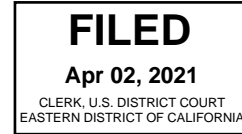


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SEALED

9 UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

10 UNITED STATES,
11
12 STATE OF CALIFORNIA,
STATE OF COLORADO,
13 STATE OF GEORGIA,
STATE OF HAWAII,
14 STATE OF MARYLAND,
COMMONWEALTH OF VIRGINIA,
STATE OF WASHINGTON,

15 *ex rel.* JEFFREY MAZIK,

16 Plaintiffs,

17 v.

18 KAISER FOUNDATION HEALTH PLAN,
19 INC., KAISER FOUNDATION HOSPITALS,
INC., and THE PERMANENTE MEDICAL
20 GROUPS,

21 Defendants.

No.: 2:19-cv-00559-JAM-KJN

**FIRST AMENDED *QUI TAM*
COMPLAINT**

JURY DEMANDED

FILED UNDER SEAL

INTRODUCTION

1
2 1. This is a civil action by *qui tam* Plaintiff-Relator Jeffrey Mazik, who files
3 this action on behalf and in the name of the United States of America, and California,
4 Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington (the “State Plaintiffs”),
5 against the Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, Inc.,
6 and the regional Permanente Medical Groups (collectively, “Defendants” and/or
7 “Kaiser”) for damages and civil penalties arising from violations of the False Claims
8 Act, 31 U.S.C. §§ 3729–3733 and the corresponding statutes of the State Plaintiffs.

9 2. As alleged herein, Kaiser has engaged in a scheme to knowingly submit,
10 cause to be submitted, and conspire to submit false claims for payment to the United
11 States in connection with Medicare Advantage programs and its participation in
12 Medicaid programs with the various states. Kaiser knowingly accepts false claims from
13 non-Kaiser physicians for services rendered to its members, submits false and
14 artificially inflated diagnostic coding for its plan enrollees to the Centers for Medicare
15 & Medicaid Services (“CMS”) and the State Plaintiffs, and uses those data to calculate
16 “risk adjustment factors” for each enrollee. This, in turn, leads to false and artificially
17 increased per-capita amounts that Kaiser receives as payment for each enrollee in its
18 Medicare Advantage and Medicaid programs.

19 3. Kaiser accomplishes this fraudulent scheme by knowingly allowing false
20 and fraudulent diagnoses codes submitted in claims for payment by non-Kaiser
21 providers (“outside providers”), incorporating those false data into its own electronic
22 data for its Medicare Advantage and Medicaid program enrollees, and thereby making
23 those individuals appear sicker or significantly less healthy than they actually are.

1 from the federal government. This Court also has subject matter jurisdiction under 31
2 U.S.C. § 3732(a) and supplemental jurisdiction over the state law causes of action
3 under 28 U.S.C. § 1367 and 31 U.S.C. § 3732(b).

4 8. This Court has personal jurisdiction under 31 U.S.C. § 3732(a) because
5 one or more Defendants can be found in, reside in, transact business in, and have
6 committed acts related to the allegations in this Complaint in the Eastern District of
7 California.

8 9. Venue is proper, pursuant to 31 U.S.C. § 3732(a), as Defendants can be
9 found in, reside in, and/or transact business in the Eastern District of California, and
10 because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within
11 this judicial district.

12 **PARTIES AND ENTITIES**

13 **A. *Relator Jeffrey Mazik***

14 10. Relator Jeffrey Mazik is a resident of California and the former Senior
15 Practice Leader for Kaiser's National Compliance Office, with over 25 years of expertise
16 in fraud control, audit, and compliance.

17 11. Relator was employed by Kaiser for almost a decade, from 2008 to 2017.
18 He first joined Kaiser in May 2008 as an Information Technology Audit Specialist, and
19 eventually transitioned to the role of Senior Practice Leader in the Fraud Control
20 Program, in or around March 2012.

21 12. In that role, Relator's duties and responsibilities included working closely
22 with regional compliance leadership to implement compliance and fraud control
23 initiatives; leading comprehensive risk assessments, using data analytics to drive
24 compliance, fraud control focus-areas, and fraud mitigation initiatives; investigating

1 cases of potential fraud, waste, and abuse; developing corrective action plans to address
2 root causes of fraud risks—particularly for areas including medical claims, accounts
3 payable, inventories, cash handling, durable medical equipment, IT and payroll; and
4 overseeing Board reporting and mandatory regulatory reporting for the fraud control
5 program.

6 13. Relator continued to personally observe the ongoing fraud detailed herein
7 until his retaliatory discharge, on or about January 5, 2017.

8 ***B. Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation***
9 ***Hospitals, Inc., and The Permanente Medical Groups***

10 14. Kaiser Permanente is an American integrated managed care consortium
11 made up of three distinct but interdependent groups of entities:

12 (a) Kaiser Foundation Health Plan, Inc. is a nonprofit corporation,
13 licensed as a health care service plan, headquartered in Alameda County,
14 California. It enrolls members in individual and group plans, and provides
15 hospital and medical services for its members through separate contracts with
16 the Kaiser Foundation Hospitals, Inc., and the regional Permanente Medical
17 Groups. As is relevant here, the Kaiser Foundation Health Plan, Inc. operates
18 several Medicare Advantage health plans—and various other government-
19 funded capitated rate plans—including certain Special Needs Plans (“SNPs”) and
20 state-administered Medicaid plans through regional subsidiaries in California,
21 Georgia, Colorado, Hawaii, Maryland, Virginia, and Washington.

22 (b) Kaiser Foundation Hospitals, Inc. is a nonprofit corporation that is
23 also headquartered in Alameda County; it operates hospitals and medical
24 centers that receive their funding from the Kaiser Foundation Health Plan and

1 provides infrastructure and facilities for the benefit of the regional Permanente
2 Medical Groups.

3 (c) The regional Permanente Medical Groups are groups of physicians
4 organized as independent professional corporations. They are privately owned
5 and managed by physician shareholders, but contract with the other Kaiser
6 entities to provide various inpatient and outpatient medical services. Each
7 Permanente Medical Group operates as a separate for-profit partnership or
8 professional corporation in its individual territory. And while none publicly
9 reports its financial results, each is primarily funded by reimbursements from its
10 respective regional Kaiser Foundation Health Plan entity.

11 15. The three aforementioned entities work in cooperation with each other to
12 form the largest managed care organization in the United States, which does business
13 under the trade name “Kaiser Permanente” in at least eight states (California,
14 Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington) and the
15 District of Columbia.

16 16. The entities act in concert as a matrix organization, sharing knowledge
17 across corporate divisions and making centralized decisions with respect to CMS
18 compliance, claim making, responsibility for tracking and reporting information that
19 goes into claims for Medicare reimbursements, etc.

20 17. As of December 2017, the Kaiser Foundation Health Plan and the Kaiser
21 Foundation Hospitals reported a combined \$72.7 billion in operating revenues and \$3.8
22 billion in net income.

1 **RELEVANT LEGAL FRAMEWORK**

2 **A. *Medicare Advantage and Other Government-Funded Capitation Rate***
3 ***Plans***

4 18. Medicare beneficiaries have the option of receiving benefits through
5 private health plans as an alternative to the traditional fee-for-service Medicare
6 program. Under this option, known as Medicare Advantage (or Medicare Part C), the
7 government pays participating Medicare Advantage organizations a capitated (per
8 enrollee) amount to provide medical benefits.

9 19. Medicare beneficiaries vary greatly in terms of their health status, which
10 in turn affects their utilization of health care services and the total cost of services they
11 receive. Those with serious illnesses, multiple chronic conditions—or who are frail—
12 have persistent costs and may require more care, which will lead to higher medical
13 costs on average than their healthier counterparts.

14 20. Accordingly, the government adjusts monthly payments to Medicare
15 Advantage organizations to reflect the health status of their enrollees. 42 U.S.C.
16 § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2). This ensures that Medicare
17 Advantage organizations are paid appropriately for their plan enrollees, in accordance
18 with the general logic that healthier enrollees should cost less than those with serious
19 or chronic medical conditions.

20 21. Broadly speaking, capitation rates are determined based on past and
21 expected future medical expenses, the location of the plan's actual and expected
22 members, the health status and demographics of those members, and whether the plan
23 will include any additional benefits. As is relevant here, the health status of members is
24 based upon diagnosis codes that Kaiser receives from healthcare providers following

1 medical encounters with its plan enrollees, which are then transmitted to CMS for the
2 purpose of calculating the appropriate capitation rates. *See generally* Medicare and
3 Medicaid Servs., Pub. No. 100-16, Medicare Managed Care Manual, ch. 7, § 40 (2014),
4 [https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf)
5 [Guidance/Guidance/Manuals/Downloads/mc86c07.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf)). These diagnosis codes
6 contribute to an enrollee’s risk score, which is used to adjust the base payment rate.

