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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *et al., ex rel*. JEFFREY MAZIK, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, *et al.*, Defendants	Case No. No.: 2:19-cv-00559-DAD-JDP **MOTION FOR ADMINISTRATIVE RELIEF FOR A TEMPORARY STAY AND ORDER OF REFERNECE**

Pursuant to Local Rule 233, relator Jeffery Mazik hereby requests that the Court enter an order granting a temporary stay of discovery and discovery cut-off deadlines. In particular, relator seeks a stay until 30 days after the district court in the consolidated cases in the Northern District of California (the *Osinek* matters)[1] rules on Mazik's motion for a share of settlement proceeds under the alternate remedy provision of the False Claims Act, 31 U.S.C. § 3730(c)(5). In addition, relator requests that the Court enter an order of reference to a magistrate judge in this District for settlement purposes.

This request is supported by this motion, the declaration of counsel, proposed order, the pleadings and orders in the dockets of this and the consolidated cases, and any further evidence or argument permitted on this application. It is based upon the following.

This action has long been impacted by developments in the related *Osinek* matters

Since the unsealing of relator's first amended complaint, this case has been bound up in the pendency of the *Osinek* consolidated cases. Mazik filed his amended complaint over Medicare Advantage capitated payments under seal on April 2, 2021, providing a copy of the amended complaint before filing and two supplemental disclosure statements thereafter. Mazik and his counsel were unaware of any pending related actions against Kaiser at that time. Friedman Decl., ¶7.

While Mazik's amended complaint was under seal, on June 25, 2021, Judge Edward Chen in the Northern District consolidated six sealed *qui tam* cases raising the same Medicare Advantage risk adjustment fraud theories (*Osinek* ECF 61). On July 27, 2021, while the consolidated cases were still sealed, the government noticed its intent to intervene (*Osinek* ECF 64), and two days later, Judge Chen ordered unsealing of the complaints and the government's election (*Osinek* ECF 65). On October 25, 2021, the government filed a complaint-in-intervention (*Osinek* ECF 110).

Subsequently, on December 1, 2021, the government filed a notice declining to intervene on Mazik's amended complaint (ECF 62). On December 6, 2021, the State of

[1]The consolidated *Osinek* matters were comprised of Case Nos. 3:13-cv-03891-EMC, 3:18-cv-01347-EMC and 3:21-cv-03894-EMC.

California filed a notice declining to intervene in Mazik's state False Claims Act claims (ECF 66). On December 2 and 6, 2021, Judge Mendez entered orders unsealing relator's amended complaint (ECF Nos. 63 and 67).

Since that time, the course and scheduling of this action has been tied to the course and scheduling of the *Osinek* matters. Kaiser filed a motion to dismiss relators in the *Osinek* consolidated case based on the first-to-file rule, 31 U.S.C. § 3730(b)(5) (*Osinek* ECF 141). Because of the relatedness between the two cases, Judge Mendez, on January 31, 2022, stayed this action until 30 days after Judge Chen ruled on Kaiser's motion (ECF 69). After Judge Chen issued his decision on May 5, 2022 (*Osinek* ECF 171), this Court, on May 23, 2022, entered a scheduling order extending the time for Kaiser to file a motion to dismiss here until July 6, 2022 (ECF 72). On July 6, 2022, Judge Mendez further extended the time for Kaiser to file its motion until July 13, 2022 (ECF 74), and the motion was filed on that date (ECF 78).

After judicial reassignment on October 26, 2022 (ECF 93), this Court, on February 13, 2024, entered an order denying in part and granting in part defendants' motion to dismiss relator Mazik's claims (ECF 104). Demonstrating relatedness again, the Court cited to an adopted several portions of Judge Chen's ruling on the motion in *Osinek*.

On April 8, 2024, Kaiser then moved to transfer this case to the Northern District so that it could be consolidated with *Osinek* (ECF 109). In a status report filed the following day (ECF 110), the parties acknowledged the transfer motion, and Kaiser proposed a discovery schedule to align as much as possible with the scheduling order in *Osinek*. Relator Mazik stated he had no objection to proceeding on a similar timetable, proposing that "the parties will proceed with discovery 90 days after the *Osinek* Cases." *Id*, at 2-3. After the government filed a Statement of Interest opposing the transfer (ECF 111), Mazik filed his response (ECF 114), pointing out that, to the extent of the overlap on Mazik's Medicare Advantage claims, counsel for Mazik and the government should be able to cooperate and coordinate on discovery. On June 14, 2024, the Court denied the motion to transfer (ECF 121).

As a result of the delays caused by the relatedness between the actions, and through no fault of Mazik, no answers were filed until May 24, 2024 (ECF Nos. 115-119), and the Court entered its scheduling order on August 24, 2024 (ECF 123).

The recent settlement and dismissals in *Osinek* will have a profound impact on the course and scope of this case

In October of 2025, the government and Kaiser defendants stipulated to a stay in the *Osinek* matters to pursue settlement discussions (*Osinek* ECF 411). A few days later, Mazik's counsel was contacted by Kaiser's new counsel retained for settlement purposes, and the parties began talking about possible settlement. Friedman Decl., ¶6. Because of the overlap between Mr. Mazik's Medicare Advantage claims and the claims presented in the *Osinek* case, however, it was difficult to move forward with concrete discussions before any settlement was reached in the Northern District.[2]

On January 14, 2026, the government announced a settlement of its amended complaint-in-intervention in *Osinek*, reporting a recovery of $556 million – the largest Medicare Part C recovery in the history of the False Claims Act. (*See* Exhs. A and B). The following day, Mazik filed a notice of claim (Exh. C) in the Northern District. On February 25, 2026, pursuant to Judge Chen's orders, Mazik filed a motion for a share of the settlement proceeds under § 3730(c)(5) (Exh. D). That motion is set for hearing before Judge Chen on April 2, 2026. Recently, on March 16, 2026, Judge Chen dismissed the *Osinek* complaints pursuant to the parties' settlements (*Osinek* ECF Nos. 445-447).

The settlement and dismissals in *Osinek* will have a direct impact on this case. Mazik intends to file a motion for modification of the Court's scheduling order as soon as possible after Judge Chen rules on the motion. Mazik's pursuit of federal False Claims Act theories predicated on false claims for Medicare Advantage capitated payments are now resolved. As explained by the Ninth Circuit in *United States ex rel. Barajas v. Northrop Corp*., 147 F.3d 905, 910 (9th Cir. 1998): "The recovery in a *qui tam* case is not

[2]For example, by December of 2025, Mazik's counsel were able to make a demand of the *qui tam* claims, but given the open question on *Osinek* negotiations, the amount demanded by Mazik was in the nine figures. Friedman Decl., ¶6.

for each false statement or bad act done to the government; it is for 'a false or fraudulent claim for payment or approval.'" The government's recovery on, and waiver of, its risk adjustment claims in *Osinek* will therefore provide Kaiser with a defense here based on *res judicata*. At the very least, Kaiser will be entitled to a damage credit of $556 million for any recovery by Mazik, making it unnecessary and unreasonable to continue pursuit of his Medicare Advantage claims in this Court.

Mazik thus intends to shift focus onto his *qui tam* claims under the state False Claims Acts, for fraud on Medicaid funds. He requests a stay now, and after Judge Chen rules he plans on filing a noticed Rule 16 motion, providing the parties with more time to conclude discovery (and retain experts) on the state Medicaid claims – claims which require refocused attention. While Medicaid programs – including Medi-Cal – also involve capitated payments, they do not rely on diagnoses codes linked to Hierarchical Condition Catagories (HCC) for the setting of capitated payments. Instead, Medicaid's per member per month (PMPM) capitated payments are adjusted for risk based on the Chronic Illness and Disability Payment System (CDPS). Moreover, PMPM rates are based on historical costs. As such, the millions of dollars in overpayments that existed by virtue of Kaiser's deactivation of software tools, as Mazik alleges, directly impacted Medicaid payments.[3]

Thus, the settlement and dismissals in *Osinek* alters Mazik's claims and the focus in this case. Once the share motion is determined, Mazik intends to file a motion for a change in the case schedule, permitting sufficient time to conclude fact discovery, retain experts and prepare for trial. He now requests the stay so that he may obtain a ruling on the share motion, and thereafter seek a modified scheduling order by noticed motion.

