



1 The United States of America (“United States” or “Government”) brings this action  
2 against Defendants Sutter Health (“Sutter”) and its affiliate, Palo Alto Medical Foundation  
3 (“PAMF”), to recover treble damages and civil penalties for their (collectively, “Defendants”)  
4 violations of the False Claims Act (“FCA”), 31 U.S.C. §§ 3729–3733, and damages and other  
5 relief for their common law violations of payment by mistake and unjust enrichment.

6 Sutter and PAMF’s violations of the FCA stem from their participation in the Medicare  
7 Advantage Program. Millions of elderly and disabled individuals throughout the United States  
8 receive healthcare benefits through Medicare, which is administered by the Centers for Medicare  
9 and Medicaid Services (“CMS”). Sutter, through its provider affiliates, including PAMF, serves  
10 more than 100 communities in Northern California and furnishes healthcare to tens of thousands  
11 of Medicare beneficiaries enrolled in the Medicare Part C Program, known as Medicare  
12 Advantage (“MA”). Sutter and PAMF violated the FCA by knowingly submitting and causing  
13 the submission of thousands of false claims, and the corresponding false statements and records,  
14 relating to the MA Program. *See* 31 U.S.C. § 3729 (a)(1)(A), (B). This misconduct resulted in  
15 tens of millions of dollars of overpayments from Medicare. Sutter and PAMF then compounded  
16 this misconduct by knowingly and improperly avoiding their obligations to repay these  
17 overpayments to Medicare. *See id.* § 3729(a)(1)(G).

18 Having filed a notice of intervention pursuant to 31 U.S.C. § 3730(b)(4), the United  
19 States alleges for its complaint-in-intervention (“Complaint”) as follows:

### 20 **INTRODUCTION**

21 1. There are four parts to the Medicare Program: Part A covers inpatient care, Part B  
22 covers outpatient care, Part C is the Medicare Advantage Program discussed below, and Part D is  
23 prescription drug coverage. A beneficiary eligible for Medicare may choose to be covered under  
24 what is commonly referred to as “traditional” Medicare, which is Medicare Parts A and B, in  
25 which CMS reimburses healthcare providers for services rendered via submission of claims.  
26 This is known as a fee-for-service payment system. Another option for a Medicare beneficiary is  
27 Medicare Advantage, in which a beneficiary may opt instead to enroll in a Medicare Advantage  
28

1 Plan (“MA Plan”) managed by a private insurance company (“MA Organization”). *See*  
2 Subchapter XVIII of the Social Security Act, 42 U.S.C. §§ 1395w-21 to 1395w-28.

3 2. Much like any other private health insurance plan, MA Plans come in a variety of  
4 forms. For reasons that will be discussed below, many MA Plans are structured similarly to an  
5 HMO (Health Maintenance Organization), in which an MA Organization organizes a network of  
6 healthcare providers that a beneficiary may go to for healthcare services with the central point of  
7 contact being the beneficiary’s primary care physician. Others are structured like a PPO  
8 (Preferred Provider Organization) that offers a network of healthcare providers that a beneficiary  
9 can use for medical care and may see a specialist without a referral.

10 3. CMS reimburses MA Plans differently than traditional Medicare. CMS pays MA  
11 Organizations a capitated (fixed) amount for each beneficiary that covers all Medicare Part A  
12 and Part B benefits (except hospice). This capitated rate is set by a bid submitted by the MA  
13 Organization that is compared to an administratively set benchmark established under the Part C  
14 statute. *See* 42 U.S.C. §§ 1395w-23(a)(1)(B) and 42 C.F.R. § 422.304.

15 4. Recognizing that the cost of care for a beneficiary will vary, CMS adjusts this  
16 fixed amount based on a methodology that takes into account various factors, including the  
17 health status of each beneficiary. This health status adjustment, referred to as risk adjustment,  
18 results in higher capitated rates for sicker patients and lower capitated rates for healthier patients.  
19 As discussed more fully below, the risk adjustment is generally based on the submission to CMS  
20 of beneficiaries’ health status or illnesses in the form of diagnosis codes. The diagnosis codes  
21 submitted for a beneficiary are reflected in what is referred to as a risk score. The risk-  
22 adjustment payment is the bid amount multiplied by the risk score for each enrollee. *See* 42  
23 C.F.R. § 422.308(e). As detailed further below, the International Statistical Classification of  
24 Diseases and Related Health Problems (“ICD”) sets forth the standards accepted by CMS and the  
25 healthcare industry for the identification of diagnosis codes by their physicians.

26 5. In many instances, MA Organizations contract with healthcare providers to  
27 participate in the MA Plan’s network. Sutter, through its provider affiliates, including PAMF,  
28 furnishes healthcare services to thousands of Part C beneficiaries under at least 10 MA Plans

1 managed by three MA Organizations: United Healthcare Group, Health Net, Inc., and Humana  
2 Inc. Pursuant to these agreements, Sutter and PAMF submit patient encounter data, which  
3 reflects information gathered during a visit with a healthcare provider, including diagnosis codes,  
4 to MA Organizations for their MA Plan enrollees. The MA Organizations, in turn, submit these  
5 diagnosis codes to CMS through what is known as the Risk-Adjustment Processing System  
6 (“RAPS”) and through the Encounter Data System (“EDS”). CMS uses these diagnosis codes to  
7 calculate a risk score for each beneficiary, which is then used to adjust the capitated payments to  
8 the MA Organizations for each MA Plan enrollee. To do so, CMS employs a risk-adjustment  
9 model, called the Hierarchical Conditions Category (“HCC”) model, which takes into account  
10 both demographic factors (such as age and gender) and medical conditions of a patient to  
11 determine the risk scores for beneficiaries in MA Plans. The medical conditions, as represented  
12 by diagnosis codes, are grouped into HCCs, which are categories of clinically-related medical  
13 diagnoses. *See* 42 C.F.R. § 422.2. The diagnosis codes grouped or “mapped” into HCCs that  
14 affect payment include major, severe, and/or chronic illnesses. These diagnosis codes are  
15 referred to as “risk-adjusting diagnosis codes.” Not all diagnosis codes result in an adjustment in  
16 risk score and thus not all diagnosis codes affect payment. Related groups of diagnoses are  
17 ranked on the basis of disease severity and the cost associated with their treatment.

18         6. Every month, CMS pays the MA Organizations the capitation amount as  
19 established by the bid and adjusted using its risk-adjustment methodology for each beneficiary.  
20 MA Organizations pay providers who care for beneficiaries through a variety of arrangements;  
21 however, many large provider groups, such as Sutter and PAMF, enter into a capitated or  
22 “gainsharing” arrangement that aligns their financial interests. Under a capitated arrangement,  
23 the MA Organization enters into a contract to pay a portion of the capitation payment from the  
24 Government to its providers like Sutter and PAMF, less a percentage fee for administration as  
25 determined by its contracts. MA Organizations also pay some providers on a fee-for-service  
26 basis for each service, such as an office visit, provided to a beneficiary. Frequently, the provider  
27 also enters into “gainsharing” agreements with the MA Organizations where they receive  
28 incentive payments based in whole or in part on total revenues that MA Organizations receive

1 from the Government for the beneficiaries cared for by these gainsharing providers. These  
2 agreements incentivize providers such as Sutter and PAMF to increase the number of risk-  
3 adjusting diagnoses they report to MA Organizations, and to report diagnosis codes for more  
4 severe risk-adjusting medical conditions. The more risk-adjustment payments obtained by the  
5 MA Organizations for the beneficiaries cared for by Sutter and PAMF, the more money MA  
6 Organizations pay to Sutter and PAMF pursuant to the capitation and gainsharing agreements.  
7 Hence, the patient risk-adjusting diagnosis codes that map to HCCs directly impact the payments  
8 received by the MA Organizations and providers like Sutter and PAMF.

9         7. The scheme in this case centers on Sutter and PAMF (1) knowingly submitting  
10 thousands of false diagnosis codes to MA Organizations and knowingly causing the submission  
11 of thousands of false diagnosis codes to CMS, and (2) knowingly retaining overpayments  
12 resulting from the submission of these false diagnosis codes. Specifically, each false diagnosis  
13 code that Sutter and PAMF knowingly submitted and that was used in CMS's risk-adjustment of  
14 payments is a false claim under the FCA. These false claims caused the MA Organization's  
15 diagnosis submissions to CMS to be false and inflated Sutter and PAMF's share of the capitated  
16 payment, resulting in overpayments from CMS. *See U.S. v. Bornstein*, 423 U.S. 303, 312-13  
17 (1976) (a subcontractor's FCA penalties are calculated based on the number of false claims  
18 submitted to a contractor, and not the number of false claims the subcontractor caused the  
19 contractor to submit to the Government).

20         8. Sutter and PAMF embarked on a campaign to maximize the number of risk-  
21 adjusting diagnosis codes that were reported to the MA Organizations, thus increasing the CMS  
22 payment to those MA Organizations, and in turn, to Sutter and PAMF, regardless of whether  
23 those codes accurately reflected the patients' documented medical conditions. This campaign  
24 originated at the executive levels of Sutter and PAMF, with the goal of maximizing  
25 reimbursements from CMS for patients enrolled in MA Plans.

26         9. Sutter and PAMF recklessly pursued this aggressive course without any  
27 meaningful training programs for their affiliated physicians relating to preventing Part C fraud,  
28 waste, or abuse. Sutter and PAMF also had ineffective compliance programs that did not guard

1 against the submission of erroneous, invalid, unsupported or otherwise false diagnosis codes. To  
2 the contrary, Sutter and PAMF encouraged physicians to code diagnoses aggressively and, in  
3 many instances, improperly in order to maximize Medicare reimbursements.

4 10. From no later than January 1, 2010 through at least January 31, 2016, Sutter and  
5 PAMF engaged in aggressive coding practices that resulted in the systematic submission of false  
6 risk-adjusting diagnosis codes to the MA Organizations. In so doing, Sutter and PAMF  
7 knowingly ignored numerous red flags regarding false claims, statements, records and  
8 overpayments, raised by audits conducted by their own employees, feedback provided by  
9 physicians treating MA patients, and audits and warnings by MA Organizations. Instead of  
10 reimbursing CMS for the overpayments, conducting further audits, and funding compliance and  
11 training programs, Sutter and PAMF turned a blind eye to these red flags and doubled down on  
12 their scheme to increase risk-adjusting diagnosis codes. Sutter and PAMF knew that the  
13 diagnosis codes being submitted to CMS were rife with errors and knew that the submission of  
14 these false risk-adjusting codes would inflate Sutter and PAMF's share of the Medicare Part C  
15 payments.

16 11. This scheme gives rise to FCA claims against Sutter and PAMF for submitting  
17 and causing the submission of false claims in violation of 31 U.S.C. § 3729(a)(1)(A), using and  
18 causing the use of false records and statements material to false claims in violation of § 3729(a)  
19 (1)(B), using and causing the use of false records and statements material to the obligation to  
20 repay overpayments in violation of § 3729 (a)(1)(G), and avoiding the obligation to repay  
21 overpayments in violation of § 3729(a)(1)(G).

### 22 **THE PARTIES**

23 12. Plaintiff is the United States of America, suing on behalf of the United States  
24 Department of Health and Human Services ("HHS"), which includes its operating division,  
25 CMS. At all times relevant to this Complaint, CMS administered and supervised the Medicare  
26 Part C Program and made risk-adjustment payments under Part C of the Program. The United  
27 States filed its notice of intervention in this action on December 4, 2018.





1 decreases an obligation to pay or transmit money or property to the Government.” *Id.* §  
2 3729(a)(1)(G). The FCA defines the term “obligation” to include “the retention of any  
3 overpayment.” *Id.* § 3729(b)(3).

4 23. Upon learning of a false diagnosis code resulting in an MA overpayment from  
5 CMS, the duty exists to delete or otherwise withdraw that code. *See United States ex rel.*  
6 *Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1176–77 & n.8 (9th Cir. 2016). So doing  
7 would result in CMS’s electronic processing system recalculating the payment amount, which is  
8 the first step in CMS’s process to recoup the overpayment. The failure to delete or withdraw  
9 these false codes after notice thereof constitutes the knowing retention of an overpayment in  
10 violation of 31 U.S.C. § 3729(a)(1)(G).

11 24. Under the FCA, the terms “knowing” and “knowingly” include “actual  
12 knowledge of the information,” “deliberate ignorance of the truth or falsity of the information,”  
13 or “reckless disregard of the truth or falsity of the information,” and “require no proof of specific  
14 intent to defraud.” *Id.* § 3729(b)(1)(A),(B). Congress intended that the terms “knowing” and  
15 “knowingly” “reach what has become known as the ‘ostrich’ type situation where an individual  
16 has ‘buried his head in the sand’ and failed to make simple inquiries which would alert him that  
17 false claims are being submitted.” S. Rep. No. 99-345, at 21, as reprinted in 1986 U.S.C.A.N.  
18 5266, 5286 (quotations in original.) “It is intended that persons who ignore ‘red flags’ that the  
19 information may not be accurate or those persons who deliberately choose to remain ignorant of  
20 the process through which their company handles a claim should be held liable under the Act.”  
21 H. Rep. No. 99-660, at 21 (1986) (to accompany False Claims Act of 1986, H.R. 4827). As used  
22 in this Complaint, the terms “knowing” and “knowingly” have the meaning ascribed to them by  
23 the FCA, as do their derivatives “knowledge,” “known,” and “knew.”