7 22. The process of adjusting the capitation rate to reflect a member’s health
8 status is known as “risk adjustment,” and relies upon diagnosis classifications set forth
9 in the International Classification of Diseases, 9th or 10th Edition, Clinical
10 Modification (“ICD-9-CM” or “ICD-10-CM”) system. *See* Report to Congress: Risk
11 Adjustment in Medicare Advantage (Dec. 2018), at 14,
12 [https://www.cms.gov/Medicare/Health-](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf)
13 [Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf](https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf). These individual
14 diagnosis codes are then organized into groups, called Hierarchical Condition
15 Categories (“HCCs”), upon which the capitation rates are based. *Id.* at 16–19. Every
16 HCC consists of several diagnosis codes that are clinically related and are expected to
17 require a similar level of resources to treat. Thus, for example, a patient who receives
18 ICD-10-CM diagnosis codes for conditions including diabetes, congestive heart failure,
19 acute myocardial infarction (AMI), angina pectoris, cough, contusions and sprains, over
20 the course of several hospital and physician visits, would be considered to have three
21 higher level conditions, or HCCs—(1) diabetes with chronic complications, (2)
22 congestive heart failure, and (3) acute myocardial infarction—for the purpose of
23 determining the appropriate capitation rate. *Id.* at 20.

1 23. Obviously, if the diagnosis codes that Kaiser receives from health care
2 providers are erroneous, false, or fraudulent, and Kaiser fails to identify or correct
3 those errors through an effective internal compliance program before submitting them
4 to CMS, then the capitation rates upon which they are based will also be wrong. *See*
5 *U.S. ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 673 (9th Cir. 2018) (“The
6 importance of accurate data certifications and effective compliance programs is obvious:
7 if enrollee diagnoses are overstated, then the capitation payments to Medicare
8 Advantage organizations will be improperly inflated.”).

9 24. Unfortunately, this system tends to provide improper incentives for
10 Medicare Advantage organizations like Defendants to over-report diagnoses codes or
11 engage in the practice of “upcoding” to increase their revenues by improperly inflating
12 their enrollees’ capitation rates.

13 25. With data for millions of people being submitted each year, CMS is unable
14 to adequately audit coding submissions or confirm diagnoses before calculating
15 capitation rates. Instead, the agency accepts the diagnoses as submitted, and then
16 audits some of the self-reported data several years later to ensure that they are
17 adequately supported by medical documentation. 42 C.F.R. §§ 422.310(e), 422.311.
18 These audits have revealed excess payments for unsupported diagnoses steadily
19 increasing over the last decade, reaching an estimated \$16.2 billion in fiscal year 2016.
20 *See* U.S. Gov’t Accountability Office, GAO-17-761T, Medicare Advantage Program
21 Integrity: CMS’s Efforts to Ensure Proper Payments and Identify and Recover
22 Improper Payments 1 (2017), <https://www.gao.gov/assets/690/685934.pdf> (last visited
23 Feb. 9, 2021).

1 26. In order to counteract the potential temptation that Medicare Advantage
2 organizations may have to submit unsupported diagnoses, Medicare regulations require
3 risk adjustment data to be produced according to certain best practices; specifically,
4 every diagnosis code submitted to CMS must be based on a “face-to-face” visit (with the
5 exception of certain pathology services), and medical records must be validated by
6 qualifying physician/practitioner signatures and credentials. *See generally* Medicare
7 Managed Care Manual, ch. 7, §§ 40, 120.1.1, Further, electronic medical records must
8 meet special signature requirements and use software that is protected against
9 modification. *Id.* (citing Ctrs. for Medicare and Medicaid Servs., Pub. No. 100-08,
10 Medicare Program Integrity Manual, ch. 3, § 3.3.2.4 (2018),
11 [https://www.cms.gov/Regulations-and-](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf)
12 [Guidance/Guidance/Manuals/downloads/PIM83c03.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf) (last visited Feb. 9, 2021)).

13 27. CMS sets risk scores based on risk adjustment data submitted for services
14 provided during the year preceding the payment year. 42 C.F.R. §§ 422.310(g),
15 423.329(b)(3). The annual deadline for submitting risk adjustment data to CMS is in
16 early September. *Id.* The data submitted by the September deadline determines
17 members’ preliminary risk scores for the following year. Thereafter, CMS continues to
18 accept risk adjustment data submissions through a reconciliation process that triggers
19 additional payments or adjustments, to account for codes submitted after the
20 September deadline.

21 28. Because this process determines capitation rates, Medicare Advantage
22 organizations must carefully monitor risk adjustment claims to ensure the
23 completeness and accuracy of their submissions. Thus, Medicare Advantage
24

1 organizations are required to “[a]dopt and implement an effective compliance program,
2 which must include measures that prevent, detect, and correct non-compliance with
3 CMS’ program requirements as well as measures that prevent, detect, and correct
4 fraud, waste, and abuse.” 42 C.F.R. § 422.503 (b)(4)(vi).

5 29. Importantly, Medicare Advantage organizations must certify the
6 accuracy, completeness and truthfulness of the data they provide to CMS, including
7 risk adjustment data, as a condition to receiving payment. 42 C.F.R. § 422.504.
8 Specifically, CMS requires Medicare Advantage organizations to submit annual
9 attestations, each signed by the CEO or CFO (or their authorized, direct subordinate),
10 certifying that the risk adjustment data they submit annually to CMS are “accurate,
11 complete, and truthful.” The attestation acknowledges that risk adjustment
12 information “directly affects the calculation of CMS payments ... and that
13 misrepresentations to CMS about the accuracy of such information may result in
14 Federal civil action and/or criminal prosecution.” The regulations also provide that if
15 claims data are generated by a “related entity, contractor, or subcontractor of [a
16 Medicare Advantage] organization,” that entity must similarly certify “the accuracy,
17 completeness, and truthfulness of the data.” 42 C.F.R. § 422.504(l)(3).

18 30. CMS also provides strict requirements governing Medicare Advantage
19 plans’ contractual relationship with external providers, affiliates, vendors, and other
20 entities—also known as First Tier, Downstream, and Related Entities (“FDRs”), which
21 are defined by CMS as any party that enters into a written arrangement with a
22 Medicare Advantage organization to provide certain healthcare services—that the
23
24

1 Medicare Advantage plan will rely upon to provide services to its members. For
2 example, applicable regulations provide, *inter alia*, that:

3 (a) the Sponsor must have a system in place to monitor FDRs per 42
4 C.F.R. §§ 422.503, 422.504, 423.505;

5 (b) the plan must have training and education for all employees and
6 management of all FDRs per 42 C.F.R. § 422.503(b)(4)(C)(1);

7 (c) the plan must have established, effective lines of communication
8 between all entities to report compliance issues per 42 C.F.R. § 422.503(b)(4)(D);

9 (d) compliance must not be delegated per 42 C.F.R. § 422.503(b)(4)(vi),
10 42 C.F.R. § 422.504(i)(1);

11 (e) the Plan must maintain and have “well publicized disciplinary
12 standards” to “encourage the good faith participation in the compliance program”
13 per 42 C.F.R. § 422.503(b)(4)(E); and

14 (f) the Plan must have a system for “promptly responding to
15 compliance issues as they are raised, investigating potential compliance
16 problems as identified in the course of self-evaluations and audits, correcting
17 such problems promptly and thoroughly to reduce the potential for recurrence,
18 and ensure ongoing compliance with CMS requirements” per 42 C.F.R. §
19 422.503(b)(4)(G).

