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17 UNITED STATES DISTRICT COURT  
18 NORTHERN DISTRICT OF CALIFORNIA

19 UNITED STATES OF AMERICA,  
20 *ex rel.* MARCIA STEIN and  
21 RODOLFO BONE,

22 Plaintiffs,

23 v.

24 KAISER FOUNDATION HEALTH  
25 PLAN, INC., et al.,

26 Defendants.

CASE NO. 16-cv-05337-EMC

CONSOLIDATED WITH:

CASE NO. 13-cv-03891-EMC (Lead Case)  
CASE NO. 16-cv-01558-EMC  
CASE NO. 16-cv-05337-EMC  
CASE NO. 18-cv-01347-EMC  
CASE NO. 21-cv-03124-EMC  
CASE NO. 21-cv-03894-EMC

**NOTICE OF APPEAL**

27 Notice is hereby given that Plaintiffs and Relators Marcia Stein and Rodolfo Bone  
28 hereby appeal to the United States Court of Appeals for the Ninth Circuit from an order  
entered on May 5, 2022, a copy of which is attached as Exhibit 1. Appellants' Representation  
Statement is attached as Exhibit 2.

THE ZINBERG LAW FIRM, A.P.C.

HANAGAMI LAW, A.P.C.

Dated: June 3, 2022

By: /s/William K. Hanagami  
William K. Hanagami  
Attorneys for Plaintiffs and *Qui Tam* Relators,  
Marcia Stein and Rodolfo Bone

# EXHIBIT 1

United States District Court  
Northern District of California

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UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel.  
RONDA OSINEK,

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC,  
et al.,

Defendants.

Case No. [13-cv-03891-EMC](#)

**CONSOLIDATED MEMBER CASES**

Case No. [16-cv-01558-EMC](#)

Case No. [16-cv-05337-EMC](#)

Case No. [18-cv-01347-EMC](#)

Case No. [21-cv-03124-EMC](#)

Case No. [21-cv-03894-EMC](#)

**ORDER GRANTING IN PART AND  
DENYING IN PART DEFENDANTS'  
MOTION TO DISMISS**

Docket No. 141

The above cases are all predicated on allegations that various Kaiser entities<sup>1</sup> submitted false claims for payment to the federal government as part of the Medicare Part C program, which is also called Medicare Advantage. *Osinek* was the first-filed case and was followed by five other cases: *Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca*.<sup>2</sup> The cases were consolidated in June 2021. *See Osinek*, Docket No. 61 (order). In July 2021, the United States filed a notice that it was

<sup>1</sup> The Kaiser entities are, generally speaking, various Health Plans, Hospitals, and Medical Groups. These entities “publicly hold themselves out and do business collectively as an integrated healthcare provider called “Kaiser Permanente.” U.S. Compl. ¶ 28.

<sup>2</sup> *Taylor* was initially filed in the District of Colorado in 2014; *Arefi* in the Central District of California in 2015; *Stein* in the Central District of California in 2016; *Bryant* in the Northern District of California in 2016; and *Bicocca* in the Eastern District of California in 2020.

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1 intervening in part and declining to intervene in part.<sup>3</sup> See *Osinek*, Docket No. 64 (notice of  
2 election).

3 Currently pending before the Court is Defendants’ motion to dismiss based on the first-to-  
4 file bar in the False Claims Act (“FCA”). The relevant FCA provision states as follows: “When a  
5 person brings an action under this subsection, no person other than the Government may intervene  
6 or bring a related action based on the facts underlying the pending action.” 31 U.S.C. §  
7 3730(b)(5) (emphasis added). The purpose of the first-to-file bar is twofold: (1) “to promote  
8 incentives for whistle-blowing insiders” and (2) “[to] prevent opportunistic successive plaintiffs.”  
9 *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1187 (9th Cir. 2001).  
10 Defendants argue that, with limited exceptions, the claims presented by the cases that follow  
11 *Osinek* are barred. The *Arefi* plaintiffs have filed a statement of nonopposition with respect to the  
12 motion to dismiss their case. See Docket No. 143 (nonopposition). The plaintiffs in all other  
13 cases have opposed dismissal.

14 Having considered the parties’ briefs, as well as the oral argument of counsel, the Court  
15 hereby **GRANTS** in part and **DENIES** in part Defendants’ motion.

16 **I. FACTUAL & PROCEDURAL BACKGROUND**

17 A. United States’ Complaint-in-Intervention

18 Although the United States’ Complaint-in-Intervention is not at issue in the pending  
19 motion, the Court begins with this pleading as it provides a good overview of the Medicare  
20 background.

21  
22 <sup>3</sup> The notice stated as follows:

Specifically, the United States intervenes on the allegations that  
defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.;  
Kaiser Foundation Health Plan of Colorado; The Permanente  
Medical Group, Inc.; Southern California Permanente Medical  
Group, Inc.; and Colorado Permanente Medical Group, P.C.;  
submitted, or caused to be submitted, false claims for risk-  
adjustment payments based on diagnoses improperly added via  
addenda under Medicare Part C from the years 2009 until present.  
The United States declines to intervene on all other allegations.

28 *Osinek*, Docket No. 64 (notice).

1 “Medicare is a federally operated health insurance program.” U.S. Compl. ¶ 52. It has  
2 four parts:

- 3 • Part A covers inpatient and institutional care.
- 4 • Part B covers outpatient care.
- 5 • Part C is the Medicare Advantage program at issue in this case.
- 6 • Part D covers prescription drugs.

7 *See* U.S. Compl. ¶ 52.

8 Parts A and B are “traditional” Medicare.

9 [T]he Government reimburses healthcare providers using a fee-for-  
10 service system, in which providers submit claims to CMS [Centers  
11 for Medicare and Medicaid Services] for healthcare services actually  
12 rendered, such as a provider office visit or hospital stay. CMS then  
13 pays the providers directly for each service based on payment rates  
14 predetermined by the Government.

15 U.S. Compl. ¶ 53.

16 A Medicare beneficiary can opt out of traditional Medicare and enroll instead in a  
17 Medicare Advantage plan managed by a Medicare Advantage Organization (“MAO”). *See* U.S.  
18 Compl. ¶ 54. “CMS reimburses [Medicare Advantage] plans differently than traditional  
19 Medicare.” U.S. Compl. ¶ 58. Specifically, Medicare Advantage uses a “‘capitation’ payment  
20 system.” *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under  
21 that system, “private health insurance organizations provide Medicare benefits in exchange for a  
22 fixed monthly fee per person enrolled in the program – regardless of actual healthcare usage.” *Id.*  
23 The fixed monthly fee for an enrollee is set as follows. First, there is a predetermined base  
24 payment for each enrollee in a Medicare Advantage plan. *See* U.S. Compl. ¶ 57. Second, the base  
25 payment is then adjusted “to account for (1) demographic factors such as age and gender (among  
26 others) and (2) health status. This is known as risk adjustment.” U.S. Compl. ¶ 58.

27 Risk adjustment is accomplished by assigning each beneficiary a risk score, which “acts as  
28 a multiplier that is applied to the [Medicare Advantage] plan’s base rate to determine the overall  
monthly payment for the beneficiary.” U.S. Compl. ¶ 58. A beneficiary’s risk score is determined  
through a model called the CMS Hierarchical Conditions Category (“CMS-HCC”) model, which,

1 as indicated above, is based on the patient’s demographic factors and health status. *See* U.S.  
 2 Compl. ¶ 59. With respect to health status, the model relies on diagnosis codes from the  
 3 International Classification of Diseases (“ICD”). *See* U.S. Compl. ¶ 60. “ICD diagnosis codes are  
 4 alphanumeric codes used by healthcare providers, insurance companies, and public health  
 5 agencies to represent medical conditions; every disease, injury, infection, and symptom has its  
 6 own code.” U.S. Compl. ¶ 62.

7 The ICD diagnosis codes included in the CMS-HCC model are  
 8 grouped into categories of clinically related medical diagnoses that  
 9 comprise the HCCs (i.e., the categories). For example, various  
 10 cancer diagnosis codes are grouped together (e.g., colorectal and  
 11 bladder cancers). The CMS-HCC model organizes related  
 12 conditions into hierarchies based on disease severity and expected  
 13 cost. For example, various cancer HCCs are in the same hierarchy,  
 14 with the HCC associated with metastatic cancer diagnosis codes as  
 15 the most severe. If a patient is diagnosed with conditions (diagnosis  
 16 codes) that correspond to more than one HCC in a hierarchy, only  
 17 the most severe HCC is kept and any lower-ranking HCCs are  
 18 dropped.

19 U.S. Compl. ¶ 63.

20 Each HCC is assigned a coefficient. CMS calculates a beneficiary’s  
 21 risk score by adding the coefficients associated with each of the  
 22 beneficiary’s applicable demographic characteristics (such as age  
 23 and gender) and the applicable HCCs, if any, that apply to the  
 24 beneficiary. A risk score of 1.0 reflects the average expected  
 25 Medicare-incurred expenses. A risk score of 0.75 reflects expected  
 26 costs for a particular beneficiary that are 25% less than the estimated  
 27 average costs for enrollees in the MA plan, and a risk score of 1.25  
 28 reflects expected costs that are 25% greater than the estimated  
 average costs for enrollees in the MA plan.

U.S. Compl. ¶ 65.

The CMS-HCC model is prospective in the sense that it uses diagnoses made in a base  
 year (the ‘service year’), along with demographic information (such as age and gender, among  
 others), to predict costs for Medicare benefits and adjust payments for the following year (the  
 ‘payment year’).” U.S. Compl. ¶ 60.

“To combat the ‘incentive for [Medicare Advantage] organizations to potentially over-  
 report diagnoses,’ Medicare regulations require risk adjustment data to be produced according to  
 certain best practices.” *Silingo*, 904 F.3d at 673. For example,

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- 1 the diagnosis codes that MA Organizations submit to CMS for risk-
- 2 adjustment purposes must be:
- 3 a. established by a qualified physician;
- 4 b. based on a face-to-face medical visit between the patient and
- 5 physician<sup>[4]</sup>;
- 6 c. documented in the medical record; and
- 7 d. coded in compliance with the ICD [Official Guidelines for
- 8 Coding and Reporting], including the limitation that the
- 9 condition must have required or affected patient care,
- 10 treatment, or management for the visit.<sup>[5]</sup>

9 U.S. Compl. ¶ 87 (emphasis added); *see also Silingo*, 904 F.3d at 673 (also noting best practices).

10 “[I]t is an express condition of payment that a Medicare Advantage organization ‘certify  
11 (based on best knowledge, information, and belief) that the [risk adjustment] data it submits . . .  
12 are accurate, complete, and truthful.’” *Id.* (quoting 42 C.F.R. § 422.504(l)(2)).

13 B. Osinek Complaint

14 The Court turns next to the Osinek Complaint as it provides the baseline for the Court –  
15 *i.e.*, the Court will have to compare the Osinek Complaint with the complaints in the other cases to  
16 determine whether the cases are related. *See* 31 U.S.C. § 3730(b)(5) (providing that, “[w]hen a  
17 person brings an action under this subsection, no person other than the Government may intervene  
18 or bring a related action based on the facts underlying the pending action”).<sup>6</sup>

19 The allegations below all come from Ms. Osinek’s original complaint filed in 2013. (Ms.

20 \_\_\_\_\_  
21 <sup>4</sup> For example,

22 even if an MA organization knows that a patient was diagnosed in a  
23 prior year with a chronic condition that tends not to go away, the  
24 MA organization may not submit the diagnosis for payment for the  
25 current year unless the physician has a face-to-face visit with the  
26 patient in the current year and the chronic condition required or  
27 affected care, management, or treatment during that patient visit.

28 U.S. Compl. ¶ 85.

<sup>5</sup> “In other words, only those conditions that specifically mattered to the patient care, treatment, or  
management that the physician actually provided at the visit could be submitted to CMS for  
payment.” U.S. Compl. ¶ 5.

<sup>6</sup> Similarly, later-filed complaints must be compared with all preceding complaints.

1 Osinek filed an amended complaint in 2021. For the reasons discussed below, it is Ms. Osinek’s  
2 original complaint that matters for purposes of the pending motion.)

3 Ms. Osinek has sued “Kaiser Permanente,” “a private provider of Medicare Advantage  
4 insurance under Medicare Part C.” Osinek Compl. ¶ 2. Ms. Osinek describes “Kaiser  
5 Permanente” as follows:

6 Kaiser Permanente is a California corporation with its principal  
7 place of business [in] Oakland, California 94612. Kaiser is one of  
8 the largest Medicare Advantage organizations in the country and has  
9 more enrollees in its Medicare Advantage Plans than any other  
10 organization in California. At all times relevant, Kaiser conducted  
11 business in California, including but not limited to providing  
12 healthcare services through Medicare Advantage plans and to the  
13 general public in California.

14 Osinek Compl. ¶ 6.

15 According to the complaint, starting around 2007, Kaiser Permanente began a “scheme to  
16 upcode diagnoses to ensure Medicare payments for reimbursable, high-value conditions.” Osinek  
17 Compl. ¶ 2. Not surprisingly, Kaiser Permanente “focuses . . . on high value conditions” so that it  
18 “can maximize its reimbursement from Medicare.” Osinek Compl. ¶ 25. High-value disease  
19 conditions included, *e.g.*, chronic kidney disease, congestive heart failure, depression, chronic  
20 respiratory failure, cachexia/protein calories malnutrition, severe obesity, and seizure. *See* Osinek  
21 Compl. ¶ 25.