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[3]State auditors have little visibility into Kaiser's cost, due to the use of "journal entry" data of patient visits with Kaiser physicians to claim costs. Auditors must rely on encounter data from external providers to provide actual claim submissions, actual payments, and actual post-adjudication tracking. And yet, when Kaiser repeatedly refused to disclose the databases that Mazik attempted to rectify, Kaiser was criticized and fined, leaving millions of dollars in yearly variances under actuarial scrutiny. *See* Exhs. E and F.

Mazik requires additional time for new substituted counsel and to work with the California Department of Justice

Mazik has been diligent in pursuit of his claims. He has responded to motions, propounded discovery and served discovery responses. Despite these efforts, Mazik will require additional time. Given his recent substitution and the shifting focus of the case, relator's counsel need to refocus discovery on remaining claims. One additional factor is healt of recently substituted counsel, Warner Mendenhall. He recently began medical care for a serious medical condition, requiring time and flexibility in his work schedule. A large body of materials was only recently transferred from former counsel. Time is needed to review those records, propound final discovery requests, retain experts, and prepare for trial. Friedman Decl., ¶9.[4]

Finally, Kaiser recently re-started its discovery efforts after it retained its fourth counsel, including noticing Mazik's deposition for April 3, 2026, and serving written discovery. Much of that discovery is focused on Medicare Advantage claims no longer in issue. The parties need a resolution of Mazik's share motion. They also need time for new counsel to review the sizable records in this case, and obtain additional discovery from defendants and state auditors, before closing discovery in the refocused case. Mazik intends to show good cause for modification of the schedule based upon a noticed motion, but now requests a temporary stay until 30 days after Judge Chen rules. *Id*., ¶11.

The parties would benefit from an order of reference

An order of reference to a magistrate judge would likely give the parties a real opportunity to engage in meaningful settlement discussions. Both parties have in the past indicated a willingness to do so, but efforts were stifled while *Osinek* was uncertain. Now that *Osinek* has settled, and substantial claims by Mazik will be dismissed, the parties are more likely to reach agreement on the final remaining claims. Mazik therefore requests that the Court issue a stay and refer the case while the stay is in place.

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[4]In addition, since the *Osinek* settlement, relator's counsel have conferred with California's counsel with refocus on Medi-Cal fraud. The state government must consent to any dismissal of state *qui tam* claims. Mazik requires time to complete discussions with the state attorneys, expected to be in April. *Id*., ¶10.

CONCLUSION

For the foregoing reasons, relator requests that the Court enter a temporary stay until 30 days after Judge Chen rules on the pending share motion, and an order of reference for settlement purposes.

Respectfully submitted,

Dated: March 26, 2026

Law Office of Jeremy L. Friedman
Mendenhall Law Group

By: /s/Jeremy L. Friedman
Jeremy L. Friedman

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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *et al., ex rel*. JEFFREY MAZIK, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, *et al.*, Defendants	Case No. No.: 2:19-cv-00559-DAD-JDP **DECLARATION OF JEREMY L. FRIEDMAN IN SUPPORT OF MOTION FOR ADMINISTRATIVE RELIEF FOR A TEMPORARY STAY AND ORDER OF REFERNECE**

DECLARATION OF COUNSEL

I, Jeremy L. Friedman, declare and state:

1. I am one of the attorneys representing relator Jeffrey Mazik in this action. I make this declaration in support of relator's request for a temporary stay of discovery and discovery cut-off deadlines until 30 days after Judge Chen rules upon a pending motion for a share of the settlement proceeds in the related *Osinek* matter in the Northern District of California; and for an order of reference to a magistrate judge in this District for settlement purposes. The declaration is based on my own personal knowledge. If called as a witness hereto, I would and could testify to the following.

2. Mazik filed his initial complaint under seal in this Court in 2019. I joined the action as one of the attorneys of record in March of 2021. Since that time, I have played a role in the litigation of Mazik's claims, but lead counsel has, until recently, been Adam Pollock, of Pollock and Cohen, of New York. In January of 2026, Warner Mendenhall filed a substitution of counsel for Mr. Pollock, but the substitution request was not acted upon until Mr. Mendenhall's motion for *pro hac vice was* on file. Subsequently, the Court granted Mr. Mendenhall's motions for *pro hac vice* admission, and the Mendenhall firm refiled a substitution with this Court.

3. As set forth in the pleadings and orders in the dockets in this case and the *Osinek* cases, relator's federal claims under the False Claims Act, 31 U.S.C. § 3729, *et seq*., for fraud on the Medicare Advantage program for capitated payments based on falsely inflated risk adjustment factors (RAFs)have a direct overlap with the government's initial and amended complaints-in-intervention in the consolidated actions in the Northern District. Both actions alleged that Kaiser submitted claims for payment on overlapping Medicare Advantage enrollees during the same time periods, based on inflated RAFs derived from invalid diagnoses codes. As such, when the government and Kaiser defendants reached a settlement in *Osinek* – recovering $556 million and waiving its claims for Medicare Advantage RAF fraud – the government effectively resolved Mazik's federal *qui tam* claims based on the same legal theory in this Court. Attached

hereto as Exhibit A is a true and accurate copy of the settlement agreement, and as Exhibit B is a true and accurate copy of the press release by the Department of Justice.

4. Mr. Mendenhall and I learned of the *Osinek* settlement when the government issued the press release on January 14, 2026. On January 15, 2026, I filed in the *Osinek* matter a notice of a claim to a share on behalf of Mr. Mazik of the settlement proceeds under 31 U.S.C. § 3730(c)(5). Attached hereto as Exhibit C is a true and accurate copy of the notice of claim that was filed. After the notice was filed, Judge Chen ordered the parties to meet and confer with regard to Mr. Mazik's claim, and he directed Mr. Mazik to assert his claim by noticed motion. Following two administrative motions in that case, Judge Chen extended the time for filing the share motion until February 25, 2026. On that day, I filed a noticed motion, supported by my declaration and several exhibits of pleadings, orders and exhibits to relator's disclosures. Attached hereto as Exhibit D is a true and accurate copy of the motion which set for hearing before on April 2, 2026.

5. I filed Mr. Mazik's amended complaint in this Court over Medicare Advantage capitated payments under seal on April 2, 2021. In February, I provided a copy of the amended complaint to the United States Attorney's office in this District, and after the amended complaint was filed under seal, Mr. Pollock and I provided the government with two supplemental disclosure statements, on April 19, 2021, and on May 21, 2021. At that time, Mazik and his counsel were unaware of any pending related actions against Kaiser.

6. In October of 2025, the government, Kaiser defendants and the *Osinek* relators stipulated to a stay of the case before Judge Chen in order to pursue settlement. A short period of time after that stay request was made, Mr. Pollock and I were contacted by Kaiser's new counsel – Dunn, Isaacson Rhee LLP – who had been retained by Kaiser for settlement purposes. Thereafter, Mr. Pollock and I had several informal discussions with Kaiser's attorneys regarding a possible settlement. However, because of uncertainty over a possible settlement in *Osinek,* it was difficult to move forward with meaningful settlement discussions. In our view, Mr. Mazik's Part C capitated payment claims were substantial, leading to demands on the *qui tam* claims in the nine figures.

7. Following settlement of the *Osinek* matter, however, the scope and nature of Mr. Mazik's case is about to change. As stated in the notice of claim and the motion for a share, the government's settlement and dismissals of the complaints in *Osinek* resolve the same broad legal theory presented by Mr. Mazik, resulting in an anticipated claim by Kaiser defendants of *res judicata* here. Moreover, even without claim preclusion, we anticipate that Kaiser defendants would be entitled to an offset of damages in Mr. Mazik's RAF claims, such that relator would have to win one dollar more than $556 million before he can return one dollar to the government, with 25 to 30 cents for his share. As such, Mr. Mazik will likely agree to a dismissal of his RAF Medicare Advantage fraud claims, and then file a noticed motion in this Court seeking a modification of the case scheduling order. Focus of this action will shift away from claims that have now been resolved, and be placed on the claims that remain. Mr. Mazik and his counsel wish to obtain a ruling from Judge Chen on the share motion before preparing the noticed motion under Rule 16.