20 31. CMS also imposes certain obligations to undertake corrective actions
21 where necessary to ensure compliance with other applicable laws and regulations,
22 which includes the obligation to perform a root cause analysis to identify the source of
23 any potential errors or issues. Such corrective actions must be tailored to address the
24

1 particular fraud, problem or deficiency identified, and must include timeframes for
2 specific achievements. *See* 42 C.F.R. § 422.504(i)(1). Medicare Advantage organizations
3 must also ensure that FDRs correct deficiencies and provide documentation of all
4 identified deficiencies and corrective actions taken. *Id.*

5 32. Medicare Advantage organizations know that they are required to ensure
6 the integrity of the data they submit to CMS, and that they are subject to various
7 audits that could lead to the repayment of improper claims. In 2005, CMS implemented
8 a pilot Medicare Recovery Audit Contractor (RAC) Program applicable to Medicare
9 Parts A and B, which successfully corrected more than \$1.03 billion in improper
10 payments to Medicare providers. Then, following the Patient Protection and Affordable
11 Care Act (“ACA”), enacted in March 2010, CMS expanded the Recovery Audit program
12 to the Medicare Part C programs. As a result of these statutes and associated
13 regulations, Medicare Advantage organizations are subject to various health plan
14 audits, including:

15 (a) risk adjustment medical record reviews (MRRs), which are
16 designed to ensure medical record documentation validates claims data received;

17 (b) risk adjustment data validation (RADV), where CMS may require
18 health plans to perform audits and send CMS “one best medical record” that
19 substantiates all submitted reporting; and

20 (c) DRG Payment Integrity Reviews, which are ongoing
21 comprehensive review of hospital claims that have been submitted to plans for
22 payment, including the diagnosis related groups (DRGs) – the diagnosis codes
23
24

1 used to calculate risk adjustment scores – to make sure cases are properly coded
2 and sequenced, and that billed information matches the patient record.

3 ***B. Medicaid and Dual Eligibility Special Needs Plans (“SNP”)***

4 33. Although the above-described risk adjustment model is primarily used in
5 conjunction with Medicare Advantage (Medicare Part C) plans, there are several other
6 government-funded capitation rate plans that rely upon substantially the same model—
7 including Special Needs Plans (“SNPs”), which are focused on coordinating care for
8 persons with disabilities and other special needs—and various state-administered
9 Medicaid programs—such as Medi-Cal in California, and other similar plans of the
10 State Plaintiffs.

11 34. A Special Needs Plan (“SNP”) is a Medicare Advantage coordinated care
12 plan specifically designed to provide targeted care and limit enrollment to special needs
13 individuals. These plans were first authorized by Congress in the Medicare
14 Modernization Act of 2003, which identified “special needs individuals,” including (1)
15 “dual eligible” individuals – those qualifying for both Medicare and Medicaid coverage;
16 (2) individuals with chronic conditions; and (3) institutionalized individuals. Plans
17 covering such individuals are called D-SNPs, C-SNPs and I-SNPs, respectively.
18 Because of the overlap with state Medicaid programs, the various states that
19 implement such programs will pay part of the costs associated with SNPs.

20 35. Since the initial enactment in 2003, the program has been extended by
21 Congress repeatedly, including by the Medicare, Medicaid, and State Children’s Health
22 Insurance Program (SCHIP) Extension Act of 2007 (extending the SNP program to
23 December 31, 2009); The Medicare Improvements for Patients and Providers Act of
24 2008 (MIPPA) (extending the SNP program through December 31, 2010); The Patient

1 Protection and Affordable Care Act (“ACA”) effective in 2011 (extending the SNP
2 program through December 31, 2013); The American Taxpayer Relief Act of 2012
3 (ATRA) (extending the SNP program through December 31, 2014); the Bipartisan
4 Budget Act of 2013 (Pub. L. 113-67) (extending the SNP program through December 31,
5 2015); the Protecting Access to Medicare Act of 2014 (extending the SNP program
6 through December 31, 2016) and the Medicare Access and CHIP Reauthorization Act of
7 2015 (MACRA) (extending the SNP program through December 31, 2018).

8 36. SNPs are expected to follow existing Medicare Advantage program rules,
9 including Medicare Advantage regulations at 42 C.F.R. § 422, as modified by guidance,
10 with regard to Medicare-covered services and Prescription Drug Benefit program rules.
11 Under CMS rules, SNPs should assume that, if no modification is contained in
12 guidance, existing Part C and D rules apply. Payment procedures for SNPs mirror the
13 procedures that CMS uses to make payments to non-SNP Medicare Advantage plans.
14 SNPs must prepare and submit bids like other Medicare Advantage plans, and are paid
15 in the same manner as other Medicare Advantage plans based on the plan’s enrollment
16 and risk adjustment payment methodology. All SNPs must abide by current CMS
17 guidance on cost sharing requirements.

18 **C. The False Claims Act (“FCA”)**

19 37. The U.S. Court of Appeals for the Ninth Circuit has explicitly held that
20 “the Medicare Advantage capitation payment system is subject to the False Claims
21 Act.” *Silingo*, 904 F.3d at 673–74.

22 38. As is relevant here, the FCA prohibits, *inter alia*: (a) knowingly
23 presenting (or causing to be presented) to the federal government a false or fraudulent
24 claim for payment or approval; (b) knowingly making or using, or causing to be made or

1 used, a false or fraudulent record or statement material to a false or fraudulent claim;
2 (c) knowingly making, using, or causing to be made or used, a false record or statement
3 material to an obligation to pay or transmit money or property to the government, or
4 knowingly concealing or knowingly and improperly avoiding or decreasing an obligation
5 to pay or transmit money or property to the government; and (d) conspiring to violate
6 any of these three sections of the FCA. *See* 31 U.S.C. §§ 3729(a)(1)(A)-(C), and (G). The
7 FCA also imposes an independent duty to correct known errors that will cause, or have
8 caused, a government overpayment. Accordingly, Medicare Advantage plans not only
9 have a duty to submit correct data to CMS, but also, for data they have already
10 submitted, must delete records known to be incorrect from CMS’s database using a
11 “delete code.”

12 39. Any person who violates the FCA is liable for a civil penalty of up to
13 \$23,331 for each violation, plus three times the amount of the damages sustained by
14 the United States. 31 U.S.C. § 3729(a)(1).

15 FACTUAL ALLEGATIONS

16 ***A. Defendants allow false claims by outside providers in order to*** 17 ***artificially inflate per capita payments by Medicare and Medicaid.***

18 ***1. Defendants’ Scheme to Allow False Claims by Outside Providers***

19 40. Over the course of at least a decade, Kaiser has been engaged in a
20 deliberate scheme to defraud the United States by allowing non-Kaiser providers to
21 submit to it, as a Medicare Advantage Organization, false claims for payment. Because
22 Kaiser is a recipient of Medicare and Medicaid funds, each false or fraudulent claim for
23 payment by outside providers violates the False Claims Act. Kaiser knowingly allows
24 such claims despite its obligations as a Medicare Advantage organization, because

1 those claims provide false or fraudulent diagnostic codes which Kaiser allows into data
2 maintained for each of its members. It then submits those data to CMS in order to
3 falsely inflate risk adjustment factors used to calculate its capitation rates.

4 41. Kaiser Foundation Health Plan, from its headquarters and through six
5 subsidiaries, operates various Medicare Advantage organizations and SNPs in eight
6 regions throughout the country. In all regions, the structure of the interdependent
7 components of Kaiser Permanente is the same: Kaiser Foundation Health Plan enrolls
8 members through Medicare Advantage plans and SNPs, and members receive a
9 majority of their care from “in-network” providers at Kaiser Foundation Hospitals and
10 regional Permanente Medical Groups. Kaiser Foundation Health Plan collects data
11 regarding the care delivered to its members, and the diagnosis codes that are entered
12 into its members’ electronic records. It then provides data to CMS regarding the health
13 status of those members, and claims and collects monthly capitated rates according to
14 the risk adjustment score for each member.

15 42. Despite the extensive network of Kaiser-related providers, each year some
16 members enrolled in Kaiser’s Medicare Advantage plans and SNPs require medical
17 care from outside providers. Under Medicare rules and procedures, outside providers of
18 care to Kaiser Medicare or Medicaid enrollees are required to submit to Kaiser a Health
19 Insurance Claim Form (CMS-1500) that reflects appropriate medical diagnosis and
20 procedure codes. Unlike claims under Medicare Part A and Part B, these forms are not
21 received by CMS until later, if at all.

22 43. Kaiser knows that it must audit claims by outside providers to ensure the
23 integrity of the data it submits to CMS. Part of maintaining compliant relationships
24

1 with outsourced services requires plan sponsors, like Kaiser, to oversee procedures for
2 auditing claim submissions by outside providers. Plan sponsors must undertake
3 corrective actions in response to potential noncompliance or potential fraud. Because
4 the provider claims are submitted to Kaiser rather than directly to Medicare, Kaiser
5 acts as the gatekeeper for fraudulent claims, and must take on the responsibility to
6 report only accurate information from those claim submissions to CMS.

7 44. But since at least 2008, Kaiser has knowingly misused healthcare
8 compliance software and fraud-detection programs that are designed to monitor and
9 track potential errors—so as to purposely overlook widespread fraudulent upcoding by
10 the various medical providers that treat members enrolled in Kaiser’s government-
11 funded capitation rate plans. Kaiser’s compliance program has been a complete sham –
12 intended to make the company appear as though it was engaged in comprehensive and
13 meaningful fraud-prevention efforts, while internally encouraging and embracing
14 providers that submitted false and fraudulent claims for payment.

