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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, FOUNDATION HEALTH PLAN, INC., and THE PERMANENTE MEDICAL GROUP, INC., Defendants.	Consolidated Case No. 3:13-cv-03891 -EMC RELATOR TAYLOR'S OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE Noticed Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor
UNITED STATES OF AMERICA, *ex rel.* JAMES M. TAYLOR, M.D., Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, COLORADO PERMANENTE MEDICAL GROUP, P.C., THE PERMANENTE MEDICAL GROUP, INC., and SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, Defendants.	(Original N.D. Cal. Case No. 3:21-cv-03894-EMC) RELATOR TAYLOR'S OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE Noticed Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

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Kaiser faces a host of allegations of rampant fraud on the Medicare Advantage ("MA") program, through which the United States provides health insurance coverage to 28 million American seniors. In 2013, Ronda Osinek filed a complaint under the False Claims Act ("FCA") primarily alleging that Kaiser in California improperly and fraudulently used the retrospective amendment of medical records (called "addenda") to increase its payments from Medicare by claiming diagnosis codes that were never evaluated or considered at the time of the medical encounter.

In 2014, Dr. James Taylor, a Kaiser physician and Medical Director of Revenue Cycle in Colorado, filed a complaint that alerted the United States to that fraud's existence in Colorado and nationally, as well as at least three additional types of fraud not pleaded in Osinek's complaint. Taylor alleged, among other things, that Kaiser (1) engaged in a fraudulent one-way-look chart review program in Colorado, in which it willfully ignored false codes while mining medical records for additional revenue; (2) refused in Colorado and nationally to investigate or delete diagnosis codes it knew to have consistent, high rates of falsity; and (3) knowingly relied on natural language processing software that by design did not assess the validity of previously submitted diagnosis codes and caused the submission of false diagnosis codes. Over the next several years, multiple other whistleblowers brought other claims against Kaiser. The United States partially intervened in each of these six complaints.

In an attempt to dodge the majority of the claims they face, Defendants would have the Court craft a new first-to-file rule, contrary to the statute and Ninth Circuit precedent. This wide-sweeping rule would bar any False Claims Act action by a relator once any other whistleblower has made allegations regarding any aspect of Kaiser's Medicare Advantage business anywhere in the country. And that is a broad sweep indeed: as of January 2022, the various affiliated entities

that the layperson knows as Kaiser are the fifth largest insurer in the MA program, spanning seven insurance plans, based in seven different states across the country, and covering nearly 1.8 million beneficiaries.[1]

But the statutory bar is nowhere near so broad. It rightly prohibits repetitious complaints that plead the same material facts, while welcoming those that bring new information and frauds to light. Complaints like Dr. Taylor's, which plead distinct fraudulent schemes in different regions involving different affiliated entities under different contracts, are exactly those that the rule is designed to permit. They fit the rule's purpose of incentivizing relators to come forward with information about fraud on the government.

Defendants seek shelter under a rule designed to prevent parasitic lawsuits, but Taylor's complaint brought forward new regions and new fraud claims. Taylor's claims are only similar to Osinek's when Defendants generalize the allegations, describing the complaints at the most superficial level, as if all they alleged was a summary: that the various Defendants "upcoded diagnosis codes for Medicare Advantage members." Def. Mot. to Dismiss, ECF No. 141 (January 18, 2022) at 2.

But that conflates multiple distinct fraud schemes by describing those separate schemes in the most general terms, which simply reference the method of billing the program that Kaiser is allegedly defrauding. The core determinant of payment under the MA program is the health status of beneficiaries. A Medicare Advantage Organization ("MAO") that reports insuring sicker beneficiaries will receive higher payments from the Centers for Medicare and Medicaid

[1] In addition to Kaiser's insurance business, the conglomerate also operates a large number of medical providers, across multiple states, employing over 20,000 doctors and over 300,000 total employees.

Services ("CMS") than one reporting healthier beneficiaries. The beneficiaries' health status is determined by diagnosis codes that MAOs submit to CMS. These codes are subject to certain conditions and must be accurate, and their submission is the only means of securing increased payments from CMS.

In other words, due to the structure of the program, fraudulent diagnosis codes are the *only* means of overbilling the government. Nearly any case against Kaiser's MA program would fall within this description. Defendants' position, simply put, is that any allegation of a company defrauding the MA program blocks *all* other allegations of that or any related company defrauding the MA program.

Defendants' interpretation of the first-to-file bar is improperly broad. Under their interpretation of the bar, a hypothetical defense contractor would be able to block allegations of billing for work it never performed if an affiliate of that same defense contractor was already accused of billing for installing substandard materials, merely because both sets of allegations could be described as submitting false invoices to the government. That is simply not the law.

Instead, the law instructs that the bar applies only when subsequent complaints allege the same material elements of fraud. Here, Taylor's complaint alleges different fraud schemes, different geography, different contracts at issue, and different Defendants. Thus, Taylor's claims are distinct from Osinek's and are permissible under 31 U.S.C. § 3730(b)(5) and Ninth Circuit caselaw. Both the facts and the law support this conclusion.

FACTUAL BACKGROUND

I. The Medicare Advantage Program

Through the MA program, CMS allows private health insurers to set up managed care plans to cover Medicare beneficiaries. All told, CMS currently has over 900 contracts with different insurers.

CMS pays a monthly capitation rate for each beneficiary enrolled as a member of an MA plan, known as a "per-member, per-month" payment. This predetermined base payment varies for each MA Plan depending on various factors, primarily demographics (age and sex) and health status.

