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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, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: April 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC.,

Plaintiffs,

v.

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

Defendants.

Case No. 3:16-cv-01558-EMC

REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: April 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE,

Plaintiffs,

v.

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

Defendants.

Case No. 3:16-cv-05337-EMC

REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: April 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ,

Plaintiffs,

v.

KAISER PERMANENTE, et al.,

Defendants.

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

REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: April 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: April 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiffs,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: April 14, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

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I. INTRODUCTION

Defendants'[1] Motion warned that permitting the Later-Filed Complaints to proceed based on the same fraudulent scheme alleged by Ronda Osinek in her 2013 complaint would complicate the litigation, confuse the issues, and waste resources—all pitfalls that the FCA's first-to-file bar is designed to prevent. The multiple Oppositions confirm that this warning was well founded. The Opposing Relators[2] have filed over 70 pages in response to the Motion, Oppositions that contradict one another, confuse the law, and misstate the facts alleged in *Osinek* and the other *qui tam* complaints. The Opposing Relators cannot even agree with one another on foundational questions such as whether the first-to-file bar is jurisdictional, which it is, and whether the original complaints control the Court's analysis, which they do.

The best that can be said about the Opposing Relators' varied and inconsistent Oppositions is that they have significantly narrowed the focus of their complaints, including the disputed questions that the Court must decide here. Indeed, they make several key concessions at the outset:

- The *Arefi* Relators concede that the first-to-file bar requires dismissal of their entire complaint, having filed a non-opposition to the Motion.
- The *Stein* Relators concede that the first-to-file bar requires dismissal of their FCA claims based on allegations about "refresh" practices, which were asserted against Defendants across the country.
- And Bicocca concedes that the first-to-file bar requires dismissal of his entire original complaint, which alleged that Defendants improperly pressured specialist healthcare providers to diagnose chronic medical conditions.[3]

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[1] Defined terms and acronyms have the same meaning as in Defendants' Motion, unless otherwise specified. Because the various complaints do not name all of the same defendants, "Defendants" or "Kaiser" refers to the defendants named in the complaint(s) referenced in the relevant portion of the Motion and this Reply, unless otherwise indicated. Although Kaiser Permanente is not a legal entity, Dkt. No. 141 ("Mot.") n.1, "Defendants" and "Kaiser" include Kaiser Permanente where named in the complaint at issue.

[2] The "Opposing Relators" are Taylor, the *Stein* Relators, the *Bryant* Relators, and Bicocca. The *Arefi* Relators filed a non-opposition to the Motion. Dkt. No. 143.

[3] Bicocca voluntarily dismissed his claims under the California False Claims Act. *See* Dkt. No. 159. Accordingly, even assuming his amended complaint is the relevant pleading, only his

Attempting to save the remainder of their complaints from dismissal, the Opposing Relators propose a myopic reading of Osinek's complaint, contending that it concerns only "addenda" practices in the state of California, whereas their complaints extend beyond addenda, California, or both. The Opposing Relators ignore, however, that Osinek's first-filed complaint named "Kaiser Permanente"—a trade name that describes the national collaboration among the various Defendant health plans, hospitals, and medical groups—and never limits its allegations to addenda practices. Given the broad scheme that it alleges, *Osinek* clearly put the United States on notice of a purported nationwide scheme to defraud the Medicare Advantage program that went beyond addenda practices and that implicated Medicare Advantage diagnosis-coding practices generally. And this conclusion is not speculation because, shortly after Osinek filed her complaint, the United States issued to various Defendants wide-ranging subpoenas that encompassed virtually every diagnosis-coding practice imaginable.

Unable to limit *Osinek*'s subject matter to addenda or its geographic reach to California, the Opposing Relators contend that their complaints nonetheless identify fraud schemes that the *Osinek* complaint does not. Their own allegations belie that assertion. The most the Opposing Relators can muster are inconsequential variations on the essential facts that Osinek already alleged. The factual distinctions to which they point in their Oppositions would render meaningless the intent of the first-to-file bar. Every relator in every *qui tam* action can point to some factual distinctions, but the first-to-file bar requires more—it requires material and consequential distinctions sufficient to raise distinct fraud schemes to proceed to litigation.

Taylor contends that his allegations about natural language processing, "one-way chart review," and audit results constitute distinct fraud schemes that survive the first-to-file bar. But Osinek's complaint encompasses each of these allegations. Taylor's allegations about Defendants' natural language processing program closely resemble Osinek's allegations about data mining—both concern the use of algorithms to search for additional medical conditions to report to CMS, which Taylor and Osinek allege occurred without a proper focus on data quality

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FCA claims remain, and as discussed in the Motion and *infra* at 27–31, the first-to-file bar requires dismissal of those claims as well.

and auditing. Similarly, Taylor's one-paragraph allegation about chart review simply says that Defendants hired coders to review medical records in search of additional diagnoses to report to CMS, which echoes Osinek's allegations that Defendants used data mining to identify missed diagnosis-coding opportunities. And Taylor's allegations about error rates identified in audits of diagnosis-code data do not identify a unique fraud scheme. Rather, they purport to show that Defendants had knowledge of the upcoding scheme that Osinek already alleged.

The *Stein* Relators contend that they have alleged unique fraud schemes about the way Defendants "upcoded" diagnoses of sepsis, malnutrition, and aortic atherosclerosis. But Osinek alleges an upcoding scheme and does not purport to limit it to specific medical conditions. She alleges that Kaiser Permanente submitted diagnosis codes to CMS for complex medical conditions without support, allegations which necessarily encompass the condition-specific fraud that the *Stein* Relators allege. Similar allegations in the initial *Arefi* and *Taylor* complaints—both of which preceded *Stein*—provide additional reasons to dismiss *Stein* under the first-to-file bar.

The *Bryant* Relators focus their Opposition on three fraud allegations that they contend distinguish their complaint from *Osinek*: diagnosis coding in the hospital setting, improper diagnosis coding of vent dependence, and fraud on the risk-adjustment program established by the Affordable Care Act ("ACA"). But Osinek's complaint was sufficient to put DOJ on notice of hospital-related claims, given that Osinek alleged a nationwide scheme across Kaiser-affiliated entities. The *Bryant* Relators' allegations about improper coding of vent dependence again are merely factual variations on the upcoding scheme that Osinek alleged, which describes how Kaiser Permanente instructed healthcare providers to diagnose medical conditions in ways that contravened diagnosis-coding guidelines. And the *Bryant* Relators' ACA arguments are without merit because their causes of action do not even refer to a fraud based on violations of the ACA.

Bicocca concedes that the first-to-file bar requires dismissal of his original complaint, but then argues that a single allegation from his amended complaint somehow survives dismissal. Because the first-to-file analysis centers on a comparison of original complaints, and Bicocca concedes that *Osinek* bars his original complaint, the Court should summarily dismiss his FCA claims. In any event, his amended complaint does not allege any unique fraud in comparison to

Osinek and cannot save his *qui tam* action. The single allegation that Bicocca highlights—that Defendants used "upfront diagnoses lists to re-diagnose" members—is substantively the same as Osinek's allegations that Kaiser Permanente refreshed Medicare Advantage members' medical conditions each year.

The Opposing Relators insist that they are not "opportunists" copying earlier allegations, since they did not know about *Osinek* or each other's complaints until the Court unsealed the complaints in 2021. Indeed, the *Bryant* Relators urge the Court not to "punish" them for failing to know about Osinek's prior allegations. But this argument is misdirection. The first-to-file bar is neither a punishment nor reward, and the Opposing Relators' lack of knowledge is neither unique nor relevant to the first-to-file analysis. The Opposing Relators ignore that a key purpose of the first-to-file bar is to create a virtuous race to the courthouse so that whistleblowers will bring their claims of fraud to the United States as soon as possible, and to prohibit duplicative suits that do nothing to assist DOJ in its investigation of fraud allegations. Allowing five *qui tam* actions to go forward on the same allegations of fraud would do nothing to advance this statutory goal and would permit future whistleblowers to delay bringing fraud claims without consequence. The knowledge or lack of knowledge of later relators is simply irrelevant to the statute's language and purpose. The Court should grant the Motion and dismiss all of the FCA fraud claims in the Later-Filed Complaints under the first-to-file bar.

II. ARGUMENT

A. The First-to-File Bar Is Jurisdictional and the Court's Analysis Must Focus on the Original Complaints.

As Defendants explained in the Motion, the first-to-file bar is jurisdictional, and the Court must compare original complaints for purposes of the first-to-file analysis. Mot. at 17–18. Even among themselves, the Opposing Relators cannot agree on either foundational point.

The Ninth Circuit has stated unequivocally that the first-to-file bar is jurisdictional. It did so two decades ago in *Lujan* and again fourteen years later, sitting en banc in *Hartpence*. *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186–87 (9th Cir. 2001) (explaining that 31 U.S.C. § 3730(b)(5) is a "jurisdictional bar"); *see also United States ex rel. Hartpence v.*

Kinetic Concepts, Inc., 792 F.3d 1121, 1130 (9th Cir. 2015) (en banc) ("We treat the first-to-file bar as jurisdictional."). Because the first-to-file bar implicates the Court's subject-matter jurisdiction, Defendants brought the Motion under Federal Rule of Civil Procedure 12(b)(1) rather than Rule 12(b)(6).