8. With the federal Medicare Advantage claims resolved, Mr. Mazik intends to concentrate his *qui tam* claims, for fraud on Medicaid funds under the state False Claims Acts.[1] Similar to Medicare Advantage capitated payments, Medicaid pays managed care plans like Kaiser using "per member per month" payments, or "PMPM". For example, in California, the PMPM payments on Medi-Cal are set by the Department of Health Care Services, based in part of risk adjustment using the Chronic Illness and Disability Payment System (CDPS). In addition, to a greater extent, Medicaid PMPM payments are also based upon Kaiser's historical costs associated with its Medi-Cal population. State auditors have little visibility into Kaiser's costs based on patient visits with Kaiser physicians, however, and so they rely on the auditing of encounter data from external providers. These were the very databases Mr. Mazik alleged were subject to material overpayments that could have been identified and recovered using certain data analytic

[1]This is in addition to his federal retaliation claims under § 3730(h).

tools that Kaiser deactivated. In 2017, Kaiser was fined millions of dollars by DHCS for failing to turn over the encounter data from visits with outside providers; and in 2020, an actuarial report was issued on Kaiser's 2017 Fiscal Year submissions, showing more than $24 million in variance on Kaiser's sub-capitated amounts. Attached hereto as Exhibits E and F are true and accurate copies of the notice of fines and the actuarial report, respectively. With focus on the Medicaid claims, we intend to undertake additional discovery into these findings. We therefore plan to notice a motion for modification of the case schedule, with a renewed focus on Mr. Mazik's remainign claims.

9. In the anticipated motion, counsel intend to show that relator has been diligent in pursuit of his claims, including responding to motions, propounding discovery and serving responses to discovery requests. However, given the developments in *Osinek* and the substitution of Mr. Mendenhall for Mr. Pollock, we intend to show that additional time is needed to conclude discovery and retain appropriate experts. Once critical aspect of the need for addition time involves Mr. Mendenhall's health condition. Although Mr. Mendenhall committed to this case in the fall of 2025, he obtained a serious diagnosis for a life-threatening condition in December of 2025, and shortly thereafter began extensive medical treatments. While he is undergoing care, Mr. Mendenhall continues to engage in productive work to meet his responsibilities, including on this case. On many days, however, he must limit his time to a set number of hours. On other days, he is required to travel and attend to his medical care. He can and does continue to perform necessary work; but under his physicians' orders, he must take the time necessary to rest and obtain care. Mr. Mendenhall and his office continue to hold's Mazik's case in this Court a high priority, but he will require time to review the large body of materials Mr. Pollock had amassed, and to propound final discovery requests, retain experts, and prepare for trial.

10. In addition, since the *Osinek* settlement, Mazik's counsel have conferred with the attorney from the California Department of Justice responsible for monitoring Mazik's state claims. Under the state Act, the state must consent to any dismissal of state *qui tam* claims. Mazik requires time to complete further discussions with the state

attorney regarding Mazik's Medi-Cal claims before concluding discovery on remaining Medicaid claims. I expect to follow up on those issues in April.

11. With its fourth counsel in this case, Kaiser recently re-started its discovery efforts, including noticing Mazik's deposition for April 3, 2026, and serving a round of written discovery. Much of that discovery is focused on Medicare Advantage claims no longer in issue. Before responding to that discovery and undertaking their own, Mazik's counsel request a stay, so that they can obtain a resolution of their share motion, review the trove of documents, and confer amongst themselves and with experts regarding the case needs on the remaining claims. During or immediately after the stay, Mazik intends to file a noticed motion seeking modification of the cazse schedule. For now, however, Mazik requests a temporary stay until 30 days after Judge Chen rules.

I declare under penalty of perjury under the laws of California and the United States that the foregoing is true and correct. Executed this 26th of March, 2026.

/s/Jeremy L. Friedman
Jeremy L. Friedman

EXHIBIT A

SETTLEMENT AGREEMENT

This Settlement Agreement ("Agreement") is entered into among (1) the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (OIG-HHS) of the Department of Health and Human Services (HHS), (collectively, the "United States"); (2) Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Foundation Health Plan of Colorado (KFHP-CO), The Permanente Medical Group, Inc. (TPMG), Southern California Permanente Group (SCPMG), and Colorado Permanente Medical Group, P.C. (CPMG) (collectively, "Defendants"); and (3) Ronda Osinek and James M. Taylor, M.D. (each a "Relator" and collectively, the "Relators") (the United States, Defendants, and Relators are hereafter collectively referred to as the "Parties"), through their authorized representatives.

RECITALS

A. KFHP is a California corporation, and KFHP-CO, a wholly owned subsidiary of KFHP, is a Colorado corporation.

B. KFHP and KFHP-CO have executed contracts with the Centers for Medicare & Medicaid Services (CMS), a division of HHS, to be Medicare Advantage (MA) organizations. KFHP provides healthcare plans under the MA program, also called Medicare Part C, in California, while KFHP-CO provides MA plans in Colorado.

C. TPMG is a California professional medical corporation. SCPMG is a California general partnership of physicians. CPMG is a Colorado corporation.

D. TPMG and SCPMG provide medical services to MA beneficiaries enrolled in KFHP MA plans. CPMG provides medical services to MA beneficiaries enrolled in KFHP-CO MA plans.

E. Pursuant to the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b), the Relators have filed the following civil actions:

(1) On August 22, 2013, Relator Ronda Osinek filed a sealed *qui tam* action in the United States District Court for the Northern District of California captioned *United States ex rel. Osinek v. Kaiser Permanente, et al.*, No. 3:13-cv-03891-EMC (the "*Osinek* Action").

(2) On October 22, 2014, Relator James M. Taylor, M.D. filed a sealed *qui tam* action in the United States District Court for the District of Colorado captioned *United States ex rel. Taylor v. Kaiser Permanente, et al.*, No. 1:14-cv-02889 (the "*Taylor* Action"). Relator Taylor subsequently filed an amended *qui tam* complaint under seal in the *Taylor* Action on November 3, 2014. On May 11, 2021, the *Taylor* Action was transferred to the Northern District of California and assigned Civil Action No. 3:21-cv-03894-EMC. On June 25, 2021, the District Court for the Northern District of California issued an order consolidating the *Taylor* and *Osinek* Actions with four other *qui tam* actions (collectively, the "Consolidated Action").

F. On July 27, 2021, the United States filed a notice of partial intervention in the Consolidated Action, intervening as to all allegations that Defendants submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Advantage and declining to intervene as to all other allegations. (Dkt. No. 64.) The United States filed its Complaint-in-Intervention against Defendants on October 25, 2021, and subsequently filed an Amended Complaint-in-Intervention on December 12, 2022. (Dkt. No. 240.)

G. Relator Taylor also pursued certain declined claims as to which the United States did not intervene (the "Declined *Taylor* Claims").

H. The United States contends that Defendants knowingly submitted or caused to be submitted claims for payment to the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395lll ("Medicare").

I. The United States contends that it has certain civil claims against the Defendants for the time period between 2009 and 2018, as specified in the United States' Amended Complaint-in-Intervention. That conduct is referred to herein as the "Covered Conduct."

J. This Agreement is neither an admission of liability by the Defendants nor a concession by the United States that its claims are not well founded.

K. Relators claim entitlement under 31 U.S.C. § 3730(d) to a share of the proceeds of this Agreement and to Relators' reasonable expenses, attorneys' fees and costs.

To avoid the delay, uncertainty, inconvenience, and expense of protracted litigation of the above claims, and in consideration of the mutual promises and obligations of this Agreement, the Parties agree and covenant as follows:

TERMS AND CONDITIONS

1. Defendants have paid to the United States five hundred fifty-six million dollars ($556,000,000), plus interest at a rate of 4.250% per annum from October 15, 2025, until and including the day of payment (collectively, "Settlement Amount"), of which $278,000,000 is restitution, by the Effective Date of this Agreement by electronic funds transfer pursuant to written instructions provided by the Civil Division of the United States Department of Justice.