22 Kaiser Permanente effectuated its upcoding scheme in various ways. For example:

- 23 • Data mining. Kaiser Permanente used “algorithms to identify [high-value] disease  
24 conditions for data mining.” Osinek Compl. ¶ 25. “Kaiser identified the higher  
25 value HCCs and then determined the diagnoses its doctors would need to make to  
26 support the HCCs Kaiser wanted to submit for Medicare reimbursement.” Osinek  
27 Compl. ¶ 25.
- 28 • Refreshing. Although not clearly described in the complaint, refreshing appears to  
be a process related to chronic conditions. *See* Osinek Compl. ¶ 37 (alleging that  
“Kaiser tracks and rewards physicians based on the percentage of chronic  
conditions they are able to capture and refresh”). As indicated above, Medicare

1 Advantage plans are compensated based on medical conditions diagnosed in the  
2 previous payment year. Therefore, if a patient has a chronic condition, then that  
3 condition must be rediagnosed each year – *i.e.*, refreshed. Presumably, Kaiser  
4 Permanente used refreshing “to increase its billings for high value . . . HCCs,”  
5 Osinek Compl. ¶ 24, because a doctor would be told to include the chronic  
6 condition as a diagnosis for a visit even if that condition was not at issue in the  
7 patient visit.<sup>7</sup>

- 8 • Guidance and policies. Kaiser Permanente provided guidance or policies that  
9 supported upcoding. For example, “Kaiser told its physicians to diagnose chronic  
10 kidney disease instead of the lower value nephritis or nephropathy.” Osinek  
11 Compl. ¶ 26. As another example, “when CMS announces that HCCs are  
12 eliminated (and no longer reimbursable by Medicare), Kaiser tells its physicians to  
13 change coding practices to reflect new reimbursable codes. . . . In response to  
14 CMS’s notification that HC 131 will be eliminated, Kaiser promptly sent materials  
15 to its staff to begin prompting physicians to code diagnoses for acute kidney injury  
16 instead of chronic kidney disease stage 1, 2, or 3, which will be included in the  
17 2014 HCC list and reimbursable by Medicare.” Osinek Compl. ¶ 27.
- 18 • Addenda. In theory, “[a]ll relevant documentation is entered into a medical record  
19 at the time of service,” but CMS recognizes “there may be times that a provider  
20 will need to amend, correct, or enter documentation related to an encounter. CMS  
21

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22 <sup>7</sup> The United States’ Complaint provides further context on refreshing. *See, e.g.*, U.S. Compl. ¶ 7  
23 (“Kaiser also employed a related data-mining program called ‘refresh,’ where Kaiser would mine  
24 patient medical files to find old diagnoses that had not yet been diagnosed in the current service  
25 year. If a physician failed to address any of these old diagnoses at a patient visit, the physician  
26 would be provided a list of these ‘missed opportunities’ – *i.e.*, opportunities for risk-adjustment  
27 payment – to create an addendum to retrospectively add these diagnoses to the medical record.”);  
28 U.S. Compl. ¶ 151 (“Another category of Kaiser’s data-mining efforts focused on capturing  
diagnoses that had been made in a prior year. Kaiser referred to this program as ‘refresh’ and to  
conditions that needed to be captured as ‘unrefreshed diagnoses.’ Kaiser created algorithms that  
mined patients’ electronic medical records for any diagnoses that had been made in any setting  
during the past several (typically three) years. As detailed below, Kaiser meticulously monitored  
and tracked these diagnoses, and if a physician failed to re-diagnose these conditions at a patient  
visit, Kaiser would systematically pressure the physician to add the diagnoses via addenda, as it  
did with its other data-mining efforts.”).

1 expects supplemental documentation to be occasional and that delayed or amended  
 2 entries will be entered within a reasonable time frame. CMS will consider delayed  
 3 or amended explanations for diagnoses so long as the explanations are for  
 4 clarification and *not* for substantiating retroactive diagnoses.” Osinek Compl. ¶ 20  
 5 (emphasis added). Kaiser Permanente had its doctors use addenda to retroactively  
 6 diagnose – *e.g.*, long after a patient visit, for a condition for which the patient was  
 7 not treated at the time of the face-to-face visit, based on tests run after the face-to-  
 8 face visit, to change a diagnosis to a higher value and more complicated form of  
 9 disease, without proper support/documentation, and/or using boilerplate language.  
 10 *See, e.g.*, Osinek Compl. ¶¶ 28-32.

- 11 • Pressuring doctors. “Kaiser pressures its physicians to addend diagnoses and  
 12 capture the high value HCCs” – *e.g.*, there is “an escalation process for physicians  
 13 who do not agree with the data mining prompts”; “[p]hysicians will have to meet  
 14 one-on-one with Data Quality Trainers if they refused to make diagnoses changes  
 15 that are presented by data mining”; “physicians have personal report cards based on  
 16 how they perform in certain areas [including response to refreshing and data  
 17 mining prompts], which are tied to their compensation”; and there are “mandatory  
 18 meetings called ‘coding parties,’ where physicians are gathered in a single room  
 19 with computers and asked to review past progress notes for addenda related to  
 20 revised medical diagnoses.” Osinek Compl. ¶¶ 33-35.

## 21 **II. LEGAL ISSUES**

22 Before the Court compares *Osinek* and the later-filed cases, it first takes into consideration  
 23 four legal issues related to the first-to-file bar, each of which will have an impact on the Court’s  
 24 comparison of the cases.

- 25 (1) Is the first-to-file bar jurisdictional in nature?
- 26 (2) In comparing the first-filed and later-filed actions, should a court look at the  
 27 original complaints or any amended complaints instead (assuming amended  
 28 complaints have been filed)?

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1 (3) In comparing the first-filed and later-filed actions, must the facts in the actions be  
2 identical in order for a court to apply the first-to-file bar?

3 (4) In comparing the first-filed and later-filed actions, how should a court proceed  
4 where there are different defendants?

5 A. Jurisdiction

6 Although not all courts agree, the Ninth Circuit has expressly held that the first-to-file  
7 provision (§ 3730(b)(5)) is jurisdictional in nature. *See, e.g., United States ex rel. Hartpence v.*  
8 *Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015) (stating that “[w]e treat the first-to-file  
9 bar as jurisdictional”); *see also United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care*  
10 *Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at \*41 & n.4 (E.D. Tenn. Aug. 23,  
11 2021) (noting that the Fourth, Fifth, Sixth, Ninth, and Tenth Circuits have held that § 3730(b)(5) is  
12 jurisdictional but that the D.C., First, Second, and Third Circuits have held that it is not; citing  
13 cases).

14 The Ninth Circuit’s view of § 3730(b)(5) as jurisdictional is important because it impacts  
15 which complaints should be considered when a court compares the first-filed and later-filed  
16 actions. *See Reply at 4* (making this same point). That issue is addressed below.

17 In their papers, the *Stein* plaintiffs argue that the first-to-file bar is not jurisdictional. In  
18 support, they rely on *Gonzalez v. Thaler*, 565 U.S. 134 (2012), where the Supreme Court stated as  
19 follows: “A rule is jurisdictional ‘[i]f the Legislature clearly states that a threshold limitation on a  
20 statute’s scope shall count as jurisdictional.’” *Id.* at 141. The problem for the *Stein* plaintiffs is  
21 that, post-*Gonzalez*, the Ninth Circuit issued *Hartpence* which clearly held that the first-to-file bar  
22 is jurisdictional. *See Hartpence*, 792 F.3d at 1130. The *Stein* plaintiffs acknowledge *Hartpence*  
23 but contend that the decision should not be given any weight as it relied solely on *Lujan*, 243 F.3d  
24 at 1181, a pre-*Gonzalez* decision. The Court rejects the *Stein* Plaintiffs’ attempt to avoid  
25 *Hartpence*. *Hartpence* is binding authority that is clearly on point and was issued post-*Gonzalez*.  
26 It is not up to this Court to decide whether *Hartpence* was wrongly decided because the Ninth  
27 Circuit did not explicitly address *Gonzalez*.

28

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1 B. Original v. Amended Complaint

2 The next issue for the Court to consider is which complaints should be evaluated in  
3 determining whether the first-filed and later-filed actions are related: the original complaints or the  
4 amended complaints? All of the cases before the Court – including *Osinek* – have amended  
5 complaints except for *Arefi*. (As noted above, the *Arefi* plaintiffs do not oppose Defendants’  
6 motion to dismiss their suit.) Below is a timeline with respect to the filing of the complaints.

7

8	<b>Osinek (2013)</b>	<b>Taylor (2014)</b>	<b>Arefi (2015)</b>	<b>Stein (2016)</b>	<b>Bryant (2018)</b>	<b>Bicocca (2020)</b>
9	8/22/2013 (original complaint)					
10		10/22/2014 (original complaint)				
11		11/3/2014 (FAC)				
12			9/4/2015			
13				5/16/2016 (original complaint)		
14				11/3/2016 (FAC)		
15					3/1/2018 (original complaint)	
16						2/10/2020 (original complaint)
17						10/9/2020 (FAC)
18	7/27/2021 – U.S. notice of election to intervene in part					
19	7/29/2021 – Court order granting U.S. request to unseal complaints					
20	10/7/2021 (FAC)					
21	10/25/2021 – U.S. complaint in intervention					
22				11/12/2021 (SAC)		
23		11/15/2021 (SAC)			11/15/2021 (FAC)	
24						

25 A number of courts have held that a court should compare (1) the original complaint in the  
26 later-filed action with (2) whatever was the operative complaint in the first-filed action at the time  
27 the later-filed action was filed (which in this case would be the original complaint in *Osinek*). *See*,  
28 *e.g.*:

- 1 • *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004)  
2 (stating that “[w]e judge whether § 3730(b)(5) barred Grynberg’s [later-filed] qui  
3 tam action by looking at the facts as they existed at the time the action was  
4 brought”; at the time the Grynberg suit was filed, “Precision’s 1992 amended  
5 complaint [in the first-filed case] was pending in federal district court”).
- 6 • *U.S. ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248,  
7 259 (E.D. La. 2011) (hereinafter “*Branch II*”) (indicating that “the Court should  
8 look to the jurisdictional facts that existed at the time the action was filed, as  
9 opposed to facts that existed when the relator later filed an amended complaint”).
- 10 • *United States ex rel. Cestra v. Cephalon, Inc.*, No. 14-01842, 2014 U.S. Dist.  
11 LEXIS 143745, at \*7-8 (E.D. Pa. Oct. 9, 2014) (agreeing with *Grynberg* and  
12 *Branch*).
- 13 • *United States ex rel. Carter v. Halliburton*, No. 1:11cv602 (JCC/JFA), 144 F.  
14 Supp. 3d 869, 881 (E.D. Va. 2015) (noting, *inter alia*, that “[i]t is consistent with  
15 the jurisdictional limitation to apply the first-to-file bar at the time the initial  
16 complaint is filed, rather than when the complaint is amended”).
- 17 • *United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*,  
18 No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at \*24 (E.D. Tenn. Aug. 23,  
19 2021) (also agreeing with *Grynberg* and *Branch*).

20 In the case at bar, Defendants advocate for this approach, and most of the plaintiffs agree –  
21 but not all. *See, e.g.*, Stein Opp’n at 3 n.2 (arguing that the Court should consider the SAC which  
22 was filed in November 2021); Bicocca Opp’n at 5 (arguing that the Court should consider the  
23 FAC which was filed in October 2020).

24 The district court in *Branch II* has provided the most extensive analysis as to why the  
25 above approach should be followed. *Branch II* was the later-filed action. The first-filed action  
26 was known as *Rigsby*. After Branch filed its original complaint in August 2006, it filed two  
27 different amended complaints. The court gave several reasons why – for purposes of § 3730(b)(5)  
28 – the original complaint in *Branch II* (and not any amended complaint) should be compared with

1 the complaint in *Rigsby*.

2 First, the text of § 3730(b)(5) supports this approach.

3 The first-to-file bar [in § 3730(b)(5)] and the original source  
 4 exception to the public disclosure bar [in § 3730(e)(4)] refer  
 5 specifically to jurisdictional facts that must exist when an "action,"  
 6 not a complaint, is filed. Under 31 U.S.C. § 3730(b)(5), *a qui tam*  
 7 plaintiff may not "bring a related action based on the facts  
 8 underlying the pending action." As the Seventh Circuit has noted,  
 9 "[o]ne 'brings' an action by commencing suit." *United States ex rel.*  
 10 *Chovanec v. Apria Healthcare Group Inc.*, 606 F.3d 361, 362 (7th  
 11 Cir. 2010). Further, in order to be an original source under 31  
 12 U.S.C. § 3730(e)(4)(B), a relator must provide the information on  
 13 which the allegations are based to the government "before filing an  
 14 action under this section which is based on the information." Both  
 15 provisions appear to contemplate that certain requirements must be  
 16 met at the time a *qui tam* action is filed. The use of the term  
 17 "action" in both provisions indicates that the Court should look to  
 18 the jurisdictional facts that existed at the time the action was filed, as  
 19 opposed to facts that existed when the relator later filed an amended  
 20 complaint.

21 As the Third Circuit has noted, however the FCA is based on the  
 22 model of a single-count complaint, and it sometimes uses the term  
 23 "action" when it likely means "claim." *United States ex rel. Merena*  
 24 *v. SmithKline Beecham Corp.*, 205 F.3d 97, 101-02 (3d Cir. 2000).  
 25 For example, under § 3730(b)(2) and (4), the government may  
 26 choose to "proceed with the action" or may "decline to take over the  
 27 action," yet it is commonplace for the government to proceed with  
 28 only certain claims and not with others. *Id.* at 102. But even if  
 "action" can mean "claim" in some contexts, it is perfectly natural to  
 read the first-to-file bar and the original source provision as  
 imposing certain requirements that must be met at the time the suit  
 begins.