Only the *Stein* Relators contest that the bar is jurisdictional, and they offer no persuasive reason to deviate from Ninth Circuit precedent. Dkt. No. 157 ("*Stein* Opp'n") at 9–10. They point to the Supreme Court's statement in *Gonzalez v. Thaler* that a rule is jurisdictional if the legislature "clearly states that a threshold limitation on a statute's scope shall count as jurisdictional," *see* 565 U.S. 134, 141 (2012), arguing that the first-to-file bar does not use such clear language. *Stein* Opp'n at 9. But *Thaler*, a habeas decision, does not address the first-to-file bar. Nor does *Thaler* state that a statute must use the word "jurisdiction" to be jurisdictional. The first-to-file bar clearly states that "no person other than the Government" can bring an FCA action related to a pending action—stripping non-governmental litigants of the ability to bring, and thus courts of the ability to hear, any such related case. 31 U.S.C. § 3730(b)(5). While at least one other circuit has concluded that the bar is not jurisdictional,[4] such decisions are not binding on this Court; *Lujan* and *Hartpence* are binding precedent. This Court must follow the Ninth Circuit's en banc decision—which, in any event, postdates *Thaler*—and evaluate the Motion under Rule 12(b)(1).[5] *See United States ex rel. Doe v. Janssen Pharm. N.V.*, 2018 WL 5276291, at *2 (C.D. Cal. Apr. 19, 2018) (noting that "some courts have questioned" whether the first-to-file bar is jurisdictional, but following "Ninth Circuit guidance" and dismissing a complaint barred by § 3730(b)(5) under Rule 12(b)(1)).

While none of the other Opposing Relators contests that § 3730(b)(5) is jurisdictional, they cannot agree on which complaints the Court should compare when conducting the first-to-file analysis. The *Bryant* Relators do not contest that the Court should compare original

[4] *See, e.g.*, *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 121 (D.C. Cir. 2015).

[5] The Fourth, Fifth, and Tenth Circuits also have concluded that the first-to-file bar is jurisdictional. *See United States ex rel. Carter v. Halliburton*, 866 F.3d 199, 203 (4th Cir. 2017); *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 376–77 (5th Cir. 2009); *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1278 (10th Cir. 2004).

complaints. But the *Stein* Relators and Bicocca ask the Court to focus on their most recent amended complaints.[6] *Stein* Opp'n at 10; Dkt. No. 154 ("*Bicocca* Opp'n") at 5–6. And without any authority, Taylor takes the inexplicable position that the Court should evaluate his first amended complaint—not his original or even his operative second amended complaint.[7] Dkt. No. 156 ("*Taylor* Opp'n") at 6 n.4.

The Relators' original complaints govern the analysis. This conclusion accords with the bar's jurisdictional nature, its plain text, and common sense. As the Motion explained, subject-matter jurisdiction must exist at the time the action was commenced. *Strudley v. Santa Cruz Cnty. Bank*, 747 F. App'x 617, 618 (9th Cir. 2019) ("This Circuit has adhered to the time-of-filing rule, which provides that '[s]ubject matter jurisdiction must exist as of the time the action is commenced.'" (quoting *Morongo Band of Mission Indians v. Cal. State Bd. of Equalization*, 858 F.2d 1376, 1380 (9th Cir. 1988))). "[F]ederal jurisdiction cannot be created by amendment if it did not exist at the outset" of an action. *Sepehry-Fard v. Countrywide Home Loans. Inc.*, 2014 WL 2707738, at *3 (N.D. Cal. June 13, 2004); *see also United States ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248, 261 (E.D. La. 2011) ("[A] court cannot proceed if it lacked jurisdiction at the time the initial complaint was filed.").

The *Stein* Relators point to a footnote in *Hartpence* stating that the court would look to amended complaints to determine jurisdiction there, but that was merely dictum in the opinion's factual background section and the statement is distinguishable in two respects. *Stein* Opp'n at 10; *Hartpence*, 792 F.3d at 1125 n.2. First, in making that statement, the Ninth Circuit relied exclusively on the Supreme Court's opinion in *Rockwell*, which evaluated a different FCA provision that also was at issue in *Hartpence*, but is not at issue here. *See Hartpence*, 792 F.3d at 1125 n.2 (citing *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 473–74 (2007), which discusses the FCA's public-disclosure bar in 31 U.S.C. § 3730(e)(4)). Second, *Rockwell*

[6] Bicocca's amended complaint is substantively similar to his original complaint, so the first-to-file analysis would not change in any event for the *Bicocca* action.

[7] Like Bicocca's amended complaint, Taylor's first amended complaint is similar to his original complaint with minor factual variations.

concerned when a plaintiff can "amend himself or herself ***out of jurisdiction*** by withdrawing allegations that appeared in the original complaint." *See Branch*, 782 F. Supp. 2d at 261 (emphasis added); *see also Rockwell*, 549 U.S. at 468 ("[T]he issue is whether . . . a clear and explicit *withdrawal* of jurisdiction withdraws jurisdiction." (emphasis in original)). But *Rockwell* "does not suggest that a plaintiff can establish jurisdiction by amendment when jurisdiction did not previously exist." *Branch*, 782 F. Supp. 2d at 261–62. That is why courts continue to conclude that the first-to-file analysis requires an evaluation of original complaints. *Id.*; *United States ex rel. Carter v. Halliburton*, 144 F. Supp. 3d 869, 882 (E.D. Va. 2015); *United States ex rel. Moore v. Pennrose Props., LLC*, 2015 WL 1358034, at *15 (S.D. Ohio Mar. 24, 2015).

The plain text of § 3730(b)(5) confirms this view. *See Carter*, 144 F. Supp. 3d at 880. The statute bars a person from "***bring[ing] a related action*** based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5) (emphasis added). As the U.S. District Court for the Eastern District of Virginia found in analyzing this same issue, a plaintiff "does not 'bring an action' by amending a complaint, 'one brings an action by commencing suit.'" *Carter*, 144 F. Supp. 3d at 880 (quoting *United States ex rel. Chovanec v. Apria Healthcare Grp., Inc.*, 606 F.3d 361, 362 (7th Cir. 2010)).[8] Accordingly, the Court must follow the text of § 3730(b)(5) and compare the Opposing Relators' original complaints to Osinek's original complaint.

Focusing the first-to-file analysis on original complaints also makes good sense. It has "the advantage of simplicity," a virtue that is "apparent in this case, which involves multiple claims, complaints, and defendants, as well as other relators whose complaints have themselves been amended and involve multiple defendants." *Branch*, 782 F. Supp. 2d at 264. If the rule were otherwise, the first-filed complaint could constantly change based on relator amendments, and § 3730(b)(5) could be thwarted any time a relator amended a complaint. *See Carter*, 144 F.

[8] *See also Moore*, 2015 WL 1358034, at *14 ("[T]he language of the first-to-file bar does suggest that Congress intended to isolate the determination of subject matter jurisdiction to the time of filing of a complaint."); *United States ex rel. Shea v. Verizon Commc'ns, Inc.*, 160 F. Supp. 3d 16, 29 (D.D.C. 2015) ("[T]he language of § 3730(b)(5) itself . . . requires the Court to look to the moment when Plaintiff filed his initial Complaint . . . . What offends the first-to-file bar is the bringing of the action (*i.e.*, filing an initial complaint), not the failing to amend a complaint or litigating the case.").

Supp. 3d at 882 ("allowing a relator to avoid the first-to-file bar by amending would interfere with the efficient operation of *qui tam* suits"). While the Court's "jurisdiction may expand or shrink as amendments are made to the complaint," "that jurisdiction must rest upon a solid foundation. That foundation is the Court's jurisdiction over the original complaint. Without it, the case cannot proceed." *Branch*, 782 F. Supp. 2d at 264.

B. Osinek Alleges an Enterprise-Wide Upcoding Scheme Implicating Defendants' Risk-Adjustment Diagnosis-Coding Practices Across the Nation.

Even if the first-to-file bar were not jurisdictional, and even if the Court compares amended complaints, the bar still requires dismissal here: the Opposing Relators' amended complaints allege fraudulent schemes that are fully encompassed by *Osinek*. To avoid dismissal under § 3730(b)(5), some Relators have mischaracterized *Osinek* as a relatively narrow complaint, contending that it concerns only Defendants' addenda-related business practices in California. *Taylor* Opp'n at 5–6, 11; *Stein* Opp'n at 12; Dkt. No. 155 ("*Bryant* Opp'n") at 6–7. But Osinek's broad allegations belie that description. In fact, her allegations, concessions by other Relators, and DOJ's investigation all confirm that her complaint put DOJ on notice of a broad upcoding scheme that was not limited to addenda practices in California.

1. Osinek alleges an upcoding scheme that extends beyond addenda.

Osinek's complaint is not limited to an alleged fraud relating to the use of addenda. Rather, as detailed in the Motion, she broadly alleges that Kaiser Permanente (which she also calls simply "Kaiser") "upcode[d] diagnoses to ensure Medicare payments for reimbursable, high-value [medical] conditions." Dkt. No. 1 ¶ 2.

