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24
25 **IN THE UNITED STATES DISTRICT COURT**
26 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

27 UNITED STATES OF AMERICA, *ex rel.*)
28 RONDA OSINEK,)

29 Plaintiffs,)

30 v.)

31 KAISER PERMANENTE, *et al.*,)

32 Defendants.)

33 Case No. 3:13-cv-03891-EMC
34 (Consolidated)

35 Hearing Date: March 31, 2022

36 Time: 1:30 p.m.

37 Judge Hon. Edward M. Chen

38 Courtroom: 5, 17th Floor

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UNITED STATES OF AMERICA and)
STATE OF CALIFORNIA, *ex rel.*)
GLORYANNE BRYANT and)
VICTORIA M. HERNANDEZ,)
)
Plaintiffs,)
)
v.)
)
KAISER PERMANENTE, *et al.*,)
)
Defendants.)
)
)

Case No. 3:18-cv-01347-EMC

**RELATORS BRYANT AND
HERNANDEZ'S RESPONSE IN
OPPOSITION TO DEFENDANTS'
MOTION TO DISMISS PURSUANT
TO FALSE CLAIMS ACT FIRST-
TO-FILE BAR**

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1 **I. INTRODUCTION**

2 Kaiser's Motion to Dismiss (ECF No. 141, the "Motion") seeks to flip the False Claims Act's
3 first-to-file doctrine on its head. Kaiser would have this Court believe that the consolidated FCA
4 cases before it are an extraordinary example of "parasitic" or "opportunistic" relators in competition
5 for a single FCA award. But that is clearly not this case. On the contrary, it is the scope and extent
6 of Kaiser's avarice that is extraordinary here. Not one, but a dozen different relators, in six different
7 cases, came forward under seal, unknown to one another and their respective filing statuses, in aid
8 of the government, to expose Kaiser's disparate, fraudulent activities. With the government partially
9 intervening in just a portion of these consolidated cases, and several of the "later-filed" relators
10 pursuing declined, unique portions of their claims, applying the first-to-file bar to narrow the claims
11 against Kaiser would work a stark injustice, favoring the wrongdoer (Kaiser) over relators and the
12 government on whose behalf they are suing.

13 Under Kaiser's improper formulation, the first-to-file bar precludes all later-filed FCA
14 complaints here once the earliest complaint (*Osinek*) asserted upcoding fraud in Kaiser's massive
15 Medicare Advantage plans. That is not how the bar operates. There is no basis to apply the first-to-
16 file doctrine where relators' claims are, at least in part, materially different from an earlier FCA
17 complaint, bringing to the government unique allegations of fraud that were not inevitably
18 discovered after the earlier disclosure.

19 As applied here, the billions that Kaiser receives each year in Medicare Advantage dollars
20 are comprised of millions of individual patient diagnoses and their related codes. Diagnoses and
21 coding are the basic currencies of Medicare Advantage; over-diagnosing and upcoding are thus the
22 basic currencies of Medicare Advantage fraud. To say that one relator blowing the whistle on
23 Medicare Advantage over-diagnosing and upcoding by Kaiser based on specific diagnoses and
24 codes, in specific Kaiser regions, during a discrete time period, operates as a bar to any other relator
25 coming forward with different upcoding, in different diagnoses, in different regions and timeframes,
26 carries the FCA's first-to-file doctrine well beyond its legal limit.

27 The first-to-file bar is particularly inapplicable to the 2018 complaint filed by relators
28 Gloryanne Bryant and Victoria Hernandez (the "*Bryant/Hernandez* Complaint," Case No. 3:18-cv-

1 01347-EMC, ECF No. 1). These relators, senior leaders in Kaiser's national and regional coding and
 2 audit departments respectively, brought to the government unique information and never-before-
 3 asserted fraud claims based on events and evidence that the purported first-to-file relator (*Osinek*)
 4 did not and could not have known about when she filed her complaint, and which were not inevitably
 5 discovered based on her (or anyone else's) earlier, substantially narrower, and materially different
 6 allegations. Specifically, unlike the *Osinek* complaint, the *Bryant/Hernandez* Complaint exposes
 7 Kaiser's upcoding fraud: (i) relating to a specific high-value diagnosis code, mechanical ventilator
 8 dependence status, that first came to light *after* *Osinek* filed her suit; (ii) not just on the Medicare
 9 Advantage program, but on a different government program (the Affordable Care Act) run by a
 10 different government agency entirely (the Department of Health and Human Services); and (iii)
 11 within Kaiser's insurance and physician-practice behemoths in all regions, not just one region, and
 12 also within Kaiser's massive hospital operation across Kaiser's regions, which was not even part of
 13 the *Osinek* suit.

14 One relator identifying one or more fraudulent straws in an enormous stack of hay (*e.g.*,
 15 Kaiser's massive Medicare Advantage plans) does not inevitably lead to the government's discovery
 16 that fraud will be found elsewhere in the stack, or where to look for it. Here, it took Relators Bryant
 17 and Hernandez to expose different Kaiser frauds, and different material elements of other frauds,
 18 that would not have been discovered otherwise, including fraud on a different haystack entirely (the
 19 Affordable Care Act). Kaiser's motion to dismiss should be denied as to Bryant and Hernandez.

20 **II. BACKGROUND**

21 **A. Government Programs' Payments Are Premised on Diagnosis Codes**

22 **1. Medicare Advantage Program**

23 Millions of elderly and disabled individuals throughout the United States receive their
 24 Medicare benefits through the Medicare Advantage Program (also referred to as "Medicare Part C").
 25 *Bryant/Hernandez* Complaint ("Compl.") ¶ 1. A central, distinguishing feature of the Medicare
 26 Advantage Program is the provision of Medicare benefits by private healthcare insurance
 27 organizations. *See* 42 U.S.C. §§ 1395w-21 to 1395w-28. Medicare beneficiaries enroll in managed
 28 healthcare insurance plans called Medicare Advantage Plans ("MA Plans") that are owned and

1 operated by these private organizations, called Medicare Advantage Organizations ("MA
2 Organizations" or "MAOs"). Compl. ¶ 1. *See also* 42 C.F.R. § 422.2.