15 45. Although this may have caused Kaiser to lose some monies in the form of
16 overpayments to certain unaffiliated outside providers, Kaiser willingly overlooked
17 these overpayments because the subsequent submission of those unsupported
18 diagnostic codes to CMS served to increase the capitation rates that it received from the
19 government—all whilst allowing its affiliated hospitals, physicians, and other medical
20 providers to profit from higher reimbursement rates. When viewed from a purely profit-
21 driven business perspective, these overpayments were merely short-term losses that
22 effectively served as an investment in the longer-term profitability of Kaiser’s Medicare
23 Advantage program, and other similar government-funded capitated plans.

1 **2. *Intentionally improper use of fraud-detection software***

2 46. Kaiser consistently and intentionally fails to properly utilize fraud-
3 detection tools to monitor and track potential claims errors, lacks enforcement of proper
4 compliance mechanisms, and lacks transparency with regional offices on implementing
5 corrective actions for identified defects and misrepresentations.

6 47. In an effort to appear facially compliant, Kaiser contracts with various
7 data analytics vendors to perform claims review of Kaiser's outside claims for each
8 regional office. Typically, the vendors provide software applications that perform
9 various types of reviews. Some detect claims that are incorrectly billed or coded outside
10 of an established payment, medical or contract policy; other programs identify
11 intentionally manipulated claims that technically fall within plan rules; and other
12 software programs identify excess administrative costs associated with inefficient
13 manual processes.

14 48. Although Kaiser purchases and uses various standard compliance and
15 fraud detection tools and software, which if used properly would detect claims
16 overpayments, Kaiser intentionally misused these tools to avoid identification and
17 detection of overpayment. At best, Kaiser uses them at minimum capacity to decrease
18 the chances of catching claims errors and anomalies.

19 49. For instance, Kaiser intentionally disabled certain claims-editing
20 functionalities in these auditing tools, so as to avoid the identification of certain types
21 of errors. In other words, Kaiser used standard compliance tools, but turned on very few
22 of those features that were designed to detect claim anomalies and overpayments. In
23 doing so, Kaiser outwardly appeared to be engaging in efforts to utilize monitoring and
24

1 tracking tools to be compliant, when in fact, Kaiser was actively working to avoid
2 detecting and correcting the fraud.

3 50. When Relator joined Kaiser's compliance office in 2012, he reported to
4 Mia Okinaga, who was then the Vice President of the National Compliance Office. Ms.
5 Okinaga personally recruited Relator to join the compliance team. She considered
6 Relator a valuable addition to the team, announcing that his role would focus on
7 integrating regional and national departments to enhance the effectiveness of
8 monitoring and tracking fraud control.

9 51. Relator worked closely with Ms. Okinaga, who actively pushed her
10 initiative to direct Kaiser and the regional offices to effectively utilize various
11 diagnostic compliance and fraud detection tools. Such tools were developed by vendors
12 such as Verisk Health ("Verisk") and FICO, both of which are data analytics companies
13 that work with clients to identify fraud and abuse in various financial sectors. Ms.
14 Okinaga and Relator believed that such vendors and their tools could be used to
15 substantially reduce losses from health care billing error, abuse, and fraud.

16 52. Relator also worked closely with Jay Loden, Assistant Director of
17 Information Analytics and Compliance Technology, on tools and analytical studies,
18 Judy Sarles, Senior Director, on compliance systems, and Daren Pursche, Director of
19 Government Audit & Reimbursement, on external and internal compliance standards.

20 53. Ms. Okinaga was eventually pushed out because she lacked the full
21 support from senior management in the compliance office to prioritize those initiatives--
22 and because she was detecting and uncovering significant overpayments that had
23 previously been intentionally concealed.

1 54. Kaiser made the announcement that Ms. Okinaga's position was
2 eliminated on August 21, 2015. Thereafter, Relator reported to Marita Janiga,
3 Executive Director of Investigations in Kaiser's National Compliance, Ethics &
4 Integrity Office, for about a year—and then to Lauren Sutcliffe, a Senior Manager in
5 the Special Investigations Unit.

6 55. Towards the end of 2015, Relator was tasked with conducting a
7 comparative analysis between the functionalities provided by McKesson (another
8 claims data vendor) and Verisk.

9 56. McKesson and Verisk are notable key vendors that contracted, and still
10 continue to contract, with Kaiser to perform claims data review, purportedly in efforts
11 to monitor and detect potential overpayments and other fraud.

12 57. McKesson offers a rules-driven auditing process, utilizing a software
13 called ClaimsXten that provides Kaiser with a robust set of rules which, if used
14 properly, detects abusive billing and prevents wasteful payments. But Kaiser decided to
15 de-activate 25 of the 54 editing rules or features in ClaimsXten – the principal software
16 program that they were supposedly relying on detect such billing fraud.

17 58. Relator, Mr. Loden, Sean Kelly, Project Manager, and Dave
18 Bohnenstingel, Strategic Account Manager at Verisk, worked together on this project,
19 using claims data only from the Georgia region.

20 59. Their efforts, in collaboration with Verisk, identified \$5.3 million in
21 overpayments for the Georgia region alone, which stemmed directly from the Kaiser's
22 previous decision to deactivate various features in McKesson ClaimsXten.

1 60. Of course, the most obvious solution or corrective action to undertake in
2 response to these findings would have been for Kaiser to simply re-activate these built-
3 in editing features in the ClaimsXten software. But that never happened.

4 61. When Relator, Mr. Kelly, Mr. Loden, and Mr. Bohnenstingel presented
5 their findings to Ms. Janiga and Ms. Sarles, neither supervisor expressed an intent to
6 address or rectify the identified overpayments in the Georgia region.

7 62. The findings were also brought before Sean Killeen, Executive Director of
8 Payment Integrity in the Claims-Cost Containment Department and Mike Wathen,
9 Vice President of Georgia Claims Administration. Mr. Killeen's response to the
10 overpayments was indifferent. Mr. Wathen was interested in learning more about the
11 issue, but Mr. Killeen got in the way of any follow-up with the matter by acknowledging
12 his receipt of the issue. In short, nothing was ever done about these issues, either by
13 the national compliance leadership or the regional claims management in Georgia.

14 63. A few months later, in mid-February 2016, Relator detected significant
15 amounts of overpayments due to erroneous codes from all other regions, discovering
16 that they had not been recorded or included in any claims adjustment, credit balance,
17 or self-reported refund. He then prepared a Webex presentation to report his findings to
18 Ms. Janiga and Mr. Pursche.

19 64. In this presentation, Relator also pointed out that, pursuant to applicable
20 regulations, Kaiser was required to review and investigate all identified overpayments
21 within 60 days. The purpose of Relator's analysis was to put his superiors on notice and
22 lay out various options for the necessary corrective action.

1 65. The presentation was received with a lack of interest from Ms. Janiga and
2 Mr. Pursche. They admitted that compliance had “never done this before.” Indeed, this
3 very basic level review that Relator conducted to detect unsupported diagnostic codes
4 and resulting overpayments had never been done before Relator took it upon himself in
5 2016.

6 66. There was no follow-up action requested of Relator, no request for his data
7 or root-cause analysis conducted by Ms. Janiga, Mr. Pursche, or anyone else. Instead,
8 Kaiser dismissed, ignored, and buried Relator’s findings. His superiors refused to
9 investigate any further. Shockingly, they even took overt steps to prevent Relator from
10 investigating any further himself.

11 67. Based on the foregoing, Kaiser clearly failed to perform one of the most
12 basic functions of a Medicare Advantage plan sponsor—that is, to monitor and
13 supervise providers, and to identify overpayments and/or other forms of waste, fraud,
14 and abuse.

15 68. Medicare Advantage plan sponsors like Kaiser are not simple pass-
16 through entities; they must undertake corrective actions in response to instances of
17 noncompliance and/or fraud by providers of medical services. As alleged herein, Kaiser
18 had a particular responsibility to prevent false or fraudulent claims data from outside
19 physicians, since it – and not CMS – was the only entity in a position to monitor such
20 claims and detect fraudulent activities.

21 69. But even after the identification of widespread overpayments to outside
22 providers, Kaiser refused to take appropriate corrective actions, and refused to address
23 known compliance lapses that were facilitating continuous billing and claims errors.