The *Taylor*, *Stein*, and *Bryant* Oppositions point to allegations about addenda in Osinek's complaint to argue that she focuses solely on addenda. *Taylor* Opp'n at 5–6, 11; *Stein* Opp'n at 12; *Bryant* Opp'n at 6–7. But their Oppositions gloss over Osinek's other allegations that do not mention addenda at all. In faulting Kaiser Permanente's data-mining program, for example, Osinek contends that Kaiser Permanente "identified the higher value HCCs and then determined the diagnoses its [healthcare providers] would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement." Dkt. No. 1 ¶ 25. Again without mentioning addenda,

she emphasizes that the "focus on refreshing and data mining for missed opportunities is that [healthcare providers] take into consideration HCCs and the Medicare payment system when coding and recording . . . encounters." *Id.* ¶ 26. *Osinek* makes clear that a healthcare provider can "refresh" a medical condition directly through a visit with a member. *See id.* ¶ 38 (citing a document discussing how refresh efforts involved "Seeing Patients" for appointments). Similarly, Osinek's complaint criticizes Kaiser Permanente for advising healthcare providers "to change coding practices to reflect new reimbursable codes," and does not allege that providers used such codes only in addenda. *Id.* ¶ 27; *see also id.* ¶ 36 (stating generally that "Kaiser also pressures [providers] to diagnose Medicare [members] through incentive programs"). Osinek's allegations about incentives to healthcare providers "to capture and refresh" medical conditions also are not limited to addenda. *See id.* ¶ 37. And her summary allegation, after describing various business practices, specifically ties Kaiser Permanente's purported FCA violations to "data mining prompts" and does not mention addenda. *Id.* ¶ 42.

Bicocca's Opposition confirms the breadth of the allegations in *Osinek*. In conceding that his original complaint is barred by *Osinek*, *see Bicocca* Opp'n at 2, Bicocca effectively corroborates Defendants' view that Osinek's complaint did, in fact, put the United States on notice of an alleged fraud that extended to an array of Defendants' purported upcoding practices. Bicocca does not allege an upcoding scheme focused solely on addenda; his original complaint does not even mention "addenda," and his amended complaint mentions "addenda" only once. *See Bicocca* Dkt. No. 16 ¶ 106. Bicocca's allegations instead focus on how Defendants allegedly "pressur[ed]" specialists to diagnose medical conditions that the specialists "may not have the expertise to address." *Id.* ¶ 105; *see also id.* ¶¶ 111–15, 125; Mot. at 13–14. Even though his original complaint does not reference addenda, Bicocca acknowledges that "the claims alleged in his original Complaint are barred by Osinek's original Complaint based on the first-to-file rule." *Bicocca* Opp'n at 2.

Further, the United States' subpoenas to Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group—issued just months after Osinek filed her complaint—requested documents

beyond those related to addenda practices. The United States sought virtually any document or communication concerning "the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage [members]." Dkt. No. 142 ("RJN"), Exs. A–D at 14.[9] These broad requests confirm that Osinek put the United States on notice of a purported upcoding scheme related to practices well beyond addenda.

2. Osinek alleges a nationwide scheme that extends beyond California.

Osinek's complaint also describes an alleged upcoding scheme that extends beyond California. As noted in the Motion, the only defendant Osinek names in her original complaint is "Kaiser Permanente." *See* Dkt. No. 1 ¶ 6. Kaiser Permanente is the trade name used to describe all Kaiser-affiliated entities across the nation, including health plans, hospitals, and medical groups, underscoring the national scope of her allegations. *See id*. The Opposing Relators recognize that "Kaiser Permanente" refers to a national enterprise. Taylor alleges that Kaiser Permanente refers to a group of health plans, hospitals, and medical groups that operate nationally. *Taylor* Dkt. 1 ¶¶ 16–17. The *Bryant* Relators allege that Kaiser Permanente "is a healthcare consortium that operates one of the nation's largest health plans . . . and provides medical services" through regional affiliates across the country. *Bryant* Dkt. 1 ¶ 25. Similarly, the *Stein* Relators assert that "Kaiser Permanente" describes a "national integrated health care delivery system." *Stein* Opp'n at 1. As such, they allege a fraud scheme against multiple Kaiser Permanente entities operating across the country, including in California, Colorado, Georgia, Hawaii, and Washington. *See Stein* Dkt. No. 1 ¶¶ 5–24, 80. And they concede that *Osinek* entirely bars their FCA claim based on alleged refresh practices. *Stein* Opp'n at 1 ("Relators do

[9] Of the Opposing Relators, only Taylor objects to Defendants' request that the Court judicially notice the subpoena-related documents. *Taylor* Opp'n at 23–25. Yet he does not cite a single case holding that the type of materials submitted by Defendants are not judicially noticeable or that requests for judicial notice are prohibited on a Rule 12(b)(1) motion under the first-to-file bar. *Id.* He cites only cases where courts have rejected requests for evidentiary hearings. *Id.* But Defendants have not requested an evidentiary hearing. They have submitted materials that are not subject to reasonable dispute. Courts, including this one, routinely consider such unobjectionable materials when deciding pleadings motions. *See, e.g.*, *Wen v. Greenpoint Mortg. Funding, Inc.*, 2021 WL 5449048, at *1 n.1 (N.D. Cal. Nov. 22, 2021) (Chen, J.).

not oppose the Kaiser Defendants' first-to-file attack against Relator's [*sic*] Refresh fraud claim.").

Taylor and the *Bryant* Relators nonetheless argue that Osinek's complaint alleges a California-specific fraud, because Osinek focuses on "examples" and "events" in California. *Taylor* Opp'n at 19–20; *see also Bryant* Opp'n at 6–7. But in doing so, they ignore her repeated allegations about Kaiser Permanente's general practices: "***Kaiser*** defrauded the United States," "***Kaiser's*** upcoding scheme" violates the FCA, "***Kaiser*** focuses its data mining on high value conditions," "***Kaiser*** tells [healthcare providers] to change diagnoses," "***Kaiser*** also addended and submitted diagnostic codes for complex conditions without proper support," "***Kaiser*** tracks and rewards [providers] based on the percentage of chronic conditions they capture and refresh," "***Kaiser*** ties funding allocations to a facility's refresh and data mining rates," and so on. Dkt. No. 1 ¶¶ 2, 3, 25–27, 30–33, 37, 39 (emphases added). Osinek supports these enterprise-wide allegations with examples from her own personal experience in California, but that does not mean her complaint is limited to an alleged fraud perpetrated only in California. Taylor and the *Bryant* Relators cannot seriously contend otherwise—their own complaints focus heavily on alleged events and practices in the geographic regions where they worked, yet also purport to allege a fraud spanning multiple regions.

A similar fact pattern arose in *United States ex rel. Batiste v. SLM Corp.*, a case that based dismissal of a later-filed *qui tam* action on a broadly framed first-filed action. 659 F.3d 1204 (D.C. Cir. 2011). There, the first relator's suit "discussed activities" at a parent company's "subsidiary office," but also "name[d] the parent company . . . as the lead defendant." *Id.* at 1209. Despite the first relator's focus on "activities at [the] subsidiary office," § 3730(b)(5) barred a subsequent relator's suit that "focuse[d] on activities at [a different] office[.]" *Id.* In finding the first-to-file bar applied, the D.C. Circuit emphasized that the first complaint "would suffice to equip the government to investigate [defendant's] allegedly fraudulent forbearance practices nationwide." *Id.*; *see also United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214, 219 (D.C. Cir. 2003) (holding that first complaint's "broad allegations" of "corporate-wide" fraud barred similar fraud allegations in later complaint under § 3730(b)(5),

even though later complaint focused on fraud at a subsidiary operating in a state not mentioned in the first complaint). Similarly here, Osinek alleges an enterprise-wide upcoding scheme, but does not allege details about how that scheme functioned in every single geographic region in which Defendants operate. As in *Batiste* and *Hampton*, here Osinek's broad allegations require dismissal of similar allegations of fraud in specific regions. *See id.*

Because Osinek alleges a nationwide fraud, the Court also should reject Taylor's argument that Osinek's complaint does not allege a fraud scheme in Colorado. *See Taylor* Opp'n at 19–20. Although Taylor now asserts that different CMS contracts govern Defendants located in California and Colorado, neither his complaint nor Osinek's first-filed complaint says anything about these contracts and their differences; those complaints govern the first-to-file analysis, not assertions by counsel in motion papers. Regardless, the argument is irrelevant given that Osinek's complaint put DOJ on notice that Defendants purportedly used the same methods to allegedly defraud the United States in both California and Colorado. Contrary to Taylor's assertion, *id.* at 20, this is not a case like *Savage*, where one relator alleged a fraud scheme about one contractor and another relator alleged a similar fraud scheme about a completely different contractor. *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, 2015 WL 5794357, at *8–9 (E.D. Wash. Oct. 1, 2015). Osinek's broad allegations put DOJ on notice of the ***same*** alleged fraud scheme perpetrated by the ***same*** entities at issue in both her complaint and the Later-Filed Complaints. That the Defendants in the various regions may have had different contracts with CMS is entirely immaterial under the first-to-file analysis. *See United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009).

Even if Osinek had not intended to allege a fraud scheme outside California, she named a nationwide defendant and identified practices that could apply to regions outside California without explicitly cabining them to California—her complaint was thus sufficient to give DOJ notice to investigate her allegations nationwide. *See United States ex rel. Heineman-Guta v. Guidant Corp.*, 718 F.3d 28, 35 (1st Cir. 2013) (holding that the first-to-file bar applies where "the first-filed complaint contains enough material information (the essential facts) about the potential fraud, the government has sufficient notice to launch its investigation"). "Once the

government is put on notice of its potential fraud claim, the purpose behind allowing *qui tam* litigation is satisfied." *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004). Allowing the Later-Filed Complaints to survive the first-to-file bar simply because they focus on geographic locations not explicitly addressed in *Osinek* would subvert this purpose and "allow an infinite number of copycat *qui tam* actions to proceed." *Branch*, 560 F.3d at 379.