3 The government pays each MA Organization a fixed monthly payment for each Medicare
4 beneficiary enrolled in its plans. Compl. ¶ 2. *See also* 42 U.S.C. § 1395w-23; 42 C.F.R. §§ 422.250
5 - 422.330 (Subparts F and G). The government adjusts these payments for various risk factors that
6 affect expected healthcare expenditures, including the health status of each enrollee. Compl. ¶ 2.
7 The adjustments are intended to ensure that MA Organizations are paid more for those enrollees
8 expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower
9 costs. *Id.*

10 To obtain payments based on adjustments for health status, MA Organizations submit
11 diagnosis codes to the government for the beneficiaries in their MA Plans. *Id.* ¶ 3. These diagnosis
12 codes are from the beneficiaries' medical encounters (*e.g.*, office and hospital visits). *Id.* Using these
13 diagnosis codes, the government calculates a risk score for each beneficiary. *Id.* The beneficiary's
14 risk score is then used to calculate monthly payments to the MA Organization for that beneficiary
15 for the following year. *Id.* *See also* 42 U.S.C. § 1395w-23(a)(1)(G); 42 C.F.R. § 422.308(e). In
16 general, the more numerous the conditions diagnosed, and the more severe the conditions, the higher
17 the risk score for a beneficiary and the greater the risk-adjusted payments made to the MA
18 Organization for that beneficiary. Compl. ¶ 3.

19 Thus, the Centers for Medicare & Medicaid Services' ("CMS's") health-based risk
20 adjustment model — known as the Hierarchical Conditions Category ("HCC") model — takes into
21 account diagnoses from inpatient hospital stays, emergency and outpatient surgery encounters, and
22 physician office or clinic visits. Compl. ¶ 41. *See also* 42 U.S.C. § 1395w-23; 42 C.F.R.
23 § 422.208(c). The HCC model is prospective, meaning that it relies on diagnoses for certain medical
24 conditions documented in the medical record and assigned to beneficiaries by their physicians in a
25 one-calendar-year timeframe to set the payment for each beneficiary for the following year. Compl.
26 ¶ 42. The medical conditions included in the model are grouped into HCCs, which are categories of
27 clinically related medical diagnoses. *Id.* *See also* 42 C.F.R. § 422.2. Related groups of diagnoses are
28

1 ranked on the basis of disease severity or burden, and the cost associated with their treatment.
2 Compl. ¶ 42.

3 Risk adjustment claims are true, and the resulting risk adjustment payments are valid, only
4 to the extent that the diagnosis codes submitted by the MA Organizations are valid. Compl. ¶ 49.
5 The diagnoses must be coded according to the *International Classification of Diseases (ICD)*
6 *Clinical Modification Guidelines for Coding and Reporting* ("ICD-9- CM" & "ICD-10-CM") and
7 documented with sufficient clinical specificity. *Id. See also* 42 C.F.R. § 310(d)(1); 45 C.F.R. §
8 162.1002. CMS publishes each year the many thousands of ICD diagnoses that map to HCCs for
9 purposes of Medicare Advantage risk adjustment. *See, e.g.,* [https://www.cms.gov/Medicare/Health-](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Risk-Adjustors-Items/Risk2013)
10 [Plans/MedicareAdvgtgSpecRateStats/Risk-Adjustors-Items/Risk2013](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Risk-Adjustors-Items/Risk2013) (listing ICD to HCC mapping
11 for 2013, the year the *Osinek* complaint was filed).

12 This payment model creates powerful incentives for MA Organizations to over-document
13 and over-report diagnosis codes in order to exaggerate the expected healthcare costs for their
14 enrollees. Compl. ¶ 4. In order to combat these incentives and protect the government from making
15 erroneous payments to MA Organizations, the government requires that submitted diagnoses be
16 supported and validated by the beneficiaries' medical records. *Id.* It is a well-established requirement
17 that all diagnosis codes submitted to the Medicare Program for risk adjustment payments must be
18 unambiguously supported by clinical documentation included in the beneficiaries' medical records.
19 *Id.* In addition, each MA Organization must expressly certify in "Risk Adjustment Attestations,"
20 submitted to CMS, that the diagnosis codes it has provided are accurate and truthful. *Id.* ¶ 5; 42
21 C.F.R. § 422.504(1)(2). Each MA Organization must also "[a]dopt and implement an effective
22 compliance program, which must include measures that prevent, detect, and correct non-compliance
23 with [the government's] program requirements as well as measures that prevent, detect, and correct
24 fraud, waste, and abuse." Compl. ¶ 5; 42 C.F.R. § 422.503(b)(4)(vi).

25 2. Affordable Care Act

26 The United States also contributes to premiums paid by individuals to private health
27 insurance companies, including Kaiser's private health plans, under the Affordable Care Act
28 (sometimes referred to as the "ACA"). Compl. ¶ 7. The Affordable Care Act authorizes the

1 Department of Health and Human Services (HHS) to utilize criteria and methods similar to those
2 utilized under the Medicare Advantage program to implement risk adjustment, and requires similar
3 attestations/certifications from health insurance companies as to the accuracy and documentation of
4 their risk adjustment data. *Id. See also, e.g.*, 42 U.S.C. §§ 18021 to 18024; 45 C.F.R. §§ 153.610 -
5 153.630. The HHS risk adjustment methodology developed by and on behalf of the CMS is based
6 on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency,
7 and not the health status of the enrolled population. Compl. ¶ 7. Accordingly, as under the Medicare
8 Advantage program, the more risk-adjusted diagnosis codes that are reported, the higher premiums
9 the companies are permitted to charge, and the higher contributions will be made to such premiums
10 by the United States. *Id.* When premiums are artificially high due to documentation and coding
11 fraud, both enrollees and the United States are harmed by the overcharges. *Id.* ¶ 52.