24 25. The term “material,” as used in the FCA, “means having a natural tendency to  
25 influence, or be capable of influencing, the payment or receipt of money or property.” 31 U.S.C.  
26 § 3729(b)(4).

27 26. The FCA imposes liability of treble damages plus a civil penalty for each false  
28 claim in an amount (as pertinent here) not less than \$5,500 and not more than \$11,000 for claims

1 submitted prior to August 1, 2016; not less than \$10,781 and not more than \$21,563 for claims  
2 submitted between August 1, 2016 and February 3, 2017, and as appropriately statutorily  
3 adjusted for inflation each successive year under the Bipartisan Budget Act of 2015, Pub. L. 114-  
4 74, § 701, 129 Stat. 584, 599-601 (2015). See 31 U.S.C. § 3729(a)(1).

#### 5 **THE MEDICARE ADVANTAGE SYSTEM AND THE ROLE OF PROVIDERS**

6 27. Medicare is a federally-operated health insurance program administered by CMS  
7 benefiting individuals 65 and older and the disabled. See 42 U.S.C. § 1395c *et seq.* Parts A and  
8 B of the Medicare Program are known as “traditional” Medicare. Part A covers inpatient and  
9 institutional care. Part B covers physician, hospital, outpatient, and ancillary services and  
10 durable medical equipment. Under Medicare Parts A and B, CMS reimburses healthcare  
11 providers using the fee-for-service system, in which providers submit claims to CMS for  
12 healthcare services actually rendered, such as a physician office visit or hospital stay. CMS then  
13 pays the providers directly for each service based on payment rates pre-determined by the  
14 Government.

15 28. Under Medicare Part C, Medicare beneficiaries may opt out of “traditional”  
16 Medicare and instead may enroll in MA Plans and receive healthcare services managed by those  
17 Plans. The MA Plans are run by MA Organizations, which are often private insurers. See 42  
18 C.F.R. §§ 422.2, 422.503(b)(2). Many MA Organizations contract with hospital networks,  
19 physician groups, and other providers, such as Sutter and PAMF, to furnish healthcare services  
20 under the MA Plans.

21 29. Pursuant to Medicare regulations, Sutter and PAMF are classified as “first tier  
22 entities” and “related entities.” See *id.* §§ 422.2 & 422.500. A first tier entity “means any party  
23 that enters into a written agreement, acceptable to CMS, with an MA organization . . . to provide  
24 . . . healthcare services for a Medicare eligible individual under the MA program.” *Id.*, §§ 422.2.  
25 A related entity “means any entity that is related to the MA organization by common ownership  
26 or control and (1) [p]erforms some of the MA organization’s management functions under  
27 contract or delegation; [or] (2) [f]urnishes services to Medicare enrollees under an oral or written  
28 agreement . . .” *Id.* First tier and related entities such as Sutter and PAMF must, among other

1 things, perform their services in a manner that complies with the MA Organization’s contractual  
2 obligations to the Government, *id.* at 422.504(i)(3)(iii); agree to “comply with all applicable  
3 Medicare laws, regulations, and CMS instructions,” *id.* at 422.504(i)(4)(v); and receive effective  
4 compliance training and education relating to preventing fraud, waste, and abuse, *id.* at § 422.  
5 503(b)(4)(vi)(C)(1). Furthermore, if a related entity or first tier entity generates data relating to  
6 an MA Organization’s claims for payments from the MA Program, it (as well as the MA  
7 Organization) must certify the accuracy and truthfulness of that data. *Id.* at § 422.504(1)(3).

### 8 **MEDICARE PART C RISK-ADJUSTMENT PAYMENTS**

9 30. In Medicare Part C, the Government pays to each MA Organization a fixed,  
10 capitated (per beneficiary enrollee in each MA Plan) amount, adjusted by the expected risk of  
11 each beneficiary, on a monthly basis for the provision of items and services that are covered for  
12 Medicare beneficiaries under Parts A and B of the Social Security Act. This per-member, per-  
13 month payment does not depend on the amount of healthcare services provided to an  
14 enrollee. Each year this payment is based on a bidding process with CMS, in which each MA  
15 Plan, through an MA Organization, submits a bid amount, which is then compared to an  
16 administratively set benchmark set by CMS based on a statutory formula. *See* 42 U.S.C.  
17 § 1395w-23; *see also* 42 C.F.R. § 422.2, subparts F and G. Since 2000, Congress has required  
18 that the capitated payments be adjusted for each MA Plan enrollee based on (1) each enrollee’s  
19 demographic factors such as age, and gender, among others, and (2) each enrollee’s health  
20 status. *See* 42 U.S.C. § 1395w-23 (a)(1)(C). This is known as risk adjustment, and the risk  
21 score, sometimes referred to as the risk-adjustment factor or “RAF,” acts as a multiplier that is  
22 applied to the MA Organization’s bid for covering Part A and B services. 42 U.S.C. § 1395w-  
23 23(a)(1)(G) and 42 C.F.R. § 422.308(e).

24 31. The Secretary of HHS has the authority to determine the risk-adjustment  
25 methodology. *See id.* Since 2004, CMS has employed an HCC model to calculate a risk score  
26 for each beneficiary in an MA Plan. As directed by Congress, the HCC model takes into account  
27 demographic factors and health status. With respect to health status, the HCC model relies on  
28 diagnosis codes documented by authorized health care providers, *e.g.*, physicians in patient

1 encounters during office visits and hospital outpatient and inpatient stays. In fact, diagnoses are  
2 the sole determinant in the calculation of any risk-adjustment payment based on a beneficiary's  
3 health status.

4 32. The ICD classifications set forth the standards accepted by CMS and the  
5 healthcare industry for the identification of diagnosis codes for health conditions. *See* 45 C.F.R.  
6 § 162.1002(a)(1)(i), (b)(1), (c)(2)(i) ; 42 C.F.R. § 422.310 (d)(1); CMS, *Medicare Managed*  
7 *Care Manual* Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004). ICD codes are alphanumeric  
8 codes used by the healthcare providers, insurance companies and public health agencies to  
9 represent diagnoses; every disease, injury, infection and symptom has its own code. The  
10 applicable standards for these ICD diagnosis codes are set forth in the International  
11 Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9") through October 1,  
12 2015, and thereafter the International Classification of Diseases, Tenth Revision, Clinical  
13 Modification ("ICD-10"). To ensure accuracy, the patient's diagnoses must result from a face-  
14 to-face encounter between physician and patient during the relevant year and must be  
15 appropriately documented in the patient's medical record at the time of the encounter. In  
16 addition, codes should be based on documented conditions that require or affect patient care  
17 treatment or management. *See* CMS, *Medicare Managed Care Manual* Chapter 7, § 111.8 (Rev.  
18 57, Aug. 13, 2004), *see also* CMS, *2008 Risk Adjustment Data Technical Assistance for*  
19 *Medicare Advantage Organizations Participant Guide* (2008).

20 33. The HCCs are categories of clinically-related medical diagnoses including major,  
21 severe, and/or chronic illnesses. *See* 42 C.F.R. § 422.2. Each HCC correlates with the marginal  
22 predicted cost of medical expenditures for that set of medical conditions based on CMS's data  
23 from administering the traditional Medicare Fee-For-Service program. Higher relative values  
24 (sometimes referred to as a relative factor, multiplier, or coefficient) are assigned to HCCs that  
25 include diagnoses with greater disease severity and treatment costs. Between 2004 and 2013,  
26 there were 70 HCCs in the Part C risk-adjustment model, and starting in 2014 that number  
27 increased to 79, as CMS revised its risk-adjustment model. A single beneficiary may have none,  
28 one, or multiple HCCs. Some examples of HCC codes are HIV/AIDS (HCC 1), metastatic

1 cancer and leukemia (HCC 8), congestive heart failure (HCC 80), and ischemic stroke (HCC  
2 100). HCC numerical codes changed between the 2004-13 model (known as Version 12) and the  
3 2014 model (known as Version 22). The numerical examples of HCC codes cited herein are  
4 from the Version 22 model.

5 34. The HCC model is prospective, meaning that it relies on risk-adjusting diagnosis  
6 codes from dates of service by a provider in one year (the “date of service year”) to determine  
7 payments in the following year (the “payment year”). Each MA Plan beneficiary’s risk score is  
8 calculated anew for the following year. The higher a MA Plan beneficiary’s risk score, the  
9 higher the payments by CMS to the MA Organizations. The MA Organization then distributes a  
10 contractually-determined percentage of these payments to providers such as Sutter and PAMF.  
11 Thus, the risk-adjusting diagnosis codes that map to HCC codes submitted by Sutter and PAMF  
12 materially impact the amount of the payments CMS makes to an MA Organization, and  
13 therefore, to Sutter and PAMF.

14 35. Illustrating this process as pertinent to Sutter and PAMF, generally after a face-to-  
15 face encounter between a physician and an MA Plan patient, the provider (generally the  
16 physician and/or coder) (1) documents the encounter in the patient’s electronic medical record,  
17 (2) assigns the diagnosis reflecting the patient’s medical conditions and uses the capabilities of  
18 the electronic medical record to assign the appropriate ICD diagnosis codes, and (3) adds those  
19 diagnosis codes into Sutter’s electronic records system. The diagnosis codes are transmitted  
20 electronically to the MA Organizations through either an electronic data submission after a  
21 patient encounter or through a monthly process in the electronic records system known at Sutter  
22 and PAMF as “sweeping” or “sweeps.” In turn, the MA Organizations electronically submit  
23 these codes to CMS. CMS maps each beneficiary’s diagnosis codes to HCCs (*i.e.*, the risk-  
24 adjusting diagnosis codes), and then calculates each beneficiary’s risk score to apply to the  
25 payment calculation and determine the reimbursement.

26 36. Regulations and guidance made clear to MA Organizations and providers such as  
27 Sutter and PAMF that CMS relies on the risk-adjusting diagnosis codes submitted by providers  
28 to determine and make accurate capitation payments for each patient enrolled in the Part C

1 Program. “Accurate risk-adjusted payments rely on the diagnosis coding derived from the  
2 member’s medical record.” *See, e.g.*, 42 C.F.R. § 422.504(1)(3); CMS, *2013 National Technical*  
3 *Assistance Risk Adjustment 101 Participant Guide* 13 (2013).

4 37. MA Organizations can delete diagnoses from both the Risk-Adjusting Processing  
5 System (“RAPS”) and Encounter Data System (“EDS”) to comply with their obligation to delete  
6 known erroneous, invalid, unsupported or otherwise false diagnosis codes previously submitted  
7 to CMS. Similarly, Sutter and PAMF also have an obligation to delete these false codes in their  
8 systems. Doing so should cause the MA Organizations to delete those codes in the RAPS  
9 system, and thereby cause CMS to adjust the RAF score for the patient downward and the  
10 capitated payment downward as well.

11 **SUTTER AND PAMF’S KNOWLEDGE AND POLICIES RELATING TO RAF**

12 38. At all times relevant to this Complaint, Sutter and PAMF knew the importance of  
13 risk adjustment and the workings of CMS’s RAPS and EDS data systems, including but not  
14 limited to: (1) how the HCC model calculated a beneficiary’s risk score; (2) regular changes to  
15 the HCC model; (3) the ICD classification system for diagnoses codes; (4) the mapping of risk-  
16 adjusting diagnosis codes to HCCs; (5) the importance of these risk-adjusting diagnosis codes in  
17 determining each beneficiary’s risk score; (6) the direct relationship between a beneficiary’s risk  
18 score and the ultimate payments to Sutter and PAMF; (7) the requirements that each diagnosis  
19 code in a patient’s records must result from a face-to-face encounter between health care  
20 provider and patient and be documented in the patient's medical records; (8) the importance of  
21 these requirements to payment under the Medicare Advantage program; and (9) the duty to  
22 delete known invalid, false or unsupported diagnosis codes and return overpayments to CMS.

23 39. A December 2013 outline authored and provided by Kathy Ormsby to Sutter and  
24 PAMF executives described the importance of PAMF physicians capturing all of the risk-  
25 adjusting patient diagnosis codes, stating:

26 Medicare Advantage plans rely entirely on the Hierarchical  
27 Condition Category for reimbursement. Because of this, it is  
28 essential for Medicare Advantage plans to ensure providers capture

1 the complete diagnostic profile of every Medicare Advantage  
2 patient . . . Medicare Advantage plans must capture HCCs  
3 conditions annually. When documentation does not support the  
4 chronic condition(s), and no identification of HCCs has taken place,  
5 no reimbursement will be collected from  
6 Medicare.

7 40. Sutter and PAMF also regularly tracked RAF data relating to (1) their MA patient  
8 population and how their average risk scores compared to state and national benchmarks, (2) a  
9 “prevalence” rate identifying the percentage of MA Plan patients assigned certain especially  
10 lucrative codes, and (3) the “HCC Recapture Rate” and “HCC Score Comparison” designed to  
11 track the performance of “acuity capture and reporting” by PAMF physicians. These data  
12 metrics were summarized on a “RAF Dashboard” which was widely distributed throughout  
13 Sutter and PAMF, including to Julie Cheung (Sutter’s RAF Program Manager) and Roger Larsen  
14 (PAMF’s Chief Financial Officer and also a Sutter Regional Vice President of Finance). Larsen  
15 followed and at times commented on these tracking numbers.