DOJ's investigation also shows that Osinek's complaint actually put DOJ on notice of an alleged enterprise-wide fraud scheme. The United States' subpoenas stated no geographic limits and applied to all subsidiaries and affiliates of the subpoenaed parties. RJN, Exs. A–D at 2. Taylor argues that this language about subsidiaries and affiliates is irrelevant boilerplate. *Taylor* Opp'n at 25. But that is belied by the course of DOJ's investigation, which extended into the Colorado region based on the ***original*** subpoenas. *See* RJN, Ex. E. Indeed, when DOJ began investigating the Colorado region, it made clear that it was just "prioritiz[ing] [Defendants'] production under the [United States'] subpoena issued [on] December 4, 2013." *Id.* at 1. DOJ thus explained that it was ***not*** indicating "a limitation of the production requests as specified" in the United States' subpoenas. *Id.* And in that same correspondence, DOJ requested documents from "all regions." *Id.* at 1, 7–8.

3. Osinek alleges a broad upcoding scheme implicating Defendants' Medicare Advantage risk-adjustment coding and documentation practices.

Under controlling precedent, Osinek's broad upcoding scheme frames the analysis here. *See Lujan*, 243 F.3d at 1189. She alleges an enterprise-wide scheme by "Kaiser Permanente" to report diagnosis codes to CMS for Medicare Advantage members that Kaiser Permanente allegedly knew did not comply with CMS coding and documentation requirements and that these diagnosis codes resulted in overpayments from the Medicare Advantage program. Dkt. No. 1 ¶¶ 2–3. And she contends that Kaiser Permanente utilized several business practices to effectuate the upcoding scheme. *See* Mot. at 5–8; Dkt. No. 141-1 ("Mot. App'x") at 1–9.

Taylor and the *Bryant* Relators insist that such a scheme is too broad to govern the analysis. *Taylor* Opp'n at 2; *see also Bryant* Opp'n at 1. Taylor, for example, asserts that Defendants' interpretation of the first-to-file bar would require dismissal of any *qui tam*

complaint that makes any allegations whatsoever about Defendants' Medicare Advantage business practices. *Taylor* Opp'n at 1–2, 9. He argues that such a result would be untenable given the large size of Defendants' Medicare Advantage business. *Id.* at 1–2.

These exaggerated fears are nothing but an objection to the legal test required by the first-to-file bar. That test asks whether the first-filed complaint put DOJ on notice of the essential facts of a fraudulent scheme that also appear in a later-filed complaint. *See Lujan*, 243 F.3d at 1189. That Osinek alleged a broad upcoding scheme, rather than a narrow and discrete fraud, is precisely the reason to apply the first-to-file bar, not a defect in the legal test. Taylor and the Bryant Relators also lose sight of the targeted business practices actually at issue in Osinek. Osinek's allegations do not implicate all of Defendants' business practices. To the contrary, all of the complaints focus on a specific part of Defendants' Medicare business operations—practices relating to the diagnosing and reporting of medical conditions to CMS for purposes of Medicare Advantage risk adjustment. Indeed, the Relators' complaints are so similar that the Court consolidated them without opposition from a single Relator.

While the scope of potential theories of FCA liability left for future relators is not relevant to the first-to-file analysis, Defendants never have argued that all future relators will be barred from bringing FCA claims based on a unique fraudulent scheme involving distinct business practices, nor do the arguments in the Motion imply such a result. As with any other first-filed *qui tam* complaint, *Osinek* bars later-in-time *qui tam* actions based on the same fraudulent scheme that she alleges, such as the FCA claims asserted by Taylor and the other Opposing Relators.

C. The Opposing Relators Do Not Allege Unique Fraud Schemes.

Unable to cabin *Osinek*'s broad allegations to addenda practices or California, the Opposing Relators latch onto factual nuances in their complaints that do not meaningfully distinguish their fraud claims from the fraud alleged in *Osinek*. As the case law makes clear, their quibbles over negligible variations of the same essential scheme are insufficient to avoid dismissal under § 3730(b)(5).

1. *Taylor*

Taylor's Opposition argues that his complaint asserts three fraud schemes not present in

Osinek that relate to (1) natural language processing, (2) chart review, and (3) audits. This argument fails because all three alleged schemes are subsumed within Osinek's allegations of a scheme to upcode the diagnoses of Medicare Advantage members. Taylor contends that certain Defendants employed natural language processing and chart review practices to identify in medical records previously unreported medical conditions for Medicare Advantage members that could then be reported to CMS for increased risk-adjusted payments. *Taylor* Dkt. No. 1 ¶¶ 191–201. Taylor also alleges that certain Defendants conducted audits of risk-adjustment data that put them on notice of medical conditions that had been upcoded and previously submitted to CMS for payment. *Id.* ¶¶ 154–61, 164, 169, 174–80. Taylor's allegations about all three business practices merely describe variations on the upcoding scheme that Osinek first identified. In any case, Osinek made specific factual allegations in her complaint that put DOJ on notice of each purportedly distinct scheme.

Natural Language Processing. Taylor argues that he alleges a unique fraud scheme based on the use of an algorithm-powered program called natural language processing ("NLP"). *Taylor* Opp'n at 18. He contends that "the NLP program uses an algorithm to search [medical records] to find words that, individually or in combination, indicate that a [member] has certain diagnoses." *Taylor* Dkt. No. 1 ¶ 191. Taylor asserts that certain Defendants used NLP to identify "new diagnoses that might be appropriate to use for the submission of additional risk adjustment claims," that those Defendants did not properly audit the diagnoses identified, and that, as a result, those Defendants submitted diagnosis codes to CMS that should not have been submitted. *Id.* ¶¶ 196–201.

But these allegations do not reflect a unique fraud scheme—as the Motion explains, Osinek's complaint describes a nearly identical "data mining" program that she contends also caused the submission of false claims to CMS. She alleges that Kaiser Permanente used "algorithms to identify . . . [medical] conditions for data mining." *See* Dkt. No. 1 ¶¶ 24–25. And she emphasizes that data mining reflected a shift away from "data quality and auditing [healthcare provider] coding." *Compare* Dkt. No. 1 ¶¶ 2, 24–25, *with Taylor* Dkt. No. 1 ¶ 191. Both Osinek's data-mining allegations and Taylor's NLP allegations concern the alleged used of

algorithms to search medical records for medical conditions without a proper focus on auditing for accuracy. The only appreciable difference is the name used to describe the practice by each Relator.

Taylor's Opposition fails to address any of these similarities. He instead falsely asserts that Defendants' entire argument is that both practices "involved some use of technology." *Taylor* Opp'n at 18. That oversimplification is contradicted by the allegations themselves. *See* Mot. at 19 ("Both [complaints] describe alleged 'data mining' algorithms used to identify medical conditions in medical records for upcoding."); Mot. App'x at 2. The two practices do not just involve "some use of technology"; they involve using algorithm-based technology ***in the same manner and for the same purpose***. As alleged in the complaints, both NLP and data mining rely on algorithms to search medical records for new medical conditions to report to CMS without a proper focus on data quality and auditing. They also both contend that the purpose of conducting these medical record reviews was to obtain additional and unwarranted risk-adjustment payments from the Medicare Advantage program. With notice from Osinek's data-mining allegations, DOJ had sufficient grounds to investigate similar programs across Defendants' operations, even if those programs had different names or varied in minor respects. And DOJ did investigate these programs. Again, the United States' subpoenas targeted virtually any document or communication about "the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage [members]." RJN, Exs. A–D at 14.

Chart Review. Taylor's Opposition also asserts that his complaint brings a distinct fraud claim based on a "one-way chart review" practice. *Taylor* Opp'n at 14–16. But Taylor alleges no such theory of fraud in his initial complaint or first amended complaint, which he argues is operative for the first-to-file analysis.[10] He asserts that his first amended complaint contains

[10] Taylor's original complaint is the operative complaint for purposes of the first-to-file analysis. *See supra* at 5–8. Because Taylor's Opposition relies on his first amended complaint, Defendants similarly cite the first amended complaint for this allegation, but all relevant allegations are identical in both the original and first amended complaints. *Compare Taylor* Dkt. No. 1 ¶ 98, *with Taylor* Dkt. No. 4 ¶ 91. As a result, for purposes of resolving this dispute over Taylor's

fourteen paragraphs describing "one-way chart review"; in reality, it contains a single allegation that alludes to a review of medical charts. *See id.* at 14–15 (citing *Taylor* Dkt. No. 4 ¶¶ 78–91). One paragraph offers the following observation related to chart review:

> Kaiser Colorado does not conduct any routine targeted audits of claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider to look for additional diagnoses present in the chart but not coded by the treating [healthcare provider]. The coders do not attempt to validate the codes submitted by the hospital. These are simply passed through to CMS for payment.

