks omitted) (quoting *Ebeid*, 616 F.3d at  
 18 998–99). Ms. Ormsby has alleged particular details of a scheme at Sutter’s non-PAMF affiliates to  
 19 submit false diagnosis codes, including by having its coders pre-populate diagnosis codes into  
 20 patients’ encounter data before physicians met with their patients, in violation of Medicare  
 21 Advantage requirements that diagnosis codes be based on a “face-to-face” visit between a  
 22 physician and a patient that is documented in the medical record.<sup>485</sup> Ms. Ormsby also alleged  
 23

24 <sup>482</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 25.

25 <sup>483</sup> *See id.* at 7 (“The government’s Complaint-in-Intervention alleges that defendants Sutter Health  
 26 and Palo Alto Medical Foundation (collectively, ‘Defendants’) submitted diagnosis codes to the  
 Medicare Advantage program that they should have known were not adequately documented by  
 medical charts.”).

27 <sup>484</sup> Defs. Mot. to Dismiss Relator FAC – ECF No. 68 at 11.

28 <sup>485</sup> *See supra* notes 401–403.

1 reliable indicia that lead to a strong inference that false diagnosis codes were submitted, including  
2 acknowledgements by Sutter executives that non-PAMF affiliates were submitting false codes.<sup>486</sup>

3 Sutter asserts that Rule 9(b) requires Ms. Ormsby to differentiate between Sutter’s affiliates  
4 and to link these affiliates to the alleged fraudulent scheme.<sup>487</sup> It cites *Swoben* to support this  
5 assertion: “Rule 9(b) does not allow a complaint to merely lump multiple defendants together but  
6 requires plaintiffs to differentiate their allegations when suing more than one defendant and inform  
7 each defendant separately of the allegations surrounding his alleged participation in the fraud.”<sup>488</sup>  
8 This argument is inapposite. Ms. Ormsby does not name Sutter’s affiliates as individual  
9 defendants (and thus does not lump multiple defendants together). Instead, she charges Sutter for  
10 misconduct that it conducted through its affiliates. In any event, “[t]here is no flaw in a pleading,  
11 however, where collective allegations are used to describe the actions of multiple defendants who  
12 are alleged to have engaged in precisely the same conduct.” *Swoben*, 848 F.3d at 1184; *accord*  
13 *Silingo*, 904 F.3d at 677 (“A good claim against one defendant did not become inadequate simply  
14 because a co-defendant was alleged to have committed the same wrongful acts.”).

15 Ms. Ormsby alleges that Sutter — through all of its affiliates (including PAMF) — used the  
16 same electronic-medical-records system and submitted diagnosis codes the same way,<sup>489</sup> had false  
17 codes and high error rates in audits,<sup>490</sup> had no process in place to delete unsupported diagnosis  
18 codes,<sup>491</sup> prevented coders from deleting unsupported diagnosis codes they found and instead  
19 submitted those codes to CMS,<sup>492</sup> and ultimately began pre-populating its patients’ medical  
20 records with diagnosis codes.<sup>493</sup> Ms. Ormsby sufficiently pleads her claim against Sutter regarding  
21 its non-PAMF affiliates.

22 \_\_\_\_\_  
23 <sup>486</sup> See *supra* notes 361, 376, 394–399.

24 <sup>487</sup> Defs. Mot. to Dismiss Relator Compl. – ECF No. 68 at 10.

25 <sup>488</sup> *Id.* at 11 (quoting *Swoben*, 848 F.3d at 1184).

26 <sup>489</sup> See *supra* note 337.

27 <sup>490</sup> See *supra* note 366, 377.

28 <sup>491</sup> See *supra* notes 378–379.

<sup>492</sup> See *supra* notes 391–399.

<sup>493</sup> See *supra* notes 401–403.

1 In sum, the plaintiffs have sufficiently pleaded that Sutter and PAMF submitted false claims  
2 and used false records or statements.

### 3 3.2.2 Scienter

4 Sutter and PAMF contend that the plaintiffs “do[] not identify a *single* diagnosis code that  
5 Defendants had identified at the time it was submitted.”<sup>494</sup> They argue that backward-looking  
6 audits (like those conducted by Ms. Ormsby and UnitedHealth) “did not give Defendants  
7 retroactive knowledge that they were submitting unsupported codes before those codes had even  
8 been submitted.”<sup>495</sup> This argument fails.

