UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES – GENERAL

Case No. 2:25-cv-11277-MWC-BFM Date: August 5, 2026

Title: United States of America, *et al.* v. Concord Hospitalist Group, *et al.*

Present: The Honorable Michelle Williams Court, United States District Judge

T. Jackson	Not Reported
Deputy Clerk	Court Reporter / Recorder
Attorneys Present for Plaintiffs: N/A	Attorneys Present for Defendants: N/A

Proceedings: (IN CHAMBERS) ORDER GRANTING IN PART AND DENYING IN PART CONCORD DEFENDANTS' MOTION TO DISMISS (DKT. [45]) AND GRANTING IN PART AND DENYING IN PART HOSPITAL DEFENDANTS' MOTION TO DISMISS (DKT. [48])

Before the Court are two motions to dismiss Plaintiff's First Amended Complaint ("FAC") (Dkt. # 43, "*FAC*"). First, Defendants Dr. Garen Derhartunian, Dr. Devinder S. Gandhi, and Concord Hospitalist Group (collectively, the "Concord Defendants") filed a Motion to Dismiss the FAC ("Concord Motion"). Dkt. # 47 ("*Concord Mot.*"). Second, Defendants USC Verdugo Hills Hospital and Dr. David A. Tashman (collectively, the "Hospital Defendants") filed a concurrent motion to dismiss the FAC ("Hospital Motion"). Dkt. # 48 ("*Hospital Mot.*"). In support of the Hospital Defendants' motion, they filed: the Declaration of Jeremy Church, Dkt. # 48-2, an exhibit, and the Declaration of David M. Devito, Dkt. # 48-4. Plaintiff-Relator Dr. Satish Deshpande ("Relator") opposed the motions to dismiss. Dkts. # 53 ("*Concord Opp'n*"), # 54 ("*Hospital Opp'n*"). Only the Concord Defendants replied. Dkt. # 62 ("*Concord Reply*").

The Court finds the matter appropriate for decision without oral argument. *See* Fed. R. Civ. P. 78; L.R. 7-15. After considering the papers and all evidence set forth, the Court **GRANTS IN PART** Defendants' Motions to Dismiss, and **DISMISSES** Relator's first, second, third, fourth, sixth, seventh, eighth, tenth, and twelfth causes of action **WITH LEAVE TO AMEND** (Dkts # 47, 48). The Court further **GRANTS** the Hospital Defendants' Motion to Dismiss and **DISMISSES** Relator's fifth and eleventh causes of action as to the Hospital Defendants **WITHOUT LEAVE TO AMEND.** Lastly, the Court **DENIES** the Concord Defendants' Motion to Dismiss Relator's fifth and eleventh causes of action as to the Concord Defendants.

I. Factual Background

Relator brings this *qui tam* action asserting claims under the federal False Claims Act ("FCA") 31 U.S.C. §§ 3729, *et seq*., the California False Claims Act ("CFCA"), Cal. Gov't Code §§ 12650, *et seq.*, and the California Insurance Frauds Prevention Act ("IFPA"), Cal. Ins. Code §§ 1871, *et seq.* arising from Defendants' alleged fraud in connection with patient referrals and hospital admissions. *See FAC* ¶¶ 1–3. The FAC alleges the following:

Relator is a specialist in internal medicine who worked as an independent contractor ("IC") for Defendant Concord Hospitalist Group ("Concord") to provide hospitalist services[1] at Verdugo Hills Hospital ("the Hospital") from June 2019 through November 2022. *Id.* ¶ 20. Defendant Dr. Tashman is the medical director for the Emergency Department ("ED") at the Hospital. *Id.* ¶ 28. Concord operates from the same location as the Hospital and uses the Hospital's resources, including office space, utilities, stationery, and billing coordination services. *Id.* ¶ 23. Defendants Drs. Devinder S. Gandhi and Garen Derhartunian are physicians and Concord's co-owners and co-presidents. *Id.* ¶¶ 24–25.

On June 26, 2019, Concord and Relator entered into a one-year Independent Contractor Agreement ("ICA"), pursuant to which Relator provided hospitalist services for Concord at the Hospital. *Id.* ¶ 58; *see id.*, Ex. A. Relator's primary responsibility was to evaluate patients whom ED physicians referred for admission and decide whether to admit them for inpatient hospital services or place them under observation. *Id.* ¶¶ 21, 56.

Relator "was instructed to admit patients when directed by the ED regardless of whether the admission was warranted by the patient's medical condition." *Id.* ¶ 21. Relator also provided follow-up inpatient care, responded to Hospital consultations, and occasionally discharged patients for whom he or another Concord physician served as the attending physician of record. *Id.* ¶¶ 21, 56.

A. Anti-Kickback & Stark Law Allegations

Since at least June 2019, all Defendants "conspired to admit patients from the ED, for observation or other inpatient services, when admission was not warranted by the patient's condition and treatment needs." *Id.* ¶ 52. The FAC alleges three distinct Anti-

[1] A hospitalist is a physician who evaluates patients from the Emergency Department ("ED") to determine whether they require admission as inpatients or placement under observation. *FAC* ¶ 20.

Kickback Statute ("AKS") and Stark Law violations relating to these unnecessary admissions: first, volume-based compensation for admissions; second, that Hospital conditioned its relationship with Concord on Concord's continued referrals for unnecessary admissions; and third, that Hospital offered free meals to induce hospitalists' ongoing referrals.

i. Kickbacks Between Concord and Hospital

The Hospital billed government healthcare programs, including Medicare and/or Medi-Cal (collectively, the "Government Healthcare Programs") for admissions that were allegedly medically unnecessary and paid illegal remuneration to Concord and hospitalists for their participation. *Id.* ¶¶ 52, 82. The Hospital paid Concord "extra for (1) every admission that exceeded a threshold of seven admissions for each hospitalist night shift, and (2) every patient visit, including admissions and subsequent hospital visits, that exceeded eighteen patient admissions/visits for each hospitalist day shift." *Id.* ¶ 5. Dr. Ghandi told Relator that "the Hospital also paid Concord for each admission that exceeded the seven-admission threshold during each 12-hour night shift and for each admission/patient visit that exceeded 18 on the day shift." *Id.* ¶ 67. Drs. Gandhi and Derhartunian led Relator to understand that maintaining a high admissions volume was necessary to Concord's continued provision of hospitalist services to the Hospital. *Id.* ¶¶ 9, 79.

ii. Volume-Based Compensation

Concord paid Relator and other hospitalists an additional $100 for each admission after the first seven admissions during a 12-hour night shift and provided further compensation for each patient visit exceeding eighteen visits during a 12-hour day shift, including both admissions and subsequent hospital visits. *See id.* ¶¶ 6, 46, 53, 59. Under the ICA, Relator received a fixed compensation of $1,560.00 for each 12-hour in-house day shift (7:00 a.m. to 7:00 p.m.) and $1,680.00 for each 12-hour in-house night shift (7:00 p.m. to 7:00 a.m.). *See id.*, Ex. A at 2.[2] Notwithstanding the fixed compensation set forth in the ICA, Concord paid Relator an additional $100 for each admission exceeding the seven-admission threshold. *Id.* ¶ 59.

Relator received additional payments for extra admissions on twenty-six separate occasions between January 2022 and October 2022, ranging from an extra $100 for one

[2] Exhibit B, however, includes statements of payment showing that Concord paid Relator $135.00 per hour for his shifts. *Id.*, Ex. B.

additional admission to an extra $900 for nine additional admissions. *Id.* ¶ 60; *see id.*, Ex. B (showing that Concord paid Relator these amounts under the designation "H&P").