16 41. Sutter and PAMF used this “acuity capture and reporting” metric not just to track  
17 the extent to which their physicians were “capturing” all possible risk-adjusting diagnosis codes  
18 for each MA Plan patient, but also to determine how well the coders and others were ensuring  
19 that the physicians aggressively captured these codes. At times, PAMF management permitted  
20 “[t]he coder . . . to make correction[s] per Management discretion” to ensure capturing diagnosis  
21 codes not recorded by a doctor in the patient’s medical records during a patient encounter. Sutter  
22 also distributed a “Critical Pathway Chart” to physicians summarizing “seven critical activities”  
23 at the “pre-visit,” “point of care,” and “post visit” stages of each patient’s “face-to-face  
24 encounter” with a PAMF doctor that “must be performed to maximize outcomes for HCC  
25 capture and reporting.” Sutter and PAMF engaged in numerous strategy meetings to achieve  
26 these goals.

27 42. Sutter was acutely aware that it had an obligation to report and return  
28 overpayments to CMS. Sutter’s written policies and procedures required Sutter and its affiliates

1 including PAMF to return overpayments to CMS. “**Overpayment Refund, 13-540 . . .**  
2 **POLICY**[:] Sutter Health and its Affiliates will report and refund overpayments from state and  
3 federal health care programs within 60 days of identification, or the due date for any applicable  
4 reconciliation” (emphasis in original.) This policy also required that “[a]s appropriate, Sutter  
5 Health and its affiliates will take remedial steps to prevent identified overpayments from  
6 recurring.” The policy defined “**Overpayment**” to include “incorrect code or modifier  
7 assignment resulting in a higher level of reimbursement, insufficient or lack of documentation to  
8 support billed services . . . lack of medical necessity, . . . or any other finding that reflects an  
9 overpayment was received as a result of inaccurate or improper coding or reporting of healthcare  
10 items or services” (emphasis in original.)

11 43. Sutter and PAMF knew that Medicare and ICD guidelines required them to  
12 properly document the diagnosis codes in a patient’s medical records. Ormsby, as part of her  
13 responsibilities as PAMF’s RAF Manager, developed an approved coding guide which was  
14 distributed to all of the certified coders who worked on RAF issues at PAMF, encapsulating  
15 CMS’s guidance for coding and documentation. In that guide, and also during training, Ormsby  
16 explained that to be documented properly as a diagnosis code the medical condition must be  
17 monitored, evaluated, and assessed or treated at a face-to-face encounter between the health care  
18 provider and patient. To avoid over-coding, the guide identified some of the common coding  
19 pitfalls that may result in false coding. These include warnings that (1) physicians should not  
20 code conditions without documentation in the medical records, (2) physicians should not code a  
21 condition as active or chronic if there is just a “history of” the condition without any  
22 management, evaluation, assessment and treatment in the current calendar year, and (3)  
23 diagnoses should be documented and coded to the highest level of specificity.

#### 24 **SUTTER AND PAMF’S AGGRESSIVE CAMPAIGN**

#### 25 **TO MAXIMIZE REIMBURSEMENTS**

26 44. Beginning no later than 2010, Sutter and PAMF began a campaign to increase the  
27 number of risk-adjusting diagnosis codes for its MA patients, in order to generate revenue and  
28 maximize reimbursements from CMS. This effort became known as the RAF Campaign.

1 Discussing the early stages of the RAF Campaign, Dr. Steven Lane (a physician in PAMF's  
2 network and PAMF's Electronic Health Record Ambulatory Physician Director), in a January 3,  
3 2012 email with the subject line "HCC codes: more to consider as chronic?," explained, "Over  
4 the past year or two . . . increasing attention has been focused on the importance of appropriately  
5 identifying and coding HCC diagnoses to improve RAF scores and Medicare managed care  
6 reimbursement . . .". Sutter and PAMF believed that doing so would be "worth tens of millions  
7 of dollars to the enterprise" that had been so far "left on the table" and tasked Nancy McGinnis  
8 (Sutter's RAF Director) "to lead the efforts to improve Sutter Health's RAF scores." By 2012,  
9 PAMF physicians and management were discussing the "urgency that the upper echelon of  
10 Sutter feels for the need to enhance our HCC RAF scores."

11 45. As part of the RAF Campaign, Sutter and PAMF identified so-called "Physician  
12 Champions" to "act as a liaison between the coding team and the physicians" on the theory that  
13 physicians would be more likely to accept diagnosis coding guidance from other physicians.  
14 With respect to PAMF, Dr. Veko Vahamaki, PAMF's Lead RAF Physician Champion,  
15 supervised the champions at PAMF's four divisions in Alameda (Dr. Amy Lin), Camino (Dr.  
16 Graham Dresden), Palo Alto (Dr. Anita Gupta), and Santa Cruz (Dr. Susan Schaefer). The  
17 Physician Champions received additional pay from Sutter for this work, and encouraged  
18 aggressive coding with management approval.

19 46. Sutter and PAMF understood and openly acknowledged that the Physician  
20 Champions were key to increasing Part C reimbursements. In late 2011, Dr. Jeffrey Burnich  
21 (Sutter Senior Vice President and Executive Officer) widely distributed a "RAF Program  
22 Summary" at Sutter and PAMF describing, among other things, the importance of the Physician  
23 Champions' role in increasing RAF scores. A few months later, in February 2012, Burnich  
24 expressed concern to Suzy Cliff (PAMF's Vice President of Revenue Cycle) and other  
25 management that PAMF, in particular, was "leaving millions of dollars on the table" from what  
26 he termed "sub-par coding." A couple of days thereafter, a member of Sutter leadership required  
27 PAMF to "identify a PAMF operational director to work with them in improving our RAF  
28 scoring/coding on our Medicare Advantage patients."

1           47. In September 2012, Dr. Jeffrey Brown (PAMF's Associate Medical Director for  
2 Managed Care) designed a "coding party" to improve MA patients' risk scores. This had been a  
3 "pilot" project at PAMF, and, in a follow-up email to PAMF executives Kris Anne Crow  
4 (Director of Coding and Education for PAMF) and Cliff, Brown highlighted that "PAMF does  
5 not have the luxury of taking a few years to get HCC initiatives off the ground and running,"  
6 noted "we are not making progress fast enough," and asked to review the data from the pilot so  
7 that "[i]f the data looks good we need to spread this quickly to the rest of the organization."

8           48. By November 2012, Sutter and PAMF had formalized the RAF Campaign, calling  
9 it the "Risk Adjusted Factor Project." The Project's goal was "to reach a 28% improvement in  
10 the HCC performance" for its MA Plan patients. By late 2012, Sutter and PAMF outlined new  
11 steps in furtherance of this goal, including approving the hiring of a "Project Manager" to  
12 coordinate the RAF Campaign and a "Database Analyst" to track the diagnostic coding  
13 performance of network physicians. Sutter also asked coders in all of its affiliates, including  
14 PAMF, to schedule annual "Medicare Wellness Exams" for MA Plan patients lacking any risk-  
15 adjusting diagnosis codes to ensure the capture of every possible code that could increase CMS's  
16 payments. Sutter also tracked the success of each affiliate, including PAMF, in scheduling the  
17 Medicare Wellness Exams and rewarded meeting a goal of 75% annual wellness visits with a 1%  
18 upside bonus at the group level. Sutter and PAMF understood that "capturing more wellness  
19 exams" increased the capture of risk-adjusting diagnosis codes and thus increased revenue.

20           49. Also, in November 2012, Brown approved coders adding risk-adjusting diagnosis  
21 codes to patient medical records that had been missed by physicians during their patient  
22 encounters. Dr. Vahamaki called this a "pit crew plan" and believed it "would significantly help  
23 with the RAF efforts." Vahamaki, who possessed significant influence in the RAF Campaign  
24 due to his position as a Physician Champion supervisor, defended this approach in response to  
25 Dr. Christopher Jaegar's (a Sutter Vice President and also its Chief Medical Informatics Officer)  
26 concern that "having a coder change an entry that I purposefully enter that has clinical meaning  
27 to me/others . . . seems like a dangerous step," and forwarded this exchange to Julie Cheung  
28 (Sutter's RAF Program Manager).

1           50.     In addition, at this time some PAMF physicians began to receive “HCC/RAF  
2 cheat sheets” to make it even easier to capture the lucrative diagnosis codes. The cheat sheets  
3 identified the risk-adjusting diagnosis codes that were common to many MA Plan patients (such  
4 as diabetes). The cheat sheets were used to pressure physicians to add these codes into the  
5 patient’s electronic medical records even during encounters focusing on other patient healthcare  
6 problems.

7           51.     Sutter-affiliated physicians, including those at PAMF, also received a customized  
8 “Problem List” for their MA Plan patients through Sutter’s electronic medical record system. A  
9 Problem List is a list of health problems with the corresponding diagnosis codes and can be used  
10 as a high-level summary of a patient’s past health problems. Sutter and PAMF management  
11 used the Problem Lists to pressure physicians to add risk-adjusting diagnosis codes that had not  
12 been “captured” during past patient encounters and to refresh risk-adjusting diagnosis codes that  
13 were not captured in the current year. To make this as easy as possible for the physicians, at  
14 management’s direction coders or Physician Champions pre-populated the Problem Lists with  
15 lucrative diagnosis codes and the Problem Lists auto-flagged these codes with “a red pushpin  
16 icon” that served as a “visual reminder” for the physician to examine the patient with that  
17 diagnosis code in mind. To document a diagnosis code in a patient’s medical records, all the  
18 physician then needed to do was electronically move the diagnosis code from the Problem List to  
19 the patient encounter part of the electronic medical record. At times, disputes arose over the pre-  
20 population of the Problem Lists. One typical dispute involved instances in which physicians or  
21 PAMF employees did not believe that patient diagnoses qualified as chronic and thus should not  
22 be captured to increase RAF scores, while management disagreed and often “err[ed] on the side  
23 of including the [diagnoses] as chronic.”

24           52.     Over time, Sutter and PAMF took this practice even further and began to pre-  
25 populate the encounter itself with risk-adjusting diagnosis codes. Physicians expressed the  
26 concern that risk-adjusting diagnoses appeared in patient medical records before the physician  
27 ever saw the patient. Yet, these risk-adjusting diagnosis codes appeared in the patient records  
28 notwithstanding what health conditions were managed, evaluated, assessed or treated by the

1 physician during the actual patient encounter. Physicians were also concerned that they did not  
2 know how to delete incorrect diagnoses from their patient's documentation (*see, e.g.*, ¶ 96 *infra*).  
3 Despite these concerns, Sutter and PAMF did not ensure that false diagnoses were appropriately  
4 deleted from the electronic medical record and not submitted for reimbursement to MA  
5 Organizations and CMS.

6 53. In early 2013, Brown sent letters to physicians with more than "20 MA patients . . .  
7 . asking those with higher than PAMF average HCC scores what they thought helped them in  
8 HCC coding and ask[ing] those with lower than PAMF average scores what the barriers to HCC  
9 coding were." He compiled these results in a survey distributed to Sutter and PAMF executives  
10 in March 2013, including Cheung and McGinnis of Sutter and Larsen, Cliff and Crow of PAMF.  
11 The survey found that for the above-average physicians, auto-flagging of diagnosis codes in the  
12 Problem Lists and the HCC/RAF cheat sheets (called in the survey, the "HCC code tip sheet")  
13 especially helped increase coding. On the other hand, the below-average coding physicians  
14 focused on patient care and treatment rather than on coding as exemplified by this statement, "I  
15 do not address longstanding stable or prior conditions when that is not important to the care  
16 being delivered at the moment." In the survey, Brown classified that statement as among the  
17 "Barriers to Better Coding."

18 54. Sutter and PAMF's data-mining practices also played an important role in the  
19 RAF Campaign. Using data mining, Sutter and PAMF "pushed" their physicians through  
20 messages in the electronic medical record to find and refresh especially high-paying risk-  
21 adjusting diagnosis codes to increase patients' RAF scores. Similarly, PAMF physicians  
22 received "queries" in the electronic medical record from coders reminding the physicians to  
23 ensure that all such diagnostic codes were captured. Numerous physicians disliked this practice  
24 and felt "pressured" to add diagnosis codes that they did not believe to be clinically accurate or  
25 relevant. Further, PAMF coders met one-on-one with physicians to discuss their diagnosis  
26 coding. During these meetings, the auditors at times encouraged the physicians to addend their  
27 patient records and add risk-adjusting diagnosis codes. An addendum to the medical record is a  
28 note drafted by a physician or other medical professional that clarifies or amends a previous note

1 made by that same professional, typically within 30 days of the encounter. Some physicians,  
2 such as Drs. Williams and Wong, when prompted to addend records from a prior year, thought it  
3 was unethical to be asked to addend old face-to-face encounters. The coders also laid out a plan  
4 to address other risk-adjusting diagnosis codes with PAMF physicians, including for major  
5 depression, cachexia, protein calorie malnutrition, morbid obesity and COPD. Those diagnosis  
6 codes were viewed as “high potential missed opportunity [to] increase RAF score.”

7 55. In August 2013, physicians in PAMF’s network began receiving “daily alert”  
8 forms for the MA Plan patients on each physician’s schedule that day. The daily alerts identified  
9 “what HCC codes have not yet been captured this year for the patient[s].” Those codes included  
10 not just previously diagnosed conditions, but also conditions that data mining software, using an  
11 algorithm, “suspects” a patient may have. The focus of the daily alerts was on pressuring  
12 physicians to increase RAF scores rather than on improving coding accuracy or meeting the  
13 clinical needs of patients.

