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ALERTS

California Federal Court Sets Oral Argument In Medicare Advantage False Claims Act Suit Against Healthcare Giant Kaiser Permanente

June 30, 2022

Highlights

Four motions to dismiss the False Claim Act allegations against Kaiser are pending in the U.S. District Court for the Northern District of California

Kaiser is alleged to have violated the False Claims Act by submitting inaccurate diagnosis codes for its Medicare Advantage Plan enrollees in order to receive higher reimbursements

Oral arguments on the pending motions to dismiss will take place on Oct. 14, 2022

Since 2013, six whistleblower lawsuits have been filed in the U.S. District Court for the Northern District of California against Kaiser Permanente Consortium members for alleged violations of the False Claims Act relating to certain Medicare Advantage claims submissions.

There are currently four motions to dismiss the False Claims Act allegations against Kaiser pending in the Northern District of California. Ronda Osinek filed the first action against Kaiser Permanente almost nine years ago, raising allegations about Kaiser's Medicare Advantage

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risk-adjustment practices. Following Osinek's filing, the government spent the next eight years investigating Kaiser as several other private parties (known as relators) filed suits similar to Osinek's against Kaiser (*Taylor, Arefi, Stein, Bryant,* and *Bicocca*) (the Kaiser actions). These cases were consolidated in June 2021. Oral argument on the pending motions to dismiss is set to take place on Oct. 14, 2022.

Background on the Kaiser Actions

In October 2021, the United States partially intervened in the six Kaiser actions and filed its own complaint alleging Kaiser violated the False Claims Act by submitting inaccurate diagnosis codes for its Medicare Advantage Plan enrollees in a concerted effort to receive higher reimbursements.

Under Medicare Advantage, also known as Medicare Part C, Medicare beneficiaries have the option of enrolling in Medicare Advantage Plans through private insurance companies. The Medicare Advantage Plans are paid a per person amount to provide Medicare-covered benefits to beneficiaries. The Centers for Medicare and Medicaid Services (CMS), which oversees the Medicare program, adjusts the payments based on demographic information and the beneficiaries' diagnoses. The adjustments are commonly referred to as "risk scores." In general, a beneficiary with more severe diagnoses has a higher risk score, and CMS makes a larger risk-adjusted payment to the Medicare Advantage Plan for that beneficiary.

The government's complaint alleges Kaiser "systematically alter[ed] patient medical records to add diagnoses that either did not exist or were unrelated" to a patient's visit with a Kaiser physician to inflate a patient's risk score. Kaiser allegedly altered the patients' medical records retrospectively using addenda to add diagnoses months, or even a year after, a patient's visit. Despite Kaiser allegedly knowing that it could not lawfully submit diagnoses unrelated to a patient's visit, it nonetheless "routinely used these diagnoses to obtain additional payments from Medicare." The government alleges that between 2009 and 2018 Kaiser added approximately 500,000 diagnoses using addenda.

On Jan. 18, 2022, Kaiser filed motions to dismiss the claims in the *Taylor, Arefi, Stein, Bryant,* and *Biccoca* complaints pursuant to the False Claims Act's first-to-file bar while also denying all allegations of liability under the False Claims Act. Subsequently, in May 2022, the court dismissed in full the *Arefi, Stein,* and *Bicocca* lawsuits and partially dismissed the *Taylor* and *Bryant* suits. According to the court, the remaining claims in *Taylor* and *Bryant* are materially different from those in *Osinek* because they allege distinct fraudulent risk-coding practices in violation of the False Claims Act. Specifically, *Osinek* discloses practices related to high-value conditions; *Taylor* identifies practices related to external providers; and *Bryant* alleges additional claims under the Affordable Care Act.

In a series of four substantive motions to dismiss filed on June 21, 2022, Kaiser argues that none of the remaining complaints – including the government's complaint – meet the heightened pleading standard of Rule 9(b) of the Federal Rules of Civil Procedure. Kaiser argues that neither the relators nor the government sufficiently alleges either the existence of a factually false claim due to inaccurate diagnosis codes or that Kaiser knew the diagnosis codes entered by its medical providers were "false" or

otherwise related to a medical condition that did not exist at the time of a patient's visit.

Kaiser further argues the government's "legal falsity" theory relies on non-binding sub-regulatory and non-governmental coding documents, which as a matter of law cannot support an enforcement action. Under the Medicare Act, the government must employ notice and comment when creating a rule that establishes or changes a substantive legal standard governing payment for services. In Kaiser's view, the government's theory of legal falsity "assumes that compliance with certain coding documents is a precondition to payment from CMS," despite the fact that these coding documents are not binding rules resulting from formal rule-making by the government. To the extent the government identifies binding regulations, Kaiser argues those regulations do not provide a basis for the government's claims because these regulations do not require defendants to comply with non-binding coding guidance when coding from addenda.

Finally, Kaiser identifies certain isolated pleading defects. For example, Kaiser contends the court lacks subject matter jurisdiction over *Osinek* because "Kaiser Permanente" is a trade name, not a legal entity.

Medicare Advantage Insurers Lose Bid to U.S. Supreme Court Seeking to Reverse 60-Day Overpayment Obligation

On a related note, the U.S. Supreme Court recently decided it would not review the U.S. Court of Appeals for the District of Columbia's determination in *United HealthCare Insurance Co et al.. v. Becerra* to leave in place the federal regulation mandating that Medicare Advantage insurers return excess payments to the government within 60 days to avoid False Claims Act liability.

Petitioners, "the nation's leading providers" of Medicare Advantage plans, argued the requirement, also known as the Overpayment Rule, creates an "apples-to-oranges" payment scheme. Specifically, they argued the Overpayment Rule imposes a "stringent definition" on private Medicare Advantage insurers "using one set of assumptions about their beneficiaries' health data" but fails to make "any corresponding adjustment to the traditional Medicare data" used to calculate Medicare Advantage payment rates.

As a result, Medicare Advantage plans could face "potentially billions of dollars" in additional payment obligations, which the petitioners noted "threatens the scope and affordability" of the care the plans are able to provide. As of 2021, Medicare Advantage plan enrollment topped 26 million – accounting for 42 percent of the total Medicare population and $343 billion of total federal Medicare spending.

Medicare Advantage insurers should consider how best to audit, review, and timely report and return overpayments that may involve unsupported diagnoses.

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