The payment statements identify the additional compensation as "H&P" payments, a shorthand that Concord's staff used to refer to an admission "history and physical." *Id.* ¶ 61; *see also* Ex. B to *FAC*. The ICA required Relator to "plac[e] an admit note on the chart and dictate an admission history and physical for an admission within the time frame guidelines of the Medical Staff Bylaws." *FAC* ¶ 61, Ex. A at 5. Concord paid other hospitalists an additional $100 for each admission exceeding the applicable thresholds. *Id.* ¶ 66.

Although the admissions were not "reasonable or necessary," Concord management, including Drs. Gandhi and Derhartunian, repeatedly pressured and directed Relator and other Concord physicians to admit patients from the ED whenever the Hospital requested such admissions. *See id.* ¶¶ 6, 8, 25, 78. "Dr. Gandhi told [Relator] that defendant Dr. Tashman insisted that [Relator] admit patients from the ED whenever requested by the Hospital, regardless of whether the admission was warranted." *Id.* ¶¶ 8, 76.

ED physicians falsified documentation by documenting conditions that did not exist or exaggerating patient risks to justify medically unnecessary admissions. *Id.* ¶ 53. But for the alleged kickback scheme and false statements, "numerous patients would not have been admitted to the Hospital." *See id.*

The allegedly illegal kickbacks induced the following unnecessary "broad categories" of admissions:

> [1] Improper admissions based on an unwarranted diagnosis of possible heart problems when no indicia of an acute heart problem requiring admission was present . . . [2] Improper admissions based on purported syncope, or fainting, when there were no indicia to support a diagnosis of syncope or when any purported syncopal episode had occurred so long before the patient's arrival at the ED that it did not justify admission. [3] Improper admissions for MRIs and other tests that were not warranted based on the patient's clinical presentation. [4] Improper admissions for surgical consultations that were not warranted based on the patient's clinical presentation and

> testing in the ED. [5] Improper admissions based on the patient lacking a social network outside the hospital to assist the patient. This type of 'social admission,' also labeled at times as a 'needs placement' at a facility such as a nursing home, is not permitted by the Medicare and Medicaid rules . . . . "

Id. ¶ 12. Concord allegedly made these admissions to secure reimbursements from Government Healthcare Programs to the Hospital, rather than as the result of independent medical determinations that admission was proper. *See id.* ¶¶ 13−14. Relator provided only a fraction of inpatient services to the patients that he admitted. *Id.* ¶ 57.

iii. Free Meals

The FAC also alleges kickbacks in the form of free meals. The Hospital provided Concord "with approximately $2,400 in free meals/food at the Hospital cafeteria to induce the hospitalists to make unwarranted admissions." *Id.* ¶ 71. At the end of each night shift, Relator "signed out" to the Concord day shift hospitalists, typically consisting of two hospitalists and a nurse practitioner. *Id.* ¶ 77. During these sign-outs, Drs. Manvel Kondradzhyan and Narbeh Tovmassian and other Concord hospitalists expressed their frustration that some inpatient admissions lacked medical necessity. *See id.* Dr. Kondradzhyan told Relator, "'When is this nonsense going to stop?' and both Drs. Kondradzhyan and Tovmassian, along with other Concord hospitalists, at times described those admissions as "facially unnecessary." *See id.* Drs. Gandhi and Derhartunian told Relator that the Hospital, including its director, Dr. Tashman, was "unhappy" because Relator questioned the Hospital's ED physicians' requests for admissions. *Id.* ¶¶ 26, 79.

Relator complained about the alleged improper admissions to Concord and the Hospital and was subsequently placed on a "Performance Improvement Plan" on March 18, 2022, and told that there should be no refusal of admissions. *Id.* ¶¶ 17, 22, 26, 79, 185. When Relator "tried to tell the ED physicians, particularly Dr. Emeen Kiureghian, that they were violating the Inspector General's regulations on medical necessity, Dr. Kiureghian responded by saying 'Let the Inspector General come and take care of the patients.'" *Id.* ¶ 80. On April 1, 2022, Relator raised concerns with the Hospital's risk manager regarding allegedly improper admissions and Dr. Tashman's role in those admissions. *See id.* ¶ 81. Relator also shared examples of allegedly unnecessary admissions, unnecessary diagnostic tests, and ED physicians' alleged exaggeration of patient's symptoms, but the Hospital did

not stop the alleged conduct. *See id.* Relator continued objecting and was ultimately terminated on November 24, 2022. *Id.* ¶¶ 17, 22, 188.

B. Patient-Specific Unnecessary Admissions

The FAC details fourteen improper inpatient admissions involving Medicare patients or dual eligible Medicare/Medicaid patients. *See generally* ¶¶ 83−184. The admissions were not medically necessary and were supported by inaccurate or falsified documentation regarding patients' conditions and risk factors. *See generally* ¶¶ 83−184. Some admissions involved placing patients on telemetry despite the absence of indications of cardiac concerns, admitting patients based on false or unsupported diagnoses (including purported concerns for arrhythmia or pneumonia), ordering unnecessary diagnostic testing or surgical consultations, or otherwise documenting conditions that did not justify inpatient admission. *See id.*

For example, the Hospital admitted "Patient 1" on September 24, 2022, based on a false diagnosis of Congestive Heart Failure ("CHF") despite laboratory results that were normal except for an elevated Pro BNP level. *Id.* ¶¶ 84, 86−87. An elevated Pro BNP level, without clinical manifestations of heart failure, did not support a CHF diagnosis. *Id.* ¶¶ 86−87. An ED physician directed Relator to admit Patient 1 for observation in the telemetry unit, even though the patient allegedly exhibited no cough, shortness of breath, or wheezing. *See id.* The ED physician's findings were not credible and were intended to support an improper CHF diagnosis. *See id.* "The Hospital submitted, or caused to be submitted, directly or indirectly, a claim to Medicare and/or Medicaid for the patient's care." *Id.* ¶ 97. The Hospital discharged the patient on September 25, 2022. *Id.* ¶ 98.

For each of these fourteen patients, the FAC alleges dates of admission and discharge and an allegation, based on information and belief, that the Hospital submitted, or caused to be submitted, directly or indirectly, claims to Medicare and/or Medicaid for the patients' care. *See id.* ¶¶ 83−184. These practices resulted in claims for payment to Government Healthcare Programs that were based on false information and certifications of compliance with applicable laws, including the AKS and Stark Law. *Id* ¶ 83. Absent the alleged remuneration paid in exchange for admissions, those admissions would not have occurred. *See id.*, ¶¶ 83−184.

C. Retaliation

From the beginning of Relator's employment at the Hospital, Relator documented concerns in patients' medical records regarding admissions and diagnoses that were

allegedly used to justify medically unnecessary admissions. *Id.* ¶ 185.[3] In Relator's first nine months at the Hospital, Dr. Ghandi met with Relator "several times to scold him about pushing back on admitting patients the Hospital wanted him to admit, even if the admission was not warranted." *Id.* ¶ 186. In March 2022, Drs. Gandhi and Derhartunian told Relator that his refusals jeopardized the Concord's relationship with the Hospital. *Id.* On March 18, 2022, Drs. Ghandi and Derhartunian put Relator on a "Performance Improvement Plan" which stated that "there should be no refusal of admissions." *Id.*

On April 1, 2022, Relator wrote a letter to the Hospital's risk manager explaining that Drs. Ghandi and Derhartunian told him that Dr. Tashman complained about Relator's objections to Hospital's ED physician's practices. *Id.* ¶ 187. In his letter, Relator noted that he had professional obligations to provide care only when it is medically necessary. *Id.* On August 26, 2022, Dr. Derhartunian emailed Relator that Concord would terminate the ICA effective ninety days from the email, due to a staffing change planned for November 1, 2022. *See id.*, Ex. C (copy of email correspondence). Despite Concord's stated reason for the termination, no new hospitalist appeared on the November or December 2022 staffing schedules. *See id.* ¶ 188. For example, Dr. Raya, another Concord Hospitalist, continued to cover the night shifts throughout November 2022. The termination occurred after Relator's April letter to the Hospital's risk management department regarding alleged improper admissions and related conduct. Concord finalized Relator's termination on November 24, 2022. *See id.*

D. Procedural History

On November 20, 2025, Relator initiated this action against Defendants. Dkt. # 1. The United States declined to intervene on April 2, 2026. Dkt. # 22. On June 17, 2026, Relator filed the FAC. Dkt. # 43.