Individuals with multiple and/or serious health conditions account for more health care costs than healthier members. Accordingly, CMS pays a substantially higher capitation rate for members who have been recently treated for one or more serious, expensive diseases or conditions. *See* 42 U.S.C. § 1395w-23(a)(1)(C). These increased payments are known as "risk adjustment" payments. The only variable that determines a beneficiary's health status is the diagnosis codes an MAO submitted on that beneficiary's behalf. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).

Because diagnosis coding is inherently linked to payment, MAOs are bound by regulation, contract, and CMS guidance to follow certain rules that dictate the conditions under which they may submit codes for risk adjustment purposes. These rules include requirements that the diagnosis code must be supported by the beneficiary's underlying medical record, must come from an acceptable provider type, must come from a face-to-face medical encounter,[2] and must

[2] Prior to March 2020 and the onset of the pandemic caused by the SARS-CoV-2 virus.

come from a visit in the relevant timeframe determining that payment, among other requirements.

A violation of any of these requirements can render a code false. The code might have been derived from a visit with an unacceptable provider type, been from the wrong year, or simply been fabricated—or, as the government's various FCA litigations show, many, many other alleged fraud schemes. Here, Kaiser is accused, by the United States, Relator Osinek, Relator Taylor, and others, of multiple types of fraudulent schemes to draw higher payments from CMS, each of which violates the FCA.

All of these varied schemes can be characterized as "upcoding." In the MA context, the term "upcoding" is akin to an allegation of "overbilling" in an FCA case involving a contract dispute. It simply means claiming more payment than is permissible.

II. Relator Osinek's Complaint

In 2013, Relator Osinek filed her original complaint against Kaiser Permanente ("KP"), which she identified as a California corporation that operated health plans and provided insurance coverage under the MA program to "the general public in California."[3] Osinek Compl. ¶ 6.

Osinek primarily alleged that KP exaggerated the disease state of its beneficiaries to garner higher payments from CMS by retrospectively amending medical records to provide support for diagnosis codes that were never evaluated or considered at the time of the medical encounter, a process Osinek refers to as "addenda." *Id.* at ¶¶ 28-32. Osinek provides a great

[3] Osinek has since amended her complaint to name Kaiser Permanente, Kaiser Foundation Health Plan, INC., and The Permanente Medical Group, INC. as Defendants.

amount of detail about the addenda process, describing KP's reaction to physicians refusing to agree to the amendment of medical records (¶¶ 33-34) and KP's practice of hosting "coding parties" at which physicians were gathered in a single room and asked to review, and approve, hundreds of addenda records (¶ 35).

Osinek also alleged that KP used data analytics to target certain conditions that it intended to exaggerate the severity of, such as coding various less serious kidney conditions as severe chronic kidney disease (*Id.* at ¶¶ 25-27), and that it was encouraging, monitoring, and paying physicians to recode certain chronic conditions year after year, which KP called "refresh" (¶¶ 36-40).

Nowhere in her complaint does Osinek mention Kaiser regions or contracts outside of California, nor does she mention any schemes outside of those involving addenda, the exaggeration of certain disease states, such as the severity of various kidney conditions, or the encouraging and incentivizing of physicians to refresh chronic conditions.

III. Relator Taylor's Complaint

Dr. James Taylor, a physician who had worked at Kaiser since 1995, filed his FCA complaint in 2014.[4] In addition to practicing medicine, Taylor also worked in a variety of Kaiser's business functions, including serving as the Medical Director of Revenue Cycle and as the Physician Director of Coding for the region. Taylor named Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation

[4] Dr. Taylor's original complaint was filed on October 22, 2014. He amended November 3, 2014, before any of the other Relators filed their initial complaints. Cites to the complaint below are to the First Amended Complaint, which is operative for purposes of comparison to later filed relators. Dr. Taylor filed a Second Amended Complaint on November 15, 2021. The Second Amended Complaint is now Dr. Taylor's operative complaint.

Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest as Defendants to his original complaint.[5]

In addition to pleading fraud in these additional regions, with separate contracts, Taylor alleged that the Kaiser entities exaggerated the disease state of their beneficiaries to garner higher payments from CMS by:

1. Conducting a one-way-look chart review program. Under this program, Kaiser Colorado reviewed all hospital records of its beneficiaries discharged from a certain chain of hospitals, then called Exempla. Kaiser Colorado did this to search for additional diagnosis codes to submit to CMS. However, despite knowledge that the original, hospital-submitted diagnosis codes were riddled with errors, Kaiser did not investigate or delete previously submitted codes that were hospital-generated and not substantiated by the Kaiser review, even though it had all the necessary information at its fingertips. Kaiser sought and retained payment for the additional codes that its reviews found and *all* hospital-submitted codes, including those the review revealed were false. Taylor FAC ¶¶ 78-91.
2. Refusing to investigate or delete diagnosis codes representing a number of conditions that Kaiser knew its providers coded with consistently high rates of falsity. These included cancer (¶¶ 95-109, ¶¶ 128-29), stroke (¶¶ 110-17), vertebral fracture (¶ 118), vascular disease (¶¶ 119-23), chronic bronchitis (¶¶ 124-27), history of heart attack

[5] Dr. Taylor's Second Amended Complaint names Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; Colorado Permanente Medical Group, P.C.; The Permanente Medical Group, INC.; and Southern California Permanente Medical Group as Defendants.

