UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	**SACV 13-1348 FMO (SHx)**	Date	**September 29, 2015**
Title	**United States ex rel. Silingo v. Mobile Medical Examination Services, Inc., et al.**		

Present: The Honorable	Fernando M. Olguin, United States District Judge	
Vanessa Figueroa	None	None
Deputy Clerk	Court Reporter / Recorder	Tape No.
Attorney Present for Plaintiff(s):	Attorney Present for Defendant(s):	
None Present	None Present	

Proceedings: (In Chambers) Order Re: Pending Motions to Dismiss

Having reviewed and considered all the briefing filed with respect to defendants' motions to dismiss, the court concludes that oral argument is not necessary to resolve them. See Fed. R. Civ. P. 78; Local Rule 7-15; Willis v. Pac. Mar. Ass'n, 244 F.3d 675, 684 n. 2 (9th Cir. 2001).

INTRODUCTION

Qui tam relator Anita Silingo ("Silingo," "relator," or "plaintiff") filed this action under seal and in camera on August 30, 2013, alleging violations of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729, et seq. and California Labor Code §§ 201, et seq. (Original Complaint, Dkt. No. 1). Silingo filed a First Amended Complaint ("Prior Complaint," Dkt. No. 10) on May 20, 2014. On August 14, 2014, the United States declined to intervene in the case. (Notice of Election by the United States of America to Decline Intervention, Dkt. No. 11). The court unsealed the Prior Complaint the next day. (See Court's Order of August 15, 2014, Dkt. No. 12). After a meet and confer in which defendants' counsel detailed the deficiencies they would raise in their motions to dismiss the Prior Complaint, Silingo sought, and the court granted, leave to file a second amended complaint. (See Stipulation for Order Granting Leave to File Second Amended Complaint, Dkt. No. 31; Court's Order of December 16, 2014, Dkt. No. 32).

Silingo filed a Second Amended Complaint ("Complaint," Dkt. No. 39) on January 9, 2015, alleging violations of: (1) 31 U.S.C. § 3729(a) against all defendants; (2) 31 U.S.C. § 3730(h) against her former employer; and (3) California Labor Code §§ 201, et seq., also against her former employer. (See id. at ¶¶ 89-112).

Silingo's former employer, defendants MedXM and Mobile Medical Examination Services, Inc. (collectively "MedXM"), filed a motion to dismiss the Complaint, to which Silingo filed an opposition, and MedXM replied. (See [MedXM's] Motion to Dismiss the Second Amended Complaint ("MedXM's Motion," Dkt. No. 58); [Silingo's] Opposition to [MedXM's] Motion to Dismiss Second Amended Complaint ("MedXM Opp'n," Dkt. No. 61); [MedXM's] Reply in Support of Motion to Dismiss the Second Amended Complaint ("MedXM's Reply," Dkt. No. 71)).

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The remaining defendants, who are health plan providers that receive services from MedXM (collectively, "health plan defendants"), also filed motions to dismiss the Complaint. The health plan defendants are:

(1) Molina Healthcare, Inc., Molina Healthcare of California, and Molina Healthcare of California Partner Plan (collectively, "Molina"). (See [Molina's] Motion to Dismiss Second Amended Complaint ("Molina's Motion," Dkt. No. 44); [Molina's] Reply in Support of Motion to Dismiss Second Amended Complaint ("Molina's Reply," Dkt. No. 65)).

(2) Health Net, Inc., Health Net of California, Inc., and Health Net Life Insurance Company (collectively, "Health Net"). (See [Health Net's] Motion to Dismiss Relator's Second Amended Complaint ("Health Net's Motion," Dkt. No. 50); [Health Net's] Reply in Support of Motion to Dismiss Relator's Second Amended Complaint ("Health Net's Reply," Dkt. No. 68)). Health Net further adopted and incorporated by reference the arguments set forth in Molina's Motion. (See Health Net's Motion at 1).

(3) Visiting Nurse Service of New York and VNSNY Choice (erroneously sued as Visiting Nurse Service Choice) (collectively, "Visiting Nurse"). (See [Visiting Nurse's] Motion to Dismiss Second Amended Complaint ("Visiting Nurse's Motion," Dkt. No. 49); [Visiting Nurse's] Reply in Support of their Motion to Dismiss Second Amended Complaint ("Visiting Nurse's Reply," Dkt. No. 67)). Visiting Nurse further adopted and incorporated by reference the arguments set forth in Molina's Motion. (See Visiting Nurse's Motion at 7-9).

(4) WellPoint, Inc., Blue Cross of California (d/b/a and erroneously sued as Anthem Blue Cross), and Anthem Blue Cross Life and Health Insurance Company (collectively, "WellPoint"). (See WellPoint Defendants' Motion to Dismiss Second Amended Complaint ("WellPoint's Motion," Dkt. No. 53); WellPoint Defendants' Reply in Support of Motion to Dismiss ("WellPoint's Reply," Dkt. No. 69)).

(5) Alameda Alliance for Health ("Alameda"). (See [Alameda's] Motion to Dismiss the First Claim for Relief in the Second Amended Complaint ("Alameda's Motion," Dkt. No. 54); [Alameda's] Reply Brief in Support of Motion to Dismiss ("Alameda's Reply," Dkt. No. 66)).

Silingo filed a single opposition to the health plan defendants' motions. (See [Silingo's] Opposition to Defendant Health Plans' Motions to Dismiss Second Amended Complaint and/or Change of Venue ("Health Plan Opp'n," Dkt. No. 62)).