9 The plaintiffs need not allege that Sutter and PAMF had actual knowledge of any specific  
10 falsity. Allegations that they were deliberately ignorant or reckless with respect to the truth or  
11 falsity of their submissions are sufficient to plead a claim. 31 U.S.C. § 3729(b)(1)(A); *Godecke*,  
12 937 F.3d at 1211. And “where [an] organization turns a blind eye to [diagnostic-code] over-  
13 reporting errors, it exhibits reckless disregard and deliberate ignorance toward the truth or falsity  
14 of the data submitted to CMS.” *Swoben*, 848 F.3d at 1175–76. Sutter and PAMF allegedly had no  
15 compliance program regarding risk-adjustment diagnosis coding.<sup>496</sup> They nonetheless pressured  
16 physicians to submit more diagnosis codes and told their internal auditors “to take off the  
17 compliance hat and put on the revenue hat,” stop removing false diagnosis codes, and focus  
18 instead on raising (not lowering) patient risk scores so that CMS would pay out more money to  
19 them.<sup>497</sup> They allegedly had non-physician coders pre-populate diagnosis codes into patient  
20 medical records (before physicians saw their patients) and add diagnosis codes retroactively to  
21 patient medical records, in violation of Medicare Advantage requirements that diagnosis codes  
22 must be based on a “face-to-face” visit between a physician and a patient that is documented in the  
23 medical record.<sup>498</sup> Collectively, these allegations plead, at the least, that Sutter and PAMF

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25 <sup>494</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 25 (emphasis in original).

26 <sup>495</sup> *Id.* at 26.

27 <sup>496</sup> See *supra* notes 148–161, 338–342, 356.

28 <sup>497</sup> See *supra* notes 54–113, 238–242, 255–257, 264–274, 283, 343–353, 400.

<sup>498</sup> See *supra* notes 114–125, 275–278, 401–403.

1 submitted risk-adjusting diagnosis codes with deliberate ignorance or reckless disregard of the  
 2 truth or falsity of their submissions. *Cf. Silingo*, 904 F.3d at 680 (allegations that health-  
 3 assessment reports were not properly signed by physicians in violation of Medicare requirements  
 4 supported a claim that the defendant showed reckless disregard or deliberate ignorance to potential  
 5 false claims and thus acted with scienter); *Swoben*, 848 F.3d at 1175 (where defendants “were on  
 6 notice that their data included a significant number of erroneously reported diagnosis codes[, w]e  
 7 do not see how a Medicare Advantage contractor who has engaged in such conduct can in good  
 8 faith certify that it believes the resulting risk adjustment data reported to CMS are accurate,  
 9 complete and truthful”).<sup>499</sup>

10  
 11  
 12 <sup>499</sup> Sutter and PAMF suggest that the government must (1) identify specific individuals at Sutter and  
 13 PAMF who submitted claims or signed certifications to CMS and (2) allege that those individuals had  
 14 knowledge that the claims or certificates were false. *See* Defs. Mot. to Dismiss Gov’t Compl. – ECF  
 15 No. 66 at 26. This is not required. The Ninth Circuit has allowed FCA claims to proceed where a  
 16 plaintiff alleges only that (1) a defendant organization submitted claims and (2) the defendant  
 17 organization had deliberate ignorance or reckless disregard (because its management had deliberate  
 18 ignorance or reckless disregard), without the plaintiff’s identifying specific individuals who submitted  
 19 the claims. *Godecke*, 937 F.3d at 1211–12; *see* Fourth Amended Complaint at 57–70 (¶¶ 171–200),  
 20 *United States ex rel. Godecke v. Kinetic Concepts, Inc.*, No. 2:08-cv-01885-CAS-AGR (C.D. Cal. filed  
 21 June 26, 2017), ECF No. 257 (making allegations against defendant organization generally and not  
 22 identifying specific individuals who submitted claims with scienter).

23 Sutter and PAMF cite *United States v. Scan Health Plan*, No. CV 09-5013-JFW (JEMx), 2017 WL  
 24 4564722 (C.D. Cal. Oct. 5, 2017) (*Swoben II*), holding that “[a] complaint may not rely on the notion  
 25 that a corporation has ‘collective scienter’ separate from the scienter of any actual human.’ This rule  
 26 — that a complaint asserting claims based on false statements must plead the unlawful state of mind of  
 27 the speaker — applies to claims alleged under the False Claims Act.” *Swoben II*, 2017 WL 4564722, at  
 28 \*5 (citing *United States v. Sci. Applications Int’l Corp.*, 626 F.3d 1257, 1274 (D.C. Cir. 2010) and  
 other authorities). The putative prohibition on “collective scienter” (or “collective knowledge”) that  
*Swoben II* references does not require the government to identify the specific individuals who  
 submitted claims or signed certifications and plead or prove that those individuals had scienter.