(¶¶ 130-31), malnutrition (¶¶ 132-34), ulcers (¶¶ 135-37), sick sinus syndrome (¶¶ 138-43), and renal insufficiency (¶¶ 144-46). Dr. Taylor alleges that the diagnosis codes were false for a variety of reasons, including but not limited to coding resolved cancer as active (¶ 98), coding history of stroke as acute stroke (¶ 111), coding a history of heart attacks from test results and not from face-to-face encounters (¶ 131), and coding an arrythmia condition once it has been resolved by a pacemaker (¶ 140). Taylor's complaint also describes several remedial steps that he suggested to improve the accuracy of the diagnosis codes Kaiser submitted to CMS, including a filter to pause the submission of certain high-risk codes for an additional level of review (¶¶ 92, 155-61), a software feature, referenced in the complaint as a pop-up, that queried, in real time, whether a physician was sure about the current state of a disease (¶¶ 103-04), and the hiring of an external consultant to review charts for accuracy for certain hospital-generated diagnosis codes (¶ 109).

3. Using a natural language processing ("NLP") software that failed to determine the validity of previously submitted diagnosis codes and also caused the submission of false diagnosis codes that did not follow CMS rules. This resulted in the submission of false codes due to the software design and implementation limitations, a fact Kaiser was acutely aware of. *Id.* at ¶¶ 184-94.

On July 29, 2021, the United States filed its Notice of Election to Intervene in Taylor's claims alleging that Kaiser "submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda . . . ." United States' Notice of Election to Intervene in Part and to Decline to Intervene in Part at 1, ECF No. 65 (July 29, 2021).

It declined to intervene in the remainder of Taylor's claims, including those just enumerated, on which Taylor is proceeding alone. *Id.*

ARGUMENT

Taylor and Osinek bring different claims, about different schemes, regarding different regions of the country, pursuant to different contracts between CMS and Kaiser entities. Under Ninth Circuit precedent and the proper reading of the first-to-file rule, Osinek's complaint does not bar Taylor's claims. Taylor is first-filed as to the intervened and non-intervened claims set out in his complaint, and his and Osinek's claims should both proceed.[6]

Although both complaints allege Kaiser defrauded CMS through the MA program, that is a generality so broad as to be meaningless for the first-to-file analysis.[7] Defendants' broad interpretation of the first-to-file bar would prevent *any* later claim against any Defendant or its affiliates. Such a reading is contrary to the statute and caselaw—and nonsensical. Osinek's complaint would not have put the government on the trail of the frauds alleged in Taylor's complaint, unless one imagines that the government should review *all* types of behavior at any defendant or its affiliate under *all* contracts, as soon as any of them is sued under the FCA. No entity doing business with the government would want that, including Defendants, who would undoubtedly resist any effort by the government to investigate every aspect of their coding

[6] Taylor's complaint thus necessarily blocks any subsequent relators who brought claims with the same material elements of fraud as those for which Taylor is first-filed. The motion before the Court, however, raises only the first-to-file implications of Osinek's complaint.

[7] Whether the broad commonalities supported consolidation of the cases is a different question.

practices at any affiliate. Defendants' overly broad reading of the statute would serve no purpose other than insulating them from legitimate claims of fraud.

I. The First-to-File Bar Only Blocks Cases Alleging the Same Material Elements of Fraud

The first-to-file bar is rooted in statutory language that dictates that "[w]hen a person brings a [qui tam action], no person . . . may . . . bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). The bar has dual purposes: to "promote incentives for whistle-blowing insiders" by encouraging prompt filing and to "prevent opportunistic successive plaintiffs" by barring their complaints. *United States ex rel. Hartpence v. Kinetic Concepts, Inc*., 792 F.3d 1121, 1130 (9th Cir. 2015) (citation omitted). Critically, the bar allows for "related but distinct fraud claims" to proceed, because that "encourages broader investigation and increases the total potential for recovery"—both for whistleblowers generally and for the government. *Id*. at 1131; *see also United States ex rel. Barrett v. Allergan, Inc.*, No. SACV 18-203 JVS, 2019 WL 4675756, at *4 (C.D. Cal. Sept. 24, 2019).

To determine whether an action is barred, the Ninth Circuit, like most Circuits to consider the issue,[8] considers whether the later-filed complaint pleads the same "material elements of

[8] Nearly all circuits use a similar approach, although sometimes by a different name. *United States v. Millenium Lab'ys, Inc.*, 923 F.3d 240, 253 n.16 (1st Cir. 2019) (noting that the First Circuit's same "essential facts" test was not meaningfully different from "material facts" test); *United States ex rel. Wood v. Allergan, Inc*., No. 10-CV-5645, 2017 WL 1843288 (S.D.N.Y. 2017) (finding cases related under essential facts test); *United States ex rel. LaCorte v. SmithKline Beecham Clinical Lab'ys, Inc.*, 149 F.3d 227, 232-33 (3d Cir. 1998) (applying the same test); *United States ex rel. Carter v. Halliburton Co*., 710 F.3d 171 (4th Cir. 2013) (joining sister circuits in adopting the "material elements test"); *Walburn v. Lockheed Martin Corp.*, 431 F.3d 966, 971 (6th Cir. 2005) (applying the same "essential facts" test); *United States ex rel. Chovanec v. Apria Healthcare Grp. Inc*., 606 F.3d 361, 363-64 (7th Cir. 2010) (applying the same material facts or essential facts tests means those on which the original relator is entitled to

fraud" as the earlier one. *United States ex rel. Lujan v. Hughes Aircraft Co*., 243 F.3d 1181, 1189 (9th Cir. 2001). As the Tenth Circuit, which uses the same approach, has explained, the analysis is "designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints." *In re Nat. Gas Royalties*, 566 F.3d at 964. No dive into evidence is required.