12 **B. Kaiser's Health-Care Consortium – A Three-Legged Stool**

13 Kaiser Permanente is a massive healthcare consortium that operates: (1) one of the nation's
14 largest health plans, serving over 11 million members; (2) among the nation's largest physician and
15 physician-service organizations; and (3) one of the nation's largest hospital chains. Compl. ¶ 25. *See*
16 *also* Motion at 1 n.1; United States Complaint in Intervention (Case No. 3:13-cv-03891 EMC, ECF
17 No. 110, "U.S. Compl.") ¶ 19. On the public insurance side, Kaiser's Medicare Advantage plans
18 serve well over 1 million members in seven different states, and generate approximately 30% of
19 Kaiser's overall profits. Compl. ¶ 26; U.S. Compl. ¶ 100. On the physician practice side, Kaiser
20 employs doctors and other medical professionals and provides direct medical services through its
21 Permanente Medical Groups, a for-profit set of regional affiliates that includes The Permanente
22 Medical Group ("TPMG") in Northern California, Southern California Permanente Medical Group
23 ("SCPMG") in Southern California, and five other regional areas including Hawaii, the Pacific
24 Northwest, Colorado, Georgia, and the Mid-Atlantic States. Compl. ¶ 25; U.S. Compl. ¶ 23. On the
25 hospital side, Kaiser owns and operates acute care hospitals in four regions (Northern California,
26 Southern California, Northwest and Hawaii), and provides care in other settings through its non-
27 profit Kaiser Foundation Hospitals ("KFH"). Compl. ¶ 25.

28

1 The three-legged stool of the Kaiser Permanente companies – health plans, medical groups,
2 and hospitals – reported revenue of \$64.6 billion in 2016. Compl. ¶ 27; U.S. Compl. ¶ 19.

3 **C. Osinek Complaint (2013)**

4 On August 22, 2013, Kaiser employee Rhonda Osinek filed a complaint under seal against
5 Defendant "Kaiser Permanente" under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, Case No.
6 3:13-cv-03891, ECF No. 1 ("*Osinek* Compl."). Osinek was employed by Kaiser's physician group
7 in Northern California (TPMG) in its Encounter Information Operations ("EIO") department as a
8 "Data Quality Trainer" and "Audit Manager" at the time of her complaint. *Osinek* Compl. ¶¶ 5, 23.
9 In that capacity, she trained TPMG physicians on coding guidelines and practices out of TPMG's
10 San Rafael, California facility. *Id.*

11 *Osinek* alleged that, beginning in 2007, the EIO department in Kaiser's TPMG region began
12 "data mining" and "diagnosis chasing" to improperly increase billings in the TPMG region for
13 certain "high value" HCCs in the Medicare Advantage program. *Osinek* Compl. ¶ 24. *Osinek* alleged
14 that the EIO department used algorithms to identify 18 specific disease conditions for its data mining
15 strategy, including chronic kidney disease and several diabetes-related conditions. *Id.* ¶ 25. *Osinek's*
16 allegations focused on TPMG EIO's efforts to "amend" or "addend" patient files after physician
17 office visits to "capture" these specific diagnoses retroactively for Medicare Advantage patients
18 even though they "were not addressed at the time of an encounter." *Id.* ¶ 28. *Osinek* alleged that
19 TPMG and EIO used boilerplate prompts, coding parties, and other incentives to "pressure[]
20 providers into approving retroactive diagnoses." *Id.* ¶¶ 28-39. According to *Osinek*, the focus on
21 data mining and high value HCCs resulted in over \$50 million in CMS Medicare Advantage
22 payments to Kaiser's Northern California (TPMG) region in 2009. *Id.* ¶ 41 (listing each specific
23 condition and associated reimbursement). On October 7, 2021, Osinek filed an Amended Complaint
24 naming TPMG and the Kaiser Foundation Health Plan, Inc. as defendants, but otherwise leaving her
25 allegations unchanged. *See* Case No. 3:13-cv-03891, ECF No. 87.

26 Osinek has never asserted fraud in either her original or amended complaints by Kaiser-
27 owned hospitals (or sued the Kaiser entity that owns and operates those hospitals), or asserted claims
28 about any of Kaiser's eight regions other than the Northern California region (or sued the Kaiser

1 entities in those other regions). The specific diagnoses that she alleges were being upcoded as of the
 2 filing of her Complaint in 2013 are specifically enumerated in her pleadings, and do not include the
 3 diagnosis of mechanical ventilation dependence. The *Osinek* Complaint is limited to allegations of
 4 fraud on CMS under the Medicare Advantage program; it does not assert any allegations of fraud
 5 on HHS under the Affordable Care Act.

6 **D. Taylor Complaint (2014), Arefi Complaint (2015) and Stein Complaint (2016)**

7 While the *Osinek* Complaint remained sealed, several other relators, unbeknownst to one
 8 another and to *Osinek*, filed new complaints against various Kaiser entities arising out of fraud on
 9 the Medicaid Advantage program. The 2014 *Taylor* Complaint filed in Colorado detailed a Medicare
 10 Advantage scheme by Kaiser largely in Kaiser's Colorado region, including coding errors caused by
 11 external providers (*e.g.*, non-Kaiser hospitals), and the upcoding of certain specific conditions (*e.g.*,
 12 cancer, stroke, and vascular disease) from 2004 to the 2014 filing of the Complaint. *Taylor*, Case
 13 No. 3:21-cv-03894-EMC, ECF No. 1.

14 The 2015 *Arefi* Complaint filed in the Central District of California alleged that Kaiser used
 15 an electronic "workflow tool" and improper physician querying to "data mine" for diagnoses
 16 mapped to high-value Medicare Advantage HCCs, leading to the upcoding of certain specific
 17 conditions (*e.g.*, angina pectoris, cachexia, and chronic kidney disease) between 2009 and 2013.
 18 *Arefi*, Case No. 3:16-cv-1558-EMC, ECF No. 1.

19 The 2016 *Stein* Complaint filed in the Central District of California focused on the upcoding
 20 of two specific Medicare Advantage diagnoses, sepsis and malnutrition (an Amended Complaint
 21 later added aortic atherosclerosis), and the use of improper physician queries and medical record
 22 reviews designed to "refresh" or add diagnoses unsupported by the medical records from 2006 to
 23 the 2016 filing of the Complaint. *Stein*, Case No. 3:16-cv-05337, ECF Nos. 1, 27.