2. Pursuant to 31 U.S.C. § 3730(d), Defendants agree to pay $764,469.00 in attorneys' fees and costs to counsel for Relator Osinek. Defendants shall pay this amount by electronic funds transfer within thirty (30) business days of the later of (1) the Effective Date of this Agreement or (2) Defendants' receipt of necessary wire transfer instructions and Form W-9 to be provided by counsel for Relator Osinek. This payment will satisfy any claims from Relator

Osinek or her counsel against Defendants for attorneys' fees, costs, and expenses pursuant to 31 U.S.C. § 3730(d) or any other legal obligation under which Relator Osinek or her counsel claims a right to attorneys' fees in connection with the Consolidated Action and the *Osinek* Action. Relator Osinek hereby releases Defendants and their predecessors and current and former parents, divisions, subsidiaries, affiliates, successors, assigns, transferees, officers, directors, attorneys, agents, and employees from any claims for expenses, attorneys' fees or costs in connection to the Consolidated Action and the *Osinek* Action.

3. Defendants have separately agreed to pay attorneys' fees and costs to counsel for Relator Taylor. This payment is described in the agreement regarding the settlement of the Declined *Taylor* Claims. The payment described in the agreement regarding the settlement of the Declined *Taylor* Claims will satisfy any claims from Relator Taylor or his counsel against Defendants for attorney's fees, costs, and expenses pursuant to 31 U.S.C. § 3730(d) or any other legal obligation under which Relator Taylor or his counsel claims a right to attorneys' fees in connection with the Consolidated Action and the *Taylor* Action. Subject to the execution of that agreement and the receipt of the payment described therein, Relator Taylor hereby releases Defendants and their predecessors and current and former parents, divisions, subsidiaries, affiliates, successors, assigns, transferees, officers, directors, attorneys, agents, and employees from any claims for expenses, attorneys' fees or costs in connection to the Consolidated Action and the *Taylor* Action.

4. Subject to the exceptions in Paragraph 6 (concerning reserved claims) below, and upon execution of this Agreement, the United States releases Defendants from any civil or administrative monetary claim the United States has for the Covered Conduct under the False Claims Act, 31 U.S.C. §§ 3729-3733 (the "FCA"); the Civil Monetary Penalties Law, 42 U.S.C.

§ 1320a-7a; the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812; or the common law theories of payment by mistake, unjust enrichment, and fraud.

5. Subject to the exceptions in Paragraph 6 below, Relators, for themselves and for their heirs, successors, attorneys, agents, and assigns, release Defendants from all claims Relators have asserted, could have asserted, or may assert in the future on behalf of the United States for the Covered Conduct.

6. Notwithstanding the releases given in Paragraphs 2 through 5 of this Agreement, or any other term of this Agreement, the following claims and rights of the United States are specifically reserved and are not released:

a. Any liability arising under Title 26, U.S. Code (Internal Revenue Code);

b. Any criminal liability;

c. Except as explicitly stated in this Agreement, any administrative liability or enforcement right, including mandatory or permissive exclusion from Federal health care programs;

d. Any liability to the United States (or its agencies) for any conduct other than the Covered Conduct;

e. Any liability based upon obligations created by this Agreement;

f. Any liability of individuals;

g. Any liability for express or implied warranty claims or other claims for defective or deficient products or services, including quality of goods and services;

h. Any liability for failure to deliver goods or services due; and

i. Any liability for personal injury or property damage or for other consequential damages arising from the Covered Conduct.

7. Relators and their heirs, successors, attorneys, agents, and assigns shall not object to this Agreement but agree and confirm that this Agreement is fair, adequate, and reasonable under all the circumstances, pursuant to 31 U.S.C. § 3730(c)(2)(B). In connection with this Agreement and the United States' Amended Complaint-in-Intervention, Relators and their heirs, successors, attorneys, agents, and assigns agree that neither this Agreement, any intervention by the United States in the *Osinek* and *Taylor* Actions, nor any dismissal of the *Osinek* and *Taylor* Actions, shall waive or otherwise affect the ability of the United States to contend that provisions in the FCA, including 31 U.S.C. §§ 3730(d)(3) and 3730(e), bar Relators from sharing in the proceeds of this Agreement. Moreover, the United States and Relators and their heirs, successors, attorneys, agents, and assigns agree that they each retain all of their rights pursuant to the FCA on the issue of the share percentage, if any, that Relators should receive of any proceeds of the settlement of their claims.

8. Relators, for themselves and for their heirs, successors, attorneys, agents, and assigns, release Defendants, and their officers, agents, and employees, from all claims Relators have asserted, could have asserted, or may assert in the future related to the Covered Conduct.

9. Defendants waive and shall not assert any defenses Defendants may have to any criminal prosecution or administrative action relating to the Covered Conduct that may be based in whole or in part on a contention that, under the Double Jeopardy Clause in the Fifth Amendment of the Constitution, or under the Excessive Fines Clause in the Eighth Amendment of the Constitution, this Agreement bars a remedy sought in such criminal prosecution or administrative action.

10. Defendants fully and finally release the United States, its agencies, officers, agents, employees, and servants, from any claims (including attorneys' fees, costs, and expenses of every kind and however denominated) that Defendants have asserted, could have asserted, or

may assert in the future against the United States, its agencies, officers, agents, employees, and servants, related to the Covered Conduct or the United States' investigation or prosecution thereof.

11. Defendants release the Relators from any claims (including attorneys' fees, costs, and expenses of every kind and however denominated) that Defendants have asserted, could have asserted, or may assert in the future against the Relators related to the Covered Conduct or Relators' investigations or prosecutions thereof.

12. The Settlement Amount shall not be decreased as a result of the denial of claims for payment now being withheld from payment by any Medicare contractor (e.g., Medicare Administrative Contractor, fiscal intermediary, carrier) or any state payer, related to the Covered Conduct; and Defendants agree not to resubmit to any Medicare contractor or any state payer any previously denied claims related to the Covered Conduct, agree not to appeal any such denials of claims, and agree to withdraw any such pending appeals.

13. Defendants agree to the following:

a. Unallowable Costs Defined: All costs (as defined in the Federal Acquisition Regulation, 48 C.F.R. § 31.205-47; and in Titles XVIII and XIX of the Social Security Act, 42 U.S.C. §§ 1395-1395lll and 1396-1396w-5; and the regulations and official program directives promulgated thereunder) incurred by or on behalf of Defendants, their present or former officers, directors, employees, shareholders, and agents in connection with:

(1) the matters covered by this Agreement;

(2) the United States' audit(s) and civil investigation(s) of the matters covered by this Agreement;

(3) Defendants' investigation, defense, and corrective actions undertaken in response to the United States' audit(s) and civil investigation(s) in

connection with the matters covered by this Agreement (including attorneys' fees);

(4) the negotiation and performance of this Agreement; and

(5) the payment Defendants make to the United States pursuant to this Agreement and any payments that Defendants may make to Relators, including costs and attorneys' fees

are unallowable costs for government contracting purposes and under the Medicare Program, Medicaid Program, TRICARE Program, and Federal Employees Health Benefits Program (FEHBP) (hereinafter referred to as Unallowable Costs).

b. Future Treatment of Unallowable Costs: Unallowable Costs shall be separately determined and accounted for by Defendants, and Defendants shall not charge such Unallowable Costs directly or indirectly to any contracts with the United States or any State Medicaid program, or seek payment for such Unallowable Costs through any cost reports, cost statements, information statements, or payment requests submitted by Defendants or any of their subsidiaries or affiliates to the Medicare, Medicaid, TRICARE, or FEHBP Programs.

c. Treatment of Unallowable Costs Previously Submitted for Payment: Defendants further agree that within 90 days of the Effective Date of this Agreement they shall identify to applicable Medicare and TRICARE fiscal intermediaries, carriers, and/or contractors, and Medicaid and FEHBP fiscal agents, any Unallowable Costs (as defined in this paragraph) included in payments previously sought from the United States, or any State Medicaid program, including, but not limited to, payments sought in any cost reports, cost statements, information reports, or payment requests already submitted by Defendants or any of their subsidiaries or affiliates, and shall request, and agree, that such cost reports, cost statements, information reports, or payment requests, even if already settled, be adjusted to account for the effect of the

inclusion of the Unallowable Costs. Defendants agree that the United States, at a minimum, shall be entitled to recoup from Defendants any overpayment plus applicable interest and penalties as a result of the inclusion of such Unallowable Costs on previously-submitted cost reports, information reports, cost statements, or requests for payment.