19 *Branch II*, 782 F. Supp. 2d at 259-60 (emphasis added).

20 Second, general jurisdictional principles also support the approach.

21 The notion that a court cannot proceed if it lacked jurisdiction at the  
 22 time the original complaint was filed is consistent with the "time-of-  
 23 filing rule," under which "the jurisdiction of the Court depends upon  
 24 *the state of things at the time of the action brought[.]*" *Mollan v.*  
 25 *Torrance*, 22 U.S. 537, 539 (1824) (diversity jurisdiction exists if  
 26 the parties are diverse when the action was brought, even if  
 27 diversity is not maintained throughout the litigation) . . . .

25 *Id.* at 260 (emphasis added).

26 Third, the Supreme Court's decision in *Rockwell International Corp. v. United States*, 549  
 27 U.S. 457 (2007), does not conflict with the above approach.

28 While the ruling [in *Rockwell*] focused on the original source

1 provision [rather than the first-to-file provision], it also made  
2 broader jurisdictional statements that are relevant to the FCA as a  
3 whole. In *Rockwell*, the relator brought a *qui tam* action relating to  
4 toxic waste disposal at a nuclear weapons plant. The Supreme Court  
5 held that the relator was not an original source of new allegations in  
6 the amended complaint just because he was an original source of the  
7 allegations in the original complaint. *Id.* at 473-74. The Court  
8 concluded that the relator, "at a minimum," must be an original  
9 source of the claims in the amended complaint. *Id.* at 473. But the  
10 Court did not suggest that the original complaint becomes irrelevant  
11 for jurisdictional purposes once an amended complaint is filed. To  
12 the contrary, the Court stated that its holding was consistent with  
13 "[t]he rule that subject-matter jurisdiction 'depends on the state of  
14 things at the time of the action brought.'" *Id.* (quoting *Mollan v.*  
15 *Torrance*, 22 U.S. 537, 539 (1824)). . . . [Cases cited in *Rockwell*]  
16 indicate that a court cannot proceed if it lacked jurisdiction at the  
17 time the initial complaint was filed.

18 *Rockwell* goes on to state that jurisdiction is also defeated if a  
19 plaintiff amends the complaint to withdraw the allegations upon  
20 which the court's jurisdiction is based, "unless they are replaced by  
21 others that establish jurisdiction." . . . But *Rockwell* does not suggest  
22 that a plaintiff can establish jurisdiction by amendment when  
23 jurisdiction did not previously exist. Indeed, such a conclusion  
24 would be directly contrary to the Court's statement that  
25 "demonstration that the original allegations were false will defeat  
26 jurisdiction."

27 *Id.* at 261-62.

28 Finally, there are several practical/policy reasons to support the approach. For example,

the pre-filing disclosure requirement of § 3730(e)(4)(B) could not  
function if a court could acquire jurisdiction over a *qui tam*  
complaint through amendment. If a court could gain jurisdiction  
over a *qui tam* action by amendment, then a relator could neglect to  
inform the government of the information upon which the  
allegations are based before filing his or her action. Instead, the  
relator could provide that information to the government at a later  
time, and then amend the complaint, even in a trivial fashion, to  
ensure jurisdiction. Such a procedure would make the statutory  
language requiring disclosure to the government "before filing an  
action" meaningless.

*Id.* at 263.

In addition,

while the first-to-file bar of 31 U.S.C. § 3730(b)(5) encourages  
relators to quickly report fraud about which they become aware,  
problems arise when a relator files without yet having direct and  
independent knowledge of the information underlying the  
allegations. As discussed *infra*, the Fifth Circuit has held that even  
skeletal allegations can bar other actions under the first-to-file bar in  
at least some circumstances. *See United States ex rel. Branch*

1            *Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 379 (5th Cir. 2009).  
 2            It would be anomalous if a relator could secure a place in the  
 3            jurisdictional queue with merely skeletal allegations, only to then  
 4            file an amended complaint after actually becoming an original  
 5            source, and thereby trump any meritorious, related actions that were  
 6            filed in the meantime. *Cf. United States ex rel. Ortega v. Columbia*  
 7            *Healthcare, Inc.*, 240 F. Supp.2d 8, 14 (D.D.C. 2003) (amended  
 8            complaint could not "relate back" to the date the original complaint  
 9            was filed in order to jump ahead in line). Such an approach would  
 10            shut out deserving relators while rewarding those who bring actions  
 11            without having direct and independent knowledge of their publicly  
 12            disclosed allegations. A relator, under this scenario, could secure  
 13            first-to-file status before actually conducting the investigation that  
 14            uncovers direct and independent information about the fraud.  
 15            Requiring jurisdiction at the time the original complaint was filed  
 16            allows a court to dismiss such an attempt, regardless of later  
 17            amendments.

18            *Id.* at 264.<sup>8</sup>

19            Finally, the time-of-filing rule has the advantage of simplicity. The  
 20            benefits of a clear-cut rule are apparent in this case, which involves  
 21            multiple claims, complaints, and defendants, as well as other relators  
 22            whose complaints have themselves been amended and involve  
 23            multiple defendants. *See United States ex rel Rigsby v. State Farm*  
 24            *Ins. Co.*, No. 06-433, 2006 U.S. Dist. LEXIS 98179 (S.D. Miss.  
 25            2006) (discussed *infra*); *United States ex rel Denenea v. Allstate Ins.*  
 26            *Co.*, No. 07-2795, 2011 U.S. Dist. LEXIS 6419 (E.D. La.); *United*  
 27            *States ex rel Sonnier v. Allstate Ins. Co.*, No. 09-1038 (M.D. La.).  
 28            The Court's jurisdiction may expand or shrink as amendments are  
 made to the complaint, but that jurisdiction must rest upon a solid  
 foundation.

*Id.*

          The analysis in *Branch II* is sound and persuasive. Furthermore, the analysis in *Branch II*  
 does not conflict with Ninth Circuit law, including *Hartpence*. Admittedly, in *Hartpence*, the  
 Ninth Circuit made the following comment in a footnote: "For purposes of determining  
 jurisdiction, we look to the allegations in the amended complaints. *Rockwell Int'l Corp. v. United*  
*States*, 549 U.S. 457, 473-74 (2007)." *Hartpence*, 792 F.3d at 1125 n.2. But this footnote in  
*Hartpence* does not mean that, for purposes of the first-to-file bar, that a court should look to an  
 amended pleading in a later-filed case.

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<sup>8</sup> Relatedly, if the rule were that an amended complaint in the later-filed action should be  
 considered (and not the original), that would give the relator in the later-filed action an incentive  
 to amend its complaint once the first-filed action becomes public – *i.e.*, so as to try to distinguish  
 the later-filed action from the first-filed action.

1 First, *Hartpence* referred to two different FCA provisions, not only the first-to-file bar (in  
2 § 3730(b)(5)) but also the public disclosure bar (in § 3730(e)(4)). *Hartpence*'s reference to  
3 *Rockwell* in footnote 2 may well have related to the public disclosure bar, which would make  
4 sense since *Rockwell* was a public disclosure case and not a first-to-file case

5 Second, as the *Branch II* court pointed out, *Rockwell* (the case that *Hartpence* cited)  
6 acknowledged the "rule that subject-matter jurisdiction 'depends on the state of things at the time  
7 of the action brought.'" *Rockwell*, 549 U.S. at 473.

8 Third, *Rockwell*'s statement that "courts look to the amended complaint" must be  
9 evaluated in context. The *Rockwell* Court noted that, if "original allegations [related to  
10 jurisdiction] were false," then jurisdiction is defeated. *Id.* "So also will the withdrawal of those  
11 allegations unless they are replaced by others that establish jurisdiction. Thus, when a plaintiff  
12 files a complaint in federal court and then voluntarily amends the complaint, courts look to the  
13 amended complaint to determine jurisdiction." *Id.* at 473-74. As indicated by the above text, the  
14 *Rockwell* Court made the last statement in the context of a plaintiff *withdrawing* allegations that  
15 gave rise to jurisdiction and pleading new allegations.

16 Finally, courts have recognized the context in which the *Rockwell* statement above was  
17 made and thus taken note of the limits of *Rockwell*. For instance, the Fifth Circuit has stated:

18 The [*Rockwell*] Court did not hold . . . that the original complaint is  
19 irrelevant to jurisdiction or that a relator need not establish  
20 jurisdiction from the moment he first files his action. Indeed,  
21 *Rockwell* did not speak to the question whether a relator can use an  
22 amended complaint to establish jurisdiction when the original  
23 complaint is lacking. Consequently, we fall back on the  
longstanding rule that the amendment process cannot "be used to  
create jurisdiction retroactively where it did not previously exist." If  
[the relator's] complaint did not establish jurisdiction, it should have  
been dismissed; his amendments cannot save it.

24 *U.S. ex rel. Jamison v. McKesson Corp.*, 649 F.3d 322, 328 (5th Cir. 2011). Similarly, in *Strudley*  
25 *v. Santa Cruz County Bank*, 747 F. App'x 617 (9th Cir. 2019), the Ninth Circuit held that the  
26 plaintiffs could not amend as a matter of right to cure a jurisdictional defect in the original  
27 complaint. "In line with Supreme Court precedent, this Circuit has adhered to the time-of-filing  
28 rule, which provides that '[s]ubject matter jurisdiction must exist as of the time the action is

1 commenced.” *Id.* at 618. The court went on to reject the plaintiffs’ reliance on *Rockwell*.

2 *Rockwell* stands for the proposition that a plaintiff may voluntarily  
3 amend its original complaint to *remove* federal jurisdiction (except  
4 when a case has been removed to federal court). Plaintiffs amended  
5 their complaint for the exact opposite purpose in this case [*i.e.*, in  
the attempt to create jurisdiction]. Therefore, the district court  
correctly looked to the original complaint in concluding that it  
lacked subject matter jurisdiction over this case.

6 *Id.*; *see also Black Hills Media, LLC v. Pioneer Corp.*, No. CV 13-05980 SJO (PJWx), 2014 U.S.  
7 Dist. LEXIS 132030, at \*9 (C.D. Cal. Jan. 14, 2014) (“The court in *Rockwell* had jurisdiction over  
8 the original complaint when it was first filed, and the issue before the Supreme Court was whether  
9 the amended complaint *divested* the court of that existing jurisdiction. The Supreme Court  
10 determined that it did so. The opposite was true in [a Federal Circuit case], where the court had no  
11 jurisdiction over the original complaint, and the amended complaint would therefore grant the  
12 court jurisdiction that would not otherwise exist.”) (emphasis added).

13 Accordingly, the Court shall compare the original complaint in *Osinek* (*i.e.*, the operative  
14 complaint in the first-filed action at the time the later-filed action was filed) with the original  
15 complaints in the later-filed actions.

16 C. “Identical Facts” Test v. “Material Facts” Test

17 Turning to the heart of the matter, the Court considers next what is the legal standard for  
18 determining whether a first-filed suit and a later-filed suit are related for purposes of § 3730(b)(5).  
19 Like other circuit courts, the Ninth Circuit has rejected the position that the first-filed and later-  
20 filed actions must be based on “identical facts” in order to be deemed related. Instead of an  
21 “identical facts” test, the Ninth Circuit applies a “material facts” test.

22 Most of the few courts that have addressed § 3730(b)(5) have  
23 rejected an identical facts test. The cases’ common principle is that  
24 “section 3730(b)(5) precludes a subsequent relator’s claim that  
alleges the defendant engaged in the same type of wrongdoing as  
25 that claimed in a prior action even if the allegations cover a different  
time period or location within a company.” *United States ex rel.*  
*Capella v. United Technologies Corp.*, 1999 U.S. Dist. LEXIS  
26 10520, 1999 WL 464536, at \*9 (D. Conn. June 3, 1999)  
(summarizing the tests used by other courts). The Third Circuit, the  
27 only appellate court to discuss and apply § 3730(b)(5), rejected an  
identical facts test. *See LaCorte*, 149 F.3d at 233-34. We find the  
28 Third Circuit’s reasoning persuasive.

1 Section 3730(b)(5)'s plain language refers to "related" not  
 2 "identical" actions. Therefore, we need not review the legislative  
 3 history. *See Hockings*, 129 F.3d at 1071. Even if the language were  
 4 considered ambiguous, the single sentence from the legislative  
 5 history does not compel a different result. Furthermore, an identical  
 6 facts test would defeat the congressional objectives for the 1986  
 7 amendments: "adequate incentives for whistle-blowing insiders with  
 8 genuinely valuable information and discouragement of opportunistic  
 9 plaintiffs who have no significant information to contribute of their  
 10 own." *United States ex rel. Springfield Terminal Ry. v. Quinn*, 304  
 11 U.S. App. D.C. 347, 14 F.3d 645, 649 (D.C. Cir. 1994). Limiting §  
 12 3730(b)(5) to only bar actions with identical facts would be contrary  
 13 to the plain language and legislative intent: (1) using a narrow  
 14 jurisdictional bar, such as an identical facts test, would decrease  
 15 incentives to promptly bring qui tam actions; (2) multiple relators  
 16 would expect a recovery for the same conduct, thereby decreasing  
 17 the total amount each relator would potentially receive and  
 18 incentives to bring the suit; and (3) a narrow identical facts bar  
 19 would encourage piggyback claims, which would have no additional  
 20 benefit for the government," since once the government knows the  
 21 essential facts of a fraudulent scheme, it has enough information to  
 22 discover related frauds." *LaCorte*, 149 F.3d at 234.

23 Therefore, we hold that § 3730(b)(5) bars later-filed actions alleging  
 24 the same material elements of fraud described in an earlier suit,  
 25 regardless of whether the allegations incorporate somewhat different  
 26 details.