14 56. In addition to the daily alerts, each physician received a weekly list of MA  
15 patients scheduled to see them that week and a monthly report of MA Patients needing to  
16 schedule Medicare Wellness Exams by year end. The purpose of these forms was to “aid in your  
17 capturing of chronic conditions.” In response, physicians raised concerns about this pressure and  
18 requested that the messages from RAF coders be “nicer.”

19 57. Also, by August 2013, PAMF executives including Cliff and Vahamaki also  
20 received these daily alerts, the weekly lists, and the monthly reports in order to interact with and,  
21 if necessary, pressure PAMF physicians to increase diagnosis coding during their MA Plan  
22 patient encounters. One way PAMF management would do this was to have a coder review a  
23 physician’s documentation after a patient encounter and identify any overlooked risk-adjusting  
24 diagnosis codes. The coder would then tell the physician to confirm the addendum in the  
25 patient’s medical records. For example, in August 2013, Vahamaki developed “Dr. V’s PCP  
26 [primary care physician] Audit Letter Template,” explaining, “The diagnostic coding team has  
27 added this code to your visit as an addendum . . . Please email back to confirm that this patient  
28 has this diagnosis.”

1           58.     Sutter and PAMF’s RAF Campaign achieved results. The RAF Campaign set a  
2 goal of capturing 80% of risk-adjusting diagnosis codes within its HCC focus areas: chronic  
3 obstructive pulmonary disease, diabetes, and vascular disease. For example, the “Diagnostic  
4 Coding Champions Meeting Minutes” for the August 13, 2013 meeting attended by most of  
5 PAMF’s senior executives identified “gains” over the past two months in these “3 Key Areas” of  
6 coding and compared the performance among PAMF’s four divisions. Also, Sutter data from  
7 early 2014 showed \$4.4 million in revenue gains from the RAF Campaign in comparing year-  
8 end results for 2013 with 2012. Further, in March 2015, Sutter reported “a 20% overall system  
9 wide increase” in the RAF risk scores of MA Plan patients, including increases at all four of  
10 PAMF’s divisions between 15% and 23% that were expected to achieve \$4.173 million in  
11 additional Medicare reimbursements.

12                           **RED FLAG – POOR RESULTS IN MA ORGANIZATION AUDITS**

13           59.     Each MA Organization, contractually through its provider agreement, requires  
14 Sutter and its affiliates, including PAMF, to participate and cooperate in medical chart reviews  
15 and audits conducted by the MA Organization or other related entities. The results of an audit  
16 and medical chart review by United Health Group (“UHG”), an MA Organization, and Optum (a  
17 UHG affiliate) raised red flags for Sutter and PAMF concerning false risk-adjusting diagnosis  
18 codes for dates of service in 2010, 2011 and 2012.

19           60.     In particular, UHG conducted a “Risk-Adjustment Coding Compliance Review”  
20 (“RACCR”) audit, which is a retrospective medical chart review focusing on so-called “outlier”  
21 risk-adjusting diagnosis codes that the provider being examined submitted much more frequently  
22 than the industry average among other large providers. UHG and Optum auditors identified  
23 HCC 82 (acute myocardial infarction, or heart attack) as an outlier and determined that 27 out of  
24 30 of the patient records containing diagnosis codes mapping to this HCC were erroneous,  
25 invalid, unsupported or otherwise false in one audit (a 90% failure rate) in October 2012. A later  
26 audit found that six out of seven patient records contained underlying diagnosis codes that were  
27 similarly false (an 86% failure rate).

1           61.     With respect to the October 2012 audit with the 90% failure rate, Sutter and  
2 PAMF leadership, including Larsen and Brown (PAMF’s Associate Medical Director for  
3 Managed Care), knew of these findings. At a December 2012 “PAMF Coding and Compliance  
4 Committee” meeting, Larsen lamented about “the negative impact to our reimbursement”  
5 resulting from deleting these codes in the medical records due to the audit results. But, rather  
6 than taking steps to determine whether other records contained similarly false diagnosis codes,  
7 the supposed “compliance committee” deliberately decided not to perform any follow-up audits.  
8 Crow admitted at the same meeting that the coding department “presently does not have the  
9 bandwidth to support such an effort [to perform follow-up audits]” despite the need to do so. No  
10 coders or auditors were assigned by PAMF or Sutter to perform follow-up audits.

11           62.     Later audits by Optum and UHG auditors focused on the heart attack risk-  
12 adjusting diagnosis code at PAMF’s Camino location 28 out of 30 erroneous, invalid,  
13 unsupported or otherwise false codes for dates of service in years 2013, 2014, and 2015 (a 93%  
14 failure rate) and three out of four similarly false codes at its Mills-Peninsula location (a 75%  
15 failure rate). Sutter and PAMF knew that they were required to delete these codes. While they  
16 deleted the specific diagnosis codes identified by the Optum and UHG auditors, Sutter and  
17 PAMF deliberately ignored the much larger coding problems identified by these high audit  
18 failure rates and refused to expand auditing of diagnoses that mapped to heart attack specifically  
19 and to any of the other risk-adjusting diagnosis codes more generally.

20                           **RED FLAG - THE INEFFECTIVE COMPLIANCE AND**  
21                           **TRAINING PROGRAMS FOR RISK-ADJUSTMENT CODING**

22           63.     As highlighted by these audit results, Sutter and PAMF lacked any effective  
23 compliance or training program related to diagnostic coding for its Medicare Part C program.  
24 While there was a PAMF coding and compliance committee, as noted above its members  
25 focused primarily on Sutter’s RAF Campaign and little on audits examining the validity of the  
26 coding or other compliance efforts.

27           64.     For example, in March 2013, Crow informed Katie Borgstrom, PAMF’s Interim  
28 Chief Operating Officer, that one of PAMF’s divisions, Mills-Peninsula, “has never been audited

1 and we have no idea what is going on there.” Crow also admitted that PAMF’s coding and  
2 training group “had no credibility” with physicians and summarized these ineffective coding and  
3 compliance efforts, stating: “Historically, the coding department has had no structure, no policies  
4 and really no accountability in terms of education provided and timely feedback” to the  
5 physicians in PAMF’s network. At that time, Crow discussed these problems with Richard  
6 Slavin, PAMF’s Chief Executive Officer, who agreed that PAMF must improve in these areas.

7 65. On May 6, 2013, Sutter hired the relator, Kathy Ormsby, as PAMF’s Risk-  
8 Adjustment Project Manager. She reported to Kris Crow and at times to Suzy Cliff. In this  
9 position, Ormsby served as “the primary liaison between [the] coding, revenue cycle, quality &  
10 clinical departments with regards to the Medicare Advantage RAF/HCC coding initiative.”

11 66. Ormsby had earned a coding certification from the American Academy of  
12 Professional Coders. She also possessed substantial experience with HCC codes, risk-adjusting  
13 diagnosis codes mapping to HCC codes, the ICD standards, and Medicare Part C compliance and  
14 training through her previous, six-year employment at an MA Organization. There, her  
15 responsibilities included training physicians in the MA Organization’s network on accurate  
16 coding, supervising risk-adjustment auditors, and helping to ensure compliance with Medicare  
17 rules and regulations relating to the MA Program.

18 67. Within the first few days on the job, Ormsby became aware that PAMF lacked a  
19 compliance or coding training program relating to Medicare Part C. As Ormsby explained in  
20 notes written at a PAMF performance review several years later, on the first day “I was sent to a  
21 cube with nothing in it but an empty desk,” “with absolutely no support, tools or guidance.” In  
22 another performance review, Kris Crow, her supervisor, admitted that when Ormsby arrived no  
23 coding compliance or training program existed at PAMF.

24 68. Ormsby also realized that the same problems existed system-wide at Sutter. She  
25 knew there were no Sutter coding compliance manuals or training guides for physicians on  
26 diagnosis coding. Also, a discussion with Cheung (Sutter’s RAF Program Manager), within the  
27 first month of Ormsby’s employment, confirmed the lack of any compliance program at Sutter  
28 concerning risk-adjustment diagnosis coding or compliance. Indeed, Cheung admitted to

1 Ormsby that prior to joining Sutter she possessed no coding or compliance experience, and  
2 Ormsby knew from her work with Cheung that she primarily focused on the RAF Campaign  
3 rather than on Medicare Part C compliance.

4 69. Despite Ormsby's efforts detailed below, the compliance and training problems at  
5 Sutter and PAMF did not improve. An August 2014 coding survey of dozens of physicians in  
6 PAMF's network (reflecting physician discussions between March and August 2014 with the  
7 coding and auditing team Ormsby hired at PAMF) revealed no meaningful improvement in  
8 coding compliance or training. PAMF executives Larsen, Vahamaki, Cliff, and Crow all  
9 received the survey results showing widespread confusion among physicians (as well as the  
10 compliance department) about the coding requirements. Not surprisingly, this survey also  
11 showed these physicians' patient medical records were replete with false diagnosis codes,  
12 including codes mapping to HCC codes for different types of cancer, diabetes, renal failure,  
13 emphysema, pulmonary disease, and vascular disease, among others. In fact, the little physician  
14 education that PAMF physicians had received on diagnosis coding (prior to Ormsby's efforts)  
15 focused on increasing RAF scores. For example, in February 2014, Dr. Karen Suskiewicz told a  
16 PAMF auditor who questioned the adequacy of the patient's medical record documentation for a  
17 diabetes diagnosis, "I was told [at] the coding meeting last year that we should 'upcode'  
18 whenever possible . . ." (quotation in original.)

19 70. Over time, the attitude of Sutter and PAMF management towards coding  
20 compliance became more dismissive, as management continued to ignore red flags as well as  
21 warnings by Ormsby. Under the tenure of Christian Gabriel (Ormsby's new supervisor) that  
22 began in early February 2015, compliance became even less of a priority than it had been under  
23 her former supervisor, Kris Crow. As described below, this did not happen by chance, but  
24 represented a calculated effort by Sutter and PAMF to further the RAF Campaign and improve  
25 their efforts at maximizing Medicare reimbursement.

26 //

27 //

28 //

1        **RED FLAG - ORMSBY'S AUDIT RESULTS PROVIDED SUTTER AND PAMF**  
2        **WITH ACTUAL NOTICE ABOUT THOUSANDS OF FALSE CLAIMS**

3        71.        Concerned about the lack of coding compliance and training, Ormsby personally  
4 conducted, within a few weeks of her hiring, a random diagnosis coding audit of 42 physician-  
5 patient encounters at PAMF occurring in the first two quarters of 2013. In so doing, she  
6 followed the ICD-9 coding guidelines used by Medicare. This type of audit is called an  
7 “Encounter Audit.” It evaluates one physician-patient encounter in a given year and is useful to  
8 establish a baseline for coding accuracy. However, an Encounter Audit alone does not determine  
9 the extent of overpayments from CMS. A patient may have more than one encounter with the  
10 physician annually or an encounter with a different physician or in a different setting later that  
11 year that may establish the validity of a diagnosis.

12        72.        Ormsby completed this audit in early June 2013. She discovered an 85% coding  
13 failure rate, with 53 of the 62 risk-adjusting diagnosis codes being false. All of these codes had  
14 been submitted by PAMF for reimbursement, which raised a red flag of overpayments from  
15 CMS.

16        73.        A month later, on July 8, 2013, one of the MA Organizations, UHG, sent  
17 McGinnis, Sutter’s RAF Director, a letter “identif[ying] your practice as having submitted one or  
18 more HCCs at significantly higher rates than your peers,” requesting supporting documentation,  
19 and noting UHG’s engagement of a consulting firm to conduct a medical chart review. Cheung,  
20 Sutter’s RAF Program Manager, received and forwarded the UHG letter to Ormsby, among  
21 others, who responded to Sutter and PAMF executives that the letter “identifies [PAMF] as  
22 having some red flags and I want us to be compliant.” Ormsby also began lobbying for auditing  
23 support, stressing “[w]e really need to get on the ball with our potential HCC auditor[s].”

24        74.        In light of her audit results, Ormsby created a “Corrective Action Plan” in early  
25 August 2013. Her plan called for hiring certified coders to perform audits and developing a  
26 compliance and training program to improve coding accuracy. Ormsby also cited the 85%  
27 diagnosis coding failure rate in her June 2013 audit, and identified the “root cause” as PAMF’s  
28 ineffective compliance and training. The Corrective Action Plan explained that the audit

1 “confirmed that proper instruction for documentation requirements had not been communicated  
2 clearly to providers” and that PAMF “currently lacks a clearly defined procedure for auditing  
3 and provider feedback.”

4 75. The Corrective Action Plan called for two types of audits: “Encounter Audits”  
5 similar to Ormsby’s June 2013 audit, and “FOCUS Audits” examining the error rates of several  
6 key HCCs (cancer, stroke, and fractures) that Ormsby understood from her prior experience were  
7 often miscoded and resulted in lucrative CMS reimbursements. The FOCUS Audits examined  
8 diagnosis codes in PAMF patient medical records covering an entire calendar year and thus  
9 could be used in determining overpayments from CMS. Ormsby gave her supervisor, Crow, a  
10 copy of the Corrective Action Plan. Soon thereafter, Ormsby received authorization to hire five  
11 certified coders, but no substantive feedback about the Corrective Action Plan. PAMF  
12 management above Crow approved the hiring of the five certified coders to work as auditors.  
13 However, at the time, management viewed audits as a tool to increase diagnostic coding rather  
14 than for compliance.