Here, such a comparison makes clear that Dr. Taylor's complaint is not barred. Osinek's complaint is primarily about the retrospective, fraudulent amendment of medical records in California. Dr. Taylor's, by contrast, pleads a different scope of fraud (Colorado and nationally, rather than only California), different types of fraud (fraudulent chart review, a known failure to delete codes, and fraudulent use of NLP software), and different material facts.

Precedent is clear, given the differences between these two cases, including the investigation and evidence required to prove them, that the first-to-file bar does not apply. Defendants know this, so they resort to a radically broad interpretation of the bar that would effectively prevent any subsequent claims against the same defendant or affiliates. Such a reading finds no support in the law.

In *Hartpence,* the Ninth Circuit permitted two cases brought against the same medical device producer that involved billing the Medicare program for the same device during the same time period. *Hartpence*, 792 F.3d at 1131. The first-filed action alleged billing for use of the device when it was medically unnecessary; the second, billing for the device when it was never used at all. The Ninth Circuit, reversing the district court's decision, determined that both cases

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compensation if the suit prevails); *In re Nat. Gas Royalties Qui Tam Litig. (CO2 Appeals)*, 566 F.3d 956 (10th Cir. 2009) (same).

should proceed. Comparing them side-by-side, it found that, despite the similarities, the alleged frauds "exist completely independent of one another." *Id.*

That difference sufficed to permit the claims in the later case even though, applying Defendants' logic here, both cases could be described as involving impermissible billing for the same medical device.[9] Fitting within the same category of fraud is not enough to trigger the bar; they must have the same material elements of fraud.[10] Indeed, as one District Court neatly summarized it, *Hartpence* found that the bar permitted the later case "even though the complaints named the same defendants, arose out of the same time period, involved the billing practice for the same therapy code, and were drafted by the same counsel . . . ." *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-EFS, 2015 WL 5794357 (E.D. Wash. Oct. 1, 2015).

The *Hartpence* court also explained that permitting the latter case was consistent with both goals of the first-to-file bar. Allowing it increases incentives for relators because "allowing claims for related but distinct fraud claims encourages broader investigation and increases the total potential for recovery." 792 F.3d at 1131. At the same time, opportunistic plaintiffs would not be encouraged because the second-filed relator brought information about a "different form of fraud." *Id.* at 1131-32.

Likewise, in *Barrett,* the Central District compared cases that both alleged violations of the Anti-Kickback Statute by the same pharmaceutical company for providing physicians with

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[9] The second relator did not contest the district court's decision that her claim relating to medically unnecessary use was barred. *Id.* at 1130.

[10] Although Defendants make much of the Ninth Circuit's rejection of the "identical facts" test in *Hartpence*, Taylor's claims easily survive the "same material elements" test the Circuit adopted instead. *See Hartpence*, 792 F.3d at 1130; Mot. at 16.

free samples of Botox. *Barrett,* 2019 WL 4675756, at *3. The first-filed complaint alleged a kickback scheme, and the second-filed complaint alleged a similar kickback scheme and a price inflation scheme. Despite the similarities, the court allowed the second-filed complaint to proceed because the first-filed complaint's "allegations are significantly narrower than those made by [second-filed relator]." *Id.* at *4. They alleged both different schemes and different material facts, which the Court noted would result in different damages. *Id.* Thus, both could proceed.

As *Hartpence* and *Barrett* show, the specifics of the alleged frauds matter. Separate FCA complaints do not bar another under 31 U.S.C. § 3730(b)(5) simply because they involve the same defendant and the same government program. Defendants suggest that "all six complaints allege essentially the same wrongdoing: that Defendants knowingly upcoded diagnosis codes for Medicare Advantage members . . . ." Mot. at 2.[11] They might as well say that they are barred because they are False Claims Act cases against affiliated companies engaged in the same business. That is not sufficient to trigger the first-to-file bar, which requires a look at the four-corners of the complaints. Such a review here demonstrates that Taylor's complaint should go forward.

[11] *See also United States ex rel. Galmines v. Novartis Pharms. Corp.*, No. 06-3213, 2013 WL 2649704, at *10 (E.D. Pa. June 13, 2013), on reconsideration in part, 2013 WL 5924962 (E.D. Pa. Nov. 5, 2013) (bar did not apply in cases both alleging that Novartis engaged in off-label promotion for the same drug but for different off-label purposes); *Millenium Lab'ys*, 923 F.3d at 253-54 (two complaints against clinical lab for excessive confirmatory testing alleged "different frauds with different mechanisms").

II. Taylor and Osinek Have Brought Different Claims

Taylor alleges three distinct fraud schemes that are not pleaded in the Osinek complaint.[12] Each of these schemes pleads different material elements of fraud against different Kaiser entities,[13] and Taylor's complaint should proceed on each one.[14]

A. Kaiser Colorado's One-Way Chart Review Fraud Scheme

First, Taylor uniquely alleges that Kaiser Colorado conducted a one-way chart review program, under which Kaiser Colorado reviewed each medical chart of one of its beneficiaries discharged from a particular chain of hospitals.[15] Kaiser Colorado did this to search for additional diagnosis codes to submit to CMS on its beneficiaries' behalf and collect additional money from CMS. At the same time, despite knowledge that these hospitals were consistently inaccurate in their coding, Kaiser Colorado did not compare the results of its review with the hospitals' coding, which it had already submitted to CMS. Nor did it review discrepancies between its chart review and the original cording or delete any codes that it found to be false from CMS databases. Instead, Kaiser improperly retained payments based on false information.