24 **E. Bryant/Hernandez Complaint – Unique Claims on Different Diagnoses Against**
 25 **Additional Kaiser Defendants Defrauding a Different Government Program**
 26 **During a Later Time Period**

27 On March 1, 2018, while the *Osinek*, *Taylor*, *Arefi* and *Stein* Complaints remained under
 28 seal, Relators Bryant and Hernandez, through their counsel, filed their complaint under seal against
 numerous Kaiser entities, only some of which had been implicated in the *Osinek* Complaint. Given

1 that each of the complaints were filed under seal and remained sealed to the public when Bryant and
2 Hernandez filed their complaint, none of the other complaints were known or available to Ms.
3 Bryant, Ms. Hernandez or their counsel at the time of filing, and the other relators were unaware of
4 the *Bryant/Hernandez* Complaint when that complaint was also filed under seal.

5 Gloryanne Bryant is a national leader, speaker, and educator in coding, clinical
6 documentation improvement, and physician querying, and holds numerous coding and clinical
7 documentation credentials. Compl. ¶ 22. From 2009 until her retirement in late 2017, Ms. Bryant
8 held senior leadership positions within Kaiser, including, from 2013 until her retirement, as National
9 Director for Coding Quality, Education, Systems and Support within Kaiser's national office. *Id.*
10 Victoria Hernandez also carries decades of coding experience and 20 years at Kaiser in various
11 leadership positions, including as Regional Director for Kaiser's Northern California hospitals and,
12 separately, for TPMG; she also holds numerous coding and clinical documentation credentials. *Id.*
13 ¶ 23.

14 The *Bryant/Hernandez* Complaint contained similar allegations to the *Osinek* Complaint
15 (and the others) in some respects, but also included claims and allegations that were and are entirely
16 unique. The *Bryant/Hernandez* Complaint, for example, is the first and only one to allege that Kaiser
17 is committing fraud on the government through HHS-HCC risk adjustment manipulation under the
18 Affordable Care Act, a fraud on an entirely different government agency (HHS) and statutory
19 scheme (the ACA) than the Medicare Advantage agency (CMS) and program. *Id.* ¶¶ 51-52.¹

20 The *Bryant/Hernandez* Complaint is the first and only one to allege that mechanical vent
21 dependence, just one of the dozens of diagnoses that maps to just one of the HCCs (HCC 82) under
22 both the Medicare Advantage and ACA models, was systematically over-diagnosed and over-coded
23 by Kaiser. *Id.* ¶¶ 83-106. Kaiser physicians and hospitals were directed to diagnose the condition
24 even for short-term, acute use of ventilation on patients, exactly contrary to applicable and direct
25

26 _____
27 ¹ The *Bryant/Hernandez* Complaint also asserted fraud on the State of California's Medi-Cal
28 program, an additional distinguishing feature from the *Osinek* Complaint and the others. In their
Amended Complaint, however, the *Bryant/Hernandez* Relators have dropped their allegations and
claims implicating Medi-Cal.

1 coding guidelines. *Id.* ¶¶ 84-85, 87-88. Notably, the vent dependence fraud did not even come to
2 light until late 2013, after the *Osinek* Complaint had already been filed. *Id.* ¶¶ 89-101. And when
3 Ms. Bryant and Ms. Hernandez did discover it, they did so initially in the context of a patient
4 population (newborns) receiving care under the Affordable Care Act, before later discovering that
5 Kaiser was also improperly documenting and coding the vent dependence status diagnosis for
6 Medicare Advantage patients. *Id.*

7 The vent dependence allegations in the *Bryant/Hernandez* Complaint also distinguish it from
8 the *Osinek* Complaint in another critical way. The *Osinek* Complaint focuses on fraud in upcoding
9 diagnoses after physician office visits through the use of addenda, naming only the regional Kaiser
10 physician group, TPMG, and the Kaiser Health Plan that benefitted from TPMG's upcoding as
11 defendants. In contrast, the vent dependence section of the *Bryant/Hernandez* Complaint, among
12 others, focuses on *in-hospital* over-diagnosing and upcoding, not office visits, thus implicating an
13 entirely different leg of Kaiser's three-legged consortium, Kaiser Foundation Hospitals, which is not
14 even named in the *Osinek* Complaint. The *Bryant/Hernandez* Complaint is also unique in its national
15 scope. While the *Osinek* Complaint focuses on Kaiser's Northern California region, Bryant and
16 Hernandez gathered data from *all* Kaiser regions on, *inter alia*, improper vent dependence
17 diagnosing and coding; allege that the improper "capture" of this code was discussed at regional
18 reporting group meetings attended by representatives from every Kaiser region; and detail how they
19 raised the issue with the independent, official clearing house for coding guidance (the American
20 Hospital Association's Coding Clinic), which confirmed that Kaiser's approach to coding vent
21 dependence was erroneous. *Id.* ¶¶ 86-91, 101, 104.

22 On November 15, 2021, the *Bryant/Hernandez* Relators filed their Amended Complaint,
23 which narrowed their original Complaint somewhat, but left intact their unique claims and
24 allegations under the ACA and relating to vent dependence status documentation and coding. Case
25 No. 3:13-cv-03891-EMC, ECF No. 117.

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1 **F. Consolidation and the United States' Complaint-in-Intervention (2021)**

2 On June 25, 2021, this Court granted the United States' unopposed motion to consolidate the
3 various complaints,² finding that they "involve common questions of fact and law" relating to fraud
4 alleged on the Medicare Advantage Program. Case No. 3:13-cv-03891 EMC, ECF No. 61. On July
5 27, 2021, the United States filed its notice of election to intervene in each of the actions in part and
6 to decline in part:

7 [T]he United States intervenes on the allegations that defendants Kaiser Permanente;
8 Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado;
9 The Permanente Medical Group, Inc.; Southern California Permanente Medical
10 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.

11 Case No. 3:13-cv-03891 EMC, ECF No. 65 (emphasis added).

12 On October 25, 2021, the United States filed its Complaint-in-Intervention in all of the
13 consolidated cases, including the *Bryant/Hernandez* case. Case No. 3:13-cv-03891 EMC, ECF No.
14 110. Consistent with its intervention election, the United States' claims are brought against the
15 Kaiser Health Plan and several regional physician groups, including TPMG, based on fraud on the
16 Medicare Advantage program through Kaiser's "systematically altering patient medical records to
17 add diagnoses that either did not exist or were unrelated to the patient's visit with the Kaiser
18 physician." *Id.* ¶ 1. The United States' Complaint does not name Kaiser Foundation Hospitals as a
19 defendant; includes no allegations premised on vent dependence over-diagnosing and upcoding; and
20 does not include assertions of fraud on the government under the Affordable Care Act. Those claims
21 are only being pursued by Bryant and Hernandez on behalf of the government on a non-intervened
22 basis.