ALLEGATIONS IN SECOND AMENDED COMPLAINT

Silingo was an independent contractor at MedXM from August 2011 to January 2012, (see Complaint at ¶ 14), and a MedXM employee from January 2012 to June 23, 2013. (See id. at ¶¶ 14 & 104). From January 2012 to June 23, 2013, Silingo served as MedXM's Director of Provider

Relations. (See id.). From late spring/early summer of 2012 to April 2013, Silingo served as MedXM's Compliance Officer. (See id. at ¶ 14).

The health plan defendants hired MedXM to conduct physical examinations of Medicare patients at their homes. (See Complaint at ¶¶ 7 & 13). The crux of Silingo's Complaint is that MedXM's physical examinations fraudulently claimed that the health plan defendants' Medicare patients were sicker than they really were, which caused the government to pay inflated amounts to health plan defendants under the relevant Medicare programs. (See, generally, Complaint).

According to plaintiff, the government makes capitated payments to health plan defendants, which are paid in advance for the delivery of health care services on a per patient, per unit of time basis. (See Complaint at ¶ 15). The amounts paid are based on diagnostic codes set forth in the International Classification of Disease, Ninth Revision Clinical Modification guidelines ("ICD-9 codes"), which are used to create Hierarchical Condition Category ("HCC") risk scores. (See id.). The health plan defendants submit the HCC risk scores to the Centers for Medicare and Medicaid Services ("CMS"), which uses the scores to adjust the capitated payment rates accordingly. (See id.). The higher the HCC score, the higher the capitated rate. (See id.). The lower the HCC score, the lower the capitated rate. (See id.).

As described in more detail below, Silingo challenges eight of MedXM's business practices and alleges that the health plan defendants failed to implement internal controls to monitor those business practices. (See, generally, Complaint at ¶¶ 17-88).

LEGAL STANDARD

"The focus of any rule 12(b)(6) dismissal – both in the trial court and on appeal – is the complaint." Schneider v. Cal. Dep't of Corrections, 151 F.3d 1194, 1197 n. 1 (9th Cir. 1998). To survive a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6), a complaint must set forth "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action[.]" Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555, 127 S.Ct. 1955, 1964-65 (2007). Rather, plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." Id. at 570, 127 S.Ct. at 1974; see Ashcroft v. Iqbal, 556 U.S. 662, 678, 129 S.Ct. 1937, 1949 (2009). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." Iqbal, 556 U.S. at 678, 129 S.Ct. at 1949; see Twombly, 550 U.S. at 555, 127 S.Ct. at 1965 ("Factual allegations must be enough to raise a right to relief above the speculative level, on the assumption that all the allegations in the complaint are true (even if doubtful in fact)") (citations omitted)); Moss v. United States Secret Service, 572 F.3d 962, 969 (9th Cir. 2009) ("for a complaint to survive a motion to dismiss, the non-conclusory 'factual content,' and reasonable inferences from that content, must be plausibly suggestive of a claim entitling the plaintiff to relief"). In determining whether the complaint states a plausible claim for relief, the court must "draw on [its] judicial experience and common sense," Iqbal, 556 U.S. at 679, 129 S.Ct. at 1950, and consider "'obvious alternative

explanation[s].'" Id. at 682, S.Ct. at 1951-52 (quoting Twombly, 550 U.S. at 567, 127 S.Ct. 1955). "The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." United States v. Corinthian Colls., 655 F.3d 984, 991 (9th Cir. 2011).

In considering whether to dismiss a complaint, the court must accept the allegations of the complaint as true, Erickson v. Pardus, 551 U.S. 89, 93-94, 127 S.Ct. 2197, 2200 (2007); Albright v. Oliver, 510 U.S. 266, 268, 114 S.Ct. 807, 810 (1994), construe the pleading in the light most favorable to the pleading party, and resolve all doubts in the pleader's favor. See Jenkins v. McKeithen, 395 U.S. 411, 421-22, 89 S.Ct. 1843, 1849 (1969); Berg v. Popham, 412 F.3d 1122, 1125 (9th Cir. 2005). Dismissal for failure to state a claim can be warranted based on either a lack of a cognizable legal theory or the absence of factual support for a cognizable legal theory. See Mendiondo v. Centinela Hosp. Med. Ctr., 521 F.3d 1097, 1104 (9th Cir. 2008). A complaint may be dismissed also for failure to state a claim if it discloses some fact or complete defense that will necessarily defeat the claim. See Franklin v. Murphy, 745 F.2d 1221, 1228-29 (9th Cir. 1984).

Because the False Claims Act is an anti-fraud statute, Silingo must also meet the heightened pleading requirements of Rule 9(b) of the Federal Rules of Civil Procedure. See Bly-Magee v. California, 236 F.3d 1014, 1018 (9th Cir. 2001). Rule 9(b) requires that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." This includes "the who, what, when, where, and how of the misconduct charged." Ebeid ex rel. U.S. v. Lungwitz, 616 F.3d 993, 998 (9th Cir.), cert. denied, 562 U.S. 1102 (2010). And it includes identification of "what is false or misleading about the purportedly fraudulent statement, and why it is false." Cafasso v. Gen. Dynamics C4 Sys., Inc., 637 F.3d 1047, 1055 (9th Cir. 2011) (alteration marks omitted).