Any payments due after the adjustments have been made shall be paid to the United States pursuant to the direction of the Department of Justice and/or the affected agencies. The United States reserves its rights to disagree with any calculations submitted by Defendants or any of their subsidiaries or affiliates on the effect of inclusion of Unallowable Costs (as defined in this paragraph) on Defendants or any of their subsidiaries or affiliates' cost reports, cost statements, or information reports.

d. Nothing in this Agreement shall constitute a waiver of the rights of the United States to audit, examine, or re-examine Defendants' books and records to determine that no Unallowable Costs have been claimed in accordance with the provisions of this paragraph.

14. This Agreement is intended to be for the benefit of the Parties only. The Parties do not release any claims against any other person or entity, except to the extent provided for in Paragraph 15 (waiver for beneficiaries paragraph), below.

15. Defendants agree to waive and shall not seek payment for any of the health care billings covered by this Agreement from any health care beneficiaries or their parents, sponsors, legally responsible individuals, or third-party payors based upon the claims defined as Covered Conduct.

16. Upon execution of this agreement, the Parties shall promptly sign and file a Joint Stipulation of Dismissal of the United States' Amended Complaint-in-Intervention pursuant to Rule 41(a). The Joint Stipulation of Dismissal shall provide for the Court to retain jurisdiction over any matters not resolved by this Agreement.

17. Except as to Relators' claims under 31 U.S.C. § 3730(d) for expenses or attorneys' fees and costs and as separately agreed to by the parties in writing, each Party shall bear its own legal and other costs incurred in connection with this matter, including the preparation and performance of this Agreement.

18. Each Party and signatory to this Agreement represents that it freely and voluntarily enters into this Agreement without any degree of duress or compulsion.

19. This Agreement is governed by the laws of the United States. The exclusive jurisdiction and venue for any dispute relating to this Agreement is the United States District Court for the Northern District of California. For purposes of construing this Agreement, this Agreement shall be deemed to have been drafted by all Parties to this Agreement and shall not, therefore, be construed against any Party for that reason in any subsequent dispute.

20. This Agreement constitutes the complete agreement between the Parties. This Agreement may not be amended except by written consent of the Parties.

21. The undersigned counsel represent and warrant that they are fully authorized to execute this Agreement on behalf of the persons and entities indicated below.

22. This Agreement may be executed in counterparts, each of which constitutes an original and all of which constitute one and the same Agreement.

23. This Agreement is binding on Defendants' successors, transferees, heirs, and assigns.

24. This Agreement is binding on Relators' successors, transferees, heirs, and assigns.

25. All Parties consent to the United States' disclosure of this Agreement, and information about this Agreement, to the public.

26. This Agreement is effective on the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

DATED: 1/14/2026 BY: Laurie A. Oberembt

Laurie A. Oberembt
Senior Litigation Counsel
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: 01/13/26 BY: Michelle Lo

Michelle Lo
Assistant United States Attorney
Northern District of California

DATED: 1/13/26 BY:

Marcy Cook
Kevin Traskos
Assistant United States Attorneys
District of Colorado

DATED: _____ BY: _____

Susan E. Gillin
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

26. This Agreement is effective on the date of signature of the last signatory to the Agreement (Effective Date of this Agreement). Facsimiles and electronic transmissions of signatures shall constitute acceptable, binding signatures for purposes of this Agreement.

THE UNITED STATES OF AMERICA

DATED: _____ BY: _____
Laurie A. Oberembt
Senior Litigation Counsel
Commercial Litigation Branch
Civil Division
United States Department of Justice

DATED: _____ BY: _____
Michelle Lo
Assistant United States Attorney
Northern District of California

DATED: _____ BY: _____
Marcy Cook
Kevin Traskos
Assistant United States Attorneys
District of Colorado

DATED: _____ BY: KENNETH KRAFT Digitally signed by KENNETH KRAFT Date: 2025.12.30 11:14:01 -05'00'
Susan E. Gillin
Assistant Inspector General for Legal Affairs
Office of Counsel to the Inspector General
Office of Inspector General
United States Department of Health and Human Services

DEFENDANTS

DATED: 1/13/2026 | 2:10 PM PST BY: Signed by: Vanessa M. Benavides 5128434BDF044C7...
Vanessa M. Benavides
Executive Vice President & Chief Legal Officer
Kaiser Foundation Health Plan, Inc.

DATED: 1/13/2026 | 2:10 PM PST BY: Signed by: Vanessa M. Benavides 5128434BDF044C7...
Vanessa M. Benavides
Executive Vice President & Chief Legal Officer
Kaiser Foundation Health Plan of Colorado

DATED: 1/13/2026 | 2:22 PM PST BY: Signed by: Christopher Lai E76426D3CD664BE...
Chris Lai
Assistant General Counsel
The Permanente Medical Group, Inc.

DATED: 1/13/2026 | 2:12 PM PST BY: Signed by: Hema Anwar DFFE13F002704D3...
Hema R. Anwar
Chief Legal Officer
Southern California Permanente Group

DATED: 1/13/2026 | 3:58 PM PST BY: Signed by: Cynthia Pechon AF40774AA5B54A8...
Cynthia F. Pechon
Chief Legal Officer
Colorado Permanente Medical Group, P.C.

DATED: 1/13/2026 BY:
Jeannie S. Rhee
Counsel for Defendants
Dunn Isaacson Rhee LLP

RELATORS

DATED: 1/7/2026 BY: _____
Ronda Osinek

DATED: 1/7/2026 BY: _____
Amy Zeman
Counsel for Ronda Osinek

DATED: _____ BY: _____
James M. Taylor, M.D.

DATED: _____ BY: _____
Michael Ronickher
Counsel for James M. Taylor, M.D.

RELATORS

DATED: _____ BY: _____
Ronda Osinek

DATED: _____ BY: _____
Amy Zeman
Counsel for Ronda Osinek

DATED: 1/13/26 BY: James M Taylor
James M. Taylor, M.D.

DATED: 1/7/26 BY: Michael Ronickher
Michael Ronickher
Counsel for James M. Taylor, M.D.

EXHIBIT B

PRESS RELEASE

Kaiser Permanente Affiliates Pay $556M to Resolve False Claims Act Allegations

Wednesday, January 14, 2026

For Immediate Release

Office of Public Affairs

Affiliates of Kaiser Permanente, an integrated healthcare consortium headquartered in Oakland, California, have agreed to pay $556 million to resolve allegations that they violated the False Claims Act by submitting invalid diagnosis codes for their Medicare Advantage Plan enrollees in order to receive higher payments from the government.

The settling Kaiser Permanente affiliates are Kaiser Foundation Health Plan Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group P.C. (collectively Kaiser).

Under the Medicare Advantage (MA) Program, also known as Medicare Part C, Medicare beneficiaries may opt out of traditional Medicare and enroll in private health plans offered by insurance companies known as Medicare Advantage Organizations, or MAOs. The Centers for Medicare & Medicaid Services (CMS) pays the MAOs a fixed monthly amount for each Medicare beneficiary enrolled in their plans. CMS adjusts these monthly payments to account for various "risk" factors that affect expected health expenditures for the beneficiary. In general, CMS pays MAOs more for sicker beneficiaries expected to incur higher healthcare costs and less for healthier beneficiaries expected to incur lower costs. To make these "risk adjustments," CMS collects medical diagnosis codes from the MAOs. The diagnoses must be supported by the medical record of a face-to-face visit between a patient and a provider, and for outpatient visits, must have required or affected patient care, treatment, or management at the visit.

Kaiser owns and operates MAOs that offer MA plans to beneficiaries across the country. In a complaint filed in the Northern District of California in October 2021, the United States alleged that Kaiser engaged in a scheme in California and Colorado to improperly increase its risk adjustment payments. Specifically, the United States alleged that Kaiser systematically pressured its physicians to alter medical records after patient visits to add diagnoses that the physicians had not considered or addressed at those visits, in violation of CMS rules.

"More than half of our nation's Medicare beneficiaries are enrolled in Medicare Advantage plans, and the government expects those who participate in the program to provide truthful and accurate information," said Assistant Attorney General Brett A. Shumate of the Justice Department's Civil Division. "Today's resolution sends the clear message that the United States holds healthcare providers and plans accountable when they knowingly submit or cause to be submitted false information to CMS to obtain inflated Medicare payments."