15 76. While the Encounter and FOCUS audits proceeded at PAMF, Ormsby learned of  
16 additional risk-adjusting diagnosis coding problems in PAMF’s MA beneficiary medical records.  
17 In January 2014, one of the Physician Champions, Dr. Gupta, identified “thousands” of “old,  
18 outdated and incorrect” diagnoses on the Problem Lists that place “[us] at risk of incorrectly  
19 coding them in a given year.” In addition to Ormsby and her supervisor, Crow, other PAMF  
20 executives learned of this problem, including Vahamaki and the four Physician Champions.

21 77. In an April 3, 2014 proposal to Crow and Cliff seeking five more full-time coders  
22 to augment her team, Ormsby identified 185 risk-adjusting diagnosis codes that had been  
23 “incorrectly captured by providers and submitted for reimbursement” in just the first quarter of  
24 2013 alone. Ormsby explained that with these additional coders “[d]ocumentation across all of  
25 PAMF would be better supported to reach the requirements identified by CMS (Center for  
26 Medicare and Medicaid Services) and show a marked increase in compliance” (parenthetical in  
27 original.)  
28

1           78.     Shortly after this proposal, Sutter and PAMF received the results of a chart review  
2 by a consultant, Peak Health Services, engaged by UHG and Health Net, another MA  
3 Organization, for dates of service in calendar years 2012 and 2013. The Peak chart review  
4 identified over 8,000 false diagnosis codes for MA Plan patients that Sutter and its affiliates  
5 needed to delete based on “overcod[ing]” and diagnoses “not supported in documentation.”  
6 Sutter and PAMF executives, as well as Ormsby, learned of these results. Despite this additional  
7 red flag, Sutter and PAMF executives did not direct Ormsby or any other auditor to take  
8 remedial action to identify other false diagnosis codes.

9           79.     On June 3, 2014, Ormsby informed management that preliminary results of the  
10 2013 Encounter Audits were showing high failure rates. The Encounter Audits found 1,082 false  
11 risk-adjusting diagnosis codes out of a total of 2,226 patient encounters audited, a nearly 50%  
12 failure rate (48.9%).

13           80.     A few weeks later, on June 27, 2014, Ormsby informed Crow that the Physician  
14 Champions were erroneously educating PAMF physicians about the diagnosis coding  
15 requirements for morbid obesity and aortic atherosclerosis. Based on her dealings with them,  
16 Ormsby explained to Crow that “[i]t is apparent that the champions have been training our  
17 providers on aortic arthrosclerosis and morbid obesity incorrectly” and suggested an audit to  
18 uncover the extent of the problem. PAMF did not authorize any audit in response to this request.

19           81.     Approximately one month later, in late July 2014, Ormsby raised another red flag,  
20 identifying false diagnosis codes with PAMF management relating to a single MA Plan patient  
21 identified herein as Patient A dating back to a patient encounter in 2010. An MA Organization  
22 (UHG) had requested the medical records for Patient A supporting the submission of a risk-  
23 adjusting diagnosis code (prostate cancer) during dates of service in 2010. In response, Ormsby  
24 pulled Patient A’s medical records and found nothing in the record to support the prostate cancer  
25 code for that year. She provided Patient A’s medical records to UHG as requested and brought  
26 this problem to the attention of her supervisor, Crow, as well as to Cheung at Sutter. In response,  
27 Cheung reprimanded Ormsby for turning over Patient A’s medical records to UHG and ordered  
28 her never to do that again, but instead to send any patient medical records to Cheung.

1           82.     Concerned about potential liability, Crow asked Ormsby to calculate the potential  
2 reimbursements to CMS from the false coding related to Patient A in light of UHG's  
3 understanding of CMS's position that "if one HCC failed in audit, [CMS] could assume that for  
4 every patient in the plan that submitted the same HCC, [CMS] can ask for the payment back."  
5 Given the false coding of prostate cancer for Patient A, Ormsby identified a total of 484 codes  
6 for prostate cancer submitted for payment in 2010 and estimated the potential reimbursement at  
7 \$1.936 million, which she stated "is probably low."

8           83.     Also, in July 2014, Ormsby performed another Encounter Audit similar to the one  
9 she had conducted in June 2013. This time she reviewed 20 physician-patient encounters  
10 covering the one-month period of March 2013. Ormsby found a 90% failure rate, with false risk-  
11 adjusting diagnosis codes in 18 of the 20 encounters.

12           84.     In December 2014, Ormsby and her audit team memorialized the final tally of the  
13 2013 FOCUS Audit of risk-adjusting diagnosis codes for cancer, stroke, and fracture. For cancer  
14 (HCC 10, categorizing breast, prostate, colorectal and other cancers and tumors), 164 of the 182  
15 patient records audited for the 2013 calendar year were erroneous, invalid, unsupported or  
16 otherwise false for HCC 10. Ormsby calculated the "HCC 10 Accuracy" rate at 9.88% for this  
17 cancer code. For stroke (HCC 99/100, including cerebral hemorrhage and ischemic or  
18 unspecified stroke), 162 of the 169 patient records audited for the 2013 calendar year were  
19 similarly false for HCC 99/100. Ormsby calculated the "HCC 99/100 Accuracy" rate at 4.1% for  
20 these stroke codes. For fracture (HCC 169/170, including vertebral fractures without spinal cord  
21 injury and hip fracture/dislocation), 57 of the 86 patient records audited for the 2013 calendar  
22 year were also false for HCC 169/170. Ormsby calculated the "HCC 169/170 Accuracy" rate at  
23 33.7% for these fracture codes.

24           85.     As noted in ¶ 75 *supra*, FOCUS Audits are especially important for compliance  
25 purposes because they identify false risk-adjusting diagnosis codes that result in inflated  
26 Medicare reimbursements and, upon identification, trigger the duty to delete these codes to  
27 ensure the appropriate reimbursement. On December 16, 2014, Ormsby met with Marcella  
28 Alaniz, a PAMF Compliance Analyst, to discuss these poor results. Ormsby also discussed the

1 2013 FOCUS Audit results with Jessica Driver-Zuniga, Sutter's lead RAF/HCC coder, including  
2 the continuing problem of false diagnosis codes still being submitted to MA Organizations and  
3 subsequently to the CMS reimbursement system.

4 86. Three days later, on December 19, 2014, Ormsby widely distributed the 2013  
5 FOCUS Audit results to PAMF senior management, flagging the high failure rates (cancer 90%,  
6 stroke 96%, and fracture 64%). Ormsby identified the audit as a high-priority compliance issue  
7 encompassing over 7,500 encounters in one year of service. That same day Ormsby notified  
8 PAMF senior management that there were additional false risk-adjusting diagnosis codes that  
9 had been submitted to CMS and that required reimbursements of the overpayments from CMS.  
10 She wrote, "We have identified 94 encounters that have been submitted to CMS without  
11 supporting documentation for HCC conditions billed" from PAMF physicians. Ormsby also  
12 wrote that she "expect[ed] this number to increase daily until a resolution can be implemented."

13 87. These audit results further showed that over 3,500 patient encounters from 2013  
14 dates of service remained un-reviewed. In fact, Ormsby's auditing team had the capacity to  
15 review only a small percentage of the cancer, stroke and fracture encounters for 2013 dates of  
16 service at PAMF, which itself was only a small portion of the encounters that should have been  
17 reviewed. No other dates of service had been reviewed, and Ormsby raised that concern to her  
18 immediate supervisor, Suzy Cliff, in writing, on January 21, 2015.

19 88. The false coding problems highlighted by the 2013 FOCUS and Encounter Audits  
20 came as no surprise to PAMF management. Indeed, throughout 2014, Ormsby distributed the  
21 monthly RAF Dashboard results to management, including to Larsen and Cliff of PAMF. These  
22 results detailed hundreds of erroneous, invalid, unsupported or otherwise false diagnosis codes  
23 compiled as the Encounter and FOCUS Audits progressed.

24 89. In early January 2015, Ormsby raised a new problem concerning "misleading  
25 labels" for stroke in Sutter's electronic medical record system to management at Sutter and  
26 PAMF, including Cheung at Sutter and Cliff at PAMF. Ormsby attached a screen shot showing  
27 these misleading labels, which stated that various types of stroke, as long as they took place  
28 within eight weeks of the visit, were considered acute and carried an "HCC" label. Ormsby

1 explained that this diagnosis code should not be captured after a patient is discharged from the  
2 hospital in an in-patient setting (much less within eight weeks), but “[t]he labels are causing  
3 providers to capture the incorrect ICD-9 codes and we are being reimbursed inappropriately.” In  
4 response to Ormsby’s request to remove the words “8 weeks” from the label, Cheung resisted,  
5 noting that “[t]he Compliance Reimbursement Team hasn’t yet weighed in.” Cheung also  
6 admitted that these misleading electronic medical record labels were a system-wide problem at  
7 all of Sutter’s affiliates, not just PAMF, and cautioned that a change in labelling “won’t be made  
8 for just one organization.”

9         90. Finally, in March 2015, Ormsby updated her FOCUS and Encounter Audit results  
10 at the request of her new supervisor, Christian Gabriel, who started working in that position at  
11 PAMF on or about February 1, 2015. The updated 2013 FOCUS Audit results showed Ormsby  
12 and her auditing team’s deletion of 1001 false diagnosis codes that had been submitted for  
13 reimbursement. These deletions resulted in downward adjustments of the CMS reimbursements  
14 that had been inflated by these false codes. Also, the 2013 and 2014 Encounter Audit results  
15 showed the deletion in the electronic medical record system of 777 false diagnosis codes in 2013  
16 and 517 false diagnosis codes in 2014. Upon reviewing this data, Gabriel asked Ormsby to  
17 calculate an overpayment amount for these false codes. She estimated it at approximately \$4.2  
18 million and explained to him that this likely represented just the tip of the iceberg. For example,  
19 3,844 encounters remained unaudited in date of service year 2013 alone and thousands of later  
20 encounters also were never audited. Based on the aggressiveness of the RAF Campaign, the  
21 substantial encounter coding error rates identified by Ormsby and the auditing team, and, as  
22 detailed further below, management’s refusal, starting in early 2015, to use audits as a tool to  
23 identify erroneous coding, Sutter and PAMF knowingly submitted and caused the submission to  
24 Medicare of thousands of false risk-adjusted diagnosis codes (*i.e.* false claims) for date of service  
25 years 2014, 2015, and 2016 and did not delete those false codes or refund overpayments to CMS.

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1           94. Another illustration of this attitude came in September 2012, when Dr. Brown of  
2 PAMF designed the “coding party” to improve MA patients’ risk scores. See *supra* at ¶ 47. In  
3 so doing, Brown characterized emphasizing patient care to the physicians as a strategy to  
4 increase coding “as opposed to simply hammering on them to code better.”

5           95. Similarly, in response to UHG’s October 2012 audit of 30 patient charts that  
6 identified a 90% error rate for one code, the “PAMF Coding and Compliance Committee”  
7 focused on the loss of revenue from the audit and rejected any expansion of audits due to a lack  
8 of resources in PAMF’s coding department. See ¶¶ 59-61 *supra*.

9           96. In addition to these internal discussions prioritizing the RAF Campaign above  
10 coding compliance and training, Sutter and PAMF received a steady stream of complaints from  
11 physicians in PAMF’s network highlighting their concerns about the push for aggressive risk-  
12 adjusting diagnosis coding. Among the examples:

- 13           • Dr. Joann Falkenburg expressed discomfort several times to Physician  
14 Champions Dr. Amy Lin and Dr. Vahamaki about the RAF Campaign’s  
15 encouragement of upcoding, including: (i) “I got two new HCC [daily] alerts  
16 today and have concerns about both of them”; (ii) “they [coders] suggested [a  
17 patient] get diagnosed with COPD [asthma] based on a diagnosis in UC a year  
18 and a half ago . . . I don’t feel it is legitimate to code this”; (iii) “with my patient  
19 on hospice, there is something that seems unseemly about pursuing a new  
20 diagnosis of PVD [pulmonary vascular disease] when she has weeks to live”; (iv)  
21 “it makes me feel a little fraudulent to be considering it”; and (v) “I try to be  
22 pretty legitimate about how I diagnose, document and chart and want to avoid  
23 any possibility that it looks like I am working someone up just for the financial  
24 upside.”
- 25           • Dr. Douglas Tucker complained to Vahamaki and others in PAMF’s management  
26 about a coder changing a patient diagnosis, stressing that: (i) “changing a  
27 diagnosis from acute bronchitis to pneumonia is not a simple or unimportant  
28 change”; and (ii) “it is so obviously unethical.”

- 1 • Dr. Heather Linebarger complained to Vahamaki, among others, about the  
2 Medicare Wellness Exams: “I have serious questions about the new policy of  
3 booking in Medicare Advantage patients to review all HCC codes . . . This  
4 represents a waste of time for the patient and a loss of appointment and  
5 worsening of access for me.”
- 6 • Dr. Thomas Deetz told a PAMF auditor, Lydia McGriff, “pre-populating  
7 diagnoses into his visit encounter is possibly fraud . . . Does CMS know about  
8 what you all are doing?” McGriff then relayed Deetz’s concerns to Gabriel.
- 9 • Dr. Lisa Gervin told a PAMF auditor, Lawrence Poms, she did not know how to  
10 delete an incorrect HCC code entered by a coder after her patient visit, and Poms  
11 then told Gabriel about this incident.
- 12 • “[M]ultiple doctors” complained to one of the Physician Champions, Dr. Graham  
13 Dresden, about the “harshness of the messages” on the daily alerts: “they were  
14 offended by the messages and . . . felt like the message was either confusing,  
15 fraudulent, excessive, etc.” Dresden relayed this complaint to PAMF  
16 management.