Although qui tam suits are "meant to encourage insiders privy to a fraud on the government to blow the whistle on the crime[,]" the requirement that insiders comply with the heightened pleading standard of Rule 9 is reasonable because they "should have adequate knowledge of the wrongdoing at issue[.]" Bly-Magee, 236 F.3d at 1019 (emphasis in original). Ultimately, plaintiff's allegations must be "specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged so that they can defend against the charge and not just deny that they have done anything wrong." Neubronner v. Milken, 6 F.3d 666, 671 (9th Cir. 1993).

While the circumstances constituting fraud must be alleged with particularity, "[m]alice, intent, knowledge, and other conditions of a person's mind may be alleged generally." Fed. R. Civ. P. 9(b); see Corinthian Colls., 655 F.3d at 992 & 996 ("Notably, Rule 9(b) requires only that the circumstances of fraud be stated with particularity; other facts may be plead generally, or in accordance with Rule 8.") (emphasis omitted). Thus, under Rule 8(a), a plaintiff need allege only "enough facts to raise a reasonable expectation that discovery will reveal evidence of" defendants' state of mind. See Cafasso, 637 F.3d at 1055 (alteration marks omitted) (quoting Twombly, 550 U.S. at 556; 127 S.Ct. 1955).

With these standards in mind, the court now turns to the arguments raised by MedXM and the health plan defendants in their motions.

DISCUSSION

I. PERSONAL JURISDICTION AND VENUE AS TO VISITING NURSE.

As an initial matter, Visiting Nurse contends that the court lacks personal jurisdiction over it, (see Visiting Nurse's Motion at 9-14), and that the Central District of California is an improper venue to hear Silingo's claims against it. (See id. at 14-16).

The relevant statute, 31 U.S.C. § 3732(a), provides:

> Any action under section 3730 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by section 3729 occurred. A summons as required by the Federal Rules of Civil Procedure shall be issued by the appropriate district court and served at any place within or outside the United States.

The first sentence of § 3732(a) is a venue provision. See United States ex rel. Thistlethwaite v. Dowty Woodville Polymer, Ltd., 110 F.3d 861, 865 (2d Cir. 1997) ("Dowty I"). The second sentence limits the exercise of personal jurisdiction. See United States ex rel. Thistlethwaite v. Dowty Woodville Polymer, Ltd., 976 F.Supp. 207, 210 (S.D.N.Y. 1997) ("Dowty II").

A. Personal Jurisdiction.

Visiting Nurse must have certain minimum contacts with the forum such that the maintenance of the suit does not offend "traditional notions of fair play and substantial justice." Int'l Shoe Co. v. Washington, 326 U.S. 310, 316, 66 S.Ct. 154, 158 (1945). "Where, as here, there is a federal statute that permits worldwide service of process, the relevant inquiry is whether the defendants have minimum contacts with the United States as a whole." Dowty II, 976 F.Supp. at 210; see 31 U.S.C. § 3732(a).

Here, the Visiting Nurse entities have a principal place of, and engage in, business in New York, New York. (See Declaration of Samuel Heller in Support of [Visiting Nurse's] Motion to Dismiss Second Amended Complaint, Dkt. No. 49-3, at ¶ 2; Declaration of Hany Abdelaal in Support of [Visiting Nurse's] Motion to Dismiss Second Amended Complaint, Dkt. No. 49-4, at ¶ 2). As such, the exercise of personal jurisdiction over the Visiting Nurse entities is proper within the meaning of 31 U.S.C. § 3732(a).

B. Venue.

Visiting Nurse contends that venue in this district is not proper because it has been mis-joined under Rule 20 of the Federal Rules of Civil Procedure. (See Visiting Nurse's Motion at 15-16). As such, the fact that MedXM can be found, resides, or transacts business in this district cannot be imputed to it. (See id.); United States ex rel. N. Santiam Watershed Council v. Kinross Gold USA, Inc., 1998 WL 118176, *2-3 (N.D. Cal. 1998) (dismissing FCA claims against co-defendants pursuant to 31 U.S.C. § 3732(a) after concluding co-defendants were misjoined under Rule 20(a)). The court does not agree.

Under Federal Rule of Civil Procedure 20(a)(2), "[p]ersons . . . may be joined in one action as defendants if: (A) any right to relief is asserted against them jointly, severally, or in the alternative with respect to or arising out of the same transaction, occurrence, or series of transactions or occurrences; and (B) any question of law or fact common to all defendants will arise in the action." As for the first prong, the Complaint alleges that MedXM and Visiting Nurse are jointly responsible for failing to accurately report Visiting Nurse's HCC risk scores to CMS. (See, e.g., Complaint at ¶¶ 76-77). According to Silingo, MedXM engaged in various acts to inflate HCC risk scores, (see id. at ¶¶ 17-70), and Visiting Nurse failed to "prevent, detect, and correct fraud waste and abuse," (id. at ¶ 71; see also id. at ¶¶ 71-77 & 85-88), and "utterly failed to implement any type of effective compliance program[.]" (Id. at ¶ 85). As such, the allegations against MedXM and Visiting Nurse arise from the same HCC risk scores submitted to the government.

As for the second prong, the Complaint alleges common legal theories, (see Complaint at ¶¶ 89-94), that are based on common factual disputes as to whether MedXM inflated HCC risk scores, and whether Visiting Nurse failed to put into place internal controls to detect such abuses. (See id. at ¶¶ 17-77 & 85-88). Some of the central factual disputes in this case relate to the HCC scores MedXM provided to Visiting Nurse. It therefore makes no sense for MedXM to litigate in the Central District of California while Visiting Nurse litigates in the Southern District of New York. In short, venue is proper as to Visiting Nurse. See 31 U.S.C.A. § 3732(a).