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[12] Contrary to Defendants' assumption (Mot. at 20), Taylor does not rely on his Second Amended Complaint for purposes of this comparison. The distinct fraud claims identified here are all present in his original and First Amended Complaint, the latter of which is operative for this analysis.

[13] At the time Taylor filed his case, Osinek had only named "Kaiser Permanente" as a Defendant. In his complaint, Taylor named Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest.

[14] The first-to-file analysis is a claim-by-claim analysis, and the Court must review each independent fraud claim as a separate question. *See, e.g, Hartpence,* where two of three claims in the second case were allowed to proceed. 792 F.3d at 1130.

[15] Kaiser, which operated no hospitals in Colorado, relied on the services of external hospitals to treat its beneficiaries.

Taylor FAC ¶¶ 78-91. This is a recognized theory of liability under the FCA, and similar, one-way-look chart review programs are the subject of several other FCA litigations and settlements. *See United States ex rel. Poehling v. UnitedHealth Group, Inc.*, No. CV 16-08697-MWF, 2018 WL 1363487 (C.D. Cal. 2018) (denying defendant's Motion to Dismiss against similar allegations); *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010 (N.D. Cal. 2020) (same; subsequently settled).

Osinek alleges no similar scheme. She does not make any allegations about chart review, let alone a one-way-look yielding fraudulent coding. That difference means Taylor's claims survive. *Hartpence*, 792 F.3d at 1131-32; *Barrett*, 2019 WL 4675756; *see also Millenium Lab'ys*, 923 F.3d at 253-54 (second complaint alleged clinical laboratory engaged in "different frauds with different mechanisms" because referenced "custom profiles" and "standing orders" which first complaint did not)]. Critically, the differences in the Kaiser regional affiliates mean that the chart review scheme Taylor alleges would not even have been possible in California, where Osinek alleges her frauds. There, Kaiser operates its own hospitals, and it has no external providers as it does in Colorado.

Defendants' motion addresses this scheme only superficially, by inaccurately quipping that it represents a "low-tech version of Osinek's data mining allegations." Mot. at 20. That is incorrect. Kaiser Colorado's chart review program involved no data mining at all. It involved the manual review of all the charts from certain hospitals. Additionally, the allegation claims that providers initially generated these false codes and Kaiser failed to delete them, a violation of the "reverse" false claims provision, 31 U.S.C. § 3729(a)(1)(G), because Kaiser improperly retained

the inflated premiums paid by CMS.[16] Osinek's data mining allegations are about the plan targeting certain diagnosis codes for improper submittal to CMS, and the Osinek complaint does not even plead a violation of 31 U.S.C. § 3729(a)(1)(G).

In brief, like the second-filed complaints in *Hartpence* and *Barrett,* Taylor alleges a unique mechanism of fraud based on different material facts.

B. Kaiser's Failure to Delete Unsupported Diagnoses Following Audits

Second, Taylor alleges a far-reaching scheme where Kaiser, in Colorado and nationally, despite knowing of large, systemic numbers of false claims in its submissions to CMS, did nothing to remedy those issues and continued to act in reckless disregard of the data it submitted to CMS.

Each year, Kaiser conducted audits of its submitted diagnosis codes for each region, including Colorado. These audits, known as "probe" audits, showed errors in the data Kaiser was submitting to CMS. These audits were prompted by Kaiser regions trying to prepare for potential Risk Adjustment Data Validation ("RADV") audits, which are periodically conducted by CMS to check the accuracy of a sample of an MAO's diagnosis code submissions. Taylor FAC ¶¶ 69-77. Certain disease categories showed consistent and very high error rates, as noted above. These audits put Kaiser on notice that they were submitting thousands of unsupported codes to the MA program. It was Defendants' duty to investigate and delete the codes that were unsupported. Defendants declined to do so, in violation of the FCA. *See e.g., United States v. Lakeshore Med.*

[16] Taylor, in his Second Amended Complaint, also alleges that this practice is a violation of 31 U.S.C. § 3729(a)(1)(A) due to certifications an MAO must sign when submitting diagnosis codes to CMS but that clarification does not appear in his initial complaint which is at issue for the purposes of the first-to-file analysis.

Clin., LTD., No. 11-CV-00892, 2013 WL 1307013, at *3 (E.D. Wis. Mar. 28, 2013) (denying a Motion to Dismiss where a "defendant ignored audits disclosing a high rate of upcoding" because that "plausibly suggests that defendant acted with reckless disregard for the truth and submitted some false claims.").

Like chart review, the Osinek complaint makes no mention of probe audits, RADV preparedness, error rates, or many of the conditions Taylor pinpoints as problematic. Nor does Osinek mention the specific reasons diagnosis codes were false that were discussed by Taylor, such as coding resolved cancer as active cancer (Taylor FAC ¶ 98), coding history of stroke as acute stroke (¶ 111), coding a history of heart attacks from non face-to-face encounters (¶ 131), and coding an arrythmia condition once it has been resolved by a pacemaker (¶ 140). In fact, the Osinek complaint only references auditing once, merely alleging that Kaiser moved away from auditing and onto other priorities, such as data mining and refresh. Osinek Compl. ¶ 24. Despite Osinek herself drawing this distinction between data mining and auditing, Kaiser now tries to obscure that difference, seemingly using the terms auditing and data mining interchangeably in its motion. *See* Mot. at 9.