Taylor Dkt. No. 4 ¶ 91 (emphasis in original). Nowhere in this paragraph—or anywhere else in his complaint—does Taylor allege that this review resulted in the submission of false or fraudulent claims to CMS.[11]

Even if this single allegation could be read to support an independent fraud scheme based on chart-review practices, all the paragraph does is identify an alleged practice that presumably resulted in the submission of false diagnosis codes to CMS based on a review of medical records. Not only is that just a variation on the upcoding scheme that Osinek alleged in 2013, but it is strikingly similar to the specific data-mining program that Osinek first described in her complaint. As Taylor explains, the chart-review program described in his complaint entailed a review of medical records "to search for additional diagnosis codes to submit to CMS." *Taylor* Opp'n at 7. Osinek similarly alleged that Kaiser Permanente "used a variety of algorithms to identify . . . disease conditions" that were then added to the medical records and ultimately submitted to CMS. Dkt. No. 1 ¶¶ 24–25. Like the chart-review practice described by Taylor, the purpose of the data-mining program alleged by Osinek was to "capture 'missed opportunities,' . . . to ensure that all possible Medicare billing opportunities are captured." *Compare id.* ¶ 24, *with* Taylor Dkt. No. 1 ¶ 98 (alleging that the purpose of the coder review is to "look for additional diagnoses present in

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chart-review allegations, it is unnecessary for the Court to decide which of the two complaints governs the analysis.

[11] The crux of the paragraph is not even about chart review—it is about audits of risk-adjustment data submitted by so-called "external providers" who are not controlled by Defendants. The mention of chart review is clearly an aside, only intended to highlight an alleged lack of targeted external-provider audits.

the chart but not coded"). That the chart-review program alleged by Taylor is a manual review and the data-mining program alleged by Osinek relies on algorithms is exactly the type of trivial detail that is insufficient to defeat dismissal under § 3730(b)(5). *See Branch*, 560 F.3d at 378.

Taylor argues that his chart-review allegation should survive because it alleges "that [healthcare] providers initially generated these false codes and Kaiser failed to delete them, a violation of the 'reverse' false claims provision" of the FCA. *Taylor* Opp'n at 15. But this point matters not a whit to the first-to-file analysis. Whether he is alleging a reverse false claim or a presentment claim under the FCA is irrelevant here, where the essential facts in Taylor's chart-review allegation mirror Osinek's data-mining allegations. DOJ needed no more than Osinek's initial allegations to investigate this purported chart-review scheme. *See* RJN, Exs. A–D at 16 (requesting documents "regarding the systems . . . used to determine, document, assign, ***review***, ***analyze***, ***report***, data mine, addend, update, or refresh the diagnosis or diagnosis codes or HCCs for Medicare Advantage [members]" (emphases added)).

Taylor also argues that "the differences in the Kaiser regional affiliates mean that the chart review scheme [he] alleges would not have even been possible in California" because there are "no external providers" in California. *Taylor* Opp'n at 15. But Taylor's own allegations contradict this argument—he explicitly alleges that Defendants' Northern and Southern California regions review diagnoses submitted by external providers. *Taylor* Dkt. No. 1 ¶ 94. And again, Osinek's allegations are not limited to California. *See supra* at 10–13. Osinek's allegations about data mining and searching for "missed opportunities" also do not exclude any type of healthcare providers.

Contrary to Taylor's Opposition, *Hartpence* does not change the analysis. There, the first-filed *qui tam* complaint alleged that a medical-device manufacturer violated the FCA by using a specific code (the "KX modifier") to certify that a treatment with its devices was medically necessary when it was not, rendering claims for reimbursement for that treatment false. 792 F.3d at 1130. The second-filed *qui tam* alleged that the manufacturer had failed to satisfy a distinct payment requirement that the manufacturer receive a "correct and completed Detailed Written Order" for treatment before delivering devices and beginning therapy. *Id.* at 1125. The relators'

theories of fraud focused on different representations: one *qui tam* action alleged a scheme to fabricate medical-necessity certifications, while the other *qui tam* action described false claims about a separate program requirement for therapy. The court concluded that because the theories of fraud differed, the first-to-file bar did not require dismissal of the second complaint. *Id.* Here, there is no such dichotomy. Both Taylor and Osinek allege that Defendants searched the medical records of Medicare Advantage members, identified medical conditions based on that search that had not previously been reported to CMS, and then submitted new diagnosis codes to CMS to increase their payments from the Medicare Advantage program. Their theory of how and why the fraud occurred is essentially the same, even if they allege some inconsequential differences in the medical-record reviews.[12]

Audits. Finally, Taylor's allegations about diagnosis-coding errors identified in audits of medical records for Medicare Advantage members do not describe a separate fraud scheme from the one Osinek first alleged. Instead, as Taylor himself explains, these audits allegedly "put Kaiser ***on notice*** that it has submitted and continues to submit" false claims to CMS. *Taylor* Dkt. No. 1 ¶ 71 (emphasis added); *Taylor* Opp'n at 16. In other words, these allegations purport to show that certain Defendants had sufficient knowledge under the FCA of the fraudulent upcoding scheme—the same fraudulent scheme that Osinek already alleged.

Knowledge is a legal element of an FCA claim that a plaintiff must establish, not a separate fraudulent scheme. *See United States ex rel. Ruhe v. Masimo Corp.*, 977 F. Supp. 2d 981, 991 (C.D. Cal. 2013); *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir.

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[12] Taylor's reliance on *Barrett* and *Millennium Laboratories* fails for similar reasons. In *Barrett*, the court rejected a motion to dismiss under § 3730(b)(5) where the first-filed complaint alleged a kickback scheme while the second-filed complaint alleged a price-inflation scheme: two distinct theories of FCA liability with different "material facts" and different alleged "damages." *See United States ex rel. Barrett v. Allergan, Inc.*, 2019 WL 4675756, at *3 (C.D. Cal. Sept. 24, 2019). In *Millennium Laboratories*, the court held that the first-to-file bar did not apply where the relators focused on "different mechanisms" of fraud—the first centered on the faulty design of diagnosis-testing kits, while the second alleged improper medical orders of unneeded diagnosis tests. *See United States v. Millennium Lab'ys, Inc.*, 923 F.3d 240, 254 (1st Cir. 2019). Here, the alleged fraud schemes are the same—an improper review of medical records for the purpose of identifying previously unreported medical conditions to submit to CMS for increased reimbursement from the Medicare Advantage program.

1996). Taylor's reliance on *Lakeshore* acknowledges as much. *Taylor* Opp'n at 16–17. In that case, the relator alleged that audits "revealed that some physicians were 'upcoding,'" and the court concluded that "[t]hese allegations plausibly suggest[] that defendant acted with reckless disregard for the truth." *United States v. Lakeshore Med. Clinic, Ltd.*, 2013 WL 1307013, at *3 (E.D. Wis. Mar. 28, 2013). The audit allegations in *Lakeshore* established the defendant's knowledge of the fraudulent upcoding scheme; the audits were not separate acts of upcoding themselves.

Taylor nonetheless argues that his audit allegations constitute a separate fraudulent scheme because the audits revealed "specific reasons" that Osinek does not explicitly discuss, such as problems with certain diagnosis codes not mentioned in Osinek's complaint. *Taylor* Opp'n at 17. But these "specific reasons" merely add factual color to the upcoding scheme that Osinek described in her complaint; they do not provide a basis to circumvent the first-to-file bar. *See Lujan*, 243 F.3d at 1185. In any event, the *Osinek* complaint actually put DOJ on notice of potential issues with audits because the United States' subpoenas—issued ***before*** Taylor filed his complaint—requested documents related to Defendants' "internal and external review or audits," as well as "compliance or monitoring activities related to . . . diagnoses or diagnosis codes or HCCs for Medicare Advantage [members]." *See* RJN, Exs. A–D at 14.

In short, Taylor has not shown that his complaint alleges a distinct fraud scheme. Taylor invites the Court to put his complaint and Osinek's complaint side-by-side, claiming that such a comparison will reveal stark differences between the two. *See Taylor* Opp'n at 11. Defendants welcome that suggestion. Indeed, Defendants provided such a side-by-side comparison for the Court in support of their Motion, appending a chart that compares all of the relevant allegations in the complaints. *See* Mot. App'x. And that chart corroborates that Taylor—and the other Opposing Relators—do no more than allege immaterial variations on the same upcoding scheme that Osinek alleges, requiring dismissal under the first-to-file bar.

2. *Stein*

The *Stein* Relators concede that § 3730(b)(5) requires dismissal of their fraud claim based on alleged "refresh" practices, *Stein* Opp'n at 1, and thus the only disputes that remain concern

their allegations about sepsis, malnutrition, and aortic atherosclerosis ("AA"). The *Stein* Relators argue that *Osinek* does not encompass these alleged frauds because her complaint is limited to allegations about "utilizing computer programs," addenda, and outpatient diagnosis coding, whereas their allegations do not relate to addenda practices and extend to hospital coding. *Stein* Opp'n at 3–7. But, as explained *supra* at 8–13, this is an overly narrow reading of *Osinek*, which alleges an enterprise-wide fraud that involves multiple business practices and implicates Defendants' diagnosis-coding practices across all Kaiser-affiliated entities—including hospitals.