II. FIRST CAUSE OF ACTION, 31 U.S.C. § 3729(a)(1).

A. Presenting, Making, or Using a False Claim or Causing a False Claim to be Presented, Made, or Used.

Plaintiff alleges that defendants violated the False Claims Act: (1) under 31 U.S.C. § 3729(a)(1)(A) by "knowingly present[ing], or caus[ing] to be presented, a false or fraudulent claim for payment or approval;" and (2) under 31 U.S.C. § 3729(a)(1)(B) by "knowingly mak[ing], us[ing], or caus[ing] to be made or used, a false record or statement material to a false or fraudulent claim[.]" (See Complaint at ¶ 90).

"The essential elements of an FCA claim are (1) a false statement or fraudulent course of conduct, (2) made with requisite scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due." Corinthian Colls., 655 F.3d at 992; see U.S. ex rel. Hendow v. Univ. of Phoenix, 461 F.3d 1166, 1174 (9th Cir. 2006), cert. denied, 550 U.S. 903 (2007).

The first element, falsity, requires "an intentional, palpable lie." See Hendow, 461 F.3d at 1172; Hagood v. Sonoma Cnty. Water Agency, 81 F.3d 1465, 1478 (9th Cir.), cert. denied, 519 U.S. 1001 (1996). The second element, scienter, requires a "knowing" state of mind, which means having actual knowledge or information, or acting in either deliberate ignorance or reckless disregard of the information's truth or falsity. See 31 U.S.C. § 3729(b). "[I]nnocent mistakes, mere negligent misrepresentations and differences in interpretations will not suffice to create liability." Corinthian Colls., 655 F.3d at 996. The "Relator[] must allege that [defendants] knew that its statements [or course of conduct] were false, or that it was deliberately indifferent to or acted with reckless disregard of the truth of the statements." Id. The third element, materiality, requires that "the false statement or course of conduct must be material to the government's decision to pay out moneys to the claimant." Hendow, 461 F.3d at 1172. Finally, under the fourth element, "[f]or a false statement or course of action to be actionable . . . , it is necessary that it involve an actual claim, which is to say, a call on the government fisc." Id. at 1173 (emphasis omitted).

1. **MedXM**.

a. *Whether a Claim for Payment was Presented to the Government.*

MedXM makes two arguments to challenge the fourth element of Silingo's FCA claim, i.e., whether a false claim was made to the government for payment. First, MedXM contends that Silingo fails to allege "that MedXM presented any claims for payment to the government, let alone a false one." (MedXM's Motion at 4). However, "FCA liability is not limited to claimants." U.S. ex rel. Brown v. Celgene Corp., 2014 WL 3605896, *3 (C.D. Cal. 2014). The FCA also reaches those who cause a false claim to be presented, made or used. See 31 U.S.C. § 3729(a)(1)(A) & (B). "[E]ven though [defendant] did not itself falsely [submit a claim], it is still susceptible to liability because it allegedly caused claimants to implicitly make such false [claims] and thereby caused the submission of false claims." Brown, 2014 WL 3605896, at *3. "That the claimants themselves may not have been aware of their non-compliance makes no difference – the claims would still be false." Id. In short, MedXM cannot avoid liability because it did not, by itself, present a false claim to the government.

Second, MedXM claims that Silingo fails to allege that the heath plan defendants submitted false claims to the government. (See MedXM's Motion at 4). "It seems to be a fairly obvious notion that a False Claims Act suit ought to require a false claim." United States v. Kitsap Physicians Serv., 314 F.3d 995, 997 (9th Cir. 2002); see Cafasso, 637 F.3d at 1055 (same). "Evidence of an actual false claim is the sine qua non of a False Claims Act violation." Kitsap, 314 F.3d at 1002 (quotation marks omitted). This is because the False Claims Act "focuses on

the submission of a claim, and does not concern itself with whether or to what extent there exists a menacing underlying scheme." Id.

Silingo, however, is not required "to identify representative examples of false claims[;]" rather, Silingo must allege "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted."[1] Ebeid, 616 F.3d at 998-99. Silingo's allegations that the health plan defendants submitted HCC risk scores to CMS, which is how the health plan defendants receive their capitated payments in the first place, (see Complaint at ¶ 15; see also id. at ¶¶ 76 & 86), alleges facts with sufficient particularity that reliably indicate that the health plan defendants submitted risk scores that incorporated MedXM's purportedly fraudulent data.

b. *Literal Falsity*.

"In an archetypal qui tam False Claims action, such as where a private company overcharges under a government contract, the claim for payment is itself literally false or fraudulent." Hendow, 461 F.3d at 1170. Silingo alleges that the health plan defendants' submission of HCC risk scores to CMS were, themselves, literally false claims for payments. (See Complaint at ¶ 20). Specifically, Silingo sets forth detailed allegations regarding eight MedXM business practices, which she alleges were implemented in order to inflate HCC risk scores:

– Allegations that a majority of MedXM's HCC risk score assessments were performed by nurse practitioners and physician's assistants without physician supervision. (See Complaint at ¶¶ 17-32).

– Allegations that MedXM overcame the barriers to electronically secured medical charts, (see Complaint at ¶ 33), submitted those unsecured charts to health plan defendants with unencrypted digital signatures, (see id. at ¶ 34), and failed to preserve information deleted from those unsecured medical charts. (See id. at ¶¶ 36-40).