27 *Lujan*, 243 F.3d at 1188-89; *see also United States ex rel. St. John LaCorte v. SmithKline*  
 28 *Beecham Clinical Labs., Inc.*, 149 F.3d 227, 234 (3d Cir. 1998) (stating that, "once the  
 government knows the essential facts of a fraudulent scheme, it has enough information to  
 discover related frauds").

As a practical matter, the material facts test often has a court consider "whether the [later-  
 filed] Complaint alleges a fraudulent scheme the government already would be equipped to  
 investigate based on the [first-filed] Complaint." *United States ex rel. Batiste v. SLM Corp.*, 659  
 F.3d 1204, 1209 (D.C. Cir. 2011) (noting, for example, "[i]f the government investigated the facts  
 alleged in [first-filed] complaint on a nationwide basis, it would discover continuing fraud in the  
 New Jersey offices [which was the focus of the later-filed complaint]"; *see also id.* at 1210 (stating  
 that "[s]ection 3730(b) is designed to allow recovery when a *qui tam* relator puts the government  
 on notice of potential fraud being worked against the government, but to bar copycat actions that  
 provide no additional material information"); *Hartpence*, 792 F.3d at 1125, 1131-32  
 ("disagree[ing] that [the later-filed] action provided no additional benefit to the government"; the

1 plaintiff in the later-filed suit “provided information about a different form of fraud, and without  
2 that information the government might not have investigated beyond [defendant’s] fraudulent  
3 coding practices”).<sup>9</sup>

4 As a frame of reference, below is a brief discussion of some cases where the material facts  
5 test was not met and where the material facts test was met.

6 1. Material Facts Test Not Satisfied

7 In *Hartpence*, the Ninth Circuit held that the material facts test was not satisfied. The  
8 defendant in *Hartpence* was KCI, a company that manufactured medical devices that speeded the  
9 healing of wounds. One such device was a V.A.C. (vacuum assisted closure) device. *See id.* at  
10 1124. “V.A.C. devices perform negative pressure wound therapy (‘NPWT’),” and Medicare has  
11 covered NPWT devices as durable medical equipment. *Id.*

12 In the first-filed suit, the plaintiff *Hartpence* alleged that KCI had engaged in fraudulent  
13 conduct by submitting claims to Medicare related to the V.A.C. devices. Specifically, *Hartpence*  
14 asserted that KCI had submitted claims with a certain billing code, which indicated compliance  
15 with certain requirements even though those requirements had not, in fact, been met in various  
16 ways. *See, e.g., id.* at 1125 (noting that “*Hartpence* alleges that KCI improperly submitted claims  
17 with the KX modifier [*i.e.*, billing code]: (1) when there was no wound improvement in the  
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19 <sup>9</sup> Dr. Taylor contends that this notice standard is no longer applicable after *Kellogg Brown & Root*  
20 *Servs. v. United States ex rel. Carter*, 575 U.S. 650 (2015). *See Taylor Opp’n* at 21-22 n.23. In  
21 support, he cites an opinion from a Washington district court, *United States ex rel. Savage v.*  
22 *CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-EFS, 2015 U.S. Dist. LEXIS 137979  
23 (E.D. Wash. Oct. 1, 2015). There, the court stated: “The Supreme Court’s ruling in *Brown*  
24 inherently limits this ‘notice’ analysis. Applying a broad ‘notice’ test does not serve the FCA’s  
25 purpose of providing private parties the opportunity to pursue actions alleging fraud against the  
26 government *once the first-to-file bar lifts following the dismissal of the earlier action.*” *Id.* at \*22  
27 (emphasis added).

28 As indicated by the language italicized above, *Savage* has no application here because the  
first-filed action – *Osinek* – has not been dismissed and therefore the first-to-file bar cannot have  
not been lifted. *See also Brown*, 575 U.S. at 662 (indicating that “an earlier suit bars a later suit  
while the earlier suit remains undecided but ceases to bar that suit once it is dismissed”; rejecting  
the argument that the first-filed action remains pending even after it has been dismissed).

Moreover, the Ninth Circuit’s decision in *Hartpence* – which applied the notice standard  
above – was issued *after* the Supreme Court’s decision in *Brown*. *Brown* was decided in May  
2015, and *Hartpence* in July 2015.

1 previous month; (2) for the treatment of wounds for which V.A.C. therapy was neither reasonable  
2 nor necessary; (3) when the required wound measurement documentation was absent; [etc.]”).

3 In the later-filed suit, the plaintiff Godecke also claimed that KCI had improperly used the  
4 same billing code – albeit for a different reason. *See id.* (taking note of allegation that “KCI  
5 violated the FCA by knowingly misusing the KX modifier in submitting claims for a full month of  
6 V.A.C. therapy, even when the therapy . . . had been stopped and restarted within the same  
7 month”). In addition, Godecke claimed that there was a FCA violation related to DWOs (detailed  
8 written orders). Suppliers of durable medical requirement were required to obtain DWOs from a  
9 patient’s treating physician before dispensing the supplied for which they sought reimbursement  
10 from Medicare. *See id.* at 1125 n.4. According to Godecke, “KCI ignored the requirement to  
11 receive correct and completed [DWOs] before delivering supplies and beginning therapy.” *Id.* at  
12 1125.

13 The Ninth Circuit effectively acknowledged the similarity of the Hartpence and Godecke  
14 complaints in that both implicated improper use of the same billing code (even though there were  
15 different reasons why the billing code was not properly used). However,

16 Godecke's second claim involves different underlying facts.  
17 Whereas Hartpence's claims all allege knowing misuse of the KX  
18 modifier [*i.e.*, billing code], Godecke's second claim is based on  
19 facts which show KCI's violation of a *different Medicare program*  
20 *requirement* – the requirement that a provider receive Detailed  
21 Written Orders for the V.A.C. device before beginning to treat  
22 patients with the device. . . . [T]he claims are based on different  
23 material facts. The rules governing use of KX modifiers and DWOs  
24 were disseminated at different times, in different publications, and  
25 are plainly treated as separate regulations under the program.

26 We further disagree that Godecke's action provided no additional  
27 benefit to the government. Unaided by Godecke's complaint, the  
28 government may have never discovered that KCI, in addition  
allegedly to misusing the KX coding system, was allegedly  
submitting V.A.C. claims before receiving DWOs. The two alleged  
frauds are materially different: the KX fraud allegations are based on  
*government payment for devices which were used, but unnecessary*  
*for treatment*, while the DWOs fraud allegations are based on the  
*government paying for devices that were never used at all*. The  
alleged frauds, in short, exist completely independent of one  
another.

*Id.* at 1131 (emphasis added).

2. Material Facts Test Satisfied

In *United States ex rel. Hampton v. Columbia/Hca Healthcare Corp.*, 318 F.3d 214 (D.C. Cir. 2003), the D.C. Circuit concluded that the material facts test was satisfied. The plaintiff Hampton's suit was the later-filed suit. The first-filed suit was brought by Boston. According to Hampton, the defendant companies and several employees had improperly billed the government under the Medicare program for home health services – *e.g.*,

the companies billed for services that were miscoded; already paid for; performed by others; never administered; or supposedly administered to Hampton's mother after she died in 1996. Hampton also claimed that [the companies] submitted bills for supplies and medications that were unnecessary or never received; and that they billed for services to patients who did not qualify under the Medicare guidelines, did not need treatment, or were not charged required copayments. The companies submitted false or inaccurate documentation to the government and, so she alleged, shredded documents in order to destroy evidence of the fraud.

[The D.C. Circuit held that Hampton's case and Boston's case were related because] Boston's allegations were along very much the same lines. He asserted that HCA home health subsidiaries billed the government for services that did not meet the Medicare eligibility criteria, for undocumented services, and for services not medically necessary. He also alleged that they submitted false or inaccurate Medicare documentation and destroyed documents.

*Id.* at 219.

Likewise, in *Batiste*, the D.C. Circuit also found the first- and later-filed cases related. The plaintiff *Batiste* filed the later action. *Zahara* filed the earlier action. The court found that “[a] side-by-side comparison has persuaded us that, although the complaints allege somewhat different facts, *Zahara*'s complaint suffices to put the U.S. government on notice of allegedly fraudulent forbearance practices at [Sallie Mae] and its subsidiaries, and *Batiste*'s complaint alleges the same material elements of the same fraud.” *Id.* at 1209. In particular,

*Zahara* and *Batiste* broadly allege that the same fraudulent activities occurred at each of their offices, for the same reasons, and that similar SLM corporate policies promoted the fraudulent behavior. They both allege SLM fraudulently increased its profits and promoted its standing with the Department of Education by falsifying forbearances. And both allege that SLM's corporate culture promoted increasing the dispensation of forbearances through quotas and a team bonus system. Though *Zahara* focused on the fabrication of oral forbearance requests, and *Batiste* focused

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on the offering of forbearances to unqualified borrowers, the allegations of the first complaint give the government grounds to investigate all that is in the second.

Under the . . . material facts test, these complaints allege essentially the same corporation-wide scheme. The Zahara Complaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide. Batiste's additional details would not give rise to a different investigation or recovery.

*Id.* at 1209-10.

D. Different Defendants

Finally, the Court must consider whether it makes a difference in “material facts” when different defendants are sued in the first-filed and later-filed actions. In *Osinek*, the original complaint named only one defendant – Kaiser Permanente – which Ms. Osinek described as “a private provider of Medicare Advantage insurance under Medicare Part C.” *Osinek Compl.* ¶ 2.

Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

*Osinek Compl.* ¶ 6. The later-filed actions named a variety of different Kaiser entities, including but not limited to Kaiser Permanente.

COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	Taylor (2014)	Arefi (2015)	Stein (2016)	Bryant (2018)	Bicocca (2020)
Kaiser Permanente	Kaiser Permanente		Kaiser Permanente	Kaiser Permanente	
	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	
	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado		

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<b>COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS</b>					
<b>Osinek (2013)</b>	<b>Taylor (2014)</b>	<b>Arefi (2015)</b>	<b>Stein (2016)</b>	<b>Bryant (2018)</b>	<b>Bicocca (2020)</b>
	Kaiser Foundation Health Plan of Georgia	Kaiser Foundation Health Plan of Georgia, Inc.	Kaiser Foundation Health Plan of Georgia, Inc.		
	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest		
		Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	
		Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group, Inc.
		The Permanente Medical Group	The Permanente Medical Group	The Permanente Medical Group	Permanente Medical Group, Inc.
		Colorado Permanente Medical Group, P.C.	Colorado Permanente Medical Group	Colorado Permanente Medical Group P.C.	
		The Southeast Permanente Medical Group	The Southeast Permanente Medical Group	Southeast Permanente Medical Group	
		Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	
		Northwest Permanente, P.C.	Northwest Permanente, P.C.		
			Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.		
			Kaiser Foundation Health Plan of Washington		

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COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	Taylor (2014)	Arefi (2015)	Stein (2016)	Bryant (2018)	Bicocca (2020)
			Mid-Atlantic Permanente Medical Group	Mid-Atlantic Permanente Medical Group, PC	
			Group Health Permanente		
				The Permanente Federation, LLC	The Permanente Federation, LLC
				Northwest Permanente Physicians & Surgeons, P.C.	
				Washington Permanente Medical Group	

The Ninth Circuit has not expressly addressed the issue of different defendants, but other circuit courts have. Most have indicated that “adding a new defendant to the mix does not necessarily allow a later-filed action to evade the first-to-file bar.” *Cho v. Surgery Partners, Inc.*, No. 20-14109, 2022 U.S. App. LEXIS 8774, at \*15 (11th Cir. Apr. 1, 2022) (emphasis in original). This is particularly true where the new defendant(s) named in the later-filed action is a subsidiary or affiliate of the defendant(s) named in the first-filed action. *See Branch I*, 560 F.3d at 379 (noting that “allegations of fraud against a corporation may bar subsequent allegations of fraud against the corporation’s subsidiaries”).

That being said, the fact that the new defendant(s) in the later-filed action is a subsidiary or affiliate of the defendant(s) in the first-filed action does not automatically mean that the first-filed and later-filed actions are related either. Ultimately, resolution depends on how the first-filed action defines the scope of the misconduct. If there are, *e.g.*, allegations in the first-filed suit that there was a nationwide problem or a corporate-wide problem, then, most likely, the fact that new subsidiaries or affiliates are named in the later-filed action will not make that action unrelated for purposes of § 3730(b)(5). *Cf. Batiste*, 659 F.3d at 1210 (related complaints “essentially alleged

1 same corporate-wide scheme”). On the other hand, if the first-filed action focuses on a local  
 2 problem, then, most likely, a broader-in-scope later-filed action will not be related, even if the new  
 3 defendant(s) in the latter action is an affiliate of the defendant named in the earlier action. *Cf.*  
 4 *United States ex rel. Chovanec v. Apria Healthcare Group, Inc.*, 606 F.3d 361, 364 (7th Cir. 2010)  
 5 (stating that, “to understand whether the suits materially overlap we must know whether the initial  
 6 suits alleged frauds by rogue personnel at scattered offices or instead alleged a scheme  
 7 orchestrated by Apria's national management”).

8 “Two cases from the D.C. Circuit, *Hampton* and *Heath*, serve as useful bookends for this  
 9 analysis.” *Cho*, 2022 U.S. App. LEXIS 8774, at \*15. *Hampton* found the first- and later-filed  
 10 actions at issue related; *Heath* found the first- and later-filed actions at issue unrelated.