23 **III. ARGUMENT**

24 After a relator files an FCA lawsuit, no subsequent relator may "bring a related action based
25 on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). The aim of the first-to-file rule
26

27 _____
28 ² After the *Bryant/Hernandez* Complaint was filed, relator Bicocca filed a sixth case against various
Kaiser entities. *See* Bicocca, Case No. 3:21-cv-03124 EMC, ECF No. 1.

1 is to "promote incentives for whistle-blowing insiders and prevent opportunistic successive
2 plaintiffs." *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir.
3 2015) (quotation omitted). Importantly, "allowing claims for related but distinct fraud claims
4 encourages broader investigation and increases the total potential for recovery." *Id.* at 1131. The
5 first-to-file focus is on whether the two lawsuits contain "different material facts;" if they do, the
6 first-to-file bar does not apply. *Id.* at 1132.

7 Against this backdrop, Kaiser's Motion fails with respect to the *Bryant/Hernandez*
8 Complaint. Kaiser argues that the first-to-file bar applies "because the business practices and
9 motives alleged to target these conditions are the same" in the *Bryant/Hernandez* Complaint and in
10 the *Osinek* Complaint. Motion at 23. Kaiser avers that the allegations in the *Bryant/Hernandez*
11 Complaint are "just factual variations" from the allegations in the *Osinek* Complaint. *Id.* But Kaiser's
12 attempt to minimize the differences between the *Bryant/Hernandez* and *Osinek* complaints falls well
13 short. Bryant and Hernandez based their complaint on their own first-hand knowledge and
14 observations of fraud pervasive at Kaiser across all of Kaiser's regions. Most importantly for the
15 purposes of the Motion, they allege "different material facts": they were the first relators to describe,
16 in great detail, how Kaiser schemed to fraudulently overbill for the specific diagnosis of vent
17 dependence status; they were the first relators to detail how Kaiser's fraud schemes defrauded both
18 CMS' Medicare Advantage program and HHS' Affordable Care Act program; and they were the first
19 relators, given their senior positions within the organization and aggressive-but-futile attempts to
20 report up the chain to Kaiser's national leadership, to witness and detail all three prongs of the Kaiser
21 empire – (1) the health plan network, (2) the hospital network, and (3) the doctor network –
22 participating in Kaiser's massive frauds, throughout Kaiser's entire geographic footprint.

23 As Bryant and Hernandez were the first relators to allege these "different material facts,"
24 their complaint is not barred by the first-to-file rule. Far from being "opportunistic," Bryant and
25 Hernandez filed their complaint with no knowledge that anyone else had already done so. Kaiser's
26 motion, if granted, would improperly weaponize the first-to-file doctrine, stripping away unique
27 relator claims being pursued on a declined basis that Kaiser should be required to defend; and
28

1 prematurely adjudicating first-to-file status on consolidated claims in which the United States has
2 intervened. Kaiser's first-to-file motion should be denied in full.

3 **A. The First-to-File Bar Does Not Apply To the *Bryant/Hernandez* Complaint,
4 Which Alleges Different Material Facts Regarding Kaiser's Schemes**

5 Bryant and Hernandez go well beyond the "material facts" of the upcoding scheme alleged
6 in *Osinek*. *Osinek* alleges that Kaiser directed the scheme at specific conditions to defraud Medicare
7 through its practice of reviewing patient encounters in physician offices and changing diagnoses in
8 patient chart and billing information by way of adding "addenda" to visit notes well after the patient
9 encounter to capture "missed opportunities." *Osinek* Compl. ¶¶ 23-25. *Osinek* does not allege that
10 the upcoding scheme went beyond the identified conditions, that it happened contemporaneously
11 with the patient's visit, or that there was a separate scheme under the ACA; instead, it alleges there
12 were specific "disease conditions for data mining" that would support the specific "higher value
13 HCCs" identified by Kaiser in after-the-fact chart reviews as targets for over-documenting and
14 upcoding for Medicare Advantage reimbursements. *Id.*

15 Bryant and Hernandez, on the other hand, allege systemic over-documenting and upcoding
16 of the specific diagnosis of mechanical ventilation dependence status (HCC 82). *Am. Compl.* ¶¶ 80-
17 103. Vent dependence diagnoses were largely made contemporaneously *during* hospital inpatient
18 stays, not through an "addendum" process as part of a chart review as alleged in *Osinek*. *Osinek* did
19 not and could not know about the vent dependence fraud since it did not even come to light until
20 late 2013, after the *Osinek* Complaint had already been filed. Patients receiving vent dependence
21 diagnoses were generally hospital patients, not the patients at Kaiser's provider network as alleged
22 in *Osinek*. Bryant and Hernandez also allege that Kaiser schemed to over-charge individuals covered
23 by the ACA, not just the Medicare Advantage program that was the sole focus of *Osinek*. *See, e.g.,*
24 *Am. Compl.* ¶¶ 10, 49-51. *Osinek* never mentions vent dependence status diagnosing or coding,
25 HCC 82, or anything related to this condition. *See, e.g., Osinek* Compl. ¶¶ 25-26. That complaint
26 never makes any allegations about the ACA. It says nothing about hospital outpatients or inpatients.
27 Simply put, it makes no allegations that would lead to an investigation into Kaiser's wrongdoing on
28 these issues brought to light by Bryant and Hernandez at all. Far from being "opportunistic

1 successive plaintiffs," the *Bryant/Hernandez* Complaint's unique allegations related to vent
2 dependence and the ACA "encourage[] broader investigation and increase[] the total potential for
3 recovery," all the while reinforcing the FCA's goal of "promot[ing] incentives for whistle-blowing
4 insiders." *See Hartpence*, 792 F.3d at 1130-31.