– Allegations that MedXM regularly performed exams "that were not the result of a face-to-face visit." (See Complaint at ¶¶ 45-59).

– Allegations that at least one MedXM examiner was not licensed to practice medicine

[1] Throughout its motion, MedXM makes the common refrain that "[t]here are no allegations [in Silingo's Complaint] about a single identified medical examiner, coder, patient, medical chart, original diagnosis, or modification / new diagnosis[.]" (MedXM's Motion at 6; see also id. at 7-11). A False Claims Act claim, however, does not require relator "to identify representative examples of false claims[.]" Ebeid, 616 F.3d at 998-99.

in the states in which she practiced. (See Complaint at ¶ 68).

– Allegations that MedXM "coders" instructed MedXM examiners "to modify the unlocked medical records in order to increase the severity of the patients' diagnoses, in an effort to increase the patients' HCC risk scores," (Complaint at ¶ 37), which affected approximately 60% of reports. (See id. at ¶ 40).

– Allegations that MedXM examiners "falsely and improperly confirmed such complex diagnoses such as atherosclerosis of the coronary arteries and other types of heart disease, COPD, secondary hyperparathyroidism, neoplasm of the small intestine and various musculoskeletal disorders," thus increasing patients' HCC risk scores, despite the fact that the MedXM examiners never performed certain important diagnostic tests, (see Complaint at¶¶ 41-44), because MedXM examiners did not carry equipment such as EKG machines or portable x-ray machines when they performed their examinations at patients' homes. (See id. at ¶ 42).

– Allegations that six MedXM examiners claimed to examine 15 to 25 patients per day, which is impossible given the travel time required to go from one patient's residence to another. (See id. at ¶¶ 45 & 48). For example, Silingo alleges that when defendant Molina expressed concern that one MedXM examiner submitted medical charts with identical data for multiple patients, MedXM performed a cursory investigation that went back only 60 days, changed data based on telephone interviews with affected patients, and resubmitted the medical charts to Molina, falsely claiming that the error was due to a "printer malfunction." (See id. at ¶¶ 49-54).

– Allegations that MedXM "routinely and knowingly submitted false HCC diagnos[e]s based in whole or in part upon laboratory blood test results that it knew were unreliable." (See Complaint at ¶ 60; see id. at ¶¶ 60-67).

Under the circumstances, Silingo has set forth detailed allegations about MedXM's business practices, which could have resulted in falsely inflated HCC risk scores. Silingo also alleges that she raised concerns regarding some of these practices on multiple occasions with MedXM's CEO and COO, but these concerns were ignored. (See Complaint at ¶¶ 54-55 & 59); Cafasso, 637 F.3d at 1055 (under Rule 8(a), plaintiff must plausibly allege "enough facts to raise a reasonable expectation that discovery will reveal evidence of" defendants' state of mind) (alteration marks omitted). Finally, Silingo alleges that MedXM's business practices were widespread, thus satisfying the materiality element of the FCA claim. (See Complaint ¶ 40) ("[a]pproximately 60% of the medical examination reports" were altered); Hendow, 461 F.3d at 1172 ("the false statement or course of conduct must be material to the government's decision to pay out moneys to the claimant").

While Silingo may fall short on some of her claims at the summary judgment stage, at this early stage of the case, the court is persuaded that she has sufficiently alleged a False Claims Act claim against MedXM. In other words, the detailed allegations in the Complaint provide MedXM fair notice of the allegations against it. See Neubronner, 6 F.3d at 671 (Plaintiff's allegations must be "specific enough to give defendants notice of the particular misconduct which is alleged to constitute the fraud charged so that they can defend against the charge and not just deny that they have done anything wrong.").

c. *Express or Implied Certification of Compliance*.

In addition to alleging a theory of literal falsity under the False Claims Act, a qui tam relator may allege a theory of express or implied false certification of compliance. An express false certification of compliance occurs when an "entity seeking payment certifies compliance with a law, rule or regulation as part of the process through which the claim for payment is submitted," but does not comply with that law, rule, or regulation. Ebeid, 616 F.3d at 998. An "[i]mplied false certification occurs when an entity has previously undertaken to expressly comply with a law, rule, or regulation, and that obligation is implicated by submitting a claim for payment even though a certification of compliance is not required in the process of submitting the claim." Id.

To survive a Rule 9(b) motion to dismiss, a complaint alleging express or implied false certification must plead with particularity allegations that provide a reasonable basis to infer that (1) the defendant explicitly undertook to comply with a law, rule or regulation that is implicated in submitting a claim for payment and that (2) claims were submitted (3) even though the defendant was not in compliance with that law, rule or regulation. See Ebeid, 616 F.3d at 998.

Silingo alleges an FCA claim based upon an express or implied false certification of compliance theory as to the following:

– Allegations that despite the fact that physician supervision is required by federal and various state laws, rules and regulations, MedXM nevertheless conducted medical examinations without physician supervision. (See Complaint at ¶ 19 (citing 42 C.F.R. §§ 410.74 & 410.75); id. at ¶¶ 18, 23-27 & 29 (citing state law violations, including California).

– Allegations that MedXM improperly maintained electronic records in violation of 42 C.F.R. § 422.310(d) and Medicare Program Integrity Manual, Ch. 3.3.2.4. (D)-(E). (See Complaint at ¶¶ 33 & 34).