11 1. *Hampton*

12 In *Hampton*, the plaintiff Hampton named the following defendants in her later-filed  
 13 action: HCA; Clinical Arts (Georgia subsidiary of HCA); and several Clinical Arts employees.  
 14 She alleged that the defendants “had improperly billed the government under the Medicare  
 15 program for home health services.” *Hampton*, 318 F.3d at 218. The court was asked to decide  
 16 whether Hampton’s action was barred by an earlier lawsuit, filed by Boston. The D.C. Circuit  
 17 noted that

18 Hampton thinks her complaint differs significantly from Boston's  
 19 because it named different defendants. Boston sued only HCA.  
 20 Hampton sued not only HCA but also HCA's subsidiary Clinical  
 21 Arts and several Clinical Arts employees. As Hampton sees it,  
 22 Boston's complaint cannot possibly have covered fraud by Clinical  
 23 Arts and its employees because it (1) fails to name Clinical Arts or  
 24 its employees as defendants and (2) specifically mentions fraud at  
 25 HCA home health care subsidiaries in six states that do not include  
 26 Georgia.

27 *Id.* The court, however, found that

28 these are not differences in the material elements of the fraud.  
 Boston was a senior manager in HCA's home care group. *He*  
*alleged a corporate-wide problem*, revealed through internal audits,  
 in which HCA perpetrated fraud in providing home health care  
 services *through numerous subsidiaries*. It is true that Boston's  
 complaint mentioned instances of fraud at particular home health  
 agencies in only six specific states, not including Georgia. But  
 Boston's complaint described these as “*examples*” and “*samplings*”  
 of “a huge number of illegal payments from Medicare . . . received

1 by Columbia/HCA's 550 home health locations *in 37 states.*” Given  
 2 Boston's broad allegations based on his position as an HCA insider,  
 3 Hampton's naming Clinical Arts – a specific HCA subsidiary – and  
 naming individual employees of Clinical Arts were merely  
 variations on the fraud Boston's complaint described.

4 *Id.* (emphasis added); *see also Batiste*, 659 F.3d at 1209 (acknowledging that plaintiff in first-filed  
 5 suit “discusses activities at [a Sallie Mae] subsidiary office in Nevada, but [still] alleges a  
 6 nationwide scheme attributable not only to the subsidiary, but also to [Sallie Mae]”; thus, “[i]f the  
 7 government investigated the facts alleged in [that plaintiff’s] complaint on a nationwide basis, it  
 8 would discover continuing fraud in the New Jersey offices”); *Chovanec*, 606 F.3d at 364 (taking  
 9 note of allegations that fraud was enabled by changes made to a computer system used in all of a  
 10 company’s offices; also taking note of allegations that national headquarters provided guidance  
 11 that enabled fraud); *United States ex rel. Marion v. Heald Coll., LLC*, No. 5:12-cv-02067-PSG,  
 12 2015 U.S. Dist. LEXIS 97767, at \*11 (N.D. Cal. July 24, 2015) (stating that “[a]llowing plaintiffs  
 13 to escape the first-to-file bar by naming specific employees who carried out a previously-alleged  
 14 corporate fraud contravenes the purpose of Section 3730(b)(5) – to prevent piggyback claims[;]  
 15 [h]ere, the previously-filed complaints against Corinthian [Colleges] allege that fraudulent conduct  
 16 extended far beyond individual campuses and pervaded the entire company”).

17 2. Heath

18 In *United States ex rel. Todd Heath v. AT&T, Inc.*, 791 F.3d 112 (D.C. Cir. 2015), the  
 19 plaintiff Heath filed the later-filed action against AT&T and nineteen of its subsidiaries. The  
 20 lawsuit was related to a federal program known as the Universal Service Fund. *See id.* at 117.  
 21 Under federal law, “every interstate telecommunications carrier must contribute a portion of its  
 22 quarterly interstate and international telecommunications revenue to the . . . Fund.” *Id.* at 116.  
 23 One of the programs administered through the Fund is “E-Rate,” which “entitles qualifying  
 24 schools and libraries to receive Internet and telephone services at discounted rates.” *Id.* at 116-17.  
 25 According to Heath,

26 AT&T orchestrated and implemented through its subsidiaries a  
 27 corporate-wide scheme to have false claims submitted to the  
 Universal Service Fund by depriving schools and libraries in the E-  
 28 Rate program of the lowest corresponding price for services.  
 Schools and libraries, unaware of those overcharges, then passed

1 those inflated costs on to the federal government for reimbursement  
2 through the Universal Service Fund.

3 *Id.* at 117. Of particular note, Heath asserted that AT&T deliberately or recklessly chose not to  
4 train its employees in the lowest-corresponding-price requirement. *See id.* (taking note of  
5 allegation that AT&T was a recidivist violator of the E-Rate Program).

6 Heath had also filed an earlier lawsuit but only against Wisconsin Bell, which was a  
7 wholly owned subsidiary of AT&T. *See id.* at 118. In this suit, Heath asserted that “Wisconsin  
8 Bell charged some E-Rate eligible schools more than others, and that Wisconsin Bell generally  
9 failed to provide school districts with the benefit of the favorable pricing it offered to state  
10 departments, agencies, and universities.” *Id.* Furthermore, “[w]hen informed of this pricing  
11 discrepancy, Wisconsin Bell’s sales representatives ‘regularly denied the existence of the  
12 agreements’ between Wisconsin Bell and other Wisconsin agencies.” *Id.*

13 One issue before the D.C. Circuit was whether Heath’s first-filed suit was a bar to his later-  
14 filed action. The court held that the first-filed suit was not a bar because the

15 two complaints target factually distinct types of frauds. The  
16 Wisconsin Bell Complaint alerted the federal government only to a  
17 limited scheme by Wisconsin Bell to defraud the E-Rate program  
18 within Wisconsin. That alleged fraud was accomplished, in part,  
19 through affirmative misrepresentations by Wisconsin Bell  
20 employees to schools and libraries within Wisconsin, in which those  
21 employees openly denied the existence of a state contract with a  
22 lower corresponding price.

23 In contrast, the AT&T Nationwide Complaint alleges a different and  
24 more far-reaching scheme to defraud the federal government  
25 through service contracts entered into across the Nation, and then to  
26 cover up that fraud. Critically, the alleged fraud was accomplished  
27 not through affirmative misrepresentations about the lowest  
28 corresponding price, but through institutionalized disregard of the  
lowest-corresponding-price requirement altogether in AT&T’s  
employee-training and billing procedures. According to the AT&T  
Nationwide Complaint, AT&T and its subsidiaries deliberately  
failed to enforce that lowest-price mandate by refusing to train or  
even tell employees about that limitation on charges, and by failing  
to incorporate that limitation into its billing practices.

*Id.* at 121.

The court continued:

On its face, the Wisconsin Bell complaint discloses nothing more  
than the rogue actions of individuals within a single AT&T  
subsidiary and their specific, overt misrepresentations. Nothing in

1 the complaint would have alerted the United States government to a  
2 nationwide scheme centered in AT&T's corporate headquarters of  
3 mischarging the E-Rate program and subsequently concealing those  
4 overpayments. Nor, given the affirmative misrepresentations at  
5 issue, would the Wisconsin Bell Complaint have pointed the federal  
6 government to AT&T's systematic refusal to institutionalize  
7 compliance by employees with the lowest-corresponding-price  
8 requirement.

9 The fraud thus manifested itself in sufficiently distinct ways in the  
10 two cases that the material elements of the fraud differ. As the  
11 Seventh Circuit has recognized, "to understand whether the suits  
12 materially overlap we must know whether the initial suit[] alleged  
13 frauds by rogue personnel at scattered offices or instead alleged a  
14 scheme orchestrated by \* \* \* national management." Because the  
15 Wisconsin Bell Complaint alleged only the former, it did not  
16 disclose the nationwide fraud grounded in institutionalized training  
17 and enforcement failures, and compounded by efforts at  
18 concealment, that is the focus of Heath's later complaint.

19 *Id.* at 121-22 (citation omitted). The D.C. Circuit distinguished, *inter alia*, *Hampton* because,  
20 there, "the first complaint alleged a broad fraudulent scheme orchestrated by a national or parent  
21 company, and the second complaint merely added additional facts or widened the circle of victims  
22 of the same fraudulent conduct." *Id.*

23 Those cases stand for the simple proposition that the greater fraud  
24 often includes the lesser. The problem for AT&T is that the lesser  
25 fraud does not, without more, include the greater. The Wisconsin  
26 Bell Complaint did not allege that AT&T encouraged Wisconsin  
27 Bell's fraud or affirmative misrepresentations, or even knew  
28 anything about them. Nor did the Wisconsin Bell Complaint  
suggest that AT&T and its subsidiaries engaged in "uniform billing  
practices" across the United States. There simply is no hint in the  
Wisconsin Bell Complaint of a country-wide, institutionalized  
corporate practice of disregarding the lowest-price requirement or of  
a calculated refusal to educate or train employees.

*Id.* at 122-23.

The court acknowledged AT&T's point that the E-Rate program is a national program but,  
it pointed out, so too "is virtually every law policed by the *federal* False Claims Act." *Id.* at 123  
(emphasis in original). The first-to-file bar could not be triggered "every time an initial complaint  
alleges that a subsidiary of a national company violated a national law" or "a broad swath of False  
Claims Act coverage" would be "erase[d]." *Id.* The court underscored that the purpose of the  
first-to-file bar was "to prevent copycat litigation, which tells the government nothing it does not  
already know" but, here, "Heath's complaints go after two materially distinct fraud schemes." *Id.*;

1 *see also United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 379 (5th Cir.  
 2 2009) (stating that the first-filed action “*Rigsby* does not allege a true industry-wide fraud or  
 3 concerted action among a narrow group of participants[;] [r]ather, looking only at the facts  
 4 pleaded . . . , *Rigsby* implicates, at most, four specific [write-your-own] insurers among the  
 5 approximately ninety-five WYI insurers conducting business in the Louisiana and Mississippi  
 6 areas during Hurricane Katrina,” and, therefore, “*Rigsby* tells the government nothing about which  
 7 of the ninety-one other WYO insurers . . . , if any, actually engaged in any fraud”).

### 8 **III. COMPARING RELATOR ACTIONS**

9 Having reviewed the major legal issues, the Court may now turn to a comparison of the  
 10 first-filed action, *Osinek*, with the various later-filed actions. The Court makes the comparisons in  
 11 the order listed below because, *e.g.*, if there are material differences between *Osinek* and *Taylor*,  
 12 that would effectively make *Taylor* the first-filed action for the new material facts. In other words,  
 13 the remaining cases would then need to be compared to both *Osinek* and *Taylor*.

- 14 • Case No. C-21-3894 EMC *Taylor* (filed in the District of Colorado in 2014 and  
 15 transferred to this District in 2021).
- 16 • Case No. C-16-1558 EMC *Arefi* (filed in the Central District of California in 2015  
 17 and transferred to this District in 2016).
- 18 • Case No. C-16-5337 EMC *Stein* (filed in the Central District of California in 2016  
 19 and transferred this District in 2016).
- 20 • Case No. C-18-1347 EMC *Bryant*.
- 21 • Case No. C-21-3124 EMC *Bicocca* (filed in the Eastern District of California in  
 22 2020 and transferred to this District in 2021).

#### 23 A. *Osinek* and *Taylor*<sup>10</sup>

24 Dr. Taylor argues that his case is materially different from *Osinek* in two ways: (1)  
 25 different defendants were sued in each case and (2) different frauds were implicated in each case.

26 \_\_\_\_\_  
 27 <sup>10</sup> Dr. Taylor argues his FAC is the operative complaint for purposes of comparing his case to  
 28 cases filed after his. *See Taylor Opp’n* at 6 n.4. But for purposes of comparing *Osinek* and  
*Taylor*, the Court compares the *Osinek* complaint to Dr. Taylor’s original complaint. At the time  
 Dr. Taylor brought his case, there was only the original complaint in *Osinek* on file.

1           1.       Different Defendants

2           Ms. Osinek sued only one entity: Kaiser Permanente. In contrast, Dr. Taylor sued multiple  
3 Kaiser entities: Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation  
4 Health Plan of Colorado; Kaiser Foundation Health Plan of Georgia; and Kaiser Foundation  
5 Health Plan of the Northwest.

6           Dr. Taylor argues that the difference in defendants is meaningful. Defendants argue to the  
7 contrary. They take the position that, by suing “Kaiser Permanente,” Ms. Osinek implicitly sued a  
8 national defendant which therefore covered all regional or local subsidiaries or affiliates.  
9 Defendants further argue that allegations made in the Osinek Complaint show that Ms. Osinek was  
10 implicating a nationwide fraud. *See* Mot. at 20. The Court finds that the Osinek complaint does  
11 not allege a nationwide fraud.

12           As a starting point, the Court takes note that there does not appear to be any legal entity  
13 with the name “Kaiser Permanente.” Rather, “Kaiser Permanente” seems to be a trade name used  
14 by various Kaiser entities. *See* Mot. at 1 (asserting that there are “various healthcare organizations  
15 operating under the Kaiser Permanente trade name”); *cf.* U.S. Compl. ¶ 28 (noting Kaiser’s Health  
16 Plans, Permanente Medical Groups, and hospitals publicly hold themselves out and do business  
17 collectively as an integrated healthcare providers called “Kaiser Permanente”); Taylor Compl. ¶  
18 16 (alleging that “Kaiser Permanente is a non-profit care consortium” that “includes three main  
19 groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation  
20 Hospitals and their subsidiaries; and (3) the Permanente Medical Groups”). Thus, the fact that  
21 Ms. Osinek (not to mention Dr. Taylor and others) sued “Kaiser Permanente” is not particularly  
22 telling one way or the other.