1 70. Kaiser knew that these issues were causing it to submit false data to CMS
2 and yet continually failed to disclose these errors (or the resulting false claims) to the
3 appropriate government authorities.

4 71. In summary, Kaiser's intentional failure to properly oversee and monitor
5 the claims of its external providers led to significant upcoding and overpayments, which
6 were never corrected as required by law, and drove up capitation rates without any
7 legitimate lawful basis, so that Kaiser and its partners could continue to line their own
8 pockets at the public's expense.

9 72. Kaiser's claims for payment to CMS and the State Plaintiffs were false
10 because they were knowingly derived from false data.

11 73. Kaiser's claims for payment were also false because Kaiser repeatedly
12 provided expressly false certifications that its risk adjustment data submissions to
13 CMS were "accurate, complete, and truthful," while knowing that the data were, in fact,
14 plagued with errors, and despite knowing that those errors would cause CMS to pay
15 unjustifiably and falsely higher capitation rates.

16 74. And Kaiser's claims for payment were also false because, as detailed
17 above, Kaiser did not, *inter alia*: (a) have an effective system in place to monitor FDRs;
18 (b) have an effective system for "promptly responding to compliance issues as they are
19 raised, investigating potential compliance problems as identified in the course of self-
20 evaluations and audits, correcting such problems promptly and thoroughly to reduce
21 the potential for recurrence, and ensure ongoing compliance with CMS requirements"
22 per 42 C.F.R. § 422.503(b)(4)(G); (c) undertake corrective actions; or (d) ensure that
23 FDRs correct deficiencies.

1 **3. *Kaiser knowingly covered up its misconduct so as to avoid scrutiny***
2 ***by the Office of the Inspector General.***

3 75. Relator subsequently discovered that Kaiser was also misrepresenting its
4 structure and operations to the government, including during a phone call with the U.S.
5 Department of Health & Human Services: Office of Inspector General (HHS OIG) on
6 June 30, 2016.

7 76. The call was a kick-off call held by HHS OIG with Kaiser to discuss
8 medical loss ratio reporting and audits, addressing issues surrounding claims accuracy
9 and claims recovered through fraud reduction efforts. Several people participated on
10 the call including: Relator, Ms. Janiga, Brian Mesaris, OPM-OIG Auditor, Stephanie
11 Oliver, OPM-OIG Manager, and Robin Richardson, OPM-OIG counsel.

12 77. During the call, OIG asked Kaiser about its general stance on claims
13 operations, informing Kaiser that part of OIG's initiative was to address potential
14 problems and raise additional concerns that prevented Kaiser from maintaining
15 accuracy and consistency of claims payments.

16 78. In response to a majority of the OIG's questions, Ms. Janiga explained
17 that the questions were irrelevant because "claims were not [Kaiser's] business." This
18 was a clear misrepresentation to the OIG since Kaiser processed outside medical claims
19 of at least \$7 billion annually.

20 79. Ms. Janiga also misrepresented that Kaiser and its regional offices were
21 "fully integrated," so there was no need for the OIG to inquire into its claims process.
22 This was also a misrepresentation, since, in fact, that was only partly true in certain
23 regions. These misrepresentations were intended to preclude the OIG from inquiring
24 into Kaiser's claims process.

1 80. Ms. Janiga was aware that Relator knew that her statements were
2 untrue. She was concerned that if he spoke during the OIG call, Relator might
3 contradict Ms. Janiga and correct her misrepresentations to the OIG. She was also
4 concerned that Relator might raise his compliance and overpayments findings with the
5 OIG.

6 81. So in the middle of the phone call with the OIG, Ms. Janiga messaged
7 Relator on intercompany messaging and instructed him to “[not] say a word.”

8 82. Relator understood this as a direct order not to correct or contradict
9 anyone on the call, especially Ms. Janiga’s misrepresentations to the OIG. He did as
10 instructed and stayed quiet on the call.

11 83. This episode had the intended chilling effect on Relator, confirming his
12 worries that Kaiser was not interested in compliance on this issue, let alone fraud
13 detection and correction.

14 **4. Kaiser’s scheme results in false claims.**

15 84. As a result of the scheme as described herein, Kaiser has allowed,
16 approved and made false claims for payment in violation of the False Claims Act. *First*,
17 as a Medicare Advantage organization, Kaiser is a contractor, grantee or recipient of
18 government money to be used to advance government programs or interests. When it
19 allows false or fraudulent claims for overpayment by outside physicians, it approves of
20 false claims as defined under § 3729(b)(2)(A)(ii).

21 85. For example, Kaiser subcontracts with Easterseals to provide health care
22 services for members diagnosed with autism. As revealed in 2013 audit with respect to
23 Easterseals, Kaiser knew that there was a 50% billing error rate, resulting in 40%
24 claims payment inaccuracies. Despite knowing that false claims for payment had been

1 made for Medicare and Medicaid funds, it ignored the violations and approved of the
2 claims.

3 86. An even larger example was witnessed by relator in September 2016,
4 when he reviewed and performed a broader audit of claims data from all of the regional
5 offices, dating from August 3, 2010 through July 30, 2016. The audit found that
6 unsupported diagnostic codes had led to over \$209 million in overpayments for services
7 provided to members of Kaiser's Medicare Advantage program, \$181 million in
8 overpayments for services provided to members of Kaiser's Medi-Cal program, and \$181
9 million overpayments for services provided to members of Kaiser's other Medicaid
10 programs during that six-year period. Despite its knowledge of these claims for
11 overpayment in violation of the Act, Kaiser approved of them.

12 87. *Second*, as part of its responsibilities under the Medicare Advantage
13 program, Kaiser is paid to conduct meaningful reviews outside physician claims. When
14 it seeks payment of Medicare and Medicaid funds, the request for payment is a "claim"
15 under the Act, including an explicit and implicit certification that it had performed core
16 functions of the Medicare Advantage organizations. Kaiser, however, did not provide
17 meaningful reviews of outside physician claims, either before paying them, or within a
18 period of time thereafter when the claim approvals could have been corrected. In
19 essence, Kaiser simply did not perform reviews, or conducted them in such a fashion
20 that the service provided was worthless. Indeed, as described herein, Kaiser's sham
21 compliance program ensured that such meaningful reviews would not be conducted,
22 protecting the claims from further scrutiny internally or by CMS.

1 88. Kaiser’s false certifications and attestations that it had performed the
2 responsibilities of a Medicare Advantage organization were material. The United States
3 and the State Plaintiffs would not have paid these monies to Kaiser had they known
4 that the certifications were false. As a result, Kaiser has knowingly received payments
5 from CMS and the State Plaintiffs, and government payors were damaged in the
6 amounts paid to Kaiser for the performance of its function as a Medicare Advantage
7 organization.

8 89. *Third*, Kaiser has knowingly received inflated payments from CMS and
9 the State Plaintiffs in the form of capitation rates that were significantly higher than
10 they would have been, if based upon patient data that were true and accurate. Kaiser
11 repeatedly submitted false certifications and attestations with respect to the accuracy,
12 completeness, and truthfulness of the diagnosis code data it provided to CMS and the
13 State Plaintiffs. Kaiser knew it had misused healthcare compliance software and fraud-
14 detection programs necessary to ensure the integrity of the data submitted to CMS and
15 the State Plaintiff, and with a sham compliance program, it could not truthfully certify
16 that the data accurately reflected the health status of its members. Indeed, it knew that
17 an actual compliance program would raise red flags regarding overpayments to outside
18 physicians, and that Kaiser had in fact submitted data that led to artificially inflated
19 capitation rates.

20 90. Kaiser certifies the “accuracy, completeness, and truthfulness of the data”
21 because CMS and the State Plaintiffs have neither the access nor the resources to
22 verify Kaiser’s compliance efforts. When Kaiser annually submitted data for its
23 members’ preliminary risk scores, and in any subsequent submission of data during the
24

1 reconciliation process, CMS and the State Plaintiffs relied upon these false data to
2 derive risk adjustment scores, which in turn set the capitation rates. Each month after
3 the inflated risk adjustment scores were determined based upon the false record data,
4 Kaiser made false claims for artificially elevated capitated payments for a growing
5 number of its members.

6 91. As a result, Kaiser has continually submitted and caused the submission
7 of false and unsupported diagnostic codes to CMS, despite knowing that the members
8 did not have the claimed diagnoses and/or had not been treated for those diagnoses.
9 Additionally, Kaiser has continually refused to correct previously submitted risk
10 adjustment claims, despite knowing that the information therein was patently false.
11 These false diagnostic codes and false risk adjustment claims were very material as
12 they directly caused the inflated payments.