That semantic game obfuscates the real differences between the alleged schemes. Osinek alleges an identification of opportunities for upcoding and then doing so. Taylor alleges that Kaiser was put on notice of false diagnosis codes, which were false for a variety of reasons and affected the coding of a variety of conditions, and then it did nothing to explore or resolve that problem, continuing to submit false codes to pad its bottom line.[17] These are different frauds.

[17] Osinek's allegations form the basis of only a "direct" false claims theory. In addition to "direct" false claims, Taylor also alleges that Defendants violated the "reverse" provision of the False Claims Act, 31 U.S.C. § 3729(a)(1)(G), because Kaiser learned information about certain

C. Kaiser's Fraudulent Use of NLP Software

Finally, Taylor alleges a scheme of using natural language processing to submit false diagnosis codes to CMS. Taylor FAC ¶¶ 184-94. Taylor alleges that Kaiser built software that both failed to determine the validity of previously submitted diagnosis codes and that it directly caused the submission of false diagnosis codes to CMS, submitting codes that did not follow CMS rules.

Osinek makes no such claim. Kaiser argues that, because both data mining and natural language processing involved some use of technology, Osinek's complaint should somehow block Taylor's on this point. Mot. at 9. That is nonsense: all administration of healthcare in the 21st century involves the use of technology.[18] Would Defendants have argued in the 20th century that the use of paper and pencil rendered fraud schemes identical?

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diagnosis codes being false after those diagnoses had already been submitted to CMS, and Kaiser failed to delete them.

[18] Defendants claim to put forward their own supposed side-by-side analysis of the complaints in Appendix A to their motion, but they focus on similarities in language, not the required analysis of the facts or schemes. First, Defendants focus on the allegation of upcoding, but as discussed above, the schemes do not overlap in the facts material to the resulting upcoding. Appdx. A at 1. Second, Taylor's acknowledgement that the company did data mine does not block any of his claims. Appdx. A at 2. Even Taylor's allegations about the natural language processing scheme, which is distinct from Osinek's data mining scheme, does not allege the submission of false diagnosis codes from data mining, as Osinek does. Third, the sections of the Taylor FAC quoted on Appdx. A at 3 do not reveal any claim blocked by Osinek's addenda allegations. Those quoted portions concern Taylor's allegations about the submission of diagnosis codes from improper visit types, not the retroactive amendment of medical records. Finally, the fact that both complaints allege the company "pressured" providers to upcode is not instructive to a first-to-file analysis. Appdx. A at 6. Pressuring employees to defraud the government in different ways, in different regions, and under different contracts, is not a meaningful area of overlap.

Like the second-filed case permitted in *Hartpence*, Taylor's complaint sets out fraud schemes that "involve[] different underlying facts." 792 F.3d at 1131. "[W]ithout that information" from Taylor's complaint, "the government might not have investigated" the frauds it spelled out. *Id.* at 1132. That is sufficient to find that each of these claims in Taylor's complaint should move forward, with no further analysis required.[19]

III. Taylor and Osinek Allege Fraud in Different Regions, on Different Contracts, and by Different Defendants

In addition to pleading different schemes, Taylor pleads MA fraud in different regions, and under different contracts than does Osinek. Although Taylor alleges certain specifics about Kaiser's two California regions (Taylor FAC ¶¶ 75, 87, 174, 178), the bulk of his complaint focuses on Colorado, where Taylor worked. By contrast, Osinek's complaint alleges no schemes in Kaiser's Colorado region, does not name the Kaiser entities operating in Colorado as Defendants, and does not even mention the word "Colorado."

Defendants argue that Osinek's complaint alleged, or at least put the government on notice, of a nationwide scheme. That is neither true nor supported by law or facts. First, Osinek does not allege a scheme spanning the various affiliated entities around the country that wear the Kaiser name. Despite only naming "Kaiser Permanente" as a Defendant, Osinek goes on to discuss only the California MA plan, cites only examples of California beneficiaries and physicians, and describes only events in California. Defendants point out that Osinek cites

[19] Defendants argue for dismissal because they assert that the later complaints are "related to the same fraudulent scheme alleged." Mot. at 2. The test is not "related," as the discussion here demonstrates, and in any event the claims are not related. These three schemes alleged by Taylor are independent of Osinek's allegations. They can and did exist regardless of whether Kaiser entities in California were using a fraudulent addenda process.

examples from both Northern and Southern California, two separate Kaiser regions. But notably both of these regions have the same contract with CMS[20] and neither overlaps with Colorado, which is under its own contract. These contract and geographic differences are an additional reason the complaints should not be found to allege the same material elements of a fraud against the government. *See Savage*, 2015 WL 5794357, at *8 (finding that where two complaints involved different prime contractors under different contracts, second case was not barred); *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 121 (D.C. Cir. 2015) (second complaint alleged a "factually distinct type[] of fraud[]" covering a wider geographic scope, notwithstanding that both complaints addressed whether AT&T (or a subsidiary) engaged in pricing misrepresentation); *United States v. Sanford-Brown, Ltd*., 27 F. Supp. 3d 940, 948 (E.D. Wis. 2014) (second complaint not barred where involved geographically different campuses of different subsidiaries within defendant's corporate structure). Even if they were in the same region, the distinct nature of the fraud described above would mean that most of Taylor's claims survive.[21]

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[20] Kaiser has seven contracts with CMS, one for each state in which the company operates an MA plan. Kaiser's contract for its California plan is numbered H0542 and is between CMS and an entity called "Kaiser Foundation Health Plan, Inc." The Colorado plan contract is numbered H0630 and is between CMS and an entity called "Kaiser Foundation Health Plan of Colorado."