5 As binding Ninth Circuit precedent dictates, the *Bryant/Hernandez* Complaint does not
6 allege mere "factual variations" on the over-documenting and upcoding scheme, so the first-to-file
7 bar does not apply. *See Hartpence*, 792 F.3d at 1121. In *Hartpence*, defendant Kinetic Concepts Inc.
8 ("KCI") submitted false claims to Medicare related to one of its medical devices, and two different
9 relators filed FCA lawsuits. Both complaints "arose out of the same time period, involved KCI's
10 billing practices for the same therapy device, alleged incorrect use of the same billing codes (the
11 KX modifier), shared '100 nearly identical paragraphs,' and were drafted by the same counsel." *Id.*
12 at 1131. In addition to KCI's fraud related to the KX modifier billing code, the later-filed complaint
13 also alleged that KCI committed fraud related to its failure to obtain "Detailed Written Orders"
14 ("DWOs") before delivering the device in question. The district court ruled that the first-to-file rule
15 barred the second complaint because it alleged "slightly different variations of false [Medicare]
16 billing" schemes for the same device as the first complaint. *Id.* The Ninth Circuit reversed, finding
17 that "[t]he rules governing use of KX modifiers and DWOs were disseminated at different times, in
18 different publications, and are plainly treated as separate regulations under the program." *Id.*

19 Similarly, *Osinek* alleges upcoding related to different conditions and HCC codes than does
20 the *Bryant/Hernandez* Complaint. The distinct HCC codes are subject to their own criteria and
21 regulations, and are as similar to each other as the KX modifier is to the DWO scheme in *Hartpence*.
22 Further, in *Hartpence*, the second complaint's allegations of the DWO fraud provided key benefits
23 to the government, as without them, "the government may have never discovered" the second
24 scheme. *Id.* The Ninth Circuit found that dismissal of the second complaint was antithetical to the
25 purpose of the first-to-file bar, because the second relator "provided information about a different
26 form of fraud," without which the government may have never investigated beyond the KX modifier
27 fraud, and never discovered the DWO fraud. *Id.* at 1131-32. The same is true here: without Bryant
28 and Hernandez's allegations of vent dependence over-documenting and upcoding, the government

1 would not inevitably search for and discover what would otherwise be a unique needle in the
2 haystack of HCC codes that Kaiser exploits; it would not have cause to investigate wrongdoing
3 under the ACA; and it would not have been led to investigate fraud at Kaiser's hospitals.

4 *United States ex rel. Barrett v. Allergan, Inc.*, No. SACV 18-203 JVS(KESx), 2019 WL
5 4675756 (C.D. Cal. Sept. 24, 2019), is also instructive. In that case, the court held that the first-to-
6 file bar did not apply, even though both relators alleged fraud pertaining to the same drug. The first
7 complaint alleged that Allergan engaged in a kickback scheme when it improperly induced
8 physicians to prescribe and promote Botox with free goods and services. *Id.* at *3. The later
9 complaint also alleged that Allergan improperly gave physicians free goods and services as part of
10 an illegal kickback scheme, but also that this scheme resulted in Allergan fraudulently "elevating
11 the price of Botox reported and paid by the Government" by manipulating the "Average Sales Price"
12 ("ASP") that Allergan reports and that the government uses to calculate its payment. *Id.* at *1. The
13 court concluded that even though both complaints centered on Botox, the "fraudulent schemes" and
14 "material facts underlying the allegations" were different, and thus the first-to-file bar did not apply.
15 *Id.* at *4. The second complaint's allegations of ASP fraud were broader than the first complaint's,
16 and would lead to different damages, *id.*, just like the *Bryant/Hernandez* Complaint's over-
17 documenting, upcoding and ACA allegations go beyond what *Osinek* alleges, and would lead to
18 different and additional damages. Notably, the first-to-file bar did not apply in *Barrett* even though
19 the first complaint also had "allegations of fraudulent ASP reporting," since the first complaint's
20 treatment of the ASP issue was narrower. *Id.* Thus, even if the allegations in *Osinek* are construed
21 to touch on issues relevant to vent dependence, its allegations are indisputably narrower than what
22 *Bryant/Hernandez* alleges.

23 Further, in *United States ex rel. Galmines v. Novartis Pharms. Corp.*, No. 06-3213, 2013
24 WL 2649704 (E.D. Pa. June 13, 2013), *on reconsideration in part*, 2013 WL 5924962 (E.D. Pa.
25 Nov. 5, 2013), two relators alleged that Novartis engaged in fraudulent off-label marketing of the
26 drug Elidel. The first relator alleged that Novartis improperly marketed Elidel for treatment of
27 psoriasis and seborrhea; the second alleged that Novartis improperly marketed it for treatment of
28 atopic dermatitis and for use in infants. Even though the two complaints alleged marketing schemes

1 pertaining to the same drug, the court held that the first-to-file bar did not bar the second relator's
2 off-label marketing allegations, as "[n]o reasonable reading" of the first complaint would have
3 informed the government of the need to investigate further potential off-label marketing abuses. *Id.*
4 at *10. Novartis' marketing of Elidel is akin to Kaiser's overall over-documenting and upcoding
5 schemes. Just as the first-to-file bar did not apply to distinct manifestations of Novartis' marketing
6 scheme, it does not apply to distinct manifestations of Kaiser's upcoding schemes or to allegations
7 of fraud on an entirely different government agency and program (HHS and the ACA), involving a
8 different arm of Kaiser (the hospital division), and covering all of Kaiser's regions.

9 Kaiser's reliance on *United States ex rel. Marion v. Heald Coll., LLC*, No. 5:12-cv-02067,
10 2015 WL 4512843 (N.D. Cal. July 24, 2015) is misplaced, as *Marion* does not relate to relators
11 alleging distinct forms of fraud. *See* Motion at 16-17. *Marion* was a case about fraud in the for-
12 profit education industry. Earlier-filed lawsuits alleged that the defendants engaged in "attendance
13 fraud" schemes, whereby attendance figures were inflated resulting in higher payments to the
14 schools. *Marion* argued that her complaint alleged an "enrollment fraud" scheme, focusing on
15 "phantom students" enrolled without consent or confirmation that they met eligibility requirements.
16 The court found the two schemes "sufficiently related" to trigger the first-to-file bar because any
17 government investigation into attendance fraud "would inevitably uncover" enrollment fraud: "The
18 government's investigation into discrepancies between actual and electronic attendance records
19 therefore would identify any student fraudulently enrolled in the manner *Marion* alleges. Her
20 allegations therefore contribute little—if anything—to the government's investigation." *Id.* at *3.