17 97. In addition to the frequent complaints from physicians, after Ormsby’s arrival  
18 Sutter and PAMF management received actual notice from Ormsby and her audit team about  
19 rampant false diagnosis coding and ineffective compliance and training. Initially, Sutter and  
20 PAMF management ignored her and continued the RAF Campaign unabated. However, as  
21 Ormsby and her auditing team deleted false diagnosis codes that mapped to HCCs and negatively  
22 impacted the reimbursement from CMS, Sutter and PAMF management took steps to impede her  
23 efforts and stop her ability to delete false codes.

24 98. As noted above, by August 2013 Ormsby had collected Encounter Audit data  
25 showing significant error rates (53 of 62 false diagnostic codes from the 42 physician-patient  
26 encounters) and developed the first Corrective Action Plan. Yet, other than hiring additional  
27 auditors, which at the time management expected would be employed to help increase RAF  
28 scores and revenue, Ormsby’s other compliance and training recommendations were ignored.

1 99. Despite discussions with management about physician complaints regarding the  
2 RAF Campaign, no changes took place. Rather, Sutter and PAMF management continued to  
3 pressure the physicians to increase risk-adjusting diagnosis coding.

4 100. On January 8, 2014, one of the Regional Physician Champions, Dr. Schaefer,  
5 stated her misgivings to Dr. Sean Gaskie concerning the RAF Campaign's "[M]edicare  
6 compliance" after reviewing a graph showing substantial increases in the "Quarterly Capture  
7 Rate" of HCC coding in 2013 compared with 2012. Schaefer understood and told Gaskie that  
8 "[M]edicare frowns on practices that just increase revenue." In response, Gaskie tried to redirect  
9 her focus to quality patient care, while admitting that "we're used to thinking of RAF as just  
10 '100M left on the table.'"

11 101. Later that month, another Regional Physician Champion, Dr. Gupta, identified to  
12 PAMF management "old, outdated, and incorrect" Problem Lists sent to the physicians via the  
13 electronic medical record system. Gupta warned that "the Problem Lists are not fully compliant"  
14 and if errors "remain on the list, then we are at risk of incorrectly coding them." *See, e.g., ¶¶ 51-*  
15 *52, 76 supra* for additional detail.

16 102. As Ormsby and her auditing team continued to identify and delete false risk-  
17 adjusting diagnosis codes that impacted Medicare reimbursements throughout 2013 and the first  
18 two quarters of 2014, Sutter and PAMF management began to impede her efforts at ensuring that  
19 Sutter and PAMF receive only the appropriate reimbursement for MA Plan patients.  
20 Notwithstanding Ormsby's multiple requests for additional auditors beginning in early April  
21 2014 and several audits identifying substantial false diagnosis coding, Sutter and PAMF  
22 prevented her from hiring the additional auditors she needed for Medicare Part C compliance and  
23 auditing.

24 103. On September 29, 2014, Ormsby attended a PAMF executive meeting with  
25 Larsen, Cliff, Vahamaki, and many others. At the meeting, Ormsby delivered a PowerPoint  
26 presentation summarizing the results, to date, of the Encounter and FOCUS Audits. The results  
27 continued to demonstrate significant concerns, with 6,082 false risk-adjusting diagnosis codes  
28 identified out of 12,220 physician-patient encounters reviewed. Ormsby also made compliance

1 and training recommendations at the meeting, including “Diagnosis Champions” to work  
2 alongside the Physician Champions and to train the physicians in PAMF’s network about proper  
3 coding and other compliance issues.

4 104. A few days after the meeting, Larsen responded. Rather than lauding Ormsby’s  
5 compliance efforts or recommending the implementation of any of her compliance and training  
6 ideas, he complained to Dr. Vahamaki, Cliff, and Dr. Michael Conroy, PAMF’s Chief Medical  
7 Officer, about his unhappiness with the pace of the RAF Campaign in increasing reimbursements  
8 from CMS. The first paragraph of Larsen’s email, dated October 1, 2014, highlights the focus of  
9 PAMF’s Chief Financial Officer on profits over compliance:

10 We are now over a year into the HCC improvement effort [*i.e.*, the  
11 formal RAF Campaign] and I see that we are making some limited  
12 progress but are behind where we could be and will likely not  
13 achieve more than a modest improvement if we continue as is.  
14 Given our existing efforts and the general mindset of the physicians  
15 I predict we will achieve at most a 10% improvement. As discussed  
16 in the original plan, critical to the success of a successful program is  
17 the shift in PCP [primary care provider] perspective to catch the  
18 vision of thinking about actively managing and thinking of patients  
19 in terms of their chronic conditions. In general, I am concerned that  
20 we do not have this shift in thinking which is critical to building a  
21 foundation for longer term and more significant improvement. We  
22 are still thinking of this as a coder supported initiative versus  
23 physician owned. I think we may need to ask the Board to  
24 reconsider implementing a physician compensation incentive along  
25 with a refocus on the other key parts of the plan to effectively change  
26 the PCP culture necessary for HCC success.

27 105. That day, Vahamaki forwarded Larsen’s email to Cheung and McGinnis of Sutter  
28 and they discussed Larsen’s focus on the RAF Campaign and Ormsby’s compliance efforts. In

1 particular, Vahamaki agreed with Larsen’s “strategic” focus on profits and identified one barrier  
2 as the coding department’s (*i.e.*, Ormsby’s) focus on compliance. Cheung agreed that Larsen  
3 “sees the significance of the physician champions” to the RAF Campaign’s success. Also  
4 criticizing Ormsby, Vahamaki expressed “shock[.]” that Ormsby had presented the PowerPoint  
5 without informing him ahead of time, claimed she had “hijacked the meeting for the first 25  
6 minutes in order to give this presentation,” and complained about her “most definitely pushing  
7 her own agenda.” He also indicated that the Physician Champions “universally questioned and  
8 disliked” Ormsby’s idea of Diagnosis Champions and did not recommend presenting this  
9 proposal at upcoming management meetings, “as it clearly does not represent PAFMG/PAMF at  
10 this time.” A few minutes later, Cheung agreed, “considering this a closed issue,” and  
11 effectively ending any possibility of Sutter or PAMF implementing Ormsby’s recommendations.

12 106. Following the plain directives from Larsen, Vahamaki and Cheung, Sutter and  
13 PAMF management took additional steps to limit Ormsby’s attempts to ensure that the RAF  
14 Campaign complied with the law. One such step was to prevent PAMF coders from deleting  
15 false diagnosis codes requiring reimbursement and instead forcing the busy network physicians  
16 to do so. On October 15, 2014, Cliff told Ormsby, in an email entitled “HCC Coding  
17 Corrections,” “[p]er our conversation this morning, please remind your team to stop performing  
18 any charge corrections on accounts until we can map out the downstream [e]ffects.”

19 107. In a related step to stop the deletion of false but lucrative diagnosis codes, on  
20 November 12, 2014, Dr. Criss Morikawa, a PAMF executive, distributed to PAMF management  
21 and Ormsby’s auditing team an email describing PAMF’s new policy prohibiting “submitting  
22 charge corrections to payors (esp. Medicare) more than 30 days after date of service”  
23 (parenthetical in original.) In response, Dr. Edward Yu, PAMF’s Medical Director, inquired,  
24 “What happens if the incorrect diagnosis code puts us at risk of [M]edicare fines for inaccurate  
25 coding?” Morikawa replied that due to the “close to a million charge transactions” that PAMF  
26 submits every month “it is not scalable to hold and review every encounter-even on say all  
27 [M]edicare.”  
28

1           108.    Thereafter, on November 26, 2014, Ormsby attended a meeting with Marcella  
2 Alaniz and Jessica Lin (both PAMF Compliance Analysts), among others. Alaniz complained  
3 that Ormsby lacked any authority to delete false diagnosis codes from patient encounters in the  
4 electronic medical record and instructed her to stop doing so immediately. Instead, only the  
5 physicians could make these deletions, while Ormsby and her auditors could make changes just  
6 to the billing records. In response, Ormsby explained that the monthly “sweeps” of diagnosis  
7 codes for reimbursement purposes related to the encounter side of the electronic medical record,  
8 not the billing side of the electronic medical record (which was intended to serve as a billing  
9 mechanism and record for patients who were enrolled in “traditional” fee-for-service Medicare).  
10 She also explained that, as a result, deleting false risk-adjusting diagnosis codes from the billing  
11 side and not the encounter side of the electronic medical record would do nothing to prevent  
12 false codes from being submitted for reimbursement to MA Organizations, and in turn to  
13 Medicare.

14           109.    A few days later, Ormsby tried to reverse management’s directive to stop her  
15 auditing team from deleting false diagnosis codes. On December 1, 2014, Ormsby warned  
16 PAMF management, including Alaniz, Cliff, Morikawa, and Debbie Troklus (PAMF’s  
17 Compliance Director), that “I don’t think this recommendation is a compliant solution.” The  
18 next day, December 2, 2014, Ormsby warned PAMF management about the importance to  
19 Medicare of proper diagnosis coding and Medicare’s upcoming focus on coding compliance.

20           110.    On December 10, 2014, Ormsby became even more explicit about Sutter and  
21 PAMF’s widespread false coding and the prospect of being caught by Medicare. She stated, “I  
22 am very concerned about the large number of non-compliant chronic HCC conditions that have  
23 been submitted to the health plans for reimbursement,” and once again highlighted the 2015  
24 “OIG Work Plan[s]” emphasis on MA audits of diagnostic coding. Ormsby also explained that,  
25 based on her experience, most physicians will not delete unsupported codes due to time pressure  
26 and inattention, and some cannot do so because they are no longer affiliated with PAMF. She  
27 sent the email to Conroy (PAMF’s Chief Medical Officer), Vahamaki and Cliff. Cliff  
28 subsequently chastised Ormsby for escalating the issue to Conroy.

1           111. Despite Ormsby's efforts, Sutter and PAMF continued the RAF Campaign  
2 without implementing any of her recommendations. Quite the contrary, that same month  
3 (December 2014), Dr. Schaefer, the Regional Physician Champion of Diagnostic Coding for  
4 Sutter, increased the coding pressure on physicians because "as we approach end of year [we] are  
5 trying to maximize capture of HCC's."

6           112. Ormsby's concerns about the new policy prohibiting the deletion of false  
7 diagnosis codes on the patient encounter side of the electronic medical record system was widely  
8 known throughout PAMF and by certain Sutter managers, leading to her at times being  
9 purposefully bypassed on internal discussions about coding problems. As Dr. Schaefer put it in a  
10 widely distributed December 2014 email discussing a coding issue, "I am not sending this to  
11 Kathy as we know what happens."

12           113. In addition, Ormsby distributed the results of her FOCUS Audit in mid-December  
13 2014 and continued raising issues about PAMF's false coding. She also raised these issues at a  
14 January 21, 2015 meeting with Cliff and sent a follow-up email the next day to PAMF  
15 management, including Vahamaki, Cliff, Troklus, Alaniz and Morikawa. In the email, she  
16 "reiterated [her] concerns regarding" five key HCC coding compliance problems, as follows:

17           1. Accuracy rates of cancer, fracture and stroke (2013 dates of service and  
18 beyond);  
19           2. Concerns regarding the payments received without supporting  
20 documentation (60 day window);  
21           3. Encounters by providers who are no longer at PAMF and have  
22 unsupported HCC submissions;  
23           4. Providers who are not responding to staff messages regarding specificity  
24 and clarification for HCC's submitted to CMS;  
25           5. Discontinued use of the auditing billing notes/corrections to rectify  
26 unsupported ICD-9" (parenthetical in original.)

27           114. Additionally, Ormsby notified management that the monthly electronic medical  
28 record "sweeps" of risk-adjusting diagnosis codes from the patient encounter records would lead

1 to the submission of many false codes to the MA Organizations and then to CMS. Highlighting  
2 this particular problem, a February 24, 2015 memo from Driver-Zuniga (Sutter's lead RAF/HCC  
3 coder) admitted that unsupported diagnosis codes that were known by PAMF and Sutter to be  
4 invalid were being "swept" into the reimbursement system.

5 115. PAMF elevated Ormsby's concerns to Sutter. Nevertheless, Sutter and PAMF's  
6 focus on profits over compliance did not change. Ormsby and her auditing team continued to be  
7 barred from deleting false diagnosis codes, and management continued to review "the financial  
8 impact of revising PAMF's RAF scores."

9 116. As a result, Ormsby's audit team did not conduct any additional Encounter,  
10 FOCUS or other compliance audits through at least May 2015 (after Ormsby left Sutter). When  
11 Ormsby's former team re-started doing audits, management directed that they focus on audits  
12 that would increase HCC coding and raise RAF scores, as explained below.

13 117. Despite the red flags raised by the FOCUS Audits and to ensure the continued  
14 aggressive approach to diagnosis coding, as noted above in early February 2015 Sutter and  
15 PAMF hired Gabriel to supervise Ormsby. *See supra* ¶¶ 70, 90. Initially, Ormsby tried to  
16 impress upon Gabriel the importance of coding compliance issues. She presented him with a  
17 recent CMS presentation highlighting, among other things, the importance of appropriate HCC  
18 coding and documentation, as well as identifying the Medicare rules related thereto. Ormsby  
19 also gave Gabriel a self-assessment relating to PAMF's MA Plan program describing the need  
20 for more auditors and compliance.