Sepsis. The thrust of the *Stein* Relators' sepsis allegations is that certain Defendants inappropriately coded sepsis without proper clinical findings, often in the hospital setting, and then reported those diagnosis codes to CMS to support increased risk-adjustment payments from the Medicare Advantage program. *See Stein* Opp'n at 3–4; *Stein* Dkt. No. 1 ¶ 50. For her part, Osinek generally alleges that "Kaiser Permanente"—which would include the Kaiser-affiliated hospitals at issue in *Stein*—submitted diagnosis codes to CMS for complex medical conditions without proper support and for the purpose of increasing their risk-adjustment payments from the Medicare Advantage program. Dkt. No. 1 ¶¶ 26, 31. Osinek, like the *Stein* Relators, also alleges that Defendants used internal guidance and policies to encourage diagnosis coding of medical conditions that should not have been coded. *Compare* Dkt. No. 1 ¶¶ 26–31, *with Stein* Dkt. No. 1 ¶ 50; *see also* Mot. App'x at 8.

Osinek's upcoding allegations were sufficient to put DOJ on the trail of the sepsis-specific scheme alleged in *Stein*. Although Osinek does not reference sepsis, her complaint does not purport to list every medical condition implicated by the alleged fraud. Instead, Osinek provides examples—indeed, she introduces them with the phrase "for example"—to illustrate the alleged enterprise-wide scheme. *See, e.g.*, Dkt. No. 1 ¶¶ 26–27, 30. The United States' subpoenas confirm that the United States understood Osinek's allegations to implicate practices extending beyond the specific medical conditions referenced explicitly in her complaint, as the United States requested documents about Defendants' internal diagnostic standards for ***all*** medical conditions of Medicare Advantage members, which necessarily includes sepsis, as well as malnutrition and AA. *See* RJN, Exs. A–D at 14.

The *Stein* Relators are not only second-in-time to Osinek, but also to Taylor and the *Arefi* Relators. *Stein* Opp'n at 7–9. The *Arefi* Relators' upcoding allegations thus provide a separate basis to dismiss the *Stein* Relators' sepsis allegations.[13] Both *Arefi* and *Stein* allege that certain Defendants engaged in an upcoding scheme. *Arefi* Dkt. No. 1 ¶ 42; *Stein* Dkt. No. 1 ¶ 50; Mot. App'x at 1. Both allege that those Defendants used incorrect diagnostic criteria and standards. *Arefi* Dkt. No. 1 ¶ 2 (allegedly using "diagnostic criteria that find no support in medical literature or accepted standards of medical or coding practice"); *Stein* Dkt. No. 1 ¶¶ 57–60 (allegedly adopting incorrect sepsis criteria). And both raise concerns about sepsis diagnoses in particular. *Stein* Dkt. No. 1 ¶¶ 50–69; *Arefi* Dkt. No. 1 ¶ 81 (alleging a 132 percent increase in the diagnosis rate of septicemia and sepsis in certain Medicare Advantage members between 2008 and 2013).

Malnutrition. The *Stein* Relators' malnutrition allegations provide yet another example of the general upcoding scheme alleged by Osinek, and § 3730(b)(5) requires dismissal on that basis. *See Stein* Dkt. No. 1 ¶ 70 (alleging that certain Defendants "participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA [members] in order to increase the risk adjustment scores for the MA [members] so diagnosed"). Osinek even cites two types of malnutrition conditions—cachexia and protein calorie malnutrition—to illustrate the alleged upcoding scheme in her complaint. Dkt. No. 1 ¶¶ 25, 37, 39, 41.

The *Taylor* and *Arefi* complaints also include allegations about malnutrition, providing further reason to bar *Stein*'s malnutrition allegations. Like the *Stein* Relators, Taylor identifies malnutrition as a medical condition that certain Defendants upcoded. *Taylor* Dkt. No. 1 ¶¶ 139–41. He alleges that "false claim[s] resulted from Kaiser coders and/or computer systems adding a

[13] Because *Arefi* was pending when *Stein* was filed, the *Arefi* Relators' notice of non-opposition to the Motion does not change this analysis. *See United States ex rel. Shea v. Cellco P'ship*, 863 F.3d 923, 930 (D.C. Cir. 2017) (holding that a later-filed *qui tam* was "incurably flawed from the moment [the relator] filed it" because the earlier-filed *qui tam* was "pending" at the time of the filing); *Lujan*, 243 F.3d at 1188 (finding that subsequently dismissed *qui tam* "should still be considered a 'pending' action for purposes of § 3730(b)(5)" because it had not yet been dismissed when the second *qui tam* was filed, and reasoning that dismissal of the later-filed action still alerted the government to the essential facts of the fraudulent scheme).

malnutrition diagnosis where the treating [healthcare providers] had not." *Id.* ¶ 141. Taylor explains that a coder, who is not an appropriate provider type, should not determine that a Medicare Advantage member has a medical condition because that determination can be made only by the healthcare provider or other appropriate provider type. *Id.* The *Stein* Relators' malnutrition allegations similarly assert that certain Defendants purportedly submitted malnutrition diagnosis codes to CMS that were not supported by a diagnosis from an appropriate provider type. *Stein* Dkt. No. 1 ¶ 71. The *Arefi* Relators likewise raise concerns about the diagnosis coding for malnutrition and allege that Defendants' upcoding scheme resulted in the submission to CMS of inappropriate diagnoses of protein calorie malnutrition. *Arefi* Dkt. No. 1 ¶ 81. While *Osinek* is independently sufficient to require dismissal of the *Stein* Relators' malnutrition allegations, the *Taylor* and *Arefi* complaints make clear that DOJ had abundant notice of such a scheme well before *Stein* was filed.

Aortic Atherosclerosis. The *Stein* Relators' AA allegations appear only in their amended complaints. Because the first-to-file analysis centers on a comparison of initial complaints, *see supra* at 5–8, the *Stein* Relators cannot rely on their amendments to manufacture jurisdiction where none existed in the first place. *Sepehry-Fard*, 2014 WL 2707738, at *3. The AA allegations therefore have no relevance to the Court's first-to-file analysis.

Even if the AA allegations were alleged in the initial *Stein* complaint, however, they would not save the complaint from dismissal. The *Stein* Relators' allegations that certain Defendants submitted AA diagnosis codes to CMS whenever AA was observed in an x-ray or listed in a medical record are no more than a factual nuance encompassed by Osinek's broad allegation that Defendants submitted diagnosis codes for complex medical conditions without proper support. *Compare* Dkt. No. 1 ¶¶ 26, 31, *with* Dkt. No. 116 ¶¶ 84–91. Additionally, the *Stein* Relators' allegation that AA was inappropriately coded based on test results mirrors Osinek's allegation that Defendants instructed their healthcare providers to review previous test results to support their diagnoses. *Compare* Dkt. No. 1 ¶ 29, *with* Dkt. No. 116 ¶ 86; *Stein* Opp'n at 6. The *Arefi* Relators likewise faulted certain Defendants for coding based on old test results and for using clinical standards that were "not based on generally accepted standards of medical

or coding practice." *Arefi* Dkt. No. 1 ¶¶ 45–46 (alleging that documentation specialists would review medical records, "including diagnostic test results, going as far back as fifteen years for clinical signs and symptoms to support additional HCCs in the current year").

The Court also should reject the *Stein* Relators' request for leave to amend. *See Stein* Opp'n at 14. Since the first-to-file bar is jurisdictional and states that "no person other than the Government" may bring an FCA action related to a pending action, 31 U.S.C. § 3730(b)(5), the *Stein* Relators cannot cure the jurisdictional deficiency through amendment.

3. *Bryant*

The *Bryant* Relators focus their Opposition on only three aspects of their complaint: (1) diagnosis coding in the hospital setting, (2) diagnosis coding of vent dependence, and (3) fraud on the risk-adjustment program established by the ACA. *Bryant* Opp'n at 2, 8–9, 12–13.[14] Having failed to identify any other allegations they contend should survive the first-to-file bar, the *Bryant* Relators effectively concede that *Osinek* bars the remainder of their allegations. Yet the three categories of allegations to which the *Bryant* Relators now cling are no more than variations on the same upcoding scheme first alleged by Osinek.

Hospital Coding. The *Bryant* Relators argue that Osinek's complaint did not encompass their allegations of fraud in the hospital setting. *Id.* at 9, 12. But this technical distinction does not save the *Bryant* complaint. That Osinek did not name "Kaiser Foundation Hospitals" as a defendant does not narrow the scope of her allegations to upcoding practices within Defendant medical groups. Again, by naming "Kaiser Permanente," Osinek alleged an enterprise-wide scheme across Defendants' affiliated entities, including the hospital division. *See supra* at 10–13. That the United States issued subpoenas directed to Kaiser Foundation Hospitals in 2013—***nearly five years before*** the *Bryant* Relators filed their complaint—shows the breadth of Osinek's allegations and DOJ's actual notice that they extended to hospital practices. RJN, Ex. D.

[14] As noted *supra* at 11, the *Bryant* Relators also argue that their complaint is "unique in its national scope." *Bryant* Opp'n at 9; *see also id.* at 2, 6–7, 18. But this argument fails because Osinek alleged an enterprise-wide scheme implicating Defendants' risk-adjustment diagnosis-coding practices across the nation. *See supra* at 10–13. Moreover, other complaints filed earlier than the *Bryant* complaint name Defendant entities outside the California region.