23           What is more significant are the allegations in Ms. Osinek’s complaint – specifically, the  
24 geographic scope of the allegations. The complaint implicates California only. For example, Ms.  
25 Osinek describes “Kaiser Permanente” as follows:

26                     a California corporation with its principal place of business [*in*]  
27                     *Oakland* . . . . Kaiser is one of the largest Medicare Advantage  
28                     organizations in the country and has more enrollees in its Medicare  
                      Advantage plans than any other organization *in California*. At all  
                      times relevant, Kaiser conducted business *in California*, including

1 but not limited to providing healthcare services through Medicare  
2 Advantage plans and to the general public *in California*.

3 Osinek Compl. ¶ 6 (emphasis added).

4 One might argue that the above paragraph is California-centric because Ms. Osinek was  
5 simply trying to establish that jurisdiction in California is proper. However, nowhere in the  
6 complaint does Ms. Osinek allege that there is a problem outside of California. She does not  
7 mention any other state. She does not allege a “corporate-wide problem” as in *Hampton*, 318 F.3d  
8 at 218. She never even uses the term “nationwide” or “corporate-wide” or otherwise suggest a  
9 “scheme orchestrated by . . . national management.” *Heath*, 791 F.3d at 122 (quoting *Chovanec*,  
10 606 F.3d at 364). Nor is it not clear that any practice identified by Ms. Osinek was necessarily  
11 nationwide or corporate-wide in nature – *e.g.*, there is no suggestion that data mining through the  
12 use of algorithms was implemented through a nationwide computer system.

13 Defendants contend that just because the Osinek Complaint gave California examples does  
14 not mean that the pleading is limited in scope to California. In principle, this is true. But there  
15 must be some indication in the pleading that the problem extends outside of California.<sup>11</sup>  
16 *Compare Hampton*, 318 F.3d at 218 (“It is true that Boston's complaint mentioned instances of  
17 fraud at particular home health agencies in only six specific states, not including Georgia. But  
18 Boston's complaint described these as ‘examples’ and ‘samplings’ of ‘a huge number of illegal  
19 payments from Medicare . . . received by Columbia/HCA's 550 home health locations in 37  
20 states.”). Indeed, if the rule were to the contrary, then there would seem to be serious policy  
21 concerns. The mere fact that a defendant company is part of a larger network of affiliated  
22 companies would be enough to deem the government on notice of a nationwide or corporate-wide  
23 problem – which would then, under the first-to-file bar, cut off all other actions. But if the  
24 government declined to investigate on a nationwide or corporate-wide scale (*e.g.*, because of  
25 limited resources), and the first filer stayed within the limited scope of its complaint as pled, then  
26 no one else would be able to bring a FCA claim to address a potentially broader problem. This

27 <sup>11</sup> Notably, where the Osinek Complaint does at one point refer to different regions, both of the  
28 regions identified are still based in California. *See* Mot. at 20 (citing Osinek Compl. ¶ 37); Osinek  
Compl. ¶ 37 (alleging that “Kaiser positioned the Southern California Region against Northern  
California in competition for the highest risk scores and physician approval rates”).

1 would run counter to the FCA which is meant to encourage the uncovering of fraud against the  
2 government. The first-to-file bar would not only “prevent copycat litigation,” *Heath*, 791 F.3d at  
3 123, but also a wide swath of litigation far broader than the first-filed suit. Here, *Taylor* is not  
4 simply an “opportunistic successive suit,” *Lujan*, 243, F.3d at 1187; *Taylor* cannot be said to have  
5 “provided no additional benefit to the government.” *Hartpence*, 792 F.3d at 1131.

6 Confronted with this obstacle, Defendants invoke the practical aspect of the material facts  
7 test, which asks whether “[t]he first-filed claim provides the government notice of the essential  
8 facts of an alleged fraud.” *Lujan*, 243 F.3d at 1187. Defendants note that, a few months after the  
9 *Osinek* complaint was filed in 2013, the government issued four subpoenas to (1) the Kaiser  
10 Foundation Health Plan; (2) the Permanente Medical Group; (3) Southern California Permanente  
11 Medical Group; and (4) Kaiser Foundational Hospitals. The subpoenas covered not only the  
12 named entities but also *all subsidiaries and affiliates*.<sup>12</sup> See RJN, Exs. A-D (subpoenas). Thus,  
13 Defendants argue, the government implicitly understood that *Osinek* pointed to a nationwide or  
14 corporate-wide problem. Defendants add that, in 2017, the government sent a letter to Defendants  
15 seeking the production of documents from the Colorado regions specifically – and cited to the  
16 2013 subpoenas in support of that request. See RJN, Ex. E.

17 Defendants’ contention is not convincing for several reasons. First, Dr. Taylor raises a  
18 legitimate argument that only the complaints should be considered in determining whether the  
19 first-to-file bar applies – not evidence outside of the complaints. *Cf. In re Natural Gas Royalties*  
20 *ex rel. United States*, 562 F.3d 1023, 1031 (10th Cir. 2009) (stating that “[t]he first-to-file bar is  
21 designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the  
22 complaints”); *Batiste*, 659 F.3d at 1209 (making a “side-by-side comparison” of the complaints in  
23 the first-filed and later-filed suits). Dr. Taylor has not been privy to all of the communications  
24

25 <sup>12</sup> See, e.g., RJN, Ex. A (Subpoena at 2) (“The term ‘KAISER FOUNDATION HEALTH PLAN,  
26 INC.’ refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland,  
27 California, and also includes all current and former: directors, officers, principals, partners,  
28 managers, and employees; independent contractors, attorneys, consultants, experts, investigators,  
agents and/or other persons or other representatives acting on your behalf, even if their actions  
were not authorized by you or were outside the proper scope of their authority; corporate parents,  
predecessors, *subsidiaries*, regions, segments, branches, groups, *affiliates*, and divisions; and joint  
ventures of which it is a part.”) (emphasis added).

1 between the United States and Defendants. It is entirely possible that some communications might  
 2 support his position here rather than Defendants.<sup>13</sup> And if the Court were to permit Dr. Taylor to,  
 3 in effect, conduct discovery into the government’s communications – or more generally, into the  
 4 government’s understanding of the *Osinek* complaint – then there would effectively be a mini trial  
 5 on a secondary matter that would only delay the process of moving forward with the case. The  
 6 task before the Court at this juncture is to compare the complaints, not conduct a mini-trial based  
 7 on facts.

8 Accordingly, the Court does not dismiss *Taylor* based on the first-to-file bar because  
 9 *Taylor* is broader in scope than *Osinek* in terms of defendants. *See Heath*, 791 F.3d at 122  
 10 (“Those cases [such as *Hampton*] stand for the simple proposition that the greater fraud often  
 11 includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include  
 12 the greater.”).

13 2. Different Frauds

14 The closer question is whether *Taylor* implicates different frauds than does *Osinek*.

15 As noted above, *Osinek* is about mining records to look for places to upcode, particularly  
 16 for high-value conditions. Upcoding was ultimately improper because it was based on, *e.g.*,  
 17 exaggerating a patient’s condition, diagnosing a patient based on a test that took place after the  
 18 patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing  
 19 without the proper support/documentation, and the like.

20 *Taylor* is essentially the flip side. It asserts the theory that, as a result of regular internal  
 21 audits, Kaiser knew there were high error rates in risk adjustment claims in certain areas but *failed*  
 22 to take action to find the false claims retroactively – and thus improperly retained the

23  
 24  
 25 <sup>13</sup> Even if the Court were to consider the 2013 subpoenas issued by the government and its 2017  
 26 letter to Defendants, Defendants do not fare any better. Although the subpoenas did refer to  
 27 subsidiaries and affiliates, that language is boilerplate in nature. And fact that the government  
 28 only issued subpoenas to four specific Kaiser entities (all of which appear to be based in  
 California) points to a more limited scope of inquiry. As for the letter, the fact that the  
 government relied on the 2013 subpoenas to justify an inquiry into Colorado in 2017 largely  
 seems a litigation tactic. Notably, by 2017, the *Taylor* complaint – which expressly implicated the  
 Colorado region – had been filed. (The original complaint in *Taylor* was filed in October 2014.)

1 government’s overpayment for those false claims (essentially, a reverse false claim theory).<sup>14</sup> See,  
 2 e.g., Taylor Compl. ¶¶ 81-82 (citing “[e]xamples of risk adjustment claims that the Kaiser audits  
 3 have identified as routinely false” and alleging that, “despite its knowledge that the categories of  
 4 risk adjustment claims . . . are false a significant percentage of the time, Kaiser routinely fails to  
 5 take reasonable steps to identify which of these claims are false . . . and then to prevent their  
 6 submission in the first place or to delete them after submission”). *Taylor* contrasts the lack of  
 7 effort by the Kaiser entities to take action to address the errors with their zealous pursuit of  
 8 reviewing records to find instances where diagnoses could be added (i.e., upcoding). See Taylor  
 9 Compl. ¶ 62 (alleging that Kaiser’s “lack of diligence contrasts starkly with [its] considerable  
 10 efforts and substantial commitment of resources to audit current and past claims to identify new  
 11 diagnoses that it could use to submit additional risk adjustment claims and thereby increase the  
 12 amount of the risk adjustment payments it receives from CMS.”).

13 Dr. Taylor argues that the flip side makes his case materially different from *Osinek*.  
 14 Specifically, he argues that his case, unlike *Osinek*, focuses on (1) Kaiser’s failure to act even after  
 15 audits revealed high error rates for certain HCCs or diagnoses; (2) Kaiser’s failure to act even after  
 16 audits revealed high error rates for diagnoses made by external providers; and (3) Kaiser’s failure  
 17 to act even after audits revealed high error rates for “True Positive” results associated with  
 18 Kaiser’s Natural Language Processing program. Each of these claimed differences is discussed  
 19 below.

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21 <sup>14</sup> In their papers, Defendants suggest that Dr. Taylor does not have a viable claim here: “Taylor’s  
 22 allegations about error rates identified in audits of diagnosis-code data do not identify a unique  
 23 fraud scheme. Rather they purport to show that Defendants had *knowledge* of the upcoding  
 24 scheme that *Osinek* already alleged.” Reply at 3 (emphasis added). Defendants likely make this  
 25 argument because, in its complaint, the United States alleges that “Kaiser’s internal audits put [it]  
 26 on . . . notice of fraudulent diagnoses.” U.S. Compl. at 68; see also U.S. Compl. ¶ 304 (alleging  
 27 that “[a] variety of internal audits provided further notice that Kaiser’s addenda and query  
 28 practices were resulting in false claims to CMS”).

29 Although Defendants fairly argue that the audits are relevant to Kaiser’s knowledge, it is  
 30 not clear why Dr. Taylor would not also have a viable claim based on the theory that Kaiser failed  
 31 to take corrective action which resulted in its being able to keep government overpayments for  
 32 false claims in violation of the FCA. Cf. *United States v. United Healthcare Ins. Co.*, 848 F.3d  
 33 1161, 1173 (9th Cir. 2016) (indicating that plaintiff had a viable theory based on allegations that,  
 34 in the face of audit error rates in excess of 20%, defendants conceived and directed retrospective  
 35 reviews that were “designed to identify only favorable reporting errors”).

1 a. High Error Rates for Certain HCCs or Diagnoses

2 Dr. Taylor first claims a violation of the FCA because Kaiser failed to act even after audits  
3 revealed high error rates in risk adjustment claims for certain HCCs or diagnoses. For example,  
4 Dr. Taylor alleges as follows with respect to cancer:

- 5 • “Every year, Kaiser’s National Compliance Office (‘NCO’) conducts a nationwide  
6 ‘Probe’ audit to test the accuracy of risk adjustment claims submitted the prior  
7 year.” Taylor Compl. ¶ 69.
- 8 • The Probe Audits “have consistently identified cancer (HCCs 7-10) as the most  
9 upcoded condition.” Taylor Compl. ¶ 102.
- 10 • “The most significant and consistent error is that Kaiser providers submit diagnosis  
11 codes representing active, current treatment of cancer when, in fact, the patient’s  
12 cancer is cured, in remission, or otherwise irrelevant to the services provided to the  
13 patient.” Taylor Compl. ¶ 103. Notably, a diagnosis of “history of cancer” does  
14 not result in a risk adjustment. *See* Taylor Compl. ¶ 105.

15 Cancer is not the only HCC/diagnosis called out as problematic. Other conditions that  
16 have had high error rates include:

- 17 • Stroke. *See, e.g.*, Taylor Compl. ¶ 118 (“Kaiser knew stroke was commonly coded  
18 as an active event, when, in fact, the patient should have been classified as having a  
19 history of stroke.”).
- 20 • Vascular disease. *See, e.g.*, Taylor Compl. ¶ 127 (“[S]ome claims erroneously  
21 claimed the patient had current vascular disease, when, in fact, they had only a  
22 history of the condition.”); Taylor Compl. ¶ 129 (“[C]ertain claims were false  
23 because of a ‘mismatching’ problem with HealthConnect, Kaiser’s EMR [electronic  
24 medical records]. HealthConnect . . . allows physicians to choose a descriptive  
25 diagnosis (as opposed to a specific ICD-9 code) when entering clinical information.  
26 HealthConnect then ‘maps’ this descriptive diagnosis to a specific ICD-9 diagnosis  
27 code, which is then inserted into the medical record documentation.”).
- 28 • Chronic bronchitis. *See, e.g.*, Taylor Compl. ¶ 134 (“Kaiser’s EMR [electronic

1 medical records] . . . pressured physicians to use the diagnosis for chronic  
2 bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk  
3 adjust.); Taylor Compl. ¶ 132 (“The probe audits regularly found COPD [chronic  
4 obstructive pulmonary disease] claims erroneous based on lack of documentation in  
5 the record, or because the doctor failed to document the patient’s condition with  
6 sufficient specificity to determine if the patient actually had COPD.”).