21 118. Nevertheless, the RAF Campaign continued to be Gabriel's priority over  
22 compliance. When Ormsby attempted to raise compliance issues, Gabriel directed her to discuss  
23 any "differences in private" with him alone rather than via emails that included the auditing  
24 team. Then, on March 9, 2015, Gabriel issued a "verbal warning" to Ormsby based on  
25 misgivings about the RAF Campaign that she had expressed at a meeting with Gabriel and her  
26 auditing team. He also made clear that at this time the audit "team, structure and process is my  
27 #1 focus" "[g]iven the lack of progress in improving our RAF/HCC scores."

1           119. Similarly, at a “Strategy Meeting” in mid-March 2015, Gabriel stressed the new  
2 focus of Ormsby’s auditing toward “rais[ing] the RAF score.” A few days later, on March 18,  
3 2015, Gabriel detailed this new focus to the auditing team at a three-hour meeting that Ormsby  
4 could not attend. In a follow-up email to the auditing team, Gabriel admitted that he had  
5 “dropped a ‘bomb’ on you in terms of a new initiative . . .” (quotation in original.) Relaying the  
6 contents of this meeting to Ormsby, Ellie Kamkar, Manager of Coding, Training and Auditing at  
7 PAMF, reported that Gabriel had directed the auditing team “to take off the compliance hat and  
8 put on the revenue hat” based on directives from senior management. Kamkar also believed that  
9 Gabriel “was asking her to teach physicians how to up code.”

10           120. A week later, at a meeting on March 25, 2015, Gabriel expressly told Ormsby that  
11 “[w]e need to audit to raise [RAF] score[s].” He also directed her and the auditing team to  
12 conduct more data-mining audits that would “support leadership’s directives for this year”  
13 regarding the RAF Campaign. These types of data-mining audits focused on alerting physicians  
14 about risk-adjusting diagnosis codes that remained on the Problem Lists and potentially could be  
15 added to patient records. Increasing Medicare reimbursement was the goal of these audits, as  
16 Gabriel explained, in a March 26, 2015 email to PAMF management and Ormsby’s auditing  
17 team. He identified “our overall goals,” as:

- 18           • Identification of new HCC’s
- 19           • Decreasing the # of patients without HCC’s
- 20           • Maintain/improve HCC capture rate for 2015
- 21           • Improve RAF/HCC scores through several techniques
  - 22               ○ Data-mining for HCC pockets of opportunities
  - 23               ○ Focus on providers that have a large volume of HCC eligible patients and
  - 24               target for review”

25 (bullet points in original.) As plans developed, the data-mining audits initially “targeted audits  
26 for DM [diabetes] with manifestations, Thrombocytopenia, PVD [pulmonary vascular disease],  
27 CKD [chronic kidney disease], MDD [major depressive disorder], and Pathological Fractures.”

1 These are all lucrative risk-adjusting diagnosis codes providing increased reimbursement from  
2 CMS.

3 121. Thereafter, Gabriel instituted new and even more aggressive policies to increase  
4 RAF scores. He required that coders pre-populate patient's medical records before any  
5 physician-patient encounter with risk-adjusting diagnosis codes that the coders suspected (but  
6 did not know) might be applicable to the patient. These codes would be swept into the electronic  
7 medical record and submitted for reimbursement unless the physician affirmatively deleted the  
8 codes from the encounter side of the electronic medical record. Moreover, Sutter and PAMF's  
9 policies precluded coders from deleting any false codes swept into the electronic medical record.  
10 Rather, coders were permitted to delete diagnosis codes only from the "billing" side, which  
11 Sutter and PAMF management knew did not prevent the submission of these false codes to MA  
12 Organizations, and in turn, to CMS during the "sweeps." By prohibiting coders from deleting  
13 false risk-adjusting diagnosis codes and using them to add codes not reported or verified by  
14 physicians in the electronic medical record, Sutter and PAMF knowingly pursued policies  
15 designed to yield inflated reimbursements through the over-reporting of diagnosis codes.

16 122. Sutter and PAMF management knew of and directed Gabriel's focus on  
17 increasing MA Plan reimbursement and on hampering Ormsby's compliance efforts. For  
18 example, at a March 27, 2015 strategy meeting with Cheung of Sutter and Arvin Magusara, a  
19 Sutter Senior Analyst, along with Gabriel and Ormsby, Cheung explained that increasing MA  
20 Plan patient risk scores "had been a concern for several years" among the RAF Steering  
21 Committee, which included Burnich, Cheung, and McGinnis of Sutter and Vahamaki of PAMF.  
22 At the same meeting, Cheung admitted that false coding problems remained and that "CMS is  
23 still receiving HCC's that we know are not correct." Nevertheless, no follow-up discussions  
24 took place at the meeting and no efforts were undertaken to correct this problem.

25 123. Another example came just a few days later, at a March 31, 2015 "Champions  
26 Meeting" that included Drs. Vahamaki, Dresden, Gupta, and Amy Lin, as well as Gabriel and  
27 Ormsby. The meeting notes indicate that Gabriel explained that each PAMF division had  
28 previously met the prior week and discussed "[h]ow both the physician and the auditor could

1 work together to identify areas to increase the RAF scores for each division.” Later during the  
2 meeting, Ormsby told management, “I want to go on the record saying that I do not agree with  
3 any auditor reviewing/auditing in search of reimbursement. I don’t believe that this is a  
4 compliant practice.” Ormsby also complained about management stopping the Encounter and  
5 FOCUS Audits used for compliance. In response, Gabriel “interrupted,” and made clear that  
6 “we are not doing any encounter audits this year,” stating that PAMF’s Compliance Department,  
7 not coding, would focus on compliance. At the same time, Gabriel admitted that PAMF was not  
8 willing to devote resources to focus on coding accuracy and compliance, acknowledging  
9 “[u]nfortunately our compliance department does not have the bandwidth to investigate  
10 compliance concerns” related to coding.

11 124. Not until the second quarter of 2016—over a year later—did Sutter resume using  
12 internal auditing to find and delete erroneous, invalid, unsupported or otherwise false diagnosis  
13 codes. At that time, the Office of Patient Experience initiated an audit attempting to establish an  
14 accuracy baseline (*i.e.*, error rate) in 2015 patient encounters resulting in diagnoses of stroke and  
15 heart attack, similar to Ormsby’s process when she was first hired in 2014. A sample of MA  
16 beneficiaries was randomly selected from each Sutter affiliate, including PAMF, for encounters  
17 by primary care physicians and specialists. After reviewing the medical records for 38  
18 beneficiaries, the accuracy rate at PAMF for diagnosis codes that mapped to the HCC for heart  
19 attack was only 39.29%. Diagnosis codes that mapped to stroke were worse, with an accuracy  
20 rate of only 22.22%. The accuracy rate of PAMF, when combined with Mills Peninsula Division  
21 of PAMF and the Mills Peninsula Medical Group (a provider affiliated with PAMF), fell to  
22 10.87% for diagnosis codes that mapped to the HCC for stroke. The error rates were similarly  
23 high system-wide at Sutter, despite a stated goal of a 95% accuracy rate. For example, a review  
24 of 206 MA beneficiaries system-wide at Sutter showed a 53.7% accuracy rate for risk-adjusting  
25 diagnoses mapping to heart attack and a 22.8% accuracy rate for risk-adjusting diagnoses  
26 mapping to stroke.

27 //

28 //

**ACCURATE DIAGNOSIS CODING'S CRITICAL IMPORTANCE TO CMS**

125. Sutter and PAMF knew that CMS depends on accurate risk-adjusting diagnosis coding to ensure appropriate reimbursement to MA Organizations and thus, payment to providers, for the healthcare services furnished under the MA Plans. *See supra* ¶¶ 38-40. Indeed, in determining the health status of each MA Plan patient, CMS's HCC model relies exclusively on risk-adjusting diagnoses that are added into a patient's medical records by physicians during (or coders after) face-to-face encounters between physician and patient. Thus, accurate diagnosis coding goes to the very essence of Medicare's bargain with and payment to MA Organizations.

126. Given the importance of accurate information, CMS requires certifications signed by MA Organization executives regarding the truth and accuracy of coding and other patient information submitted to CMS. These signed certifications are a condition of payment by CMS. *See* 42 C.F.R. § 422.504(1)(3) (requiring related entities, contractors and subcontractors of MA Organizations to certify the accuracy, completeness and truthfulness of payment data they generate). In turn, the MA Organizations require in their contractual delegation agreements with providers, like Sutter and PAMF, similar certifications signed by provider executives.

127. Additionally, CMS audits MA Organizations, and the MA Organizations in turn audit providers, concerning the accuracy of their coding because of its importance to MA Plan reimbursement. In the event that erroneous risk-adjusting diagnoses codes are "swept" into the reimbursement system, CMS requires the return of any overpayments. *See* Medicare Managed Care Manual, Chapter 7, § 40 (June 2013); *Swoben*, 848 F.3d at 1176-77 & n.8 (9th Cir. 2016). So do Sutter and PAMF's policies. *See supra* ¶ 42.

128. PAMF executives, including Dr. Vahamaki, and all of the Physician Champions, also knew that "failing a Medicare audit . . . could trigger a large scale audit" and the need to "protect . . . the organization" against such a result that could lead to the reimbursement of millions of dollars in overpayments. Highlighting the magnitude of these potential reimbursements, Ormsby provided her supervisor, Crow, with an estimate of \$1.936 million in potential reimbursements to CMS if a UHG audit identified the erroneous coding of prostate

1 cancer for Patient A in 2010. *See* ¶ 82, *supra*. Similarly, in December 2014, Ormsby informed  
2 Conroy, Cliff and Vahamaki that she was “very concerned” about the “large number” of false  
3 diagnosis codes submitted to CMS for reimbursement that potentially could be discovered in  
4 HHS-OIG MA audits. *See supra* ¶¶ 109-110.

5 129. More broadly given the need to protect the public fisc, it is black letter law that  
6 “[persons] must turn square corners when they deal with the Government.” *See Rock Island,*  
7 *Ark. & La. R.R. Co. v. United States*, 254 U.S. 141, 143 (1920). Sutter and PAMF executives  
8 knew the importance of ensuring compliant practices when billing Medicare. For example, in  
9 August 2013, Alaniz, PAMF’s Compliance Analyst, understood the need for such care in  
10 addressing coding issues, “especially since are dealing with Medicare.”

11 130. Finally, Ormsby even went so far as to warn senior PAMF executives that false  
12 coding could result in FCA liability. In mid-September 2014, she informed Dr. Conroy, PAMF’s  
13 Chief Medical Officer, about the continuing “struggl[es] with coding guidelines” of Dr.  
14 Vahamaki and the Physician Champions. In response, a week later, Conroy asked Ormsby,  
15 “what are the range of fines and regulations we are subject to . . . on an issue like inappropriate  
16 use of codes such as the obesity code?” Ormsby provided the answer to Conroy that day,  
17 explaining in an email the prospect of FCA penalties and treble damages for false coding and  
18 sending him PowerPoint slides that she had received at a Medicare presentation describing the  
19 potential FCA liabilities.

20 **SUTTER AND PAMF’S MISCONDUCT RESULTED IN THE**  
21 **SUBMISSION OF THOUSANDS OF FALSE CLAIMS**

22 131. During the period from January 2010 through December 31, 2016, Sutter and  
23 PAMF, through their unlawful conduct discussed in ¶¶ 1 through 130 above, knowingly caused  
24 the submission of thousands of erroneous, invalid, unsupported or otherwise false risk-adjusting  
25 diagnosis codes to CMS for tens of thousands of Medicare Advantage beneficiaries at PAMF.  
26 The MA beneficiary population at PAMF Mills Peninsula tallied approximately 28,000 over  
27 those six years, while PAMF served approximately 74,000 MA beneficiaries during that period.  
28 These false claims inflated CMS’s reimbursements by tens of millions of dollars.

1           132. Sutter and PAMF knew that they were required to submit accurate diagnosis data  
2 to the MA Plans and delete erroneous, invalid, unsupported or otherwise false diagnoses. *See*  
3 *supra* ¶¶ 37-38. Sutter and PAMF were also on notice from Ormsby and her audit team, as well  
4 as from other audits and chart reviews, of thousands of such coding problems. Yet, Sutter and  
5 PAMF knowingly disregarded that information and failed to investigate the prevalence of this  
6 miscoding or delete these codes. Instead, they knowingly retained the resulting overpayments.

7           133. In addition to Patient A discussed above in ¶¶ 81-82, the following are additional  
8 examples of false claims that Sutter and PAMF caused to be submitted to CMS:

9           a. Patient B - PAMF and Sutter submitted an ICD-9 diagnosis code for  
10 malignant neoplasm of thyroid gland for Patient B for date of service year  
11 2012. This diagnosis code mapped to HCC 10 and increased reimbursement  
12 from CMS. However, Patient B's medical records and treatment show the  
13 falsity of this coding because (1) Patient B's thyroid cancer was treated by  
14 thyroidectomy in July 2007, (2) no recurrence of the cancer occurred, and  
15 (3) there was no evidence of treatment, evaluation, or management of  
16 thyroid cancer in this patient's 2012 medical records.

17           b. Patient C - PAMF and Sutter submitted an ICD-9 diagnosis code for  
18 malignant melanoma of skin of scalp and neck for Patient C for date of  
19 service year 2012. This diagnosis code mapped to HCC 10 and increased  
20 reimbursement from CMS. However, Patient C's medical records and  
21 treatment show the falsity of this coding because (1) in 2012, there was no  
22 treatment, evaluation or management of skin cancer noted in Patient C's  
23 medical records, and (2) Patient C had last been treated for malignant skin  
24 cancer in 2006.