"Medicare Advantage is a vital program that must serve patients' needs, not corporate profits," said U.S. Attorney Craig H. Missakian for the Northern District of California. "Fraud on Medicare costs the public billions annually, so when a health plan knowingly submits false information to obtain higher payments, everyone — from beneficiaries to taxpayers — loses. We have an obligation to protect the American taxpayer from waste, fraud, and abuse and we will relentlessly pursue individuals and organizations that compromise the integrity of the Medicare program."

"The federal government supports the health care of millions of beneficiaries by paying hundreds of billions of dollars every year to Medicare Advantage Plans," said U.S. Attorney Peter McNeilly for the District of Colorado. "Medicare relies on the accuracy of the information submitted by those plans. This resolution sends a clear message that we will hold health care plans accountable if they seek to game the system and pad their profits by submitting false information."

"Deliberately inflating diagnosis codes to boost profits is a serious violation of public trust and undermines the integrity of the Medicare Advantage program," said Acting Deputy Inspector General for Investigations Scott J. Lampert at the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). "This outcome demonstrates HHS-OIG's commitment to protecting Medicare through a unified approach — leveraging the expertise of our investigators, auditors, and counsel, alongside our law enforcement partners. We will continue to hold accountable any entity that seeks to compromise the integrity of the risk adjustment program."

"Healthcare programs funded by the public are meant to support patients, not pad corporate bottom lines. False claims and the submission of fraudulent information weaken the Medicare system and place an unfair cost on American taxpayers who expect honesty and accountability," said Special Agent in Charge Sanjay Virmani of the FBI San Francisco Field

Office. "This settlement reflects the FBI's continued commitment to holding accountable those who put profits over patients and abuse federal healthcare programs."

The settlement announced today resolves allegations that, from 2009 to 2018, Kaiser engaged in a scheme to increase its Medicare reimbursements by pressuring physicians to add diagnoses after patient visits through "addenda" to patients' medical records. The United States alleged that Kaiser developed various mechanisms to mine a patient's past medical history to identify potential diagnoses that had not been submitted to CMS for risk adjustment. Kaiser then sent "queries" to its providers urging them to add these diagnoses to medical records via addenda, often months and sometimes over a year after visits. In many instances, the United States alleged, the diagnoses added by the providers had nothing to do with the patient visit in question, in violation of CMS requirements.

The United States further alleged that Kaiser set aggressive physician-and facility-specific goals for adding risk adjustment diagnoses. It alleged that Kaiser singled out underperforming physicians and facilities and emphasized that the failure to add diagnoses cost money for Kaiser, the facilities, and the physicians themselves. It also alleged that Kaiser linked physician and facility financial bonuses and incentives to meeting risk adjustment diagnosis goals.

The United States alleged that Kaiser knew that its addenda practices were widespread and unlawful. Kaiser ignored numerous red flags and internal warnings that it was violating CMS rules, including concerns raised by its own physicians that these were false claims and audits by its own compliance office identifying the issue of inappropriate addenda.

The civil settlement includes the resolution of certain claims brought in lawsuits under the *qui tam* or whistleblower provisions of the False Claims Act by Ronda Osinek and James M. Taylor, M.D., former employees of Kaiser. Under those provisions, private parties are permitted to sue on behalf of the United States and receive a portion of any recovery. The *qui tam* cases are captioned *United States ex rel. Osinek v. Kaiser Permanente, et al.*, No. 3:13-cv-03891 (N.D. Cal.) and *United States ex rel. Taylor v. Kaiser Permanente, et al.*, No. 3:21-cv-03894 (N.D. Cal.). The relator share of the recovery will be $95 million.

The resolution obtained in this matter was the result of a coordinated effort between the Justice Department's Civil Division, Commercial Litigation Branch, Fraud Section and the U.S. Attorneys' Offices for the Northern District of California and the District of Colorado, with assistance from HHS-OIG, HHS-Office of Audit Services, and the FBI.

The investigation and resolution of this matter illustrate the government's emphasis on combating healthcare fraud. One of the most powerful tools in this effort is the False Claims Act. Tips and complaints from all sources about potential fraud, waste, abuse and mismanagement, can be reported to the Department of Health and Human Services at www.oig.hhs.gov/fraud/report-fraud/ or 800-HHS-TIPS (800-447-8477).

The matter was handled by Fraud Section Attorneys Braden Civins, Edward Crooke, Gary Dyal, Michael R. Fishman, Martha Glover, Seth W. Greene, Rachel Karpoff, Laurie Oberembt, and Jonathan Thrope, Assistant U.S. Attorney Michelle Lo for the Northern District of California, and Assistant U.S. Attorney Kevin Traskos for the District of Colorado.

The claims resolved by the settlement are allegations only and there has been no determination of liability.

Updated January 14, 2026

Topic

FALSE CLAIMS ACT

Components

Civil Division | Federal Bureau of Investigation (FBI) | USAO - California, Northern | USAO - Colorado

Press Release Number: 26-24

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U.S. Department of Justice

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202-514-2000

EXHIBIT C

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Attorneys for Claimant Jeffrey Mazik

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:13-cv-03891-EMC **NOTICE OF RELATED ACTION AND CLAIM OF RELATOR JEFFREY MAZIK TO SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5)**

(Caption continued on next page)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:16-cv-01558-EMC **NOTICE OF RELATED ACTION AND CLAIM OF RELATOR JEFFREY MAZIK TO SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5)**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:16-cv-05337-EMC **NOTICE OF RELATED ACTION AND CLAIM OF RELATOR JEFFREY MAZIK TO SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5)**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:18-cv-01347-EMC **NOTICE OF RELATED ACTION AND CLAIM OF RELATOR JEFFREY MAZIK TO SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5)**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:21-cv-03124-EMC **NOTICE OF RELATED ACTION AND CLAIM OF RELATOR JEFFREY MAZIK TO SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5)**

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:21-cv-03894-EMC **NOTICE OF RELATED ACTION AND CLAIM OF RELATOR JEFFREY MAZIK TO SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5)**

TO THE UNITED STATES DISTRICT COURT, ALL PARTIES AND THEIR COUNSEL OF RECORD:

Please take notice that Jeffery Mazik ("Mazik"), relator and *qui tam* plaintiff in the related action entitled United States *ex rel.* Mazik v. Kaiser Foundation Health Plan, *et al.*, Eastern District of California, Case No. 2:19-cv-00559-DAD, asserts a claim to share of the settlement proceeds in this consolidated action, pursuant to the alternate remedy provision of the False Claims Act, 31 U.S.C. § 3730(c)(5). In particular, relator Mazik's claim is based upon the following:

1. Mazik is a former Kaiser compliance officer who initiated a *qui tam* action on behalf of the United States and several state plaintiffs (California, Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington), based on conduct that he observed over the course of nearly a decade while employed by and/or working with Defendants. In his First Amended Complaint, Mazik alleged that Defendants violated the federal False Claims Act, 31 U.S.C. § 3729 (Count I), and several state analogue statutes (Counts II–VIII), by running a "sham" compliance program that systematically resulted in the submission of artificially inflated risk adjustment data to Medicare, Medicaid, and other government healthcare programs.
2. Mazik filed his original complaint under seal on April 1, 2019. He filed his first amended complaint, also under seal, on April 2, 2021. At that time, the complaints by relators in this consolidated action remained under seal, and Mazik was unaware of any other prior related claims against Defendants.

3. Pursuant to the government's motion, this Court ordered consolidation of the sealed cases in this action on June 25, 2021 (ECF 61). On July 27, 2021, while the consolidated cases remained under seal, the government gave notice to partially intervene (ECF 64) in the consolidated cases. This Court, on July 29, 2021, ordered unsealing of the complaints by relators in this consolidated action and the government's notice of election to partially intervene (ECF 65).

4. Subsequently, on December 1, 2021, the government filed a notice to decline to intervention on Mazik's amended complaint. In an order issued on December 2, 2021, the United States District Court for the Eastern District of California, Hon. John A. Mendez, directed that the amended complaint be unsealed and served upon defendants. Although the government declined to intervene in Mazik's action, it determined to pursue the rights and remedies afforded under the False Claims Act in the related actions in this Court.