The FAC asserts the following twelve causes of action: violations of the FCA under 31 U.S.C. §§ 3729(a)(1)(A), (a)(1)(B), (a)(1)(G), (a)(1)C), and § 3730(h); violations of the CFCA under Cal. Gov't Code §§ 12651(a)(1), (a)(2), (a)(7), (a)(8), (a)(3), and § 12653; and violations of the California IFPA, Cal. Ins. Code § 1871.7. *FAC* ¶¶ 190–244.

[3] Relator began providing IC services at the Hospital in 2019, *see FAC* ¶ 20; however, Exhibit B reflects only the additional payments made from January 2022 through October 2022. *See id.*, Ex. B.

II. Legal Standard

A. Rule 12(b)(6)

A defendant may move to dismiss a claim in the plaintiff's complaint if the allegation "fail[s] to state a claim upon which relief can be granted." Fed. R. Civ. P. 12(b)(6). "At the pleading stage, all allegations of material fact are taken as true and construed in the light most favorable to the non-moving party." *In re Facebook, Inc. Internet Tracking Litig.*, 956 F.3d 589, 601 (9th Cir. 2020). To survive a motion to dismiss under Rule 12(b)(6), the plaintiff's complaint "must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). A claim is facially plausible "when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* at 678.

The plausibility standard is a "context-specific task that requires the reviewing court to [1] draw on its judicial experience and common sense," *Id.* at 679, and [2] to "'draw all reasonable inferences in favor of the nonmoving party.'" *Boquist v. Courtney*, 32 F.4th 764, 773 (9th Cir. 2022) (quoting *Retail Prop. Tr. v. United Bhd. of Carpenters & Joiners of Am.*, 768 F.3d 938, 945 (9th Cir. 2014)). "Ultimately, dismissal is proper under Rule 12(b)(6) if it appears beyond doubt that the non-movant can prove no set of facts to support its claims." *Id.* at 773–74 (internal citation and quotation marks omitted) (cleaned up). However, "[c]onclusory allegations and unreasonable inferences do not provide [ ] a basis" for determining a plaintiff is entitled to relief. *Coronavirus Rep. v. Apple, Inc.*, 85 F.4th 948, 954 (9th Cir. 2023) (citation omitted); *Khoja v. Orexigen Therapeutics, Inc.*, 899 F.3d 988, 1008 (9th Cir. 2018) ("The court is not required to accept as true allegations that are merely conclusory, unwarranted deductions of fact, or unreasonable inferences.") (cleaned up). Nor may the Court accept legal conclusions and threadbare recitals of the elements of a cause of action. *Malheur Forest Fairness Coal. v. Iron Triangle, LLC*, 164 F.4th 710, 723 (9th Cir. 2026) ("Plausibility requires pleading facts, as opposed to conclusory allegations or the formulaic recitation of the elements of a cause of action, and must rise above the mere conceivability or possibility of unlawful conduct that entitles the pleader to relief.") (citation omitted); *Detwiler v. Mid-Columbia Med. Ctr.*, 156 F.4th 886, 893 (9th Cir. 2025); *Doe I v. Cysco Sys., Inc.*, 73 F.4th 700, 713 (9th Cir. 2023) ("Although a reviewing court must accept a complaint's factual allegations as true, the same is not true of legal conclusions, and threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice.") (cleaned up).

Though resolution of a motion to dismiss under Rule 12(b)(6) is normally confined to the allegations stated in the complaint, the court "may also 'consider [1] materials that are submitted with and attached to the complaint'; [2] 'judicial notice of matters of public record'; and [3] unattached evidence on which the complaint necessarily relies if: [a] the complaint refers to the document; [b] the document is central to the plaintiff's claim; and [c] no party questions the authenticity of the document.'" *Beverly Oaks Physicians Surgical Ctr., LLC v. Blue Cross & Blue Shield of Ill.*, 983 F.3d 435, 439 (9th Cir. 2020) (cleaned up) (quoting *United States v. Corinthian Colls.*, 655 F.3d 984, 998–99 (9th Cir. 2011)).

B. Rule 9(b)

Rule 9(b) requires a party alleging fraud to "state with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b). Pleading fraud with particularity, requires alleging the false representations' time, place, and specific content. *See Odom v. Microsoft Corp.*, 486 F.3d 541, 553 (9th Cir. 2007). A pleader must "'identify the who, what, when, where, and how of the misconduct charged[.]'" *Davidson v. Sprout Foods, Inc.*, 106 F.4th 842, 852 (9th Cir. 2024) (quoting *Davidson v. Kimberly-Clark Corp.*, 889 F.3d 956, 964 (9th Cir. 2018)). The allegations "must set forth more than the neutral facts necessary to identify the transaction. The plaintiff must set forth what is false or misleading about a statement, and why it is false." *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1106 (9th Cir. 2003) (internal quotation marks omitted). In essence, the defendant must be able to adequately answer the fraud allegations. *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124 (9th Cir. 2009).

III. Discussion

The Court begins by assessing Relator's claims brought under the FCA and CFCA for presentment, false records, reverse false claims, conspiracy, and retaliation. *FAC* ¶¶ 190−238. The California False Claims Act was modeled on the federal FCA, "and state courts turn to federal FCA case law for guidance in interpreting the CFCA." *United States v. Somnia, Inc.*, 339 F. Supp. 3d 947, 954 (E.D. Cal. 2018) (citing *Mao's Kitchen, Inc. v. Mundy*, 209 Cal. App. 4th 132, 146 (2012)). Claims under the CFCA must meet Rule 9(b)'s heightened pleading standard. *See United States v. Sequel Contractors, Inc.*, 402 F. Supp. 2d 1142, 1152 (C.D. Cal. 2005) (citation omitted). Relator acknowledges that the "parties agree that Relator's [CFCA] claims rely on pleading and proof of the same elements as federal FCA claims." *See Hospital Opp'n* at 30. Accordingly, the Court will review Relator's FCA and CFCA claims together. *See, e.g.*, *United States v. Adventist*

Health, No. 17-CV-00613-AWI-SKO, 2020 WL 2522114, at *9 (E.D. Cal. May 18, 2020) (analyzing FCA and CFCA claims together on motion to dismiss); *United States ex rel. Lockwood v. Sanofi US Servs., Inc.*, No. 2:23-cv-05490-SVW-MRW, 2024 WL 5087330, at *15 (C.D. Cal. Dec. 9, 2024) ("Accordingly, just as Relator's federal False Claims Act claims fail for a lack of scienter, so too do Relator's state claims."); *Wittenbrock v. Sunovion Pharms. Inc.*, No. 19-342 JVS (SHKX), 2019 WL 4452977, at *3 n.1 (C.D. Cal. July 29, 2019) (employing the same analysis to FCA and CFCA retaliation claims on motion to dismiss); *In re Bank of N.Y. Mellon Corp. False Claims Act Foreign Exch. Litig.*, 851 F. Supp. 2d 1190, 1195 (N.D. Cal. 2012) ("Because the CFCA was drafted to match the Federal False Claims Act, it is appropriate to look to precedent construing the equivalent federal act.").