– Allegations that MedXM did not conduct face-to-face patient examinations in violation of CMS Medicare Managed Care Manual, Chapter 7, § 40. (See Complaint at ¶ 45).

Under the circumstances, the court is not persuaded that plaintiff has provided sufficient factual allegations to state a claim for express or implied false certification of compliance. Silingo must do more than cite a law, rule, or regulation. She must allege, with the particularity required under Rule 9(b), that MedXM "explicitly undertook" to comply with a law, rule or regulation as well as details as to how the law, rule, or regulation is "implicated in submitting a claim for payment." See Ebeid, 616 F.3d at 998 (requiring, among other things, the complaint to "plead with particularity allegations that provide a reasonable basis to [] infer that the "defendant explicitly undertook to comply with a law, rule or regulation that is implicated in submitting a claim for payment); see id. at 1000 (FCA claim failed because general allegations "lack[ed] any details or facts setting out the 'who, what, when, where, and how'" of the fraudulent conduct alleged). Accordingly, Silingo's express or implied certification of compliance claims will be dismissed with leave to amend.

2. **Health Plan Defendants**.[2]

Silingo also alleges an FCA claim against the health plan defendants[3] for their lack of internal controls. (See Complaint at ¶¶ 71-88). Specifically, Silingo alleges that Molina, Health Net, Visiting Nurse, and Alameda did not make "an attempt of any kind to satisfy the duties set forth" in 42 C.F.R. §§ 422.503 and 422.504, (id. at ¶ 76; see also id. at ¶¶ 36, 46), which detail the internal controls the health plan defendants must have in place to ensure compliance with the CMS program and to "prevent, detect, and correct fraud waste and abuse[.]"[4] (Id. at ¶ 71).

[2] Although unclear, Silingo appears to allege that MedXM did not comply with 42 C.F.R. §§ 422.503 and 422.504. (See Complaint at ¶¶ 86-87). To the extent that is the case, Silingo's allegations against MedXM for lack of internal controls fails for the same reasons set forth in this section.

[3] As for two of the eight MedXM practices that Silingo complains of, Silingo alleges that the health plan defendants "knew or should have known" or "turned a blind eye" to the fact that (1) MedXM performed examinations without physician supervision, (see Complaint at ¶ 32), and (2) MedXM did not maintain the integrity of electronically-secured medical charts. (See id. at ¶ 35). These allegations are too conclusory to plausibly allege that health plan defendants knew or consciously disregarded these aspects of MedXM's business practices.

[4] These internal controls include: (1) compliance education and training of MedXM personnel, (2) validation of MedXM's infrastructure and electronic medical record system, (3) hiring of a Compliance Officer, and (4) investigation of suspected incidences of Medicare fraud. (See Complaint at ¶ 75; see also id. at ¶ 85 (health plan defendants "utterly failed to implement any type of effective compliance program")).

Silingo alleges that "as a condition of receiving their monthly capitation payments," the health plan defendants were required to "certify that all risk adjust[ment] data, which includes the HCC Assessments and diagnosis codes at issue here, are accurate, complete and truthful" in accordance with 42 C.F.R. § 422.504. (See Complaint at ¶ 86). However, according to plaintiff, the health plan defendants' certifications were "knowingly false or made with a reckless disregard for the truth of the matter" because the health plan defendants "utterly failed to maintain an effective compliance program[.]" (Id. at ¶ 87).

Silingo's group-pleading against the health plan defendants fails the requirements of Rule 9(b), which "does not allow a complaint to merely lump multiple defendants together but requires plaintiffs to differentiate their allegations when suing more than one defendant and inform each defendant separately of the allegations surrounding his alleged participation in the fraud." Corinthian Colls., 655 F.3d at 997-98. "In the context of a fraud suit involving multiple defendants, a plaintiff must, at a minimum identify the role of each defendant in the alleged fraudulent scheme." Id. at 998 ("Rule 9(b) undoubtedly requires more" than "attribut[ing] wholesale all of the allegations against" defendants without distinguishing one from the other.).

In contrast to the other heath plan defendants, Silingo's allegations against WellPoint are more detailed, but still fail to adequately state a claim. Silingo acknowledges that WellPoint conducted a pre-contract audit of MedXM, (see Complaint at ¶¶ 78-83), and that WellPoint's audits took place in June 2011, September 2011, March or April 2012, June 2012, and November 2014. (See id. at ¶¶ 78-80 & 82). Nevertheless, plaintiff claims that the audits were "not a good faith effort to avoid receiving overpayments nor to reduce fraud," but rather, "a sham designed to paper over WellPoint's and MedXM's collective compliance deficiencies with a vernier [sic] of compliance." (Id. at ¶ 83). Silingo's allegations with respect to WellPoint's audits are too conclusory, especially in the face of her other allegations that WellPoint "issued a corrective action plan (CAP) to MedXM to correct [its deficiencies] as a condition of starting the WellPoint/MedXM contract for risk assessment services," (see id. at ¶ 78), and issued an additional CAP to MedXM in June 2012. (See id. at ¶ 82).

Accordingly, Silingo's FCA claim against the health plan defendants fails.

B. Conspiracy to Commit a False Claims Act Violation.

"To state a claim for conspiracy under the federal False Claims Act, plaintiffs must show that: (1) defendants conspired with one or more persons to induce the United States to allow or pay a false claim; (2) one or more of the conspirators performed any act to effect the object of the conspiracy and (3) the United States suffered damages as a result of the false or fraudulent claim." United States ex rel. Costa v. Baker & Taylor, Inc., 1998 WL 230979,*5 (N.D. Cal. 1998); see United States ex rel. Marion v. Heald Coll., LLC, 2015 WL 4512843, *4 n. 50 (N.D. Cal. 2015) (conspiracy requires a showing that "an agreement existed to have false or fraudulent claims allowed or paid by the United States" or "the existence of an unlawful agreement between

defendants") (citing cases).