21 In contrast, the government's investigation into Kaiser's fraud related to the upcoded
22 diagnoses identified in *Osinek* would not have "inevitably uncovered" upcoding in unidentified
23 diagnoses, particularly given the maze of diagnoses that map to risk-adjusted HCCs in the Medicare
24 Advantage program. Given the sheer number of diagnosis codes, it would be impossible for the
25 government to identify fraudulent over-documenting and upcoding in particular diagnoses without
26 being pointed in the right direction. *Osinek* never pointed the government to vent dependence over-
27 documentation and upcoding; she did not point to in-hospital coding at all; and the particular scheme
28

1 that she did identify, the use of addenda to populate diagnoses after physician office visits, is not
2 implicated in the vent dependence scheme identified by Bryant and Hernandez.

3 Kaiser also cites *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371
4 (5th Cir. 2009). Motion at 16. That case dealt with fraud by insurers in the aftermath of Hurricane
5 Katrina. *Branch*, 560 F.3d at 374. The federal government backs a flood insurance program for
6 private insurers, and pays benefits for damages caused by floods. *Id.* Normally, the insurer is
7 required to submit certain proof to the federal government that the loss is indeed caused by flood
8 waters, as opposed to other damage such as wind. *Id.* After Hurricane Katrina, the government
9 relaxed its documentation requirements in order to expedite payments to affected insureds. *Id.* The
10 first-to-file relator, Rigsby, alleged that four insurance companies exploited the weakened reporting
11 requirements to fraudulently classify damage as flood damage (and thus covered in part by the
12 federal government) instead of wind damage (which would have to be covered solely by the insurers'
13 funds). *Id.* at 374-75. The later-to-file relator, Branch, alleged the same fraudulent scheme
14 conducted by 14 insurance companies, including two of the four that *Rigsby* named.

15 As to the twelve defendants named in *Branch* but not named in *Rigsby*, the court held that
16 the first-to-file bar did *not* apply. *Id.* at 379-80. As to the two common defendants, the court held
17 the first-to-file bar applied, as the only additional allegations that Branch included were 57 specific
18 examples of the fraud in action, finding these were mere "factual details" of the same fraud scheme.
19 *Id.* at 375, 378. In sharp contrast, the *Bryant/Hernandez* Complaint alleges additional schemes than
20 the one identified in *Osinek*, involving vent dependence status documentation and coding, the
21 Affordable Care Act, and a completely different arm of Kaiser, its hospital network. *Branch* is
22 inapposite.

23 **B. The First-to-File Bar Does Not Apply To the *Bryant/Hernandez* Complaint As**
24 **It Alleges Different Material Facts Regarding the Kaiser Entities Involved in**
the Frauds

25 The fact that the *Bryant/Hernandez* Complaint alleges fraud by Kaiser's hospital division –
26 an entity not named in *Osinek* – is an independent reason why the complaint escapes the first-to-file
27 bar. So too is the fact that the *Bryant/Hernandez* Complaint's allegations implicate the entire Kaiser
28 organization in all its breadth; not just a single region's physician group and health plans like *Osinek*.

1 Bryant and Hernandez were able to make these allegations due to their roles at Kaiser, making them
 2 precisely the "whistle-blowing insiders" that Congress wanted to encourage through the FCA. Both
 3 worked for Kaiser in leadership positions – Bryant in senior national leadership, and Hernandez in
 4 regional medical coding leadership. Am. Compl. ¶¶ 20-21. As their complaint shows, this insider
 5 access gave them insight into the fraud engaged in by Kaiser throughout *all* of its main divisions
 6 across the entire country: the health plan division, the hospital division, and the provider network
 7 division. The *Bryant/Hernandez* Complaint names as a defendant Kaiser Foundation Hospitals. Am.
 8 Compl. ¶ 28. *Osinek* focuses solely on Kaiser's other two divisions and a single region. Kaiser's
 9 fraud related to hospital visits – alleged for the first time by Bryant and Hernandez – is very different
 10 from its fraud related to provider visits.³

11 In *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-
 12 EFS, 2015 WL 5794357 (E.D. Wash. Oct. 1, 2015), the first-filed lawsuit alleged that a government
 13 contractor for the Department of Energy's Hanford Site, WCH, conspired with a sub-contractor, FE
 14 & C, and violated the FCA. *Id.* at *3. Based on information learned in discovery, the relator filed a
 15 second lawsuit alleging that a second government contractor working at the Hanford Site, CHPRC,
 16 engaged in the same scheme with FE & C. *Id.* The court observed that both lawsuits "allege a similar
 17 fraudulent scheme, i.e., a prime contractor colluded with FE & C to create small, disadvantaged
 18 businesses to apply for subcontracts when the work would be performed by FE & C. . . ." *Id.* at *9.
 19 WCH (the contractor in the first case) and CHPRC (the contractor in the second case) were related
 20 entities; CH2M Hill Companies Ltd. owned all of CHPRC, and 30% of WCH. *Id.* The court
 21 concluded that the first-to-file bar was inapplicable despite the overlap between the cases and
 22 defendants, as "the allegations involve different essential facts regarding fraudulent schemes
 23 involving distinct prime contractors and distinct subcontracts at the Hanford site." *Id.* The court held
 24 that the corporate overlap between the two defendants "does not impact the determination" that the

25
 26 ³ Though Kaiser's Motion makes no argument comparing *Bryant/Hernandez* to the complaints in
 27 *Arefi* and *Stein*, those earlier-filed complaints do name Kaiser hospital entities as defendants.
 28 However, neither *Arefi* nor *Stein* say anything about vent dependence or the ACA; instead, they too
 allege schemes involving different material facts, and thus do not trigger the first-file-to bar with
 respect to the *Bryant/Hernandez* Complaint.