- 7 • Malnutrition. *See, e.g.*, Taylor Compl. ¶ 140 (“In some cases, the condition was  
8 diagnosed as current when the patient actually only had a ‘history of’ the  
9 condition.”).
- 10 • Renal insufficiency. *See, e.g.*, Taylor Compl. ¶ 152 (“Chronic kidney disease  
11 (‘CKD’) is a condition that is often miscoded . . .”).

12 As indicated by the above, Dr. Taylor takes issue with Kaiser for not reacting to the high  
13 error rates – *i.e.*, had Kaiser done so then it would have seen that the diagnoses (of high-value  
14 conditions) lacked documentation or proper support and/or that the diagnoses were irrelevant to  
15 the treatment provided to the patient. Although Dr. Taylor is correct that his claim here is about  
16 Kaiser ignoring an upcoding problem (as revealed by error rates) rather than actively creating  
17 upcoding, the Court does not see this flip side as creating a material difference with respect to  
18 *Osinek*. This is because both *Taylor* and *Osinek* are ultimately based on the same “underlying  
19 facts,” *Hartpence*, 792 F.3d at 1131: that the high-level condition that was diagnosed did not have  
20 documentation or proper support and/or did not affect patient care.

21 The practical aspect of the material facts test underscores that *Taylor* and *Osinek* are  
22 related cases, at least with respect to the above. Here, the Court must ask whether the allegations  
23 in *Osinek* “[gave] the government grounds to investigate all that is in” the Taylor Complaint.  
24 *Batiste*, 659 F.3d at 1209; *see also id.* at 1209-10 (stating that the first-filed “[c]omplaint would  
25 suffice to equip the government to investigate SLM’s allegedly fraudulent forbearance practices  
26 nationwide” and the “additional details” in the later-filed complaint “would not give rise to a  
27 different investigation or recovery”). Based on *Osinek*, the government was put on notice that  
28 high-value conditions often did not have proper support and were diagnosed even when a patient

1 was not treated for that condition at the time of service. Thus, in light of *Osinek*, the government  
 2 had grounds to investigate all that is in the Taylor Complaint which points to the same basic  
 3 problem. That, according to Dr. Taylor, the problem would have been revealed if Kaiser had  
 4 taken action in response to the high error rates, is somewhat beside the point. The error rates here  
 5 are not in themselves what is critical; rather, at bottom, Dr. Taylor's broader claim is that high-  
 6 value conditions were diagnosed without following the practices required by Medicare regulations.  
 7 This is fundamentally the same charge that Ms. Osinek makes.

8 b. High Error Rates for Diagnoses Made by External Providers

9 Dr. Taylor also claims that his complaint is different from the Osinek Complaint because  
 10 he has alleged that Kaiser failed to act even after audits revealed high error rates with diagnoses  
 11 submitted by external providers. (Dr. Taylor refers to this as "one-way look chart review" in his  
 12 papers. *See, e.g.*, Taylor Opp'n at 7.) The relevant allegations in support of this theory are as  
 13 follows:

- 14 • Several of Kaiser's regions, including Colorado, Hawaii, and, until recently,  
 15 Georgia, "rely heavily on external providers (hospitals or other facilities who are  
 16 not owned by Kaiser) to provide inpatient care to Kaiser's HMO members."  
 17 Taylor Compl. ¶ 83.
- 18 • The external providers submit claims to Kaiser after they have provided services to  
 19 Kaiser members, and Kaiser uses the external providers' diagnoses as the basis for  
 20 the risk adjustment claims that Kaiser submits to CMS. *See* Taylor Compl. ¶ 84.
- 21 • Kaiser's audits "have identified significant error rates in risk adjustment claims  
 22 [that] Kaiser submitted to CMS based on diagnoses provided by external  
 23 providers." Taylor Compl. ¶ 86. For example, for the Colorado region, the error  
 24 rates for external providers in some years was over 40% and 60%. *See* Taylor  
 25 Compl. ¶ 88; *see also* Taylor Compl. ¶ 89 (adding that "[t]he error rates for certain  
 26 large hospitals . . . are striking" – some more than 90%).
- 27 • "Despite knowing of the consistent errors in claims data from external providers,  
 28 Kaiser Colorado [for example] does not conduct any routine targeted audits of

1 claims submitted by external providers. This is particularly egregious because the  
 2 Colorado region does have a coder review each hospital stay at an external provider  
 3 *to look for additional diagnoses* present in the chart but not coded by the treating  
 4 physician.” Taylor Compl. ¶ 98 (emphasis added).

5 Here, the Court agrees with Dr. Taylor that this specific aspect of his case is not related to  
 6 *Osinek*. Problematic coding related to high-value conditions is different from problematic coding  
 7 by external providers. Notably, there is no indication that the problematic coding by external  
 8 providers was related to high-value conditions. Accordingly, this specific claim made by Dr.  
 9 Taylor involves “different underlying facts.” *Hartpence*, 792 F.3d at 1131. Furthermore, it cannot  
 10 be said that the government would likely have found the particular problem with external  
 11 providers based on its investigation into the kinds of internal upcoding practices identified in  
 12 *Osinek*.

13 c. Natural Language Processing Software

14 Finally, Dr. Taylor claims that his complaint differs from the *Osinek* Complaint because he  
 15 has made allegations about Kaiser’s Natural Language Processing (“NLP”) software. The main  
 16 allegations made in the Taylor Complaint with respect to the NLP software are as follows.

- 17 • “Broadly speaking, [a] NLP program uses an algorithm to search EMRs [electronic  
 18 medical records] to find words that, individually or in combination, indicate that a  
 19 patient has certain diagnoses.” Taylor Compl. ¶ 191.
- 20 • Kaiser developed its own NLP audit program “to try to find new diagnosis codes to  
 21 submit.” Taylor Compl. ¶ 191.
- 22 • “All face-to-face visits to a physician or hospital . . . are run through the NLP  
 23 software to identify new diagnoses that might be appropriate to use for submission  
 24 of additional risk adjustment claims. The results are grouped into four categories:  
 25 (a) True Positive: [meaning] diagnoses . . . have been confirmed by two Kaiser  
 26 coders; (b) More Information Needed: [meaning] diagnoses . . . may be present, but  
 27 further analysis is required to confirm; (c) Problem List Only: [meaning] diagnoses  
 28 . . . show up only on the member’s problem list [section of the medical record] with

1 no documentation of treatment; and (d) False Positives or Found Elsewhere.”

2 Taylor Compl. ¶ 196.

- 3 • “Kaiser allows the various regions to decide how to use [the above] information.”  
 4 Taylor Compl. ¶ 197. For some regions, if a result is True Positive, then a claim is  
 5 submitted to CMS for payment – without any further review. *See* Taylor Compl. ¶  
 6 200. This is true even though audits have revealed that there is a high error rate for  
 7 True Positives. *See* Taylor Compl. ¶¶ 198, 200.

8 As indicated by the above, Dr. Taylor is not focusing here on the fact that Kaiser uses the  
 9 NLP program to mine records for instances where it can upcode. Had he done so, then his case  
 10 would clearly be related to *Osinek*. Rather, Dr. Taylor’s point is that there is a high error rate  
 11 associated with the NLP program’s True Positives, but Kaiser still submits claims based on True  
 12 Positives without any further inquiry.

13 The Court finds that the nature of wrongdoing claimed by Dr. Taylor here involves  
 14 different “material elements” from *Osinek*. *Lujan*, 243 F.3d at 1189. Dr. Taylor is charging  
 15 Kaiser with exploiting True Positives; this is different from *Osinek* which is focused on the  
 16 exploitation of high-value conditions. Similar to above, there is nothing that suggests True  
 17 Positives appear with high-value conditions only, or even primarily. Thus, Dr. Taylor here has  
 18 “significant information to contribute of [his] own.” *Id.* The Court also notes that, under the  
 19 practical aspect of the material facts test, this part of *Taylor* should not be deemed related to  
 20 *Osinek*. Based on *Osinek*, the government would likely have looked at the NLP program given  
 21 that it was purportedly used to data mine; however, that would not lead the government to  
 22 question the True Positive results yielded by the NLP program. Rather, as a facial matter, the  
 23 more likely candidates for exploitation by Kaiser would be the categories of “More Information  
 24 Needed” and “Problem List Only,” not the True Positives.

25 d. Summary

26 The *Taylor* case is not dismissed in its entirety but only in part. *Taylor* differs materially  
 27 from *Osinek* in three ways: (1) *Taylor* points to a nationwide or corporate-wide problem whereas  
 28 *Osinek* is local or regional (*i.e.*, California-centric) in nature; (2) *Taylor* has identified a fraud

1 related to external providers rather than high-value conditions; and (3) *Taylor* asserts a problem  
2 with Kaiser failing to evaluate the True Positives results yielded by the NLP program.

3 B. *Osinek and Arefi*

4 As noted above, the *Arefi* Plaintiffs do not oppose the motion to dismiss their complaint.  
5 Thus, the Court may move on to the next complaint filed after *Arefi*.

6 C. *Osinek and Stein*

7 As an initial matter, the Court takes note that the *Stein* plaintiffs contend that the Court  
8 should compare the complaint in *Osinek* with their operative SAC, which was filed in November  
9 2021. *See* Opp’n at 3 n.2. The Court rejects that argument for the reasons discussed above.

10 Based on their original complaint, the *Stein* plaintiffs focus on two specific conditions:  
11 sepsis and malnutrition.<sup>15</sup> The main allegations are as follows.

- 12 • Sepsis. The criteria for diagnosing sepsis is not straightforward. *See, e.g.*, Stein  
13 Compl. ¶¶ 42-43, 49. In 2003, the ICD-9 diagnostic codes and ICD Guidelines  
14 were modified to, in essence, reflect that complexity. The Guidelines emphasize  
15 that “coders will likely have to query physicians when documenting Sepsis to  
16 trigger proper documentation that supports the Sepsis diagnosis due [to] the  
17 complex nature of those diseases.” Stein Compl. ¶ 48. Defendants engaged in a  
18 scheme “to up-code and falsely diagnose MA enrollees with sepsis and/or severe  
19 sepsis, i.e., sepsis with acute organ failure[] (collectively referred to as ‘Sepsis’)[,]  
20 when Sepsis was not present.” Stein Compl. ¶ 50. “[The] fraudulent scheme  
21 [involved] the identification and treatment of Sepsis for . . . MA enrollees that  
22 presented in the emergency room (ER) of [Kaiser] hospitals and was accomplished  
23 by (a) [Defendants] implementing unwritten policies that prohibited coders  
24 employed by [Defendants] from performing physician queries for Sepsis diagnoses  
25 as required by the ICD-9 Guidelines, (b) implementing unwritten policies

26  
27 <sup>15</sup> The *Stein* plaintiffs also included in their original complaint allegations on Kaiser’s practice of  
28 “refreshing.” However, in their opposition, they have conceded that this conduct was sufficiently  
implicated in earlier-filed actions. *See* Stein Opp’n at 1 (stating that the *Stein* plaintiffs “do not  
oppose [the] first-to-file attack against [their] Refresh fraud claim”).

1 requiring Kaiser’s coders to code ICD-9 diagnosis codes for Sepsis based solely on  
 2 the physician’s instructions to code Sepsis instead of relying on the supporting  
 3 clinical findings documented in the medical record, (c) using an improper Sepsis  
 4 diagnostic standard that overstated the frequency of Sepsis diagnoses, (d)  
 5 aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis  
 6 mortality rates at [Kaiser] hospitals throughout California, and (e) [Defendants], as  
 7 an express condition of receiving capitation payments from CMS, routinely and  
 8 annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were  
 9 accurate, complete, and truthful . . . .” Stein Compl. ¶ 50.

- 10 • Malnutrition. Defendants “participated in a fraudulent scheme to up-code and  
 11 falsely diagnose malnutrition and severe malnutrition of their MA enrollees.”  
 12 Stein Compl. ¶ 70. The scheme “was conducted at all [Kaiser] Hospitals  
 13 throughout California and involved the diagnoses and coding of malnutrition and  
 14 severe malnutrition based upon assessment performed by dieticians . . . . The . . .  
 15 dietician used a rubber stamp on the MA enrollee’s medical record indicating that  
 16 in his/her opinion the MA enrollee suffered from malnutrition or severe  
 17 malnutrition. [The] physicians then countersigned the stamp in the MA enrollees’  
 18 medical record. Based solely on the presence of the physician’s countersignature .  
 19 . . . , Kaiser’s coders recorded the ICD-9 diagnosis codes for malnutrition or severe  
 20 malnutrition . . . .” Stein Compl. ¶ 70. There was no face-to-face encounter nor  
 21 were there clinical findings in support, as required by federal regulations. *See*  
 22 Stein Compl. ¶ 71.

23 These claims overlap with *Osinek*. *Osinek* asserts that upcoding was improper because it  
 24 was based on exploiting high-value conditions – *e.g.*, exaggerating a patient’s condition,  
 25 diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a  
 26 condition for which the patient was not treated, diagnosing without the necessary  
 27 support/documentation, and the like. *Stein* implicates the same kind of conduct; essentially, *Stein*  
 28 involves lesser-included conduct by virtue of the fact that it focuses on two conditions (sepsis and

1 malnutrition) specifically. Notably, *Osinek*, like *Stein*, expressly identified malnutrition as one of  
 2 the high-value conditions that was being exploited.<sup>16</sup> See *Osinek* Compl. ¶ 25. The fact that  
 3 *Osinek* did not also expressly identify sepsis as a high-value condition (as *Stein* did) is not  
 4 dispositive since it is but one example of the alleged upcoding. Cf. *Hampton*, 318 F.3d at 219  
 5 (concluding actions were related because both alleged that bills were submitted for ineligible and  
 6 undocumented Medicare services and for services not medically necessary).