Even if Osinek's complaint had not been so broad as to encompass diagnosis coding in the hospital setting, the *Bryant* Relators still would not be the first to allege a hospital-related fraudulent scheme. The *Arefi* complaint, filed in 2015—nearly three years before *Bryant*—named Kaiser Foundation Hospitals as a defendant. *Arefi* Dkt. No. 1 ¶¶ 16–17. And the *Stein* Relators, who both worked at Defendant hospitals and who filed their original complaint in 2016, also named Kaiser Foundation Hospitals as a defendant. *Stein* Dkt. No. 1 ¶ 5. The sepsis and malnutrition allegations at the core of the *Stein* complaint all concern hospital-related diagnosis coding. *Stein* Dkt. No. 1 ¶¶ 50–79; *see also Stein* Opp'n at 3–5. Thus, by the time the *Bryant* Relators filed their complaint, the United States was on notice of an alleged hospital-related upcoding scheme not just through *Osinek*, but through *Arefi* and *Stein* as well.

Vent-Dependence Status. The *Bryant* Relators' allegations about diagnosis coding of vent dependence are merely factual variations on the broader upcoding scheme first alleged by Osinek, particularly her allegations that Kaiser Permanente instructed healthcare providers to diagnose medical conditions in ways that did not comport with diagnosis-coding guidelines. *See, e.g.*, Dkt. No. 1 ¶¶ 26–31. Even the *Bryant* Relators' Opposition describes their vent-dependence allegations as part of this same alleged "scheme[] to fraudulently overbill" and "systemic[ally] over-document[] and upcod[e]" specific high-value diagnoses. *Bryant* Opp'n at 11–12.

It makes no difference under § 3730(b)(5) that Osinek did not mention the specific diagnosis of mechanical vent-dependence status or its associated HCC. What matters for the first-to-file analysis is that Osinek first alleged the business practices and motives behind Defendants' purported scheme to target diagnoses improperly for increased risk-adjustment payments from the Medicare Advantage program. *Compare* Dkt. No. 1 ¶ 29 (alleging that Kaiser Permanente "tells" healthcare providers to make diagnoses in a way that is inappropriate under "guidelines" and "best practices"), *with Bryant* Dkt. No. 1 ¶ 87 (alleging that certain Defendants issued "directives" to healthcare providers that "contravene" guidance on the diagnosis coding of vent dependence issued by the American Hospital Association's Coding Clinic). The *Bryant* Relators' vent-dependence allegations "simply add[] factual details" about the same upcoding scheme alleged in *Osinek* and therefore do not survive the first-to-file bar. *Branch*, 560 F.3d at

378; *see also United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *3 (N.D. Cal. July 24, 2015). Indeed, the *Bryant* Relators' silence about other medical conditions specified in their complaint but not referenced in *Osinek* implicitly concedes that merely adding a new diagnosis to the list referenced in *Osinek* is not enough to allege a new and different fraudulent scheme under § 3730(b)(5).

The *Bryant* Relators further argue that their vent-dependence allegations are unique because they allege the medical condition was diagnosed "contemporaneously *during* hospital inpatient stays, not through an 'addendum' process." *Bryant* Opp'n at 12 (emphasis in original). But as noted *supra* at 8–13, Osinek's complaint encompasses diagnosis coding in the hospital setting and extends beyond addenda practices.

Citing no authority, the *Bryant* Relators also argue that their vent-dependence allegations cannot be barred because they relate to alleged conduct that postdated Osinek's complaint. *Bryant* Opp'n at 12. But the first-to-file bar applies to allegations that postdate the filing of the first-filed complaint where the first-filed complaint alleges an ongoing fraud, as is the case here. *See Chovanec*, 606 F.3d at 364–65 ("The [earlier-filed] complaints couldn't allege that any of [the alleged fraud] was certain to continue past their filing dates (1998 and 1999), but neither did either complaint allege that it had stopped. Fraud . . . in 2002 thus is within the scope of a national, continuing, scheme alleged in 1998 and 1999."). This argument also runs headlong into the very purpose of the first-to-file bar, which Congress added to the FCA to prevent repetitive claims once DOJ is on notice of the "essential facts" of the alleged fraud. *Lujan*, 243 F.3d at 1186–87. Because the *Osinek* complaint alleged the "essential facts" giving rise to the purported vent-dependence scheme—that Kaiser Permanente, for example, "tells its [healthcare providers] to change coding practices" and "to change diagnoses to upcode to higher value and more complicated forms of diseases," Dkt. No. 1 ¶¶ 27, 30—her allegations gave DOJ notice of the practices leading to the purported vent-dependence scheme later alleged in the *Bryant* complaint. *See Lujan*, 243 F.3d at 1188 (noting that § 3730(b)(5) "precludes a subsequent relator's claim that alleges the defendant engaged in the same ***type*** of wrongdoing as that claimed in a prior action" (emphasis added)). That the United States requested through its subpoenas in 2013 documents

encompassing Defendants' internal diagnostic standards for all medical conditions demonstrates that *Osinek* gave DOJ the information it needed to investigate Defendants' diagnosis-coding standards for medical conditions like vent dependence, whether or not the *Osinek* complaint explicitly referenced them. *See* RJN, Ex. A at 14, 16.

Affordable Care Act. Finally, the *Bryant* Relators try to distinguish their complaint from *Osinek* by arguing that they allege a separate fraudulent scheme under the ACA. *Bryant* Opp'n at 2, 8, 12, 14. But this contention is baseless on the face of their complaint. The *Bryant* Relators' FCA causes of action (Counts 1 through 4) do not even reference the ACA, citing only the Medicare program. *See Bryant* Dkt. 1 ¶¶ 208–28. For example, they allege that Defendants violated 31 U.S.C. § 3729(a)(l)(A) when they "knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the ***Medicare Program***." *Id.* ¶ 209 (emphasis added). Of the 270 paragraphs in the *Bryant* complaint, only nine reference the ACA, *id.* ¶¶ 7–9, 11, 51–54, 180, and of those nine only two generally describe risk-adjustment under the statute, *id.* ¶¶ 51–52—the others make just a passing reference to the ACA, lumping it in with allegations about the Medicare Advantage program. It is evident from the face of the *Bryant* complaint that it does not bring a distinct FCA claim involving the ACA at all.[15]

4. *Bicocca*

Bicocca concedes that all of the FCA claims alleged "in his original Complaint ***are barred by Osinek's original Complaint based on the first-to-file rule***." *Bicocca* Opp'n at 2 (emphasis added). Because the relevant complaint is Bicocca's original complaint, that concession ends the analysis under § 3730(b)(5), and the Court should dismiss Bicocca's FCA claims against Defendants. *See supra* at 5–7.

Even if the Court were to consider Bicocca's amended complaint, dismissal is still warranted. Bicocca readily admits the striking similarities between his amended complaint and Osinek's complaint: "Both complaints allege a fraud scheme involving inaccurate and

[15] Nor can the *Bryant* Relators' Opposition add new allegations to save the complaint from dismissal.

manipulated [member] diagnoses to obtain increased reimbursements from the government," and both complaints "are centered around, essentially, the same group of defendants over the same general period of time." *Bicocca* Opp'n at 7–8. In short, both complaints allege the same fraudulent scheme and motive, and both involve the same defendants as well as geographic and temporal scope.

In the face of these similarities, Bicocca concedes that many of the allegations in his amended complaint are also barred. *Bicocca* Opp'n at 6 ("To the extent that some of Bicocca's allegations overlap with the same essential elements of the fraud scheme Osinek alleges — specifically the addenda claims — Bicocca does not dispute that these allegations are barred by the first-to-file rule."). In his Opposition, Bicocca frames his amended complaint as alleging "'two sources' of diagnoses that Kaiser requires [healthcare providers] to add." *Id.* at 2. He admits that his allegations about the first "source"—the use of addenda to diagnose chronic medical conditions after a member visit—were first alleged by Osinek and are barred by § 3730(b)(5). *See id.* at 2, 6, 11. Thus, the only allegations that Bicocca contends were not first alleged by Osinek are his allegations about the second "source"—"Kaiser's use of upfront diagnoses lists to re-diagnose [members]." *Id.* at 6.

But Bicocca's "re-diagnose" allegations are not new; they merely repackage Osinek's allegations about Defendants' "refresh" practices. *See* Dkt. No. 1 ¶¶ 24, 33–34 (describing the alleged refresh scheme). According to Bicocca, the "re-diagnose" scheme centered on Defendants' practice of giving healthcare providers "a list of the [member's] past diagnoses" "*before* the [provider] meets with the [member], with the intention that the [provider] will re-diagnose each of the specific diagnoses *during* the visit ('upfront list')." *Bicocca* Opp'n at 2 (emphasis in original). The purpose of the alleged scheme was to ensure that chronic medical conditions among these Defendants' members were diagnosed each year in an effort to "improperly increase[] [Defendants'] capitation rate," and the scheme purportedly was carried out "through data mining, by a computer search of [member medical] records looking for key words." *Bicocca* Dkt. No. 16 ¶¶ 87, 110. This alleged fraud is no different than the "refresh" scheme first described by Osinek. *See, e.g.*, Dkt. No. 1 ¶ 33 (describing "data mined and refreshed

diagnoses"), ¶ 34 (describing healthcare providers' responses "to refreshing and datamining prompts"), ¶ 37 (alleging that Kaiser Permanente "tracks and rewards [healthcare providers] based on the percentage of chronic conditions they are able to capture and refresh"), ¶¶ 39–40 (discussing refresh goals for chronic medical conditions). Thus, "refresh" in *Osinek* and "re-diagnose" in *Bicocca* refer to the exact same concept: ensuring that a member's chronic medical conditions are added to the medical record each year, including through the use of data mining and prompts to identify conditions for healthcare providers to consider at the time of the member encounter.