13 92. For Kaiser, overpayments to outside providers function as a nominal
14 investment in the long-term profitability of its fraudulent capitation rate scheme. The
15 submission of erroneous and unsupported diagnostic codes actually served to increase
16 Kaiser's overall revenues by increasing the capitation rates that it received from the
17 CMS and the State Plaintiffs according to their risk adjustment frameworks.

18 93. Moreover, Kaiser's various partners and affiliates—which provide the
19 vast majority of health services to members enrolled in Kaiser's government-funded
20 health plans—also profited at the public's expense when Kaiser failed to take
21 appropriate corrective actions against rampant false coding.

1 ***B. Unlawful Retaliation and Wrongful Termination***

2 94. As recounted above, numerous widespread operational and compliance
3 issues became readily apparent to Relator after Ms. Okinaga left her position at Kaiser
4 in 2015.

5 95. Relator uncovered multiple instances of identified overpayments that
6 were not further investigated, were not disclosed, and were not corrected. Rather than
7 acting on the information given by Relator, Kaiser failed to take proper measures to
8 comply with rules, regulations, and laws on overpayments.

9 96. In fact, the more Relator spoke up about Kaiser's improper processes for
10 handling unsupported diagnostic codes and the resulting overpayments, and the more
11 Relator tried to steer Kaiser in the direction of full compliance and disclosure—the
12 more he was sidelined and closed out from data and documents, which prevented the
13 systemic operational and compliance violations from being corrected going forward.
14 Instead of taking prompt and proper corrective actions, Kaiser continued to resist,
15 obstruct, and dismiss Relator's efforts. This was especially true after Relator began
16 reporting to Ms. Sutcliffe, in or around July 2016.

17 97. Despite the lack of feedback and investigation following Relator's
18 presentations and analysis, and Ms. Janiga's instruction to keep quiet during the OIG
19 call, Relator continued his efforts to pinpoint these ongoing issues.

20 98. For example, on October 12, 2016, Relator approached Ms. Sutcliffe about
21 an analysis he had performed that uncovered approximately \$380,000 in suspected
22 overpayments relating to a particular procedure code error. Rather than acknowledge
23 Relator's efforts and the associated cost savings, and proceed to correct the systematic
24 overpayments, Ms. Sutcliffe severely criticized him for performing such an analysis

1 without obtaining her prior approval, and then placed him on a Performance
2 Improvement Plan (“PIP”).

3 99. In addition, at various points in October 2016, Relator was denied access
4 to the very software tools that were necessary for him to fully and properly perform his
5 job. For example:

6 (a) On October 15, 2016, Relator was denied access to the Claims Data
7 Warehouse, Kaiser’s internal data repository system to collect and analyze
8 claims information. Relator was looking to review some of the CDW data,
9 specifically for his ongoing triage of FICO-identified providers.

10 (b) On October 16, 2016, Relator was denied access to Kaiser
11 Permanente Health Connect, Kaiser’s internal electronic health record database
12 system. Similar to his needs for CDW access, Relator was also looking to review
13 some claims data, specifically for his ongoing triage of FICO-identified providers.

14 (c) On October 17, 2016, Ms. Sutcliffe pushed off, and ultimately never
15 followed up with, Relator’s request for access to the Member Complaint’s
16 database system. She told Relator that she needed to discuss with Ms. Janiga
17 first, but never approved this request.

18 100. In sum, Relator was denied access to every data repository necessary to
19 perform his compliance job. Given that he had never had any problems with access
20 during his long career at Kaiser, and these tools were necessary for his job, by refusing
21 to allow him access, Kaiser actively stopped or prevented Relator from being able to
22 perform his regular job.

1 101. These actions were undertaken in direct retaliation for Relator's
2 persistent investigations, findings, and recommendations on claims overpayments. Ms.
3 Sutcliffe's denial of Relator's access was meant to be punitive and to sideline the
4 Relator. Moreover, it was also a stripping of his duties and responsibilities even though
5 claims data review was the central role assigned to Relator on the compliance team.

6 102. In addition to the foregoing, Ms. Sutcliffe forbade Relator from holding
7 any meetings with anyone at Kaiser that was above her level, without her prior,
8 express approval. This directive from Ms. Sutcliffe restricted Relator's access to
9 communicating with key people at Kaiser. It also purposefully disincentivized internal
10 complaints and whistleblowing. In addition, Relator's situation also directly hindered
11 him from accomplishing one of the PIP objectives of building relationships with others.

12 103. These circumstances created an impossible work environment for Relator,
13 who became fearful of speaking up or identifying further instances of overpayments
14 stemming from unsupported diagnostic codes.

15 104. Nevertheless, Relator continued performing his duties proficiently, just as
16 he had done throughout his long career at Kaiser. And although Relator had a strong
17 speculation that he had been placed on a PIP because he had repeatedly spoken up
18 about massive overpayments, Relator made every effort to demonstrate objective and
19 measurable improvement in each of the areas identified by the PIP.

20 105. But Ms. Sutcliffe's deliberate retaliatory actions only intensified over
21 subsequent months. Furthermore, Relator's repeated requests for software and tools
22 necessary to perform his job were rejected, ignored, and rebuffed.

1 106. Ms. Sutcliffe further retaliated against Relator on or about November 3,
2 2016, by forbidding Relator from communicating with other employees, via phone or
3 Kaiser's internal instant messaging system. Instead, Relator was told that he should
4 only use email communications moving forward and was instructed to copy Ms.
5 Sutcliffe on all outgoing emails.

6 107. In sum, despite Relator's suggestions and continuous recommendations to
7 take proper measures to comply with stringent billing methods applicable to Medicare
8 and Medicaid claims, the more Relator tried to address issues and recommend
9 corrective actions, the more Relator was sidelined, refused access to personnel, software
10 and tools, severely limited in communications, and excluded from access to his duties.

11 108. Moreover, because Relator was one of the few that spoke out about
12 Kaiser's improper processes for handling overpayments, and lack thereof, Relator was
13 openly stripped of his duties and responsibilities, as well as opportunities to build and
14 maintain relationship with Kaiser employees, which was a big part of integrating
15 various sectors of Kaiser that dealt with claims and/or claims data review. He was
16 basically stripped of his ability to perform many of his core duties.

17 109. On December 13, 2016, Relator met with Ms. Janiga, summarizing the
18 retaliatory actions that had been taken against him by Ms. Sutcliffe, due to his raising
19 the above-described issues compliance issues. But Ms. Janiga failed to take any action
20 to address Relator's situation.

21 110. On December 23, 2016, Relator also requested a meeting with Jacqueline
22 Thomas in Human Resources. He had planned to complain about the harassing
23
24

1 environment that arose from him bringing unwelcomed compliance issues to light. But
2 the meeting schedule was adjusted several times and ultimately, never happened.

3 111. Instead, mere days later, on January 5, 2017, Relator was notified that
4 his employment with Kaiser was terminated. Ms. Sutcliffe inaccurately stated in
5 Relator's Termination Memo that Relator did not maintain "consistent and satisfactory
6 performance" as one of the reasons for termination, when in fact, that was not true.

7 112. Since Relator's start date at Kaiser in 2008, he had received numerous
8 performance reviews, which were consistently "successful" and "excellent" between
9 2012 and 2016, he performed exceedingly; it was not until Relator made his first
10 presentation on overpayments and Ms. Sutcliffe came into the picture in 2016, that he
11 suddenly received his first, below- level "performance needs improvement" performance
12 review—and then was placed on the PIP several months later, before ultimately being
13 terminated from his position.

14 **COUNT I**
15 **Violations of the False Claims Act**
16 **31 U.S.C. §§ 3729(a)(1)(A)–(C), (G)**

17 113. Relator hereby incorporates, by reference, all of the allegations from each
18 of the preceding paragraphs.

19 114. This is a claim for treble damages, civil penalties, and the fees and costs of
20 this action under the False Claims Act, 31 U.S.C. §§ 3279–33, as amended.

21 115. Through the acts described above, Defendants, their agents, employees,
22 and co-conspirators, knowingly presented, or caused to be presented, to the United
23 States false and fraudulent claims, and knowingly failed to disclose material facts, in
24 order to obtain payment or approval from the United States and its contractors,
grantees, and other recipients of its funds.