A. False or Fraudulent Claims/False Records or Statements

The FAC alleges presentment under the FCA and CFCA, asserting that Defendants knowingly presented to the state and federal Government false or fraudulent claims relating to inpatient admissions for reimbursement by Medicare, Medicaid, and state-funded health care programs. *FAC* ¶¶ 190–195, 214–218. The FAC also alleges that Defendants violated the AKS and Stark Law, which also constitute cognizable causes of action under the FCA, by providing volume-based compensation to induce unnecessary admissions, offering free meals to induce extra referrals, and conditioning the Hospital's relationship with Concord on Concord's ongoing provision of improper referrals for admission. *Id.* ¶¶ 14–16, 193.

An individual is liable under the False Claims Act if they "knowingly present[], or cause[] to be presented, a false or fraudulent claim for payment or approval," or "knowingly make[], use[], or cause[] to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A), (B). "A 'claim' includes direct requests for government payment as well as reimbursement requests made to the recipients of federal funds under a federal benefits program." *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 899 (9th Cir. 2017) (citing 31 U.S.C. § 3729(b)(2)(A)). To state a claim under the False Claims Act's false certification theory, a plaintiff must allege "(1) a false statement or fraudulent course of conduct, (2) made with scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due." *U.S. ex rel. Hendow v. Univ. of Phx.*, 461 F.3d 1166, 1174 (9th Cir. 2006).

"It is not the case that any breach of contract, or violation of regulations or law, or receipt of money from the government where one is not entitled to receive the money, automatically gives rise to a claim under the FCA." *U.S. ex rel. Hopper v. Anton*, 91 F.3d

1261, 1265 (9th Cir. 1996). A plaintiff "must show *an actual false claim* for payment being made to the Government." *United States v. Kitsap Physicians Serv.*, 314 F.3d 995, 1002 (9th Cir. 2002) (emphasis in original) (internal quotation marks and citation omitted).

The Concord Defendants argue that the FAC fails to plead an actual false claim by failing to allege representative claims or reliable indicia of presentment, and challenges causation. *Concord Mot.* at 8, 13–14. The Hospital Defendants argue that the FAC's presentment claim fails on three additional bases: first, the claims based on Verdugo's alleged violations of the AKS and Stark Law insufficiently plead falsity; second, the FAC does not plausibly allege the Hospital Defendants' knowledge of Concord's payments to its IC physicians, defeating scienter; and third, that the presentment allegations fail Rule 9(b)'s particularity requirement. *Hospital Mot.* at 14. The Court analyzes Defendants' arguments together.

i. False Statement or Fraudulent Course of Conduct

A plaintiff plausibly alleges the first element of an FCA claim by pleading a theory of express or implied false certification. *In re Bank of New York Mellon Corp. False Claims Act Foreign Exchange Litigation*, 851 F. Supp. 2d at 1195 (citing *Ebeid ex rel. U.S. v. Lungwitz*, 616 F.3d 993, 995 (9th Cir. 2010)). Express certification occurs when "the entity seeking payment certifies compliance with a law, rule or regulation as part of the process through which the claim for payment is submitted." *Ebeid*, 616 F.3d at 998. Implied 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.*

The FAC alleges two categories of false statements: first, improper and unnecessary hospital admissions involving patients insured by Government Healthcare Programs, *see FAC* ¶¶ 11, 82, 83, 84–184, and second, false certifications of compliance with the AKS and Stark Law, *see id.* ¶¶ 42–46, 83. The Concord Defendants challenge the FAC's falsity allegations as "conclusory, without identifying who allegedly falsified what specific record entry, when and where it occurred, or how the alleged falsification translated into the content of any reimbursement claim or certification." *Concord Mot.* at 11.

For Medi-Cal to cover hospital services, such as inpatient admissions, a "Medi-Cal consultant must approve the request, which requires the beneficiary's physician to certify the need for inpatient care and provide justification for the admission based on the medical

information submitted." *FAC* ¶ 34. Each claim for payment submitted to Government Healthcare Programs is filed on a standardized Health Insurance Claim form, which expressly certifies compliance with "applicable Federal or State laws" and requires physician or supplier signature certifying that the services on the claim "were medically indicated and necessary[.]" *Id.* ¶ 38. Entities enrolled in Medicare also impliedly certify compliance with "applicable "Medicare laws, regulations[,] and program instructions" through their Medicare Enrollment Applications. *Id.* ¶¶ 36–37. Thus, both express and implied false certification theories are implicated. *See United States ex rel. Stenson v. Radiology Ltd., LLC*, No. 22-16571, 2024 WL 1826427, at *2 (9th Cir. Apr. 26, 2024) (finding express and implied false certifications implicated on the same grounds).

a. Falsified Medical Documentation

Relator alleges that Defendants "falsified documentation" to support improper and unnecessary hospital admissions of patients insured by Government Healthcare Programs. *See, e.g.*, *FAC* ¶¶ 11, 53, 82, 83. The Concord Defendants argue that the FAC merely alleges differences in opinions of medical necessity and does not establish that any Concord Defendants "made an opinion not actually held, embedded untrue facts in a clinical judgment, or certified medical necessity with knowledge or reckless disregard of falsity," in accordance with the standard set forth in *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1117 (9th Cir. 2020). *Concord Mot.* at 11–12. In *Winter*, the Ninth Circuit held:

> [T]he FCA does not require a plaintiff to plead an 'objective falsehood.' A physician's certification that inpatient hospitalization was 'medically necessary' can be false or fraudulent for the same reasons any opinion can be false or fraudulent. These reasons include if the opinion is not honestly held, or if it implies the existence of facts—namely, that inpatient hospitalization is needed to diagnose or treat a medical condition, in accordance with accepted standards of medical practice—that do not exist.

953 F.3d at 1119. The FAC's patient-specific allegations detailing fourteen alleged improper admissions where the Hospital used falsified medical records or exaggerated patient risk *do* meet *Winter*'s standard for establishing falsity. *See FAC* ¶¶ 84–184.

But each of the fourteen alleged improper admissions attribute claim submission to the Hospital Defendants, alone. *Id.* ¶ 97, 105, 111, 115, 123, 132, 139, 144, 150, 159, 166, 172, 178, 184. The alleged improper admissions do not plead that any of the Concord Defendants submitted claims to Government Healthcare Programs. *See Concord Mot.* at 11-12; *see also id.* at 9 ("Relator does not allege participation in billing operations, coding, claims review, claim submission, compliance auditing, or revenue-cycle management.").

But even if the Concord Defendants never *directly submitted* any false claims, "the FCA holds a defendant liable if it pursues a scheme that ultimately results in the submission of a false claim, even if the defendant does not participate in the actual submission of the claim." *U.S. ex rel. Ginger v. Ensign Grp., Inc.*, No. 815CV00389JWHDFMX, 2022 WL 4110166, at *7 (C.D. Cal. Mar. 10, 2022) (quoting *U.S. ex rel. Kuzma v. N. Arizona Healthcare Corp.*, 2021 WL 120901, at *5 (D. Ariz. Jan. 13, 2021). Accordingly, the FAC's allegations relating to illegal kickbacks, discussed *infra*, directly implicate the Concord Defendants to satisfy the falsity requirement.

b. AKS and Stark Law Compliance

The FAC's second proffered false certification theory concerns Defendants "false certifications as to their compliance with applicable laws, including the AKS and Stark Law." *FAC* ¶ 83. Pleading "fraud based on falsely certified compliance with the Stark Act and the Anti–Kickback Provision" requires pleading: "(1) a false claim (2) made with scienter (3) that was material to the government's decision to pay and (4) an actual claim on the government fisc." *Frazier ex rel. U.S. v. Iasis Healthcare Corp.*, 392 F. App'x 535, 537 (9th Cir. 2010) (citing *Hendow,* 461 F.3d at 1171–73). The FAC alleges that both the Concord Defendants and the Hospital Defendants impliedly certified their compliance with applicable federal law, including the AKS and Stark Law, in their Medicare Enrollment Applications. *FAC* ¶¶ 36–37.