As the D.C. Circuit’s decision in *Science Applications* (on which *Swoben II* relies) explains, “the  
 ‘collective knowledge’ theory allows ‘a plaintiff to prove scienter [of a corporation] by piecing  
 together scraps of “innocent” knowledge held by various corporate officials, even if those officials  
 never had contact with each other or knew what others were doing in connection with a claim seeking  
 government funds.’” *Sci. Applications*, 626 F.3d at 1275 (quoting *United States ex rel. Harrison v.*  
*Westinghouse Savannah River Co.*, 352 F.3d 908, 918 n.9 (4th Cir. 2003)). Take, for example, a  
 scenario where one official wrote up a hypothetical false claim for use in a compliance training  
 exercise, and a second official submitted it to CMS (without knowing the claim was false and without  
 being deliberately ignorant or reckless). The putative prohibition on a collective-scienter theory might  
 prevent a plaintiff from piecing together the knowledge of those two officials — each of whom was  
 “innocent” on his own — to impute “collective scienter” to the organization. *But see id.* at 1275–76  
 (“Under the FCA, if a plaintiff can prove that a government contractor’s structure prevented it from



1 Sutter and PAMF assert that the plaintiffs are “arguing that there *must* be something improper  
2 about Defendants’ efforts to increase their Medicare Advantage reimbursements. But . . . there is  
3 nothing improper — let alone fraudulent — about attempting to do a better job of capturing  
4 members’ diagnoses.”<sup>500</sup> But the plaintiffs do not challenge legitimate Medicare Advantage  
5 reimbursements. They challenge false diagnosis codes that, as Sutter and PAMF executives  
6 acknowledged, “CMS is still receiving . . . [and] we know are not correct.”<sup>501</sup>

7 In sum, the plaintiffs have sufficiently pleaded Sutter’s and PAMF’s scienter.  
8  
9

10 \_\_\_\_\_  
11 learning facts that made its claims for payment false, then the plaintiff may establish that the company  
acted in deliberate ignorance or reckless disregard of the truth of its claims.”).

12 But the putative prohibition on a collective-scienter theory does not require a plaintiff to plead or  
13 prove that the individuals who — on behalf of the defendant organization — submitted claims or  
certifications had scienter themselves. “If [courts] established such a rule, corporations would establish  
14 segregated ‘certifying’ offices that did nothing more than execute government contract certifications,  
thereby immunizing themselves against FCA liability.” *Harrison*, 352 F.3d at 919. It is sufficient to  
15 plead that the defendant organization had scienter (whether imputed knowledge from any employee  
who had scienter or otherwise), regardless of whether the individuals who submitted the claims or  
16 certifications were wholly innocent and had no scienter themselves. *See, e.g., Harrison*, 352 F.3d at  
919–20; *United States ex rel. Zissa v. Santa Barbara Cty. Alcohol, Drug, & Mental Health Servs.*, No.  
CV 14-6891-DMG (RZx), 2019 WL 3291579, at \*5 (C.D. Cal. Mar. 12, 2019) (allegations that the  
17 organization’s employees had knowledge of falsity pleads that the organization had knowledge, under  
a “basic agency theory of liability[, which] applies to FCA cases”) (citing cases); *see also United*  
18 *States ex rel. Ling v. City of Los Angeles*, No. CV 11-974 PSG (JCx), 2018 WL 3814498, at \*10–11  
(C.D. Cal. July 25, 2018) (finding *Swoben II* unpersuasive because it relied on cases addressing the  
19 Private Securities Litigation Reform Act “without noting the differing statutory bases”).

20 <sup>500</sup> Defs. Reply in Supp. of Mot. to Dismiss Gov’t Compl. – ECF No. 86 at 6–7 (emphasis in original)  
(citing *United States ex rel. Integra Med Analytics, LLC v. Baylor Scott & White Health*, No. 5:17-CV-  
21 886-DAE, 2019 WL 3713756 (W.D. Tex. Aug. 5, 2019), *appeal docketed*, No. 19-50818 (5th Cir.  
filed Sept. 5, 2019)).