1 122. This is a claim brought by Relator and the State of California to recover
2 treble damages, civil penalties, and the fees and costs of this action, under the
3 California False Claims Act, Cal. Gov't. Code §§ 12650 *et seq.*

4 123. The California False Claims Act provides liability for any person who (1)
5 knowingly presents, or causes to be presented, to an officer or employee of the state or
6 of any political division thereof, a false claim for payment or approval; (2) knowingly
7 makes, uses, or causes to be made or used a false record or statement to get a false
8 claim paid or approved by the state or by any political subdivision; (3) conspires to
9 defraud the state or any political subdivision by getting a false claim allowed or paid by
10 the state or by any political subdivision; or (8) is a beneficiary of an inadvertent
11 submission of a false claim to the state or a political subdivision, subsequently discovers
12 the falsity of the claim, and fails to disclose the false claim to the state or the political
13 subdivision within a reasonable time after discovery of the false claim. Cal. Gov't Code
14 § 12651(a).

15 124. Through the acts described above, Defendants, their agents, employees,
16 and co-conspirators, knowingly presented, or caused to be presented, to the State of
17 California false and fraudulent claims, and knowingly failed to disclose material facts,
18 in order to obtain payment or approval from the State of California and its contractors,
19 grantees, and other recipients of its funds.

20 125. Through the acts described above, Defendants, their agents, employees,
21 and co-conspirators, knowingly made, used, and caused to be made and used false
22 records and statements, which also omitted material facts, in order to induce the State
23 of California to approve and pay false and fraudulent claims.

1 132. This is a claim brought by Relator and Colorado to recover treble
2 damages, civil penalties, and the fees and costs of this action, under the Colorado
3 Medicaid False Claims Act, C.R.S. 25.5-4-303.5, et seq.

4 133. The Colorado Medicaid False Claims Act provides liability for any person
5 who:

6 (a) Knowingly presents, or causes to be presented, a false or
7 fraudulent claim for payment or approval;

8 (b) Knowingly makes, uses, or causes to be made or used a false
record or statement material to a false or fraudulent claim;

9 ...

10 (f) Knowingly makes, uses, or causes to be made or used, a false
11 record or statement material to an obligation to pay or transmit
12 money or property to the state in connection with the “Colorado
13 Medical Assistance Act”, or knowingly conceals or knowingly and
improperly avoids or decreases an obligation to pay or transmit
money or property to the state in connection with the “Colorado
Medical Assistance Act”;

14 (g) Conspires to commit a violation of paragraphs (a) to (f) of this
subsection (1).

15 C.R.S. § 25.5-4-305.

16 134. Through the acts described above, Defendants, their agents, employees,
17 and co-conspirators, knowingly presented, or caused to be presented, to the State of
18 Colorado false and fraudulent claims, and knowingly failed to disclose material facts, in
19 order to obtain payment or approval from the State of Colorado and its contractors,
20 grantees, and other recipients of its funds.

21 135. Through the acts described above, Defendants, their agents, employees,
22 and co-conspirators, knowingly made, used, and caused to be made and used false
23
24

1 records and statements, which also omitted material facts, in order to induce the State
2 of Colorado to approve and pay false and fraudulent claims.

3 136. Through the acts described above, Defendants, their agents, employees,
4 and co-conspirators, knowingly made, used, and caused to be made and used false
5 records and statements material to an obligation to pay and transmit money to the
6 State of Colorado, and knowingly concealed and improperly avoided and decreased an
7 obligation to pay and transmit money to the State of Colorado.

8 137. Through the acts described above, Defendants, their agents, employees,
9 and other co-conspirators knowingly conspired to submit false claims to the State of
10 Colorado and to deceive the State of Colorado for the purpose of causing the State of
11 Colorado to pay or allow false or fraudulent claims.

12 138. The State of Colorado, unaware of the falsity of the records, statements,
13 and claims made and submitted by Defendants, its agents, employees, and co-
14 conspirators, and as a result thereof, paid money that it otherwise would not have paid.

15 139. By reason of the payments made by the State of Colorado, as a result of
16 Defendants' fraud, the State of Colorado has suffered damages and continues to be
17 damaged.

18 **COUNT IV**
19 **Violations of the Georgia Taxpayer Protection Against False Claims Act**
20 **Ga. Code §§ 23-3-120, *et seq.***

21 140. Relator hereby incorporates, by reference, all of the allegations from each
22 of the preceding paragraphs.

23 141. This is a claim brought by Relator and Georgia to recover treble damages,
24 civil penalties and the fees and cost of this action, under the Georgia Taxpayer
Protection Against False Claims Act, Ga. Code §§ 23-3-120 *et seq.*

1 142. The Georgia Taxpayer Protection Against False Claims Act provides
2 liability for any person who:

3 (1) Knowingly presents or causes to be presented a false or
4 fraudulent claim for payment or approval;

5 (2) Knowingly makes, uses, or causes to be made or used a false
6 record or statement material to a false or fraudulent claim;

7 (3) Conspires to commit a violation of paragraph[s] [1-7] of this
8 subsection;

9 ... or ... (7) Knowingly makes, uses, or causes to be made or used
10 a false record or statement material to an obligation to pay or
11 transmit money or property to the state or local government, or
12 knowingly conceals, knowingly and improperly avoids, or
13 decreases an obligation to pay or transmit money or property to
14 the state or a local government.

15 Ga. Code § 23-3-121(a).

16 143. Through the acts described above, Defendants, their agents, employees,
17 and co-conspirators, knowingly presented, or caused to be presented, to the State of
18 Georgia false and fraudulent claims, and knowingly failed to disclose material facts, in
19 order to obtain payment or approval from the State of Georgia and its contractors,
20 grantees, and other recipients of its funds.

21 144. Through the acts described above, Defendants, their agents, employees,
22 and co-conspirators, knowingly made, used, and caused to be made and used false
23 records and statements, which also omitted material facts, in order to induce the State
24 of Georgia to approve and pay false and fraudulent claims.

 145. Through the acts described above, Defendants, their agents, employees,
and co-conspirators, knowingly made, used, and caused to be made and used false
records and statements material to an obligation to pay and transmit money to the

1 State of Georgia, and knowingly concealed and improperly avoided and decreased an
2 obligation to pay and transmit money to the State of Georgia.

3 146. Through the acts described above, Defendants, their agents, employees,
4 and other co-conspirators knowingly conspired to submit false claims to the State of
5 Georgia and to deceive the State of Georgia for the purpose of causing the State of
6 Georgia to pay or allow false or fraudulent claims.

7 147. The State of Georgia, unaware of the falsity of the records, statements,
8 and claims made and submitted by Defendants, its agents, employees, and co-
9 conspirators, and as a result thereof, paid money that it otherwise would not have paid.

10 148. By reason of the payments made by the State of Georgia, as a result of
11 Defendants' fraud, the State of Georgia has suffered damages and continues to be
12 damaged.

13 **COUNT V**
14 **Violations of the Hawaii False Claims Act**
15 **Haw. Rev. Stat. §§ 661-21, *et seq.***

16 149. Relator hereby incorporates, by reference, all of the allegations from each
17 of the preceding paragraphs.

18 150. This is a claim brought by Relator and Hawaii to recover treble damages,
19 civil penalties, and the fees and costs of this action, pursuant to the Hawaii False
20 Claims Act, Haw. Rev. Stat. §§ 661-21, *et seq.*

21 151. The Hawaii False Claims Act provides liability for any person who:

22 (1) Knowingly presents, or causes to be presented, a false or
23 fraudulent claim for payment or approval;

(2) Knowingly makes, uses, or causes to be made or used, a false
record or statement material to a false or fraudulent claim;

24 ...

1 (7) Is a beneficiary of an inadvertent submission of a false claim
2 to the State, who subsequently discovers the falsity of the claim,
3 and fails to disclose the false claim to the State within a
4 reasonable time after discovery of the false claim; or

(8) Conspires to commit any of the conduct described in this
subsection.

5 Haw. Rev. Stat. § 661-21(a).

6 152. Through the acts described above, Defendants, their agents, employees,
7 and co-conspirators, knowingly presented, or caused to be presented, to the State of
8 Hawaii false and fraudulent claims, and knowingly failed to disclose material facts, in
9 order to obtain payment or approval from the State of Hawaii and its contractors,
10 grantees, and other recipients of its funds.

11 153. Through the acts described above, Defendants, their agents, employees,
12 and co-conspirators, knowingly made, used, and caused to be made and used false
13 records and statements, which also omitted material facts, in order to induce the State
14 of Hawaii to approve and pay false and fraudulent claims.

15 154. Through the acts described above, Defendants, their agents, employees,
16 and co-conspirators, knowingly made, used, and caused to be made and used false
17 records and statements material to an obligation to pay and transmit money to the
18 State of Hawaii, and knowingly concealed and improperly avoided and decreased an
19 obligation to pay and transmit money to the State of Hawaii.