Bicocca's argument that *Osinek* encompassed the first source of purportedly false diagnoses he alleged (*i.e.*, the addenda scheme) but not the second source (*i.e.*, the "re-diagnose" scheme) asks the Court to ignore the scope of *Osinek*'s refresh allegations. Osinek's complaint alleges that the "refresh" scheme was not limited to diagnoses added to the medical record via addenda, and that Kaiser Permanente encouraged healthcare providers to diagnose certain medical conditions during the member's visit, including through the use of data mining and prompts. *See id.* ¶¶ 24, 26, 33–34. This distinction between refreshed and addended diagnoses makes intuitive sense: for any chronic medical condition, a healthcare provider might diagnose the condition ***at the time*** of the member encounter (*i.e.*, refresh or "re-diagnose" the condition) or ***after*** the encounter (*i.e.*, in an addendum). Because *Osinek* described both scenarios, Bicocca's allegations are barred by § 3730(b)(5).

Bicocca nevertheless argues that his "re-diagnose" allegations are unique because of additional details he alleges in his complaint, allegations that "hard copy" lists were "provided to [healthcare providers] for their daily Medicare [members] that include[d] 'the [member's] chronic conditions that [Defendants] wanted the [provider] to check off in the EMR.'" *Bicocca* Opp'n at 3 (quoting *Bicocca* Dkt. No. 16 ¶ 94). But these "hard copy" lists, which were called "MDP reports," *see Bicocca* Dkt. No. 16 ¶¶ 94–97, were first alleged by Osinek using the exact same terminology. *See* Dkt. No. 1 ¶ 33 (screenshot of an internal document advising Defendant The Permanente Medical Group to "[i]mplement process for printing MDPs for same day appointments"). Further, the methods that Bicocca alleges certain Defendants used to ensure that

chronic medical conditions were "re-diagnosed"—such as tracking healthcare provider performance, pressuring providers to comply, "turning chronic condition management into a performance metric" as "a means to increased salary, bonuses, and potentially other benefits," and the "use of dot phrases"—also were first alleged by Osinek. *Compare Bicocca* Dkt. No. 16 ¶¶ 127–45, *with* Dkt. No. 1 ¶¶ 28, 32–37.

Bicocca makes much of the fact that he alleged two "underlying issues" with the refresh or "re-diagnose" scheme—(1) healthcare providers did not always have sufficient time to properly confirm and diagnose chronic medical conditions suggested by the MDP reports, *see Bicocca* Dkt. No. 16 ¶¶ 114–17; and (2) healthcare providers did not always have adequate expertise or specialization to diagnose the suggested chronic conditions, *see id.* ¶¶ 118–23. But neither of these allegations save his complaint from dismissal. These allegations are "merely variations" on the refresh scheme first alleged by Osinek and do not describe a materially different fraud. *Hampton*, 318 F.3d at 218. Indeed, the *Stein* Relators' concession that their refresh allegations are barred by Osinek's complaint shows the breadth and scope of the refresh scheme first alleged by Osinek. *See Stein* Opp'n at 1 ("Relators do not oppose the Kaiser Defendants' first-to-file attack against Relator's [*sic*] Refresh fraud claim."). There is simply no basis to find that Bicocca's allegations about the same purported scheme survive in light of the *Osinek* and *Stein* complaints.

Bicocca's case citations do not compel a different result. In *Hartpence*, as described *supra* at 18–19, the first-to-file bar did not preclude the second relator's claims premised on violations of the detailed written order requirement because those claims were based on different material facts than those alleged by the first relator. 792 F.3d at 1131. Here, in contrast, Bicocca's alleged "re-diagnose" scheme is the same as Osinek's alleged refresh scheme. Both schemes are based on the same material facts, the same alleged motive, and do not allege a separate fraud.

United States ex rel. Heath v. AT & T, Inc. is distinguishable for the same reason. 791 F.3d 112 (D.C. Cir. 2015). There, the first-filed complaint alleged a fraudulent scheme against the federal Education Rate program in Wisconsin based on the "affirmative misrepresentations"

of Wisconsin Bell employees who allegedly lied about the existence of a state contract with a lower price. *Id.* at 121. The second-filed complaint, by contrast, was against Wisconsin Bell's parent company, AT&T, and alleged a "more far-reaching scheme" that purportedly occurred across the country based on AT&T's institutionalized and corporate-wide training and billing procedures. *Id.* Here, Osinek's complaint reflects a "more far-reaching scheme," whereas Bicocca's complaint alleges just a variant of the upcoding scheme that Osinek already alleged.

United States ex rel. Chin v. CVS Pharmacy, Inc. is also readily distinguishable because the two complaints concerned a similar fraudulent scheme but involved different, independent defendants. 2017 WL 4174416 (C.D. Cal. Aug. 15, 2017). There, the court found that the first-to-file bar did not apply because the first-filed complaint named Walgreens as a defendant, whereas the second-filed complaint named CVS. *Id.* at *4–5. Although both complaints alleged similar facts—that the pharmacies provided gift cards and coupons in exchange for customers transferring their prescriptions—nothing in the first-filed complaint suggested that CVS provided gift cards to federal healthcare plan beneficiaries or alleged any facts suggesting an industry-wide fraudulent scheme. *Id.* at *4. Here, Osinek's complaint alleged a broad, enterprise-wide scheme by "Kaiser Permanente," and Bicocca does not even argue that his amended complaint could somehow survive dismissal simply because he named specific Kaiser-affiliated entities as defendants.

Finally, the court's decision in *Savage* turned on the fact that the first-filed and second-filed *qui tam* actions each named different prime contractors as defendants, and the different defendants were operating under different Department of Energy contracts and performing different remediation work. 2015 WL 5794357, at *8–9. As a result, proving the claims in both *qui tam* actions would have required materially different evidence. *Id.* at *9. Here, Bicocca's allegations and Osinek's allegations implicate the same Defendants, and proof of Bicocca's "re-diagnose" scheme would require the same evidence as proof of Osinek's refresh scheme.

D. The Motion Is "Ripe."

The Court should reject any suggestion from the Opposing Relators that the Motion is not yet "ripe" given the early stage of the litigation. *See Bryant* Opp'n at 19. The *Bryant* Relators

argue that, because DOJ has intervened on addenda-related allegations, and there has not been a final judgment or settlement as to DOJ's intervention complaint, deciding first-to-file issues now would be "premature." *Id.* Notably, the *Bryant* Relators have not cited a single authority stating that first-to-file issues should be left for resolution until after final judgment or settlement where DOJ has intervened.[16] And the *Bryant* Relators' argument would turn logic on its head—requiring this Court to decide a threshold jurisdictional question at the ***end*** of a case—without providing any meaningful standard to distinguish this case from countless others that have decided, without controversy, first-to-file questions on a motion to dismiss.

A rule allowing relators to keep their *qui tam* cases pending until a final resolution even if the first-to-file bar requires dismissal makes no sense. In addition to a lack of grounding in statutory text or case law, it contravenes the policies of the first-to-file bar. Delay would not help DOJ police fraud or mitigate the burden of litigating duplicative allegations. The outset of the case is precisely the right time to make first-to-file determinations, especially where, as here, there are several *qui tam* cases at issue and their dismissal can simplify the case for other parties and the Court. The *Arefi* Relators apparently realized this fact, filing a non-opposition to the Motion that will result in the dismissal of their complaint in its entirety. And the Court has a duty to resolve this matter now given that its subject-matter jurisdiction is at issue. *See Corral v. Select Portfolio Servicing, Inc.*, 878 F.3d 770, 773 (9th Cir. 2017) ("[T]he court has an 'independent obligation to determine whether subject-matter jurisdiction exists, even in the absence of a challenge from any party.'" (quoting *Arbaugh v. Y&H Corp.*, 546 U.S. 500, 514 (2006))). Accordingly, the Court should decide the Motion on its merits now before further progression in the litigation.

III. CONCLUSION

The Opposing Relators' concessions already have narrowed this case—requiring dismissal of *Arefi* and *Bicocca* in their entirety as well as the refresh allegations in *Stein*. Unable to limit

[16] The case that the *Bryant* Relators cite stands for the uncontroversial proposition that the DOJ's intervention complaint "necessarily incorporate[s] the material elements of fraud from the earliest-filed complaints containing those elements." *Bryant* Opp'n at 19 (quoting *United States v. Berkeley Heartlab Inc.*, 225 F. Supp. 3d 487, 495 (D.S.C. 2016)).

Osinek to addenda practices or California, Taylor and the *Bryant* Relators also effectively concede that all but a select number of allegations in their complaints should be dismissed. But the Court should not stop there. Osinek alleged a broad upcoding scheme targeting Defendants' Medicare Advantage diagnosis-coding practices that not only could have ***but did*** put DOJ on notice of a purported nationwide fraud scheme. The Oppositions merely point to allegations that do not explicitly appear in *Osinek*, but are nonetheless encompassed by Osinek's upcoding allegations. That is not sufficient to avoid dismissal under the first-to-file bar. The Court should grant the Motion and dismiss the *Taylor*, *Arefi*, and *Stein* complaints in their entirety, as well as Counts 1 and 2 of the operative *Bicocca* complaint and Counts 1 through 4 of the operative *Bryant* complaint.

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Respectfully submitted,

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