7 The *Stein* plaintiffs suggest that their case is still materially different because the frauds  
 8 implicated in their complaint were committed when “patients . . . were admitted to a KFH hospital  
 9 or in the case of Sepsis, treated as a hospital outpatient through the emergency room.” Opp’n at  
 10 12-13. But nothing about *Osinek* excepts a hospital setting from the alleged upcoding.

11 The only place where *Stein* is materially different from *Osinek* is with respect to the scope  
 12 of the alleged misconduct. *Stein* suggests – by virtue of the Kaiser entities sued – that the alleged  
 13 misconduct goes beyond California. While this does make *Stein* different from *Osinek* (the latter  
 14 being California-centric in scope), *Stein* runs into a problem still because *Taylor*, the next case  
 15 filed after *Osinek*, implicates a nationwide or corporate-wide problem and is broad enough to  
 16 encompass the basic kind of upcoding practices alleged in *Stein*.

17 The Court therefore dismisses the *Stein* case based on the first-to-file bar – in its entirety.  
 18 The *Stein* plaintiffs have asked for leave to amend but that is a futile request since the Court’s  
 19 evaluation is limited to the original *Stein* Complaint.

20 D. *Osinek* and *Bryant*

21 As a preliminary matter, the Court takes note that Defendants do not seek to dismiss  
 22 *Bryant* in its entirety. It recognizes that *Bryant* has retaliation claims (based on the FCA and on  
 23 \_\_\_\_\_

24 <sup>16</sup> The *Stein* FAC (filed in May 2016, *i.e.*, a few months after the original *Stein* Complaint) did  
 25 add in a new condition – *i.e.*, aortic atherosclerosis (“AA”). See *Stein* FAC ¶ 83 (noting that AA  
 26 “is a chronic condition that results in the build up of arterial plaque or fatty deposits in the  
 27 patient’s aorta”). According to the *Stein* Plaintiffs, “Kaiser’s coders coded . . . MA patients with  
 28 an AA diagnosis based solely upon the physician’s notation of AA in the medical record, without  
 the medical record reflecting that the patient was treated for his/her AA condition.” *Stein* FAC ¶  
 84. Even if the Court were to consider this new condition identified in the *Stein* FAC (as well as  
 the *Stein* SAC), there would still be overlap with the *Osinek* complaint. The nature of the conduct  
 is similar such that AA is a condition that the government likely would have investigated given  
*Osinek*’s description of Kaiser exploiting high-value conditions.

1 other federal and state law) which are not subject to the first-to-file bar. *See* Mot at 1 n.3 (“This  
 2 Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except for the retaliation  
 3 causes of action in the operative *Bryant* complaint (Counts 5 through 8) and the California False  
 4 Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . .”).<sup>17</sup>

5 According to the *Bryant* plaintiffs, their case is materially different from *Osinek* in that,

6 unlike the *Osinek* complaint, the *Bryant/Hernandez* Complaint  
 7 exposes Kaiser's upcoding fraud: (i) relating to a specific high-value  
 8 diagnosis code, mechanical ventilator dependence status, that first  
 9 came to light after *Osinek* filed her suit<sup>18</sup>; (ii) not just on the  
 10 Medicare Advantage program, but on a different government  
 11 program (the Affordable Care Act) run by a different government  
 12 agency entirely (the Department of Health and Human Services);  
 13 and (iii) within Kaiser's insurance and physician-practice behemoths  
 14 in all regions, not just one region, and also within Kaiser's massive  
 15 hospital operation across Kaiser's regions, which was not even part  
 16 of the *Osinek* suit.

17 *Bryant* Opp'n at 2.

18 For (iii), as noted above, it does not matter that the hospital setting was not expressly  
 19 implicated in *Osinek*. Nothing in *Osinek* suggests that it excludes the hospital setting. The *Bryant*  
 20 plaintiffs fairly argue that *Osinek* is California-centric; however, as noted above, *Taylor* – the case  
 21 next in line after *Osinek* – put the government on notice of a nationwide or corporate-wide  
 22 problem related to the upcoding of high-value conditions.

23 As for (i), *see* *Bryant* Compl. ¶¶ 85-86 (alleging that “a patient is vent dependent only if  
 24 the patient relies on the ventilation to live on a long-term basis and not for the short-term acute  
 25 phase of a condition” but Defendants fail to comply with that guidance) (emphasis omitted), the  
 26 *Bryant* plaintiffs are basically making the same kind of argument that the *Stein* plaintiffs did. *See*  
 27 *Bryant* Opp'n at 15 (“Given the sheer number of diagnosis codes, it would be impossible for the  
 28 government to identify fraudulent over-documenting and upcoding in particular diagnoses without

<sup>17</sup> At one point, the *Bryant* plaintiffs also had California FCA claims but they dropped those claims in their FAC.

<sup>18</sup> In their complaint, the *Bryant* plaintiffs explicitly identified additional high-value HCCs or diagnoses but implicitly recognize that these conditions have already been expressly named by plaintiffs in earlier-filed actions. *See, e.g.*, *Bryant* Compl. ¶¶ 56, 107, 136, 144, 146-49 (referring to aortic atherosclerosis, sepsis, malnutrition, acute renal failure, acute kidney injury, and respiratory failure, arrhythmia for members with pacemakers, major depression, and acute stroke).

1 being pointed in the right direction.”). But as with *Stein*, this is lesser-included conduct and  
 2 sufficiently similar to the conduct put at issue in *Osinek* – *i.e.*, Defendants were exploiting high-  
 3 value conditions by failing to provide support/documentation for the upcoding. *Cf. Hampton*, 318  
 4 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for  
 5 ineligible and undocumented Medicare services and for services not medically necessary). The  
 6 fact that the practice allegedly was not discovered until after *Osinek* was filed does not mean that  
 7 *Bryant* cannot be a related case. That Defendants may have allegedly expanded their misconduct  
 8 to other high-value conditions does not negate the government being put on notice of the  
 9 fraudulent scheme in the first instance as a result of *Osinek*.

10 This leaves the *Bryant* plaintiffs with (ii). Here, the *Bryant* plaintiffs correctly point out  
 11 that their original complaint contains multiple allegations about payments Defendants receive  
 12 under the Affordable Care Act (and not just Medicare Advantage). For example, the *Bryant*  
 13 plaintiffs allege as follows:

- 14 • “The United States contributes to premiums that individuals pay to private health  
 15 insurance companies such as Kaiser under the Affordable Care Act. *See Bryant*  
 16 *Compl.* ¶ 7; *see also Bryant Compl.* ¶ 52 (alleging that the government contributes  
 17 through tax credits).
- 18 • “The Affordable Care Act sets up a program of risk adjustment in individual and  
 19 group markets to lessen or eliminate the influence of risk selection on the premiums  
 20 that plans charge. In the risk adjustment model utilized under the AA, which is  
 21 named the HHS-Hierarchical Condition Categories (‘HHS-HCC’) risk adjustment  
 22 model, HHS [*i.e.*, the Department of Health and Human Services] utilizes criteria  
 23 and methods similar to those utilized under the Medicare Advantage Program, and  
 24 adapts Medicare Advantage HCCs for use in the HHS-HCC model.” *Bryant*  
 25 *Compl.* ¶ 51; *see also Bryant Compl.* ¶ 7.
- 26 • Thus, “as under the Medicare Advantage Program, the ACA risk adjustment model  
 27 creates powerful incentives for private health insurance companies like Kaiser to  
 28 over-report diagnosis codes in order to exaggerate the expected healthcare costs for

1 their enrollees; the more codes that are reported, the higher premiums the  
2 companies are permitted to charge, and the higher contributions will be made to  
3 such premiums by the United States.” Bryant Compl. ¶ 7.

- 4 • “Defendants overdocument and upcode risk adjustment claims relevant to  
5 individuals covered by the ACA in the same manner and pursuant to the same  
6 schemes as relevant to the Medicare Advantage program . . . .” Bryant Compl. ¶  
7 11(b).
- 8 • The *Bryant* plaintiffs “seek . . . to recover damages and civil penalties arising from  
9 the false or fraudulent records, statements and/or claims that the Defendants made  
10 or caused to be made in connection with false and/or fraudulent claims for  
11 Medicare Advantage risk adjustment payments [and] Affordable Care Act  
12 insurance premiums . . . .” Bryant Compl. ¶ 18.

13 In response, Defendants point out that the actual causes of action asserted by the *Bryant*  
14 plaintiffs at the end of their complaint refer to risk adjustment payments under Medicare only.  
15 *See, e.g.*, Bryant Compl. ¶¶ 209-10, 214-15, 220, 224-26. Nowhere do the causes of action refer  
16 to risk adjustment payments under the Affordable Care Act. Although Defendants are correct, the  
17 *Bryant* plaintiffs fairly point out that each cause of action does incorporate all paragraphs  
18 previously pled. Accordingly, although the *Bryant* plaintiffs could have drafted a better and  
19 clearer pleading, they have not pled themselves out of FCA claims based on the Affordable Care  
20 Act as Defendants contend.

21 At the hearing, Defendants argued that, even if the *Bryant* plaintiffs have claims predicated  
22 on the Affordable Care Act, they are nonetheless still barred by the first-to-file provision because  
23 the government would have been put on notice of that alleged fraudulent scheme by virtue of  
24 *Osinek*. The Court does not agree. The Affordable Care Act is an entirely different scheme, not  
25 run by CMS specifically, and covering a broad range of individuals outside of the reach of  
26 Medicare. The ACA claims thus state causes of action entirely different and distinct from the  
27 Medicare Advantage claims. The government was put on notice of a problem with the Medicare  
28 Advantage program only. That the Affordable Care Act also uses risk adjustment does not mean

1 that the government’s investigation of Medicare Advantage would naturally lead to an  
2 investigation of the Affordable Care Act.

3 Accordingly, the Court dismisses *Bryant* but only in part. The claims that survive are the  
4 retaliation claims, as well as the claims based on the Affordable Care Act.

5 E. *Osinek and Bicocca*

6 Defendants do not seek to dismiss the entirety of *Bicocca*. Specifically, they recognize that  
7 Dr. Bicocca has claims pursuant to the California FCA that are not subject to the first-to-file bar.  
8 *See* Mot. at 1 n.3 (“This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety  
9 except . . . the California False Claims Act causes of action in the operative *Bicocca* complaint  
10 (Counts 3 and 4) . . .”).

11 Second, the Court takes note that Dr. Bicocca admits his original complaint (filed in  
12 February 2020) is barred by the first-to-file provision. He argues, however, that his FAC (filed in  
13 October 2020) adds a theory that is not in *Osinek*. *See* *Bicocca* Opp’n at 2. Because, as discussed  
14 above, it is Dr. Bicocca’s original complaint that must be compared to the *Osinek* Complaint, he is  
15 out of luck.

16 However, even if the Court were to consider the FAC, Dr. Bicocca’s contention that his  
17 case is materially different from *Osinek* is without merit. He states:

18 Relator Bicocca’s Amended Complaint describes “two sources” of  
19 diagnoses that Kaiser requires physicians to add. *Bicocca* Dkt. 16 ¶  
20 108. One of these sources is addenda that Kaiser gives physicians  
21 *after* a patient visit, which include additional diagnoses for the  
22 physician to *retroactively* add to the patient’s chart. *Id.* at ¶¶ 106,  
110. The other is a list of the patient’s past diagnoses, which Kaiser  
gives to physicians *before* the physician meets with the patient, with  
the intention that the physician will re-diagnose each of the specific  
diagnoses *during* the visit (“upfront list”). *Id.* at ¶ 109.

23 *Bicocca* Opp’n at 2 (emphasis in original); *see also* *Bicocca* FAC ¶ 109 (“The first source [for  
24 diagnoses that physicians are required to add onto Medicare] are diagnoses that these patients had  
25 already, confirmed in previous years by other physicians. While, as a matter of first impression,  
26 this does not seem to be a violation of regulations, since the patients have already had the  
27 diagnoses confirmed by others, having physicians re-confirm these diagnoses without spending  
28 sufficient time on it and without having any expertise on these diagnoses is still a violation of

1 Medicare’s regulations on confirming diagnoses for the purpose of risk adjustment.”). The  
2 problem for Dr. Bicocca is that the latter is essentially refreshing, which has already been put at  
3 issue in *Osinek*.

4 Accordingly, the Court grants the motion to dismiss Dr. Bicocca’s claims, and the only  
5 claims that survive are those based on the California FCA which Defendants have not contested  
6 for purposes of the first-to-file bar.

7 **IV. CONCLUSION**

8 For the foregoing reasons, the Court grants in part and denies in part Defendants’ motion  
9 to dismiss based on the first-to-file bar. Specifically:

- 10 • *Arefi* and *Stein* are dismissed in their entirety.
- 11 • *Taylor* is dismissed except to the extent that it pleads (1) a nationwide or corporate-  
12 wide fraud; (2) a fraud based on improper coding by external providers; and (3) a  
13 fraud based on True Positive results from the NLP program.
- 14 • *Bryant* is dismissed except to the extent that it pleads (1) retaliation claims and (2)  
15 claims based on fraud in the Affordable Care Act program.
- 16 • *Bicocca* is dismissed except to the extent that it pleads claims based on the  
17 California FCA.

18 This order disposes of Docket No. 141.

19  
20 **IT IS SO ORDERED.**

21  
22 Dated: May 5, 2022

23  
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25 EDWARD M. CHEN  
26 United States District Judge

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