Having established that both Concord Defendants and Hospital Defendants made certifications, Relator must next establish the existence of a false claim. *See Frazier*, 392 F. App'x at 537–38 (Relator may plead false certification by "sufficiently alleg[ing] an illegal kickback scheme violating the Stark Act or the Anti–Kickback Provision *and* provid[ing] a sufficient basis to infer that [Defendant] . . . expressly certified compliance with those provisions" in submitting claims to government healthcare programs).

Here, Relator alleges three AKS and Stark Law violations: (1) Defendants paid volume-based compensation to induce unnecessary inpatient admissions; (2) Concord's relationship with the Hospital was conditioned on Concord's ongoing provision of improper admissions; and (3) and third, Hospital offered free meals to induce hospitalists' ongoing referrals. The Court need only address the first of these theories to find that Relator has sufficiently alleged an illegal kickback scheme in violation of the AKS.

The AKS prohibits "knowingly and willfully offer[ing] or pay[ing] any remuneration . . . directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person . . . for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program." 42 U.S.C. § 1320a-7b(1)(A). The AKS only requires that "'one purpose of the payment' be to induce future referrals, 'even if the payments were also intended to compensate for professional services.'" *United States v. Hong*, 938 F.3d 1040, 1048 (9th Cir. 2019) (quoting *United States v. Kats*, 871 F.2d 105, 108 (9th Cir. 1989)). The Stark Law prohibits submitting "Medicare or Medicaid claims for certain services performed as a result of patient referrals from physicians who have improper 'financial relationship[s]' with an entity to which they refer patients." *U.S. ex rel. Sam Jones Co., LLC v. Biotronik, Inc.*, 152 F.4th 946, 951 (9th Cir. 2025), *as corrected* (Sept. 15, 2025), (citing the Stark Law, 42 U.S.C. § 1395nn, and the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)), *cert. denied sub nom. Biotronik, Inc. v. U.S. ex rel. Sam Jones Co., LLC*, 224 L. Ed. 2d 833 (May 18, 2026).

1. Volume-Based Compensation

The FAC alleges that Concord paid Relator and other IC hospitalists an extra $100 for every additional admission exceeding seven admissions in a twelve-hour night shift, and paid "additional compensation for each patient visit, including admissions and subsequent patient visits" exceeding "the first 18 visits on their day shift." *FAC* ¶¶ 6, 59, 60, 66. The FAC further alleges that this volume-based bonus compensation occurred "by agreement with the Hospital." *Id.* at 15. The Concord Defendants do not dispute this scheme. *See generally Concord Mot.* Second, the FAC alleges that the Hospital paid Concord for each admission exceeding the seven-per-night-shift threshold and eighteen-per-day-shift threshold. *FAC* ¶¶ 5, 67.

The Concord Defendants do not challenge Relator's allegations that Concord paid Relator and hospitalists additional compensation based on the volume of their patient

visits and admissions. *See Concord Mot.* at 8. But Concord argues that these payments, alone, "do not substitute for claim-level indicia" and "do[] not establish that any claim was submitted to a government payor." *Id.* The Concord Defendants further raise that Relator's allegations fail to (1) address who prepared and submitted the claims, (2) identify the alleged false certifications, and (3) establish causation between alleged remuneration and the claims. *See Concord Mot*. at 10–11.

Accepting Relator's allegations as true, the FAC plausibly alleges that the Hospital Defendants expressly and impliedly certified compliance with the law to receive federal funds and then violated that agreement by submitting false claims; and plausibly alleges that the Concord Defendants pursued a scheme of volume-based payments in violation of the AKS and Stark Law. Thus, Relator has established false certifications to satisfy the first element of the FCA analysis.

ii. Evidence of Actual Claims

All Defendants argue that the FAC fails to plead reliable indicia that any false claims were actually submitted, and the Concord Defendants further argue that the FAC fails to allege which Defendant(s) submitted false claims. *See Concord Mot.* at 8–9, 16; *Hospital Mot.* at 27–29. A relator need not "identify representative examples of false claims to support every allegation." *Ebeid*, 616 F.3d at 998. But a relator must allege "particular details of a scheme to submit false claims paired with . . . reliable indicia that lead to a strong inference that the claims were actually submitted," *Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1209 (9th Cir. 2019) (internal quotation marks and citation omitted). A false claim or statement to the government is the "*sine qua non* of receipt of state funding." *Campie*, 862 F.3d at 899 (internal quotation marks and citation omitted). Courts must rely on reliable indicia of submission to specific agencies, and general allegations are insufficient. *See, e.g.*, *U.S. ex rel Modglin v. DJO Glob. Inc.*, 48 F. Supp. 3d 1362, 1407–09 (C.D. Cal. 2014) (allegations of false claims submitted to one federal agency do not provide reliable indicia of defendant-specific claim submission to other specific government programs).

Here, the FAC fails to allege a false claim with particularity that Rule 9(b) requires. The FAC details fourteen instances of alleged improper admissions and states, for each admission, that the "[t]he patient was enrolled in" a Government Healthcare Program, "and, on information and belief, the Hospital submitted or caused to be submitted, directly or indirectly, a claim" to the Government Healthcare Programs for the patient's care. *FAC* ¶¶ 97, 105, 111, 115, 123, 132, 139, 144, 150, 159, 166, 172, 178, 184. For ten of these

patients, the FAC alleges that the Hospital submitted a claim to Medicare (*Id.* ¶¶ 105, 115, 123, 132, 139, 144, 150, 159, 166, 172), for two patients, the FAC alleges that the Hospital submitted a claim to "Medicare and/or Medicaid" (*Id.* ¶¶ 97, 111), and for the final two patients, the FAC merely alleges that a claim was "submitted" (*Id.* ¶¶ 178, 184) without specifying to whom the submission was made. Yet elsewhere in the FAC, Relator alleges that Defendants submitted false claims to Medi-Cal and other "state-funded health care programs," *see id.* ¶¶ 11, 216, and to commercial insurers, *see id.* ¶¶ 3, 11, 13, 82, 241, but offers no further information to differentiate between potential recipients of false claims.

General allegations of claim submission to unspecified programs are insufficient. *Modglin v. DJO Glob. Inc.*, 48 F. Supp. 3d at 1407–09. The FAC does not offer any support for its allegation that Defendants received payment for the alleged fourteen improperly admitted patients beyond Relator's information and belief. *See generally id.* Generally, fraud-based allegations predicated on information and belief fail to satisfy Rule 9(b). *See Neubronner v. Milken*, 6 F.3d 666, 672 (9th Cir. 1993). Even in contexts where the information is exclusively within the defendant's possession, a party still must provide the factual basis for its belief. *See id.*; *see also Ebeid*, 616 F.3d at 999 (declining to apply in the False Claims Act context a relaxed pleading standard for information solely within the defendant's possession, because "[t]o jettison the particularity requirement simply because it would facilitate a claim by an outsider is hardly grounds for overriding the general rule, especially because the FCA is geared primarily to encourage insiders to disclose information necessary to prevent fraud on the government.").