1 two cases were "materially different." *Id.* See also *United States ex rel. Chin v. CVS Pharmacy, Inc.*,
2 No. CV 09-1293 PSG PJWx, 2017 WL 4174416, at *5 (C.D. Cal. Aug. 15, 2017) (first-filed
3 complaint named Walgreens as defendant, but contained allegations against CVS; later-filed
4 complaint against CVS not barred since the first complaint "does not plead any material facts
5 necessary to establish a valid FCA claim against CVS or contain any allegations regarding CVS's
6 specific conduct, such that the government would be on sufficient notice to investigate.").

7 By adding allegations about an entirely different division of the Kaiser empire, as well as
8 allegations about all regions throughout the nation that Kaiser operates in, Bryant and Hernandez
9 have alleged a "more far-reaching scheme to defraud the federal government," taking their complaint
10 outside the ambit of the first-to-file rule. See *United States ex rel. Heath v. AT & T, Inc.*, 791 F.3d
11 112, 121 (D.C. Cir. 2015). The *Osinek* Complaint's allegations, which say nothing about Kaiser's
12 hospital network, did not provide the government with reason to investigate that distinct arm of
13 Kaiser. *Id.* at 123 ("one subsidiary's infractions do not presumptively symptomize a corporate-
14 pervading problem. A single broken branch does not mean that the entire tree is diseased.").

15 Kaiser's argument that the first-to-file rule bars later lawsuits against "different members of
16 the same corporate family" fails with respect to the *Bryant/Hernandez* Complaint, and Kaiser's cases
17 are distinguishable. Motion at 17. In *United States ex rel. Hampton v. Columbia/HCA Healthcare*
18 *Corp.*, 318 F.3d 214, 218 (D.C. Cir. 2003), the first relator filed suit against HCA, and alleged a
19 corporate-wide fraud perpetrated through numerous but unnamed subsidiaries. The court held that
20 the first-to-file rule barred a later suit against an HCA subsidiary that operated in Georgia. *Id.*
21 *Hampton* is inapposite because *Osinek* makes no allegations at all about Kaiser's hospital division.
22 Bryant and Hernandez do not just add a regional subsidiary of the same corporate parent; they allege
23 fraud by a different division of the Kaiser corporate family entirely. As Kaiser's other cited case
24 observed, one reason that the first-to-file bar can apply to claims against related subsidiaries is that
25 "they will often be jointly liable for the same underlying conduct." *In re Nat. Gas Royalties Qui*
26 *Tam Litig.*, 566 F.3d 956, 962 (10th Cir. 2009). Kaiser does not argue that its hospital division is
27 jointly liable with its health plan or healthcare provider divisions, yet another reason why the first-
28 to-file bar is inapplicable to Bryant and Hernandez.

1 **C. The First-to-File Doctrine Should Have No Impact on Bryant's and**
 2 **Hernandez's Status as Relators in the Intervened Complaint in These**
 3 **Consolidated Cases**

4 The government's election to intervene, in part, in the *Bryant/Hernandez* Complaint, along
 5 with the other consolidated cases, renders decision on the first-to-file issue premature, at least as it
 6 relates to those claims that are proceeding on an intervened basis. "If, as it does here, the
 7 Government intervenes in multiple overlapping *qui tam* actions, its complaint in intervention will
 8 necessarily incorporate the material elements of fraud from the earliest-filed complaints containing
 9 those elements." *United States v. Berkeley Heartlab, Inc.*, 225 F. Supp. 3d 487, 495 (D.S.C. 2016).
 10 Thus, the government's complaint-in-intervention "necessarily" incorporates material elements of
 11 fraud first alleged in *Bryant/Hernandez* and in each of the other consolidated cases. See U.S. Compl.
 12 ¶¶ 12-18 .

13 In the event there is a judgment or settlement in the United States' intervened case, there may
 14 come a time when first-to-file issues will be ripe amongst the relators to determine which allegations
 15 form the basis of the intervened case's resolution, and then who was the first relator to allege them.
 16 But that time is not now. Kaiser cites no authority for the proposition that a FCA defendant, through
 17 early first-to-file motion practice, can strip from the government's complaint-in-intervention in a
 18 series of consolidated cases all references to one or more relators and their cases. Bryant and
 19 Hernandez should continue to be relators in the intervened case regardless of Kaiser's first-to-file
 20 challenge.

21 **IV. CONCLUSION**

22 The *Bryant/Hernandez* Complaint survives Kaiser's first-to-file challenge because it alleges
 23 key, distinct material facts when compared to *Osinek's* (or any other relator's) complaint. Without
 24 the hard work and diligence of Bryant and Hernandez, the government would have no reason to
 25 suspect wrongdoing by Kaiser related to vent dependence, Kaiser's hospital arm, and the ACA, all
 26 taking place throughout Kaiser's entire geographic footprint. Bryant and Hernandez's diligence and
 27 courage in coming forward with their claims brought these aspects of Kaiser's fraud to light.
 28 Punishing them as Kaiser asks because, completely unbeknownst to Bryant and Hernandez,
 someone else filed related but materially different lawsuits runs afoul of the FCA. *See, e.g.*,

1 *Hartpence*, 792 F.3d at 1132. The Court should deny Kaiser's Motion as to Relators Bryant and
2 Hernandez.

3 Dated: February 15, 2022

4 Respectfully submitted,

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6 VICTORIA M. HERNANDEZ

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24
25 **IN THE UNITED STATES DISTRICT COURT**
26 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**

27 UNITED STATES OF AMERICA, *ex rel.*)
28 RONDA OSINEK,)

29 Plaintiffs,)

30 v.)

31 KAISER PERMANENTE, *et al.*,)

32 Defendants.)

33 Case No. 3:13-cv-03891-EMC
34 (Consolidated)

35 Hearing Date: March 31, 2022

36 Time: 1:30 p.m.

37 Judge Hon. Edward M. Chen

38 Courtroom: 5, 17th Floor

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UNITED STATES OF AMERICA and)
STATE OF CALIFORNIA, *ex rel.*)
GLORYANNE BRYANT and)
VICTORIA M. HERNANDEZ,)
)
Plaintiffs,)
)
v.)
)
KAISER PERMANENTE, *et al.*,)
)
Defendants.)
)

Case No. 3:18-cv-01347-EMC

[PROPOSED] ORDER

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[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.

HON. EDWARD M. CHEN
United States District Judge