22 <sup>501</sup> *See supra* notes 225, 281, 392, 398. Sutter’s and PAMF’s reliance on *Integra Med Analytics* is  
23 misplaced. In that case, “nothing in Plaintiff’s complaint implicates a conclusion that these targeted  
efforts requested, demanded, or encouraged doctors and staff to diagnose in a way that was not  
24 justified by the physicians[’] own medical opinions, judgments, and the medical record[.]” *Integra*  
*Med Analytics*, 2019 WL 3713756, at \*5. Here, by contrast, Sutter and PAMF allegedly pressured  
25 physicians to diagnose and code in a way that the physicians thought was not justified (and thought  
was potentially fraudulent), had non-physicians add diagnosis codes, and knew that false diagnosis  
26 codes were being submitted. *See, e.g., Gov’t Compl. – ECF No. 41 at 33–34* (¶ 96) (PAMF physicians  
complaining about Sutter’s and PAMF’s pressure: “I don’t feel it is legitimate to code this,” “it makes  
27 me feel a little fraudulent to be considering [upcoding],” “it is so obviously unethical,” and “pre-  
populating diagnoses into [physician’s] visit encounter is possibly fraud . . . Does CMS know about  
28 what you are doing?”) (ellipsis in complaint), 42 (¶ 121) (Sutter’s RAF Program Manager  
acknowledging that “CMS is still receiving HCC’s that we know are not correct.”).



### 1 3.2.3 Materiality and causation

2 The false claims at issue here are false diagnosis codes.<sup>502</sup> Diagnosis codes are the only factors  
3 that CMS uses to determine a beneficiary’s health status to calculate Medicare Advantage  
4 payments for that beneficiary.<sup>503</sup> When MA Participants submit false risk-adjusting diagnosis  
5 codes, CMS pays more money (and, conversely, when they delete risk-adjusting diagnosis codes,  
6 CMS pays less money).<sup>504</sup> This establishes that the diagnosis codes are material. *United States ex*  
7 *rel. Poehling v. UnitedHealth Grp., Inc.*, No. CV 16-08697-MWF (SSx), 2018 WL 1363487, at  
8 \*9–10 (C.D. Cal. Feb. 12, 2018) (government’s allegations that diagnosis codes are “the sole  
9 determinant in the calculation of any risk adjustment payment based on a beneficiary’s health  
10 status” and that CMS adjusts payments upwards or downwards based on addition or deletion of  
11 diagnosis codes sufficiently pleads that diagnosis codes are material).

12 Sutter and PAMF challenge materiality with respect to a separate issue: whether the separate  
13 certifications that they had to submit to CMS — attesting to the accuracy, completeness, and  
14 truthfulness of the data (including diagnosis codes) — are material.<sup>505</sup> The diagnosis codes are  
15 material.<sup>506</sup> Also, by alleging that Sutter and PAMF submitted false diagnosis codes that caused  
16 CMS to pay them money, the plaintiffs sufficiently plead causation.

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20 <sup>502</sup> Gov’t Opp’n – ECF No. 82 at 16, 18 (“[T]he diagnoses submitted to CMS because of Defendants’  
21 fraud are the material false claims, not the certifications. . . . The unsupported diagnosis codes are the  
22 false claims that Defendants caused to be submitted to Medicare.”).

23 <sup>503</sup> *See supra* note 35–37.

24 <sup>504</sup> *See supra* notes 38–40.

25 <sup>505</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 26–28. As noted above, Medicare regulations  
26 require, as a condition of receiving payment, that MA Participants such as Sutter and PAMF certify the  
27 accuracy, completeness, and truthfulness of data they submit to CMS. 42 C.F.R. § 422.504(l). Separate  
28 and apart from the underlying diagnosis codes, these certifications can also constitute “claims” and  
provide an additional basis for an FCA claim. *Swoben*, 848 F.3d at 1173 (“[A] claim under the False  
Claims Act can be false where a party merely falsely certifies compliance with a statute or regulation  
as a condition to government payment.”) (quoting *United States ex rel. Hendow v. Univ. of Phoenix*,  
461 F.3d 1166, 1171 (9th Cir. 2006)).

<sup>506</sup> Sutter and PAMF do not meaningfully challenge that the diagnosis codes are material. *See* Defs.  
Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 27–28.

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**3.3 Common-Law Claims**

Sutter and PAMF move to dismiss the common-law claims on the ground that if they were not overpaid, the government has no claim for unjust enrichment or payment by mistake.<sup>507</sup> Because the court has held that payments predicated on false diagnosis codes are overpayments, the court denies the motion to dismiss the common-law claims.

**CONCLUSION**

The court denies Sutter’s and PAMF’s motions to dismiss and grants the motion for judicial notice.

This disposes of ECF Nos. 66, 68, and 81.

**IT IS SO ORDERED.**

Dated: March 16, 2020



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LAUREL BEELER  
United States Magistrate Judge

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<sup>507</sup> Defs. Mot. to Dismiss Gov’t Compl. – ECF No. 66 at 18 n.4; Defs. Reply in Supp. of Mot. to Dismiss Gov’t Compl. – ECF No. 86 at 14.