20 155. Through the acts described above, Defendants, their agents, employees,
21 and other co-conspirators knowingly conspired to submit false claims to the State of
22 Hawaii and to deceive the State of Hawaii for the purpose of causing the State of
23 Hawaii to pay or allow false or fraudulent claims.

1 (3) Conspire to commit a violation under this subtitle;

2 ...

3 (7) Knowingly make, use, or cause to be made or used, a false
4 record or statement material to an obligation to pay or transmit
money or other property to the State;

5 (8) Knowingly conceal, or knowingly and improperly avoid or
6 decrease, an obligation to pay or transmit money or other
property to the State; or

7 (9) Knowingly make any other false or fraudulent claim against
a State health plan or a State health program.

8 Md. Code, Health-Gen. § 2-602.

9 162. Through the acts described above, Defendants, their agents, employees,
10 and co-conspirators, knowingly presented, or caused to be presented, to the State of
11 Maryland false and fraudulent claims, and knowingly failed to disclose material facts,
12 in order to obtain payment or approval from the State of Maryland and its contractors,
13 grantees, and other recipients of its funds.

14 163. Through the acts described above, Defendants, their agents, employees,
15 and co-conspirators, knowingly made, used, and caused to be made and used false
16 records and statements, which also omitted material facts, in order to induce the State
17 of Maryland to approve and pay false and fraudulent claims.

18 164. Through the acts described above, Defendants, their agents, employees,
19 and co-conspirators, knowingly made, used, and caused to be made and used false
20 records and statements material to an obligation to pay and transmit money to the
21 State of Maryland, and knowingly concealed and improperly avoided and decreased an
22 obligation to pay and transmit money to the State of Maryland.

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8. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Commonwealth or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Commonwealth.

Va. Code § 8.01-216.3.

171. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly presented, or caused to be presented, to the State of Virginia false and fraudulent claims, and knowingly failed to disclose material facts, in order to obtain payment or approval from the State of Virginia and its contractors, grantees, and other recipients of its funds.

172. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements, which also omitted material facts, in order to induce the State of Virginia to approve and pay false and fraudulent claims.

173. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements material to an obligation to pay and transmit money to the State of Virginia, and knowingly concealed and improperly avoided and decreased an obligation to pay and transmit money to the State of Virginia.

174. Through the acts described above, Defendants, their agents, employees, and other co-conspirators knowingly conspired to submit false claims to the State of Virginia and to deceive the State of Virginia for the purpose of causing the State of Virginia to pay or allow false or fraudulent claims.

1 Wash. Rev. Code § 74.66.020(1).

2 180. Through the acts described above, Defendants, their agents, employees,
3 and co-conspirators, knowingly presented, or caused to be presented, to the State of
4 Washington false and fraudulent claims, and knowingly failed to disclose material
5 facts, in order to obtain payment or approval from the State of Washington and its
6 contractors, grantees, and other recipients of its funds.

7 181. Through the acts described above, Defendants, their agents, employees,
8 and co-conspirators, knowingly made, used, and caused to be made and used false
9 records and statements, which also omitted material facts, in order to induce the State
10 of Washington to approve and pay false and fraudulent claims.

11 182. Through the acts described above, Defendants, their agents, employees,
12 and co-conspirators, knowingly made, used, and caused to be made and used false
13 records and statements material to an obligation to pay and transmit money to the
14 State of Washington, and knowingly concealed and improperly avoided and decreased
15 an obligation to pay and transmit money to the State of Washington.

16 183. Through the acts described above, Defendants, their agents, employees,
17 and other co-conspirators knowingly conspired to submit false claims to the State of
18 Washington and to deceive the State of Washington for the purpose of causing the State
19 of Washington to pay or allow false or fraudulent claims.

20 184. The State of Washington, unaware of the falsity of the records,
21 statements, and claims made and submitted by Defendants, its agents, employees, and
22 co-conspirators, and as a result thereof, paid money that it otherwise would not have
23 paid.

1 False Claims Act, Cal. Gov't Code § 12653, which prohibits the discharge, demotion,
2 suspension, threatening, harassment, or other discrimination against an employee
3 because of any lawful act done by the employee or others in furtherance of an action
4 under that statute.

5 191. As a direct and proximate result of Defendants' unlawful retaliation,
6 Relator has suffered, and will continue to suffer, economic and non-economic harm for
7 which Defendants are liable, including but not limited to back pay, interest on the back
8 pay, front pay, compensation for any special damages sustained as a result of the
9 discrimination, punitive damages, and attorneys' fees.

10 **COUNT XI**
11 **Unlawful Retaliation in Violation of the California Labor Code**
12 **Cal. Lab. Code § 1102.5(b)**

13 192. Relator hereby incorporates, by reference, all of the allegations from each
14 of the preceding paragraphs.

15 193. Through the acts described above, Defendants, their agents, employees,
16 and co-conspirators, unlawfully retaliated against Relator, in violation of the California
17 Labor Code, which provides that an employer "shall not retaliate against an employee
18 for disclosing information ... to a person with authority over the employee or another
19 employee who has the authority to investigate, discover, or correct the violation or
20 noncompliance ... if the employee has reasonable cause to believe that the information
21 discloses a violation of state or federal statute, or a violation of or noncompliance with a
22 local, state, or federal rule or regulation, regardless of whether disclosing the
23 information is part of the employee's job duties." Cal. Lab. Code § 1102.5(b).

24 194. As a direct and proximate result of Defendants' unlawful conduct, Relator
has suffered, and will continue to suffer, economic and non-economic harm for which

1 Defendants are liable, including but not limited to back pay, interest on the back pay,
2 front pay, compensation for any special damages sustained as a result of the
3 discrimination, punitive damages, and attorneys' fees.

4 **COUNT XII**
5 **Retaliatory Common Law Termination in Violation of Public Policy**

6 195. Relator hereby incorporates, by reference, all of the allegations from each
7 of the preceding paragraphs.

8 196. At all times relevant herein, Relator was an employee and Defendants
9 were his employer, as recognized by California common law.

10 197. It is the public policy of the State of California, as expressed through its
11 statutes and regulations, that employees with information regarding improper,
12 wasteful and unlawful activities by government entities and employees be encouraged
13 to disclose such information both internally within the government agencies and
14 externally with government or law enforcement officials, without fear of retaliation.
15 Through such public policies, the State of California recognizes that whistleblowing
16 disclosures, such as those made by the Relator in this case, are in the public interest,
17 and that both private and public sector employees should be afforded protection from
18 retaliation in order to achieve said public interest.

19 198. Defendants' retaliatory actions against violated clear public policy and are
20 the actual and proximate cause of his injuries, as described herein.

21 **PRAYER**

22 WHEREFORE, *qui tam* Relator Jeffrey Mazik prays for a judgment against
23 Defendants, as follows:
24

1 (a) that Defendants cease and desist from violating the federal False
2 Claims Act, 31 U.S.C. §§ 3729–33, and the analogue state versions of the False
3 Claims Act in California, Colorado, Georgia, Hawaii, Maryland, Virginia, and
4 Washington;

5 (b) that the Court enter judgment against Defendants in an amount
6 equal to three times the amount of damages sustained by the United States and
7 all States named herein, as a result of Defendants' actions, as well as a civil
8 penalty of \$23,331 for each violation of 31 U.S.C. § 3729, and additional civil
9 penalties under the applicable provisions of each analogue state version of the
10 False Claims Act in California, Colorado, Georgia, Hawaii, Maryland, Virginia,
11 and Washington;

12 (c) that Plaintiff-Relator be awarded the maximum amount allowed
13 pursuant to 31 U.S.C. § 3730(d) of the federal False Claims Act, and in
14 accordance with the maximum amount permitted by the *qui tam* provisions of
15 each analogue state version of the False Claims Act in California, Colorado,
16 Georgia, Hawaii, Maryland, Virginia, and Washington;

17 (d) that Plaintiff-Relator be awarded front pay compensation in lieu of
18 reinstating Plaintiff-Relator to a position similar to that he would have had, but-
19 for the retaliation; two times back pay, plus interest; and compensation for
20 additional and special damages sustained as a result of the retaliation, including
21 litigation costs and reasonable attorneys' fees.

22 (e) that Plaintiff-Relator be awarded all costs of this action, including
23 attorneys' fees and expenses; and
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(f) any other such relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Plaintiff-Relator Jeffrey Mazik hereby demands a jury trial with respect to all issues triable of right by jury.

Dated: March 31, 2021

POLLOCK COHEN LLP

By: /s/ Adam Pollock
Adam Pollock (pro hac vice)

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