25           c. Patient D - PAMF and Sutter submitted an ICD-9 diagnosis code that  
26 mapped to stroke (specifically, cerebral artery occlusion, unspecified, with  
27 cerebral infarction) for Patient D for date of service year 2014. This  
28 diagnosis code mapped to HCC 96 and increased the reimbursement from

1 CMS. However, Patient D's medical records and treatment show the falsity  
2 of this coding because (1) Patient D's past medical history reflected a  
3 cerebellar infarction, a transient rather than a chronic medical condition and,  
4 thus, not mapped to any HCC code, (2) the cerebellar infarction took place  
5 in 1990 without further recurrence, and (3) no stroke or cerebrovascular  
6 accident event was noted in the patient's medical documentation for service  
7 year 2014.

8 d. Patient E - PAMF and Sutter submitted an ICD-9 diagnosis code that  
9 mapped to stroke (specifically, cerebral artery occlusion, unspecified, with  
10 cerebral infarction) for Patient E for date of service year 2014. This  
11 diagnosis code mapped to HCC 96 and increased reimbursement from  
12 CMS. However, Patient E's medical records and treatment show the falsity  
13 of this coding because (1) Patient E's 2013 diagnostic test of magnetic  
14 resonance angiography reflected normal results without signs of a stroke,  
15 and (2) no stroke or cerebrovascular accident event is noted in Patient E's  
16 medical documentation for service year 2014. A billing note further  
17 highlighted the falsity of this coding, noting a correction of the diagnosis  
18 code to a "history of cerebrovascular accident," but that the physician's  
19 original code is "associated with an order and cannot be removed."

20 e. Patient F - PAMF and Sutter submitted and ICD-9 diagnosis code for  
21 cerebral artery occlusion, unspecified with cerebral infarction for Patient F  
22 for date of service year 2013. This diagnosis code mapped to HCC 96/100  
23 (stroke) and increased reimbursement from CMS. However, Patient F's  
24 medical records and treatment show the falsity of this coding because (1)  
25 Patient F was admitted in August 2011 for a stroke, (2) no recurrence of the  
26 stroke occurred, (3) Patient F had been on Warfarin (an anticoagulant) long-  
27 term since her stroke in 2011, and (4) there was no evidence of treatment,  
28

1 evaluation, or management of a stroke event or cerebrovascular accident in  
2 this patient's 2013 medical records.

3 f. Patient G - PAMF and Sutter submitted an ICD-9 diagnosis code for  
4 Cerebral embolism with cerebral infarction; cerebral artery occlusion,  
5 unspecified with cerebral infarction for Patient G for date of service year  
6 2013. This diagnosis code mapped to HCC 96/100 (stroke) and increased  
7 reimbursement from CMS. However, Patient G's medical records show the  
8 falsity of this coding because (1) no stroke or cerebrovascular accident event  
9 is noted in Patient G's medical documentation for service year 2014, (2) a  
10 history of a cerebrovascular accident is noted in the medical record as taking  
11 place in August 2004, for which the patient subsequently underwent  
12 rehabilitation, (3) there was no evidence of treatment, evaluation, or  
13 management of a cerebrovascular accident in this patient's 2012 medical  
14 records.

15 g. Patient H - PAMF and Sutter submitted an ICD-9 diagnosis code for  
16 hip/femur fracture, specifically, traumatic fracture of the mid-cervical  
17 section and unspecified part of the neck of the femur, closed for Patient H  
18 for date of service year 2014. This diagnosis code mapped to HCC 158 and  
19 increased reimbursement from CMS. However, Patient H's medical  
20 records show the falsity of this coding because (1) no management,  
21 evaluation or treatment of an acute hip or femur fracture is noted in Patient  
22 H's medical records for service year 2014, (2) Patient H was last treated for  
23 fracture of the right hip in 2011, and (3) Patient H received a total hip  
24 replacement in December 2011.

25 h. Patient I - PAMF and Sutter submitted an ICD-9 diagnosis code that  
26 mapped to hip/femur fracture, specifically, traumatic fracture of the pelvis  
27 for Patient I for date of service year 2014. This diagnosis code mapped to  
28 HCC 158 and increased reimbursement from CMS. However, Patient I's

1 medical records show the falsity of this coding because (1) no management,  
 2 evaluation or treatment of an acute hip or femur fracture is noted in Patient  
 3 I's medical records for service year 2014, (2) Patient I's fracture happened  
 4 in 2013 per her medical records, and (3) only a history of pelvic fracture is  
 5 documented in the 2014 medical records.

- 6 i. Patient J - PAMF and Sutter submitted an ICD-9 diagnosis code for benign  
 7 neoplasm of the brain for cerebral meninges for Patient J for date of service  
 8 year 2014. This diagnosis code mapped to HCC 10 and increased  
 9 reimbursement from CMS. However, Patient J's medical records and  
 10 treatment show the falsity of this coding because (1) the patient's last brain  
 11 MRI was in 2012, (2) a 2014 encounter noted a history of a "small  
 12 meningioma," (3) no recurrence of a brain neoplasm is noted, and (4) there  
 13 was no evidence of treatment, evaluation, or management of brain cancer in  
 14 this patient's 2014 medical records.

### 15 **FIRST CLAIM FOR RELIEF**

#### 16 **False Claims Act: Reverse False Claims**

#### 17 **31 U.S.C. § 3729 (a)(1)(G)**

18 134. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 133  
 19 above as though they are fully set forth herein.

20 135. Defendants Sutter and PAMF violated the second part of 31 U.S.C. § 3729(a)  
 21 (1)(G) as follows: Sutter and PAMF knowingly concealed and knowingly and improperly  
 22 avoided or decreased an obligation to pay or transmit money or property to the Government by  
 23 failing to repay Medicare overpayments to which they were not entitled.

24 136. Had CMS been aware of Sutter and PAMF's knowing false coding and knowing  
 25 failure to return overpayments, it would have taken steps to recover them, and CMS has now  
 26 done so via this suit that it has authorized.

1 137. By virtue of the said acts of concealment and/or improper avoidance, the United  
2 States has incurred damages and therefore is entitled to treble damages under the FCA, plus a  
3 civil penalty for each violation of the Act.

4 **SECOND CLAIM FOR RELIEF**

5 **False Claims Act: Reverse False Claims**

6 **31 U.S.C. § 3729 (a)(1)(G)**

7 138. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 133  
8 above as though they are fully set forth herein.

9 139. Defendants Sutter and PAMF violated the first part of 31 U.S.C. § 3729(a)(1)(G)  
10 as follows: Sutter and PAMF knowingly made, used, and caused to be made or used, false  
11 records and statements material to an obligation to pay or transmit money or property to the  
12 Government by creating false records and making false statements relating to their failure to  
13 repay Medicare overpayments to which they were not entitled.

14 140. Had CMS been aware of Sutter and PAMF's knowing false coding and knowing  
15 failure to return overpayments, it would have taken steps to recover them, and CMS has now  
16 done so via this suit that it has authorized.

17 141. By virtue of the said false records, statements, and other acts of concealment and  
18 improper avoidance, the United States has incurred damages and therefore is entitled to treble  
19 damages under the FCA, plus a civil penalty for each violation of the Act.

20 **THIRD CLAIM FOR RELIEF**

21 **False Claims Act: Presentation of False or Fraudulent Claims**

22 **31 U.S.C. § 3729 (a)(1)(A)**

23 142. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 133  
24 above as though they are fully set forth herein.

25 143. Defendants Sutter and PAMF violated 31 U.S.C. § 3729(a)(1)(A) by knowingly  
26 presenting and causing the presentment of false or fraudulent claims for payment or approval  
27 resulting in inflated Medicare reimbursements to which they were not entitled.

1 144. Had CMS been aware of Sutter and PAMF’s knowing false coding, it would have  
2 refused to make risk-adjustment payments based on the false coding and/or pursued other legal  
3 remedies to avoid the potential disruption of MA Plan benefits to thousands of Medicare  
4 beneficiaries to whom Sutter and PAMF provided healthcare services, and CMS has now done  
5 so via this suit that it has authorized.

6 145. By virtue of the said false or fraudulent claims, the United States has incurred  
7 damages and therefore is entitled to treble damages under the FCA, plus a civil penalty for each  
8 violation of the Act.

9 **FOURTH CLAIM FOR RELIEF**

10 **False Claims Act: Making or Using False Records or Statements**

11 **31 U.S.C. § 3729 (a)(1)(B)**

12 146. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 133  
13 above as though they are fully set forth herein.

14 147. Defendants Sutter and PAMF violated 31 U.S.C. § 3729(a)(1)(B) by knowingly  
15 making, using, and causing to be made or used, false records and statements material to false or  
16 fraudulent claims resulting in inflated Medicare reimbursements to which they were not entitled.

17 148. Had CMS been aware of Sutter and PAMF’s knowing false coding, it would have  
18 refused to make risk-adjustment payments based on the false coding and/or pursued other legal  
19 remedies to avoid the potential disruption of MA Plan benefits to thousands of Medicare  
20 beneficiaries to whom Sutter and PAMF provided healthcare services, and CMS has now done  
21 so via this suit that it has authorized.

22 149. By virtue of the said false records and statements, the United States has incurred  
23 damages and therefore is entitled to treble damages under the FCA, plus a civil penalty of each  
24 violation of the Act.

25 **FIFTH CLAIM FOR RELIEF**

26 **Payment by Mistake**

27 150. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 133  
28 above as though they are fully set forth herein.

1 151. As a consequence of Sutter and PAMF's misconduct and the acts set forth above,  
2 Sutter and PAMF received monies from the United States as a result of a mistaken  
3 understanding. Specifically, the United States reimbursed MA Organizations, who in turn  
4 reimbursed Sutter and PAMF, under the mistaken understanding of the United States that such  
5 claims were based on valid risk-adjustment diagnoses. Had the United States known the truth, it  
6 would not have paid such claims. Payment was therefore by mistake.

7 152. As a result of such mistaken payments, the United States has sustained damages  
8 for which Sutter and PAMF are liable in an amount to be determined at trial.

9 **SIXTH CLAIM FOR RELIEF**

10 **Unjust Enrichment**

11 153. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 133  
12 above as though they are fully set forth herein.

13 154. As a consequence of Sutter and PAMF's conduct and the acts set forth above,  
14 Sutter and PAMF were unjustly enriched at the expense of the United States. In equity and good  
15 conscience such money belongs to the United States.

16 155. The United States is entitled to recover such money based on Sutter and PAMF's  
17 unjust enrichment in an amount to be determined at trial.

18 **PRAYER**

19 WHEREFORE, the United States requests that judgment be entered in its favor and  
20 against Defendants Sutter and PAMF as follows:

21 On Claims I, II, III, and IV (False Claims Act), against all Defendants jointly and  
22 severally, for: (i) the amount of the United States' damages, trebled as required by law; (ii) the  
23 maximum civil penalties allowed by law, (iii) the costs of this action, plus interest as provided by  
24 law, and (iv) any other relief that this Court deems appropriate.

25 As to Claim V (Payment Under Mistake of Fact), for: (i) an amount equal to the money  
26 paid by the United States through the Medicare Advantage program as a result of Defendants'  
27 false submissions, plus interest; (ii) the costs of this action, plus interest, as provided by law; and  
28 (iii) any other relief that this Court deems appropriate.

1 As to Claim VI (Unjust Enrichment), for: (i) an amount equal to how much Defendants  
2 were unjustly enriched, plus interest; (ii) the costs of this action, plus interest, as provided by  
3 law; and (iii) any other relief that this Court deems appropriate.

4 **DEMAND FOR JURY TRIAL**

5 The United States of America hereby demands a trial by jury.

6  
7 Date: March 4, 2019

Respectfully submitted,

8 JOSEPH H. HUNT  
9 Assistant Attorney General, Civil Division

10 DAVID L. ANDERSON  
11 United States Attorney

12 MICHAEL D. GRANSTON  
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18 United States Department of Justice

19 /s/ Kimberly Friday  
20 KIMBERLY FRIDAY  
21 Assistant United States Attorney

22 Attorneys for the United States of America  
23  
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25  
26  
27  
28

**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that she is an employee of the Office of the United States Attorney for the Northern District of California and is a person of such age and discretion to be competent to serve papers. The undersigned further certifies that she is causing a copy of:

**United States' Complaint-In-Intervention**

to be served on this date upon counsel for Defendants Sutter Health and Palo Alto Medical Foundation as follows:

Katherine Lauer, Esq.  
Latham & Watkins LLP  
12670 High Bluff Drive  
San Diego, CA 92130  
katherine.lauer@lw.com

\_\_\_\_\_ BY FIRST CLASS MAIL, by placing such envelope(s) with postage thereon fully prepaid in the designated area for outgoing U.S. mail in accordance with this offices practice.

\_\_\_\_\_ BY PERSONAL SERVICE, (MESSENGER)

\_\_\_\_\_ FEDERAL EXPRESS

\_\_\_\_\_ FACSIMILE, (FAX) Telephone No.:

BY E-MAIL: I caused each such document to be sent by email to the person or offices of each address above, such person having consented to service of documents by e-mail.

\_\_\_\_\_ CERTIFIED MAIL, by placing such envelope(s) with postage thereon fully prepaid in the designated area for outgoing U.S. mail in accordance with this offices practice.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Dated: March 4, 2019

By: /s/ Kimberly Friday  
KIMBERLY FRIDAY  
Assistant United States Attorney