5. On January 1, 2022, Defendants filed a motion to dismiss (ECF 141) pursuant to the False Claims Act's first-to-file rule, 31 U.S.C. § 3730(b)(5). In light of the filing of Defendants' first-to-file motion to dismiss in this Court, Defendants and Mazik on January 28, 2022, agreed to stay briefing in the *Mazik* action until 30 days after this Court ruled on Defendants' motion in the consolidation action. The Eastern District court granted the stay on January 31, 2022.

6. On May 5, 2022, this Court entered an order (ECF 171), granting in part and denying in part Defendants' motion to dismiss pursuant to the first-to-file rule. Pursuant to the temporary stay order in the Eastern District, the parties then briefed Defendants' motion to dismiss the *Mazik* action. On July 13, 2022, Defendants filed a motion to dismiss relator Mazik's action, predicated in part on the first-to-file rule. Mazik opposed the motion on

August 29, 2022, arguing that this Court's ruling on the first-to-file rule provided a "blueprint" for resolution of Defendants' motion to dismiss.

7. After reassignment, on February 13, 2024, the Eastern District court issued an order granting in part and denying in part Defendants' motion to dismiss Mazik's complaint. A copy of that order is attached to this notice as an exhibit. As is relevant here, the court compared the allegations by Mazik to the allegations made by relator Taylor. The court concluded that Mazik's federal False Claims Act claim is "barred by the first-to-file rule except to the extent relator alleges that defendants deliberately tampered with compliance software to ensure that it did not identify erroneous diagnosis codes." Order, at 12:26-28. Because Mazik was the first relator to allege that Defendants had tampered with compliance software to achieve their unlawful ends, "'the nature of the wrongdoing claimed by [relator Mazik] here involves different "material elements" from' the wrongdoing in the Taylor Complaint" (*id*., at 13:16-19) (quoting this Court's ruling, 601 F. Supp 3d at 569). Accordingly, the district court in the *Mazik* action followed this Court's ruling in the Consolidated action, and it dismissed the Mazik complaint only in part. See Order, at 14:5-16.

8. Pursuant to the court's order, Mazik filed a compliant second amended complaint on March 26, 2024.

9. Because Mazik retained federal False Claims Act claims involving the risk adjustment fraud, Defendants then sought to transfer Mazik's action to the Northern District of California so that it could be consolidated with this action. Defendants filed the motion on April 8, 2024. The United States opposed the motion to transfer, filing a statement of interest on April 22, 2024. On June 14, 2024, the district court denied the motion to transfer. The court thoroughly reviewed the various factors weighing in favor of, and against, transfer, including points of judicial economy and efficiency. The

court noted that this Consolidated action and the *Mazik* action "both concern an alleged effort by defendants to knowingly submit false diagnosis codes to CMS in an effort to defraud the Medicare Advantage program in violation of the federal FCA." The court concluded that the potential for gains in efficiency with consolidation weighed in favor of transfer, "though only slightly." Both involve defendants' alleged violations of the federal False Claims Act via incorrect diagnoses and deficient compliance programs, but *Mazik*'s claims survived the first-to-file motion only to the extent that it did not share the material factual basis with the *Osinek* matters. In other words, the complaints shared the underlying claim that Defendants had defrauded the United States by submitting false diagnostic codes, but the factual elements were sufficiently different, when weighed against the other factors, to warrant denial of the transfer motion.

10. On January 14, 2026, the government announced a settlement of the consolidated action, including resolution of the claims by relators Osinek and Taylor. As a result of the settlement, the government will recover $556 million, and in return, the Defendants will be released of all "covered conduct" claims, defined by the claims asserted in the government's complaint in intervention.

11. Relator Mazik anticipates that, as a result of the settlement and release in the consolidated action, Defendants will contend that the doctrines of *res judicata* and collateral estoppel will act to extinguish Mazik's federal False Claims Act claims. Despite the fact that Mazik's complaint raises factual elements that were not expressly addressed in the Osinek and Taylor complaints, Mazik anticipates that the settlement may well act to preclude Mazik from further pursing his *qui tam* claims under the federal False Claims Act. Even if relators Osinek and Taylor did not plead elements about defendants fraudulent manipulation of the fraud-detection software on

claims by outside physicians, the government's agreement to settle and waive its claims to recovery on the fraudulent diagnostic codes and risk adjustment databases will essentially preclude any further litigation into those claims. The government cannot recover damages for the same fraud twice, even if it did not specify material factual elements leading up to the fraud in its complaint in intervention. Moreover, in the complaint in intervention, the government expressly identified Defendants' use of broad data analytic tools used by Kaiser on its health care records to determine which files and data to falsify, and these types of data analytic tools are precisely the ones claimed by Mazik to have been part of Kaiser's sham compliance efforts. Thus, while the factual elements of Mazik's federal false claims were absent in the Taylor and Osinek complaints, the settlement announced in this case likely heralds an effective and direct resolution of Mazik's claims.

12. Under the alternate remedy provision of the False Claims Act, 31 U.S.C. § 3730(c)(5), when the government does not intervene in a relator's action or claim, the relator "shall have the same rights in such proceeding as such person would have had if the action had continued under this section." "The reach of this subsection is quite broad, for it encompasses 'any alternate remedy available to the [g]overnment' through which the government has elected "to pursue its [FCA] claim.' In such circumstances, the inquiry is 'whether there exists any overlap between Relator's allegations and the conduct discussed in the settlement agreement.' Where a settlement agreement 'extinguished all of Relators' pending federal False Claims Act pricing claims and thus effectively settled that aspect of their action,' denying the relators a share 'would be inconsistent with Congress' legislative intent to encourage private citizens to file qui tam suits.'" *United States ex rel. Birchall v. Spinefrontier, Inc*.,2024 U.S. Dist. LEXIS

204367, at *15-16 (D. Mass. Nov. 4, 2024) (citing and quoting *United States ex rel. Sun v. Baxter Healthcare Corp*., 892 F. Supp. 2d 341, 344 (D. Mass. 2012), *United States ex rel. Barajas v. United States*, 258 F.3d 1004, 1010 (9th Cir. 2001), and *United States ex rel. Bledsoe v. Cmty. Health Sys*., 342 F.3d 634, 651 (6th Cir. 2003).

13. There is no doubt that the alternate remedy provision would apply in this case. There is a substantial, material overlap between the claims brought in Mazik and the claims resolved in the consolidate case settlement agreement. Even though Mazik's complaint raised material elements that were not specified in the *Osinek* or *Taylor* complaints, and thus Mazik was entitled to pursue his claims despite the first-to-file rule, any claim by Kaiser to *res judicata* or collateral estoppel – or even a "damage credit" applicable to diminish Mazik's *qui tam* recovery – means that the government obtained relief through an alternate remedy. The government was fully aware of Mazik's claims and their overlap with the consolidated actions when it declined intervention, and Mazik was ready and willing to pursue those claims nonetheless. But now that the government is recovering damages and extinghuishing Mazik's claims through the intervened cases, Mazik is entitled to a share of the proceeds under § 3730(c)(5).

In light of the above, relator Mazik requests that the Court, the government and the parties take notice of Mazik's claim to share in the settlement proceeds. He further requests that the Court take oversight in the distribution of settlement funds and/or relators' share until any dispute over Mazik's rights is finally resolved.

///

///

Respectfully submitted,

Dated: January 15, 2026

Law Office of Jeremy L. Friedman
Mendenhall Law Group

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EXHIBIT A

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

JEFFREY MAZIK,

Plaintiff-Relator,

v.

KAISER PERMANENTE, INC., et al.

Defendants.

No. 19-cv-00559-DAD-KJN

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION TO DISMISS RELATOR'S FIRST AMENDED COMPLAINT

(Doc. No. 78)

This matter is before the court on the motion to dismiss relator's first amended complaint filed on July 13, 2022, by defendants Kaiser Foundation Health Plan, Inc. ("KFHP"), Kaiser Foundation Hospitals ("KF Hospitals"), The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (the latter three defendants will be referred to herein collectively as "the PMG defendants").[1] (Doc. No. 78.) On October 4, 2022, the pending motion was taken under submission by the previously

[1] In his first amended complaint, relator named as a defendant "The Permanente Medical Groups," which defendants argue is not an existing entity. (*See* Doc. No. 78 at 2.) Pursuant to the parties' stipulation and the court's order, that defendant has been replaced with The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (Doc. No. 69 at 4.) Throughout his first amended complaint, relator refers to all defendants collectively as "Kaiser." (*See* Doc. No. 48 at ¶ 1.)

assigned district judge.[2] (Doc. No. 92.) For the reasons explained below, defendants' motion to dismiss will be denied in part and granted in part, with leave to amend also being granted.