[21] The cases cited by Defendants do not support dismissal of any parts of the Taylor case. *United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204 (D.C. Cir. 2011) involved two cases alleging the exact same type of fraud: falsifying forbearances on the same Department of Education contract, just in different offices. Even if the Court were to adopt the idea that geographic difference alone is insufficient, that would not bar Taylor's claims. Here, unlike in *Batiste,* the types of fraud, and the government contracts in question, are distinct between the complaints. *Batiste* based its ruling on the fact that the later-filed complaint's "additional details would not give rise to a different investigation or recovery." *Id.* at 1210. In contrast, Taylor's complaint clued the government into a new region, key evidence, and new types of fraud: not just fraudulent use of addenda, but deliberately turning a blind eye to known instances of false

Finally, Osinek's case did not suffice to put the government on notice of the fraud allegations Taylor brought forward.[22] It is simply implausible, and not the case here, that every time a *qui tam* plaintiff files a complaint, the government is on notice and obliged to investigate all of that defendant's dealings with the government, as well as those of the defendant's corporate relatives. In this case, Defendants together treat and insure nearly two million MA beneficiaries. For the government to discover all the disparate frauds pleaded by relators here simply from Osinek's complaint, which focuses on the improper use of addenda, it would have had to engage in a comprehensive review of all Kaiser affiliates' practices around the country, potentially reviewing every aspect of the coding of tens of millions of medical charts spanning more than a decade. That is not how FCA investigations work, and every defense counsel worth their hourly rate works diligently to constrain the focus of the government's investigation at every turn. Thus a single complaint like Osinek's cannot be considered meaningful notice of different fraud schemes, such as those alleged by Taylor and discussed above.[23]

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coding. Both the regions and additional fraud claims add new sets of damages beyond what Osinek alleged.

The case of *United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214 (D.C. Cir. 2013) is equally inapposite. That case involved a first-filed complaint where a senior manager "alleged a corporate-wide problem, revealed through internal audits" about fraud in home health services, mentioning 37 states. That tracks the Taylor complaint much closer than it does the Osinek complaint. In *Hampton,* the second-filed complaint added no detail and alleged an identical scheme, which is not the case here.

[22] As the First Circuit has pointed out under its similar standard "[m]ere notice—particularly of a different fraud than the government chose to pursue—is not enough. . . . '[W]e must ask not merely whether the first-filed complaint provides some evidence from which an astute government official could arguably have been put on notice, but also whether the first complaint contained all the essential facts of the fraud it alleges.'" *Millenium Lab'ys*, 923 F.3d at 254.

[23] The District Court in *Savage* cast doubt on the validity of this theory about "notice of the need to investigate" in light of the Supreme Court's decision in *Kellogg Brown & Root*

Defendants do not set a limiting principle of what notice would mean. If a defense contractor is sued under the FCA alleging inflating invoices on a contract to build tanks, the government is not on notice of fraud on different contracts. If a pharmaceutical company is sued under the FCA alleging kickbacks with regard to a single drug, the government is not on notice of a price inflation scheme the company might also be performing. Courts have agreed. *Hartpence*, 792 F.3d at 1130 (second-filed suit not barred despite both cases alleging a medical device manufacturer misbilled the government in two ways when billing for the same device); *Barrett*, 2019 WL 4675756, at *4 (second-filed suit not barred despite both cases alleging different kickback schemes involving free Botox samples); *Savage*, 2015 WL 5794357, at *8 ("[E]ven though *Savage I* may have notified the U.S. government of the need to ensure that all prime contractors at Hanford were correctly claiming their . . . credits . . . the Court finds *Savage I* and *Savage II* are not based on the same material elements of fraud."); *United States ex rel. Chin v. CVS Pharmacy Inc.*, No. CV-09-1293 PSG, 2017 WL 4174416, at *5 (C.D. Cal. Aug. 15, 2017) (concluding that the government was not put on notice of a kickback scheme involving gift cards despite an earlier filed complaint mentioning it). Osinek's complaint did not put the government on notice of the claims brought by Taylor, including the expansion of her addenda claims to new regions.[24]

Servs., Inc. v. U.S. ex rel. Carter, 575 U.S. 650 (2015), which found that earlier filed suits that had been dismissed were no longer "pending" and thus do not serve as a bar to later suits. The District Court reasoned that this ruling "inherently limits" the analysis because a "broad 'notice' test does not serve the FCA's purpose of providing private parties the opportunity to pursue actions alleging fraud against the government once the first-to-file bar lifts following the dismissal of the earlier action." 2015 WL 5794357, at *8.

[24] It is notable that the United States did not intervene only in Osinek's complaint, or only against the California-based Defendants Osinek described, despite pursuing only the addenda theory.

Even were the Court to disregard the differences in geography, defendants, and contracts, which it should not, Taylor's three unique claims enumerated above nonetheless may move forward because they are distinct theories of fraud.

IV. Defendants' Request for Judicial Notice Should Be Denied, and Their Cherry-Picked Documents Would Not Change the Outcome

Defendants attempt to put a one-sided view of the government's investigation before the Court with an improper use of judicial notice, but that ploy should fail, because it is unwarranted and unsupported. Even if the Court were to take notice of the requested documents, they would not change the outcome of its first-to-file analysis.