Though Relator argues that the fourteen patient scenarios "set forth 'ample circumstantial evidence from which to infer [the Concord Defendants] submitted' false claims," *see Concord Opp'n* at 11–13 (quoting *United States ex rel. Anita Silingo v. WellPoint, Inc.*, 904 F.3d 667, 679 (9th Cir. 2018)), the FAC only proffers conclusory allegations that "the Hospital submitted, or caused to be submitted" claims to Government Healthcare Programs. *See FAC* ¶¶ 97–184 (alleging claim submission on "information and belief.") Mere conclusory allegations of claim submission, absent more, cannot suffice as reliable indicia that a claim was submitted:

> [Relator] provides only conclusive statements that [Defendant healthcare corporation] submitted claims to Medicare for the treatments of Patients B, C, E, and F . . . For example, [Relator] repeats for each patient that, '[Defendant healthcare corporation] submitted claims to Medicare for the treatment of Patient ——.' Thus, even assuming that medically unnecessary

> procedures were performed on the identified patients, [Relator] fails to plead any facts providing reliable indicia that [Defendant healthcare corporation] thereafter submitted claims seeking federal reimbursement for such procedures.

U.S. ex rel. Frazier v. IASIS Healthcare Corp., 812 F. Supp. 2d 1008, 1017 (D. Ariz. 2011). Accordingly, the FAC fails to plead submission of actual claims with the particularity necessary to satisfy Rule 9(b).

iii. Collective Pleading

Even if the FAC presented reasonable indicia of claim submission, the FAC's failure to distinguish between Defendants in alleging these submissions is also fatal under Rule 9(b). *See, e.g., U.S. ex rel. Walner v. NorthShore Univ. Healthsystem*, 660 F. Supp. 2d 891, 897 (N.D. Ill. 2009) (finding deficient collective pleading where Relator failed to "differentiate among" Defendants and failed to "plead each Defendants role in the fraud, including but not limited to who submitted the false claim."); *see also United States ex rel. Kuzma v. N. Arizona Healthcare Corp.*, No. CV18-8041-PCT-DGC, 2020 WL 5819568, at *5 (D. Ariz. Sept. 30, 2020) (admonishing "collective allegations" of false claims for failing to specify each defendant's role "in making allegedly false claims or false statements in support of claims" and "the persons by whom the false claims and statements were made. . ." among other deficiencies).

Because the FAC fails to plead with particularity a false statement or fraudulent course of conduct, the Court need not reach the other elements under the False Claims Act and must dismiss Relator's FCA and CFCA causes of action for presentment and false records. *See U.S. ex rel. Hawaii v. Hawaii Pac. Health*, 409 Fed. Appx. 133, 134 (9th Cir. 2010) ("Because Relators have failed to establish the existence of any false claim or fraudulent conduct, their claims under the FCA must fail.") (citing *Hendow*, 461 F.3d at 1171, 1174).

The Court therefore **GRANTS** Defendants' motions to dismiss Relator's first, second, sixth, and seventh causes of action under the FCA and CFCA.

B. Conspiracy

Because the FAC fails to plausibly state a claim under the FCA, Relator's claim for conspiracy under the FCA must also fail. *See Hawaii ex rel. Torricer v. Liberty Dialysis-Hawaii LLC*, 512 F. Supp. 3d 1096, 1118 (D. Haw. 2021) ("[T]here can be no conspiracy

to violate the FCA if no false and material claims were submitted.") (citation and footnote omitted); *U.S. ex rel. Woodruff v. Hawaii Pac. Health*, 560 F. Supp. 2d 988, 1004 (D. Haw. 2008) ("Because the court concludes that Defendants did not submit false claims based on the UB–92s, Plaintiffs' conspiracy claim fails. Absent evidence of a false claim as alleged, Defendants did not conspire to have a false claim paid by the United States.") (citation omitted). Accordingly, the Court **GRANTS** Defendants' motions to dismiss Relator's fourth and tenth cause of action under the FCA and CFCA.

C. Reverse False Claim

Relator has also failed to allege reverse false claims. The FCA provides a cause of action for reverse false claims where one "knowingly makes . . . a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or . . . improperly avoids or decreases" a payment obligation to the government. 31 U.S.C. § 3729(a)(1)(G). Stating a reverse false claim under the FCA requires pleading five elements:

> (1) a record or statement was false, (2) the defendant had knowledge of the falsity, (3) the defendant made or used (or caused to be made or used) the false record or statement, (4) the defendant's purpose was to conceal, avoid, or decrease an obligation to pay the government, and (5) the false record or statement was material.

U.S. ex rel. Ormsby v. Sutter Health, 444 F. Supp. 3d 1010, 1055–56 (N.D. Cal. 2020) (citing *United States v. Bourseau*, 531 F.3d 1159, 1164–71 (9th Cir. 2008). Once the plaintiff establishes all five elements, the complaint must plead that "the defendant (1) concealed or improperly avoided or decreased an obligation to pay the government and (2) did so knowingly." *Ormsby*, 444 F. Supp. 3d at 1055–56.

The Concord Defendants aver that the FAC fails to "identify any specific overpayment, repayment duty, demand for repayment, quantification methodology, deadline, or act of concealment by any [Concord] Defendant." *Concord Mot.* at 14. The Hospital Defendants similarly argue that the FAC fails to "allege a particular 'obligation'" of any Hospital Defendant to pay the government; and describes this claim as a "tagalong cause of action redundant to [Relator's] presentment claims." *Hospital Mot.* at 29–30 (citations omitted). The Court agrees that the FAC fails to identify a specific payment obligation, with respect to both the Concord and Hospital Defendants. As discussed, *supra*,

the FAC has not adequately alleged reliable indicia that false records or statements were submitted to the government, nor does the FAC adequately specify who made any alleged submissions, let alone provide indicia that such claims resulted in any government payment. Relator merely alleges that "the fraudulent scheme resulted in overpayments by the Government healthcare programs that Defendants were not entitled to retain." *Concord Opp'n* at 22; *see also FAC* ¶¶ 202–203. Relator's reverse FCA claim is also susceptible to the collective pleading issue, discussed above, in that Relator fails to make Defendant-specific allegations in alleging reverse false claims. *See Concord Mot.* at 16; *FAC* ¶¶ 202–203; *see also United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184 (9th Cir. 2016) ("There is no flaw in a pleading . . . where collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct . . . but . . . failure to allege particular details of the scheme as applied to [specific defendants]" is deficient under Rule 9(b)).

The Court therefore **GRANTS** Defendants' motions to dismiss Relator's third and eighth causes of action for reverse false claims.

D. Retaliation Claim

The FAC's fifth and eleventh causes of action assert whistleblower retaliation under the FCA and CFCA. *FAC* ¶¶ 208–13, 233–238. "The False Claims Act protects 'whistle blowers' from retaliation by their employers." *Moore v. Cal. Inst. of Tech. Jet Propulsion Lab'y*, 275 F.3d 838, 845 (9th Cir. 2002) (citation omitted). An employee is entitled to relief if that employee is "discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment" based on their whistleblowing conduct. *See* 31 U.S.C. § 3730(h)(1). An employee must prove three elements to prevail on a False Claims Act retaliation claim: "(1) that the employee engaged in activity protected under the statute; (2) that the employer knew that the employee engaged in protected activity; and (3) that the employer discriminated against the employee because she engaged in protected activity." *Moore*, 275 F.3d at 845.