Silingo has failed to allege, with the particularity required under Rule 9(b), the existence of an unlawful agreement between any defendant, particularly MedXM, on the one hand, and any other defendant, particularly any health plan defendant, on the other. (See, generally, Complaint). Specifically, although Silingo insists that she has adequately alleged a conspiracy between WellPoint and MedXM as to WellPoint's "sham" audit, those allegations lack the particularity required by Rule 9(b). Thus, Silingo's conspiracy claim fails.

C. "Reverse False Claims Act" Claim.

The "reverse false claims" provision makes actionable the knowing use of a "false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government[.]" 31 U.S.C. § 3729(a)(1)(G). This provision "attempts to provide that fraudulently reducing the amount owed to the government constitutes a false claim." Cafasso, 637 F.3d at 1056 (discussing prior "reverse false claims" provision, 31 U.S.C. § 3729(a)(7)).

Fundamentally, Silingo alleges that defendants engaged in acts or omissions with the goal of causing the government to overpay the health plan defendants. (See Complaint at ¶¶ 17-88). She does not allege anywhere in the Complaint that MedXM or the health plan defendants acted in any way to avoid paying an obligation it owed to the government. (See, generally, id.). In her oppositions to MedXM's and the health plan defendants' motions, Silingo tacitly concedes that she cannot state a claim for relief under a "reverse false claims" theory by abandoning arguments in support of that theory altogether. (See, generally, MedXM Opp'n & Health Plan Opp'n); see, e.g., Silva v. U.S. Bancorp, 2011 WL 7096576, *3 (C.D. Cal. 2011) (ruling that plaintiff's failure to respond in his opposition brief to defendants' argument in motion to dismiss amounted to a concession that his claim should be dismissed); Tatum v. Schwartz, 2007 WL 419463, *3 (E.D. Cal. 2007) (explaining that a party "tacitly concede[d] [a] claim by failing to address defendants' argument in her opposition"). In short, Silingo's "reverse false claims" cause of action is insufficient.

III. SECOND CAUSE OF ACTION, 31 U.S.C. § 3730(h).

Silingo alleges that MedXM terminated her in retaliation for raising concerns about MedXM's practices conducting physical examinations of Medicare patients. (See Complaint at ¶¶ 95-107). Specifically, Silingo states that the retaliation stems from concerns she raised beginning in January 2013, when a MedXM examiner submitted medical charts with identical data for multiple patients. (See id. at ¶ 99). When MedXM performed a cursory investigation that went back only 60 days, changed data based on telephone interviews (rather than face-to-face interactions), and resubmitted the medical charts to Molina while falsely claiming that the error was

due to a "printer malfunction," (see id. at ¶¶ 49-54 & 100-101), Silingo resigned her post as Compliance Officer. (See id. at ¶ 102). Silingo alleges that MedXM (1) hired a replacement even though she had not been terminated, (2) promoted one of her subordinates (who would report directly to the CEO), to write MedXM's coding policies and procedures, without informing her, (3) took her off a project, (4) terminated her employment on June 23, 2013, and (5) failed to timely pay her compensation pursuant to California Labor Code §§ 201, et seq. (See id. at ¶ 104).

The FCA protects employees from being "discharged, demoted, . . . or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee . . . in furtherance of an [FCA] action[.]" 31 U.S.C. § 3730(h). An FCA retaliation claim requires proof of three elements: "(1) the employee must have been engaging in conduct protected under the [FCA]; (2) the employer must have known that the employee was engaging in such conduct; and (3) the employer must have discriminated against the employee because of her protected conduct." United States ex rel. Hopper v. Anton, 91 F.3d 1261, 1269 (9th Cir. 1996), cert. denied, 519 U.S. 1115 (1997). "[T]he heightened pleading requirements of Rule 9(b) do not apply to FCA retaliation claims. Instead, a FCA retaliation claim must meet the Rule 8(a) notice pleading standard." Mendiondo, 521 F.3d at 1103.

Silingo has adequately alleged that she was engaging in protected conduct. (See Complaint at ¶ 99). Silingo also alleges that she raised her concerns to MedXM's CEO and COO, but was ignored. (See id. at ¶¶ 54-55 & 59). After plaintiff raised her concerns with MedXM's CEO and COO, MedXM's management allegedly discriminated against her by, among other things, hiring her replacement before she was terminated, assigning tasks to her subordinates without her knowledge or approval, taking her off projects, and terminating her. (See id. at ¶ 104).

IV. THIRD CAUSE OF ACTION, CALIFORNIA LABOR CODE §§ 201, et seq.

MedXM contends that if the court dismisses the federal False Claims Act claims, it should decline to exercise supplemental jurisdiction over the state law claim for violation of California Labor Code §§ 201, et seq. (See MedXM's Motion at 26; MedXM's Reply at 15). Because Silingo has adequately alleged a False Claims Act claim against MedXM, including her claim for retaliation, the court will exercise supplemental jurisdiction over the state law claim.