Defendants proffer a selection of documents from the government's investigation to try to create a misleading view of the response to Osinek's complaint. Judicial notice of these documents is inappropriate and unnecessary for an evaluation of the first-to-file bar. A first-to-file analysis is "designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints." *In re Nat. Gas Royalties*, 566 F.3d at 964. Thus, it would be inappropriate for the Court to go beyond the pleadings to make the first-to-file determination. *LaCorte*, 149 F.3d at 235 n.6 ("Because we may decide whether the later complaints allege the same material elements as claims in the original lawsuits simply by comparing the original and later complaints, further factual development is unnecessary."); *see also United States ex rel. Ferrara v. Novo Nordisk, Inc.*, No. CV 11-1596 (RBW), 2019 WL 4305503, at *11 (D.D.C. Sept. 11, 2019); *United States ex rel. Ortega v. Columbia Healthcare, Inc.*, 240 F. Supp. 2d 8, 15 (D.D.C. 2003) (rejecting an evidentiary hearing on the ground that "[t]he only evidence needed to determine if a complaint is barred by § 3730's first-to-file rule is the complaints themselves"). The Court should therefore deny the judicial notice request as irrelevant to the issue before it. *See, e.g., Franklin v. City of San Leandro*, No. 17-cv-00789-HSG, 2017 WL 5665656, at *4 n.2

(N.D. Cal. Nov. 27, 2017) (denying as moot defendants' request for judicial notice where the court "did not rely on the documents in question to reach its disposition").

The documents Defendants seek to add to the record also offer only a partial view of the investigation, making them unsuitable for judicial notice under these circumstances—or if notice is taken, they should be accorded no weight. Judicial notice is only proper for facts "not subject to reasonable dispute . . . ." Fed. R. Evid. 201(b); *United States ex rel. Hong v. Newport Sensors Inc.*, 728 Fed. Appx. 660 (9th Cir. 2018).

The existence of the letters may not be under dispute, but their context is, and Relators do not have full access to the investigative back-and-forth between the United States and Defendants. It is plainly not appropriate on a Motion to Dismiss to permit discovery or introduce the comprehensive factual evidence about the focus, depth, breadth, and evolution of the government's investigation that would be required to give a full view of how the United States' investigation unfolded. Nor, again, is it necessary to the first-to-file determination, which looks only to the complaints.

Even if the Court were to take notice of the documents in isolation, they would not change the outcome. If the government initially sought broad discovery of Kaiser entities, that is standard practice, as is defendants' typical response: To insist on narrowing the investigation to what is really in the government's crosshairs.

Even on their own terms, Defendants' arguments about the subpoenas fail, as an examination of them reveals: The HHS OIG subpoenas target the allegations in Osinek's complaint but not those in Taylor's, not referencing NLP, Chart Review, or Probe Audits, while specifically mentioning data mining and the refresh of diagnosis codes. The focus on Kaiser's hospital network also strongly implies an investigation into business practices outside of

Colorado, a region in which Kaiser owned or operated no hospitals. Def. Req. for Judicial Notice, ECF No. 142 (January 18, 2022) (RJN), Exs. A–D at 6-10. Defendants' only connection between the Taylor case and the RJN exhibits are the fact that the subpoenas mention all "affiliates" and "subsidiaries" of the named entities and the fact that a 2017 letter from the Department of Justice clarified that the 2013 subpoenas applied to Kaiser's Colorado region. Mot. at 20. The boilerplate references to "affiliates" and "subsidiaries" in an OIG subpoena that names four Kaiser entities in California that the Osinek allegations focus on does nothing to show that the government was aware of any of Taylor's specific allegations. It is merely standard language in a cover letter.

Kaiser's argument about the 2017 letter, RJN Ex. E, fails as well. This letter was sent three years into the Taylor investigation and was clearly triggered by Taylor's complaint. The fact that certain of the documents would have been responsive to the 2013 subpoenas, had those subpoenas focused on Colorado, does not demonstrate overlapping claims between Osinek and Taylor. This is merely a shifting of focus of the government's investigation, as is common when the government is investigating disparate fraud schemes brought forward by multiple relators.

CONCLUSION

Because the Taylor and Osinek complaints allege different fraud schemes, regarding different government contracts, in different regions, by different Defendants, the first-to-file bar under 31 U.S.C. § 3730(b)(5) does not apply to Taylor's claims.

DATED: February 15, 2022

Respectfully submitted,

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, FOUNDATION HEALTH PLAN, INC., and THE PERMANENTE MEDICAL GROUP, INC., Defendants.	Consolidated Case No. 3:13-cv-03891 -EMC [Proposed] Order Noticed Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor
UNITED STATES OF AMERICA, *ex rel.* JAMES M. TAYLOR, M.D., Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, COLORADO PERMANENTE MEDICAL GROUP, P.C., THE PERMANENTE MEDICAL GROUP, INC., and SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, Defendants.	(Original N.D. Cal. Case No. 3:21-cv-03894-EMC) [Proposed] Order Noticed Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

[PROPOSED] ORDER

This matter coming to be heard on this 31st day of March 2022, upon consideration of DEFENDANTS' MOTION TO DISMISS PURSUANT TO THE FALSE CLAIMS ACT'S FIRST-TO-FILE BAR, and the Court being full advised in the premises;

IT IS HEREBY ORDERED that Defendants' Motion is DENIED as to Relator Dr. James Taylor.

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HON. EDWARD M. CHEN
United States District Judge