A plaintiff alleging retaliation under the FCA need not show that the defendant actually submitted a false claim to the government, only that plaintiff reasonably suspected that defendant submitted the false claim. *See Mendiondo v. Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1104 (9th Cir. 2008). "As such, the heightened pleading standard for fraud claims does not apply, and the standard employed is established by Rule 12(b)(6)." *United States v. Grp. Health Co-op.*, No. CIV. C09-603 RSM, 2011 WL 814261, at *3 (W.D. Wash. Mar. 3, 2011).

i. Hospital Defendants

The Hospital Defendants argue that "Relator pleads his retaliation claim against 'Defendants' collectively . . . but does not allege any retaliatory action taken by Verdugo or Dr. Tashman against him." *Hospital Mot.* at 31. In his opposition, Relator clarified that he does not assert these retaliation claims against the Hospital Defendants. *Hospital Opp'n* at 10 n.1. The Court recognizes this as Relator abandoning his claim for retaliation with respect to the Hospital Defendants. *See, e.g., Ramachandran v. Best Best & Krieger*, No. 20-cv-03693-BLF, 2021 WL 428654, at *9 (N.D. Cal. Feb. 8, 2021) (finding claim abandoned where plaintiff failed to respond oppose defendant's arguments to dismiss) (citation omitted); *Mireskandari v. Mail*, 2013 WL 12129559, at *11 (C.D. Cal. July 30, 2013) (deeming claim abandoned and granting dismissal where "plaintiff's opposition fails to respond in any way to [Defendant's] argument that the claim should be dismissed.").

Accordingly, this Court **GRANTS** Hospital Defendants' motion to dismiss with respect to Relator's fifth and eleventh causes of action for retaliation as asserted against the Hospital Defendants.

ii. Concord Defendants

The Concord Defendants argue that the FAC fails to establish that each Concord Defendant understood Relator's activities as "efforts to stop FCA violations[] rather than voicing disagreement about admissions practices and operational expectations" and assert that the FAC pleads only conclusory facts establishing causation. *Concord Mot.* at 15–16. The Court disagrees.

a. Protected Activity

"[A]n employee engages in protected activity where (1) the employee in good faith believes, and (2) a reasonable employee in the same or similar circumstances might believe, that the employer is possibly committing fraud against the government." *Moore*, 275 F.3d at 845. Here, Relator alleges he was "admonished . . . by Concord management, including the Individual Defendants, for questioning admissions requested by the Hospital's ED physicians and putting notes in the patient files questioning the admissions and diagnoses that were falsely used to justify them." *FAC* ¶ 185. In March 2022, Drs. Gandhi and Derhartunian scolded Relator for disputing patient admissions, and placed him on a Performance Improvement Plan which stated, in part, that "[t]here should be no refusal of admissions." *Id.* ¶ 186. In April 2022, Relator wrote a letter to the Hospital's risk manager raising "concerns about improper admissions and the role of Dr. Tashman" where he

relayed the information "conveyed to him" by Drs. Gandhi and Derhartunian, explained that "he had a professional obligation to question unnecessary testing," provided examples of medically unnecessary admissions, and "discussed the ED physicians' exaggeration and exacerbation of patients' symptoms to justify admitting them." *Id.* ¶ 81.

Accordingly, Relator sufficiently established that he engaged in a protected activity because he reasonably believed and investigated the Concord Defendants' conduct unlawfully pressuring Relator and other hospitalists to pursue "medically unnecessary" admissions and testing, paying illegal kickbacks for these admissions, and falsifying medical records to do so. *See FAC* ¶¶ 6–8, 81, 185–186; *see also United States ex rel. Macias v. Pac. Health Corp.*, No. CV1200960RSWLJPR, 2016 WL 8722639, at *5 (C.D. Cal. Oct. 7, 2016) ("Protected activity will be found if an employee reasonably believes that their employer is possibly committing fraud against the government"); *Mendiondo*, 521 F.3d at 1104.

b. Employer Knowledge

The FAC also adequately alleges employer knowledge. The Concord Defendants argue that the FAC "does not plead facts showing that each [Concord] Defendant understood" Relator's internal complaints and writing to risk management to be "FCA-protected . . . rather than voicing disagreement about admissions practices and operational expectations." *Concord Mot.* at 15–16. This argument lacks merit. The FAC alleges that "Dr[s]. Gandhi and . . . Derhartunian told Relator that Dr. Tashman was very unhappy because of Relator's push-back on admitting patients based solely on the Hospital's demands that he admit them. On March 18, 2022, Drs. Gandhi and Derhartunian instructed Relator, in a Performance Improvement Plan, that '[t]here should be no refusal of admissions.'" *FAC* ¶ 79. Co-presidents of a corporation clearly qualify as agents whose knowledge may be imputed to the defendant corporation for purposes of FCA liability. *See, e.g., U.S. ex rel. Rosales v. San Francisco Hous. Auth.*, 173 F. Supp. 2d 987, 1003 (N.D. Cal. 2001) ("When . . . managers and executives are implicated in the knowing submission of false claims to the government, there can be little question that the entity itself is answerable for their conduct. . . . So long as the agent has actual or apparent authority to bind the entity, the fraud of the agent is sufficient to support civil liability against the entity.").

The Concord Defendants also maintain that the FAC does not "plead facts showing [Concord] Defendants understood" Relator's activity to be "efforts to stop FCA violations." *Concord Mot.* at 15. But the FAC alleges that Relator wrote a letter to the

Hospital's risk manager detailing Concord's unlawful practices with explicit reference to 42 C.F.R. § 1004 and further reference to Relator's "professional obligations" to provide only medically necessary care. *FAC* ¶ 187. Relator also reported that Drs. Gandhi and Derhartunian objected to him "documenting information in patients' charts that contradicted the ED physicians' documentation, which purportedly jeopardized payment for the Hospital from insurance companies, including Government Healthcare Programs and commercial insurers." *Id.* ¶¶ 187, 81. The Concord Defendants do not contest their knowledge of Relator's letter to risk management, *see Concord Mot.* at 15–16; *Concord Reply* at 10. If there was any doubt as to Defendants' knowledge that Relator was investigating fraudulent practices, his letter directly invoking 42 C.F.R. § 1004 resolves these concerns to establish employer knowledge. *See Mendiondo*, 521 F.3d at 1104 ("[V]ague" reference to "possible . . . 'civil violations' can be construed to include the suspected Medicare fraud" to sufficiently establish Defendant's knowledge of Relator's protected activity); *see also Campie*, 862 F.3d at 908 ("[A]n allegation of knowledge is not a high bar.").

This Court is satisfied that the FAC's allegations sufficiently demonstrate that Drs. Gandhi and Derhartunian knew of Relator's attempt to stymie FCA violations. *Mendiondo*, 521 F.3d at 1104; *Rosales*, 173 F. Supp. 2d at 1003.

c. Employer Discrimination

Finally, the FAC plausibly alleges that the Concord Defendants discriminated against Relator because he engaged in a protected activity. *See Moore*, 275 F.3d at 845. The Concord Defendants contend that the FAC only provides conclusory facts to allege causation and in their motion provide an alternative basis for Relator's termination. *Concord Mot.* at 15–16. The Court disagrees.

Specifically, the FAC alleges that Concord provided Relator with a termination notice explaining that Concord terminated him due to "staffing issues." Ex. C to *FAC*. The FAC alleges that this proffered reason was pretextual, that no "staffing change" ever took place, and that Concord terminated him in retaliation for complaining about and resisting the alleged fraud. *See FAC* ¶ 188. That the Concord Defendants offer a conflicting and unrelated basis for Relator's termination "*may* also indicate pretext" if the two justifications are so "fundamentally different" as to "suggest the possibility that neither of the official reasons was the true reason[.]" *Mooney v. Fife*, 118 F.4th 1081, 1098 (9th Cir. 2024) (quoting *Washington v. Garrett*, 10 F.3d 1421, 1434 (9th Cir. 1993)) (emphasis in original) (quotation marks omitted).