V. LEAVE TO AMEND.

Rule 15 of the Federal Rules of Civil Procedure provides that the court "should freely give leave [to amend] when justice so requires." Fed. R. Civ. P. 15(a)(2); see Morongo Band of Mission Indians v. Rose, 893 F.2d 1074, 1079 (9th Cir. 1990) (The policy favoring amendment must "be applied with extreme liberality."). However, "[i]t is settled that the grant of leave to amend the pleadings pursuant to Rule 15(a) is within the discretion of the trial court." Zenith Radio Corp. v. Hazeltine Research, Inc., 401 U.S. 321, 330, 91 S.Ct. 795, 802 (1971). This decision is guided by an examination of several factors, including: (1) whether the amendment causes the opposing

party undue prejudice; (2) whether the amendment is sought in bad faith; (3) whether the amendment causes undue delay; (4) whether the amendment constitutes an exercise in futility; and (5) whether the plaintiff has previously amended his or her complaint. See DCD Programs, Ltd. v. Leighton, 833 F.2d 183, 186 & n. 3 (9th Cir. 1987).

A "district court's discretion to deny leave to amend is particularly broad where the plaintiff has previously amended the complaint." Cafasso, 637 F.3d at 1058. Having liberally construed and assumed the truth of the allegations in the Complaint, the court is persuaded that plaintiff's claims based on conspiracy to commit a False Claims Act violation, 31 U.S.C. § 3729(a)(1)(C), and the reverse False Claims Act claim, 31 U.S.C. § 3729(a)(1)(G), cannot be saved through amendment. In other words, the court is not persuaded that giving plaintiff a fourth opportunity to state a claim with respect to those causes of action would be enough to cure the deficiencies in the claims. Accordingly, those claims will be dismissed without leave to amend.

CONCLUSION

This Order is not intended for publication. Nor is it intended to be included in or submitted to any online service such as Westlaw or Lexis.

Based on the foregoing, IT IS ORDERED THAT:

1. MedXM's motion to dismiss (**Document No. 58**) is **granted in part** and **denied in part**. The conspiracy to commit a False Claims Act violation, 31 U.S.C. § 3729(a)(1)(C), and the reverse False Claims Act claim, 31 U.S.C. § 3729(a)(1)(G), are **dismissed without leave to amend**. MedXM's motion to dismiss the remaining claims, i.e., presenting, making, or using a false claim, 31 U.S.C. § 3729(a)(1)(A) and 31 U.S.C. § 3729(a)(1)(B); retaliation, 31 U.S.C. § 3730(h), and violations of California Labor Code §§ 201, et seq., are **denied**.

2. The health plan defendants' motions to dismiss (**Document Nos. 44, 49, 50, 53 & 54**) is **granted in part and denied in part**. Visiting Nurse's motion to dismiss on the grounds of lack of personal jurisdiction and improper venue is **denied**. The conspiracy to commit a False Claims Act violation, 31 U.S.C. § 3729(a)(1)(C), and the reverse False Claims Act claim, 31 U.S.C. § 3729(a)(1)(G), are **dismissed without leave to amend**. The remaining claims in the Second Amended Complaint, i.e. presenting, making, or using a false claim, 31 U.S.C. § 3729(a)(1)(A) and 31 U.S.C. § 3729(a)(1)(B), are **dismissed with leave to amend**.

3. If plaintiff still wishes to pursue this action, she is granted until **October 22, 2015**, to file a Third Amended Complaint attempting to cure, to the extent she believes is warranted by existing law, the alleged defects outlined in defendants' motions and this order.

4. The amended complaint must be labeled "Third Amended Complaint," filed in compliance with Local Rule 3-2 and contain the case number assigned to the case, i.e., Case No.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES - GENERAL

Case No.	**CV 13-1348 FMO (SHx)**	Date	**September 29, 2015**
Title	**United States ex rel. Silingo v. Mobile Medical Examination Services, Inc., et al.**		

CV 13-1348 FMO (SHx). In addition, plaintiff is informed that the court cannot refer to a prior pleading in order to make her Third Amended Complaint complete. Local Rule 15-2 requires that an amended pleading be complete in and of itself without reference to any prior pleading. This is because, as a general rule, an amended pleading supersedes the original pleading. See Loux v. Rhay, 375 F.2d 55, 57 (9th Cir. 1967), overruled in part, Lacey v. Maricopa Cnty., 693 F.3d 896, 925-28 (9th Cir. 2012) (en banc).

5. In the event one or more defendants wish to file another motion to dismiss, then counsel for the parties shall, on **November 2, 2015, at 10:00 a.m.**[5] meet and confer in person at an agreed upon location within the Central District of California to discuss defendants' motion(s) to dismiss. Defendants' motion(s) must include copies of all meet and confer letters as well as a declaration that sets forth, in detail, the entire meet and confer process (i.e., when and where it took place, how long it lasted and the position of each attorney with respect to each disputed issue that will be the subject of the motion). Failure to include such a declaration will result in the motion(s) being denied.

6. Plaintiff is cautioned that failure to timely file a Third Amended Complaint may result in this action being dismissed without prejudice for failure to prosecute and/or failure to comply with a court order. See Fed. R. Civ. P. 41(b); Link v. Wabash R.R. Co., 370 U.S. 626, 629-30, 82 S.Ct. 1386, 1388 (1962).

7. Defendants shall file their Answer to the Third Amended Complaint or a motion pursuant to Fed. R. Civ. P. 12 no later than **November 12, 2015**.

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[5] Counsel may agree to meet and confer at another time and place without seeking court approval for such an agreement.