Even if the Court were to take the Concord Defendants at their word that Concord terminated Relator due to "ongoing disputes," the very "disputes" to which Concord refers are, themselves, allegations supporting Relator's claims of retaliation. For example, Relator alleges being "admonished . . . by Concord management, including the Individual Defendants, for questioning admissions requested by the Hospital's ED physicians and putting notes in the patient files questioning the admissions and diagnoses that were falsely used to justify them." *FAC* ¶ 185. Relator describes being "scold[ed]" by Dr. Gandhi "about pushing back on admitting patients the Hospital wanted [Relator] to admit, even if the admission was not warranted." *Id.* ¶ 186. Drs. Gandhi and Derhartunian also put Relator on a Performance Improvement Plan which explicitly stated "There should be no refusal of admissions"—directly affirming the Concord Defendants' frustration with the protected activity Relator alleges in his retaliation claims. *Id.* ¶¶ 17, 22, 26, 79, 186.

Finally, the temporal proximity between Relator's protected activity and termination also supports a finding that Defendants' proffered reason for terminating Relator was pretextual. *See Mooney*, 118 F.4th at 1098. Here, less than six months after Drs. Gandhi and Derhartunian issued Relator's Performance Improvement Plan, and less than five months after Relator wrote to the Hospital risk manager relaying his conversations with Drs. Gandhi and Derhartunian and concerns about alleged improper practices, Dr. Derhartunian emailed Relator that Relator's contract terminated "in 90 days" due to "staffing issues." *FAC* ¶ 188; Ex. C to *FAC*. Relator has therefore sufficiently alleged causation. *See Pencheng Si v. Laogai Rsch. Found.*, 71 F. Supp. 3d 73, 102 (D.D.C. 2014) (finding the "allegation that [Defendant] terminated Relator within months of learning that Relator had reported fraudulent billing practices to a board member" to be "sufficient to give rise to an inference of causation.").

The Court therefore **DENIES** the Concord Defendants' motion to dismiss Relator's fifth and eleventh causes of action for retaliation.

E. Commercial False Claims

Relator's twelfth cause of action alleges commercial false claims in violation of the California Insurance Fraud Prevention Act ("IFPA"), Cal. Ins. Code §§ 1871, *et seq.*, including by:

> (a) referring patients for unnecessary admissions to Defendant Hospital in exchange for bonus payments, benefits, and other remuneration paid to Concord and the individual Defendants

> in violation of the federal AKS, California AKS, and EKRA, (b) conspiring to conceal those violations, (c) providing false information to commercial insurers, and (d) concealing the scheme from other providers, patients, commercial insurers, and the State of California.

FAC ¶¶ 239–244.

The IFPA prohibits knowingly employing persons "to procure clients or patients to perform or obtain services or benefits under a contract of insurance or that will be the basis for a claim against an insured individual or their insurer." Cal. Ins. Code § 1871.7. Relator also brings claims under Cal. Penal Code sections 549 and 550, which provide penalties to IFPA violations, and bar the submission of fraudulent insurance claims. "Because the federal False Claims Act and California's Insurance Fraud Prevention Act are anti-fraud statutes, complaints brought under the statutes must meet the Rule 9(b) pleading standard." *United States v. Cedars-Sinai Med. Ctr.*, No. 2:20-CV-08439-WLH-PVC, 2025 WL 3035111, at *2 (C.D. Cal. Sept. 9, 2025) (citation omitted).

The Concord Defendants argue that Relator's IFPA claim fails to meet Rule 9(b)'s standards because the FAC fails to identify who submitted any alleged claims and fails to identify any commercial payor, claim identifier, amount billed, submission date, or false statement or certification. *Concord Mot.* at 15. The Hospital Defendants similarly argue that the FAC fails to allege "the submission of a single allegedly false claim to a commercial insurer" and correctly point out that all the "patient-specific allegations concern Medicare or Medicaid." *Hospital Mot.* at 32–33. This Court agrees with both the Concord and Hospital Defendants. Relator has "not identified a single false claim, a single private insurance company, a single patient involved with a purported false claim to a private insurance company, or any date on which such a claim was submitted." *United States v. Univ. of S. California*, No. 218CV08311SSSASX, 2023 WL 2682298, at *8 (C.D. Cal. Feb. 9, 2023). Accordingly, Relator has failed to state a claim under California's IFPA. *See id.*, *see also Cedars-Sinai Med. Ctr.*, 2025 WL 3035111 at *7 ("[T]he existence of a general guideline or coverage summary does not, without more, establish a specific . . . fraudulent claim."); *United States ex rel. Karp v. Ahaddian*, No. CV 16-500 PSG (JPRX), 2018 WL 6333670, at *4 (C.D. Cal. Aug. 3, 2018) ("[T]he fact that Defendants may have submitted false claims to private insurers is not enough to create a strong inference that they likewise submitted false claims to Medicare.")

The Court therefore **GRANTS** Defendants' motion to dismiss Relator's twelfth cause of action for commercial false claims.

IV. Leave to Amend

Courts have broad discretion to grant leave to amend a complaint. *See Nguyen v. Endologix, Inc.*, 962 F.3d 405, 420 (9th Cir. 2020). In determining whether a plaintiff should be granted leave to amend, courts consider "the presence or absence of undue delay, bad faith, dilatory motive, repeated failure to cure deficiencies by previous amendments, undue prejudice to the opposing party and futility of the proposed amendment." *Kroessler v. CVS Health Corp.*, 977 F.3d 803, 814–15 (9th Cir. 2020) (internal quotation marks and citation omitted). Generally, Rule 15 advises that "[t]he court should freely give leave when justice so requires." Fed. R. Civ. P. 15(a)(2). Indeed, "[i]t is black-letter law that district court must give plaintiffs at least one chance to amend a deficient complaint," unless there is "a clear showing that amendment would be futile." *Barke v. Banks*, 25 F.4th 714, 721 (9th Cir. 2022) (internal quotation marks and citation omitted). Here, amendment is not futile. Accordingly, the Court **GRANTS** leave to amend Relator's dismissed first, second, third, fourth, sixth, seventh, eighth, tenth, and twelfth causes of action. Because Relator has abandoned his fifth and eleventh causes of action against the Hospital Defendants, *see infra*, the Court **DENIES** leave to amend Relator's dismissed fifth and eleventh causes of action with respect to the Hospital Defendants. *Ramachandran*, 2021 WL 428654, at *9; *Mireskandari*, 2013 WL 12129559, at *11 (C.D. Cal. July 30, 2013) (deeming claim abandoned and granting dismissal where "plaintiff's opposition fails to respond in any way to [Defendant's] argument that the claim should be dismissed.").

V. Conclusion

For the foregoing reasons, the Court **ORDERS** the following:

1. Defendants' Motions to Dismiss (Dkt. # 47, 48) are **GRANTED IN PART**. Relator's First, Second, Third, Fourth, Sixth, Seventh, Eighth, Tenth, and Twelfth Causes of Action are **DISMISSED WITH LEAVE TO AMEND**;

2. Hospital Defendants' Motion to Dismiss is **GRANTED IN PART.** Relator's Fifth and Eleventh Causes of Action (Dkt. # 48) is **GRANTED WITHOUT LEAVE TO AMEND**;

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES – GENERAL

Case No. 2:25-cv-11277-MWC-BFM Date: August 5, 2026

Title: United States of America, *et al.* v. Concord Hospitalist Group, *et al.*

3. Concord Defendants' Motion to Dismiss is **DENIED IN PART**. Relator's Fifth and Eleventh Causes of Action (Dkt. # 48) is **DENIED**.

4. The August 7, 2026, hearing is **VACATED**.

IT IS SO ORDERED.

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Initials of Preparer	TJ