BACKGROUND

On April 2, 2021, relator Jeffrey Mazik filed his operative first amended complaint ("FAC") under seal on behalf of the United States of America and the states of California, Colorado, Georgia, Hawai'i, Maryland, Virginia, and Washington (collectively, "the plaintiff states") against defendants pursuant to the federal False Claims Act, 31 U.S.C. §§ 3279, *et seq.* (Doc. No. 48.) In his FAC, relator alleges the following.

"Kaiser Permanente" is an "integrated managed care consortium made up of three distinct but interdependent groups of entities:" defendant KFHP, defendant KF Hospitals, and several regional Permanente Medical Groups, including the PMG defendants. (*Id.* at ¶ 14.) The PMG defendants are groups of physicians that "contract with the other Kaiser entities" to provide medical services. (*Id.*) Each PMG defendant operates within its individual territory and is funded primarily by reimbursements from its respective regional Kaiser Foundation Health Plan entity. (*Id.*) Defendant KF Hospitals is a nonprofit corporation headquartered in California that operates hospitals and provides facilities for the benefit of the PMG defendants. (*Id.*) It also receives its funding from defendant KFHP. (*Id.*) Defendant KFHP is a nonprofit corporation headquartered in California that enrolls members in health plans and provides medical services for its members through contracts with defendant KF Hospitals and the PMG defendants. (*Id.*)

Medicare beneficiaries may opt to receive benefits through private health plans instead of the traditional fee-for-service Medicare program. (*Id.* at ¶ 18.) Under that option, known as Medicare Advantage, the federal government pays Medicare Advantage organizations such as defendants a "capitated" (i.e., per enrollee) amount for the purpose of providing medical benefits. (*Id.*) The capitated rates vary depending on the health status of the enrollees; less healthy enrollees require more medical care, which necessitates higher capitation reimbursement

[2] On October 26, 2022, this case was reassigned to the undersigned. (Doc. No. 93.) The undersigned has endeavored to work through a backlog of inherited submitted motions in civil cases as quickly as possible since returning to the Sacramento courthouse in late August of 2022.

payments to the Medicare Advantage organizations. (*Id.* at ¶¶ 19, 20.) Health status in turn depends on the diagnosis codes generated by healthcare providers following encounters with enrollees. (*Id.* at ¶ 21.) In sum, enrollees see doctors such as those in the PMG defendants, who then provide diagnosis codes to defendant KFHP, which then submits the diagnosis codes to the Centers for Medicare & Medicaid Services ("CMS"). (*Id.* at ¶¶ 2, 21.) CMS uses the diagnosis codes to adjust the capitation rate for each enrollee, a process known as "risk adjustment." (*Id.* at ¶ 22.) More severe diagnosis codes lead to higher capitation rates, resulting in greater profits for all defendants—including defendant KF Hospitals and the PMG defendants. (*Id.* at ¶ 45.) Many government-funded plans other than Medicare Advantage also rely upon "substantially the same model" of risk adjustment for capitation rates, such as state-funded Special Needs Plans and "various state-administered Medicaid programs—such as Medi-Cal in California, and other similar plans of the State Plaintiffs." (*Id.* at ¶¶ 33, 34, 36.)

Medicare regulations impose certain requirements on Medicare Advantage organizations such as defendants in an effort to curb the potential for organizations to submit unsupported diagnosis codes, which would lead to improperly high capitation rates and inflated revenues to providers. (*Id.* at ¶¶ 24, 26.) For instance, Medicare Advantage organizations must adopt and implement "an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." (*Id.* at ¶ 28) (quoting 42 C.F.R. § 422.503(b)(4)(vi)). Medicare Advantage organizations must also certify the accuracy, completeness, and truthfulness of the data provided to CMS as a condition of receiving payment. (*Id.* at ¶ 29) (citing 42 C.F.R. § 422.504). Similarly, the organization must submit an annual attestation signed by its Chief Executive Officer or Chief Financial Officer certifying that the risk adjustment data submitted to CMS is "accurate, complete, and truthful," acknowledging that risk adjustment data "directly affects the calculation of CMS payments," and recognizing that "misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution." (*Id.*) CMS also imposes strict requirements on Medicare Advantage organizations' contractual relationships with entities that provide medical services to the organization's

members. (*Id.* at ¶ 30.) Finally, CMS requires organizations to take corrective actions where necessary to ensure compliance with applicable laws and regulations, including the requirement to perform a "root cause analysis" to identify the source of any potential errors or issues. (*Id.* at ¶ 31) (citing 42 C.F.R. § 422.504). State-funded Special Needs Plans are expected to follow Medicare Advantage compliance regulations such as those listed above.[3] (*Id.* at ¶ 36.)

Relator, a resident of California, is the former "Senior Practice Leader for Kaiser's National Compliance Office" and has over 25 years of experience in fraud control, auditing, and compliance. (*Id.* at ¶ 10.) He was "employed by Kaiser" from 2008 to 2017, joining as an "Information Technology Audit Specialist" in May 2008 and transitioning to the role of "Senior Practice Leader in the Fraud Control Program" in March 2012. (*Id.* at ¶ 11.) Relator's duties included working with regional compliance leadership to implement compliance and fraud control initiatives, using data analytics to improve compliance and fraud-mitigation initiatives, investigating potential fraud, and developing corrective action plans to address fraud risks. (*Id.* at ¶ 12.)

Since 2008 at the latest, defendants have schemed to defraud the federal government by allowing external, i.e., "non-Kaiser," healthcare providers to submit false diagnosis codes, which defendants in turn submit to CMS in order to inflate their capitation rates. (*Id.* at ¶¶ 40, 44.) In particular, defendants intentionally fail to properly use fraud-detection tools to monitor claims errors. (*Id.* at ¶ 46.) Defendants contract with data analytics vendors to review their external provider claims for each region. (*Id.* at ¶ 47.) The vendors provide software applications that perform various types of reviews. (*Id.*) For instance, some programs "detect claims that are incorrectly billed . . . [while] other programs identify intentionally manipulated claims that technically fall within plan rules . . . ." (*Id.*) However, defendants intentionally misused these programs and used them at minimum capacity, such as by disabling key features, in order to reduce the chances of detecting claims errors. (*Id.* at ¶¶ 48, 49.) In this way, defendants were actively working to avoid detecting and correcting fraudulent claims. (*Id.* at ¶ 50.)

[3] Relator's allegations in his FAC are ambiguous as to whether state-run Medicaid programs impose similar compliance regulations.

In late 2015, relator was tasked with comparing the functionalities offered by two claims analytics vendors, McKesson and Verisk, with which defendants routinely contracted. (*Id.* at ¶¶ 55, 56.) McKesson offers auditing software called ClaimsXten that detects fraudulent billing practices using "a robust set of rules." (*Id.* at ¶ 57.) However, defendants chose to deactivate 25 of the 54 rules used by ClaimsXten—"the principal software program that they were supposedly relying on [to] detect such billing fraud." (*Id.*) When a group of employees including relator used a Verisk program to double-check data from "the Georgia region" produced by ClaimsXten, the group found $5.3 million in overpayments stemming from defendants' decision to deactivate nearly half the rules in ClaimsXten. (*Id.* at ¶ 59.) Defendants neither reactivated the disabled rules nor rectified the $5.3 million in overpayments. (*Id.* at ¶¶ 60, 61.) Relator presented the group's findings on the Georgia region to several Kaiser executives named in the FAC, but none of those executives took any action. (*Id.* at ¶¶ 61, 62.)

In February 2016, relator detected significant overpayments due to erroneous diagnosis codes in "all other regions."[4] (*Id.* at ¶ 63.) Relator prepared another presentation on the overpayments for his superiors and pointed out that defendants were required by the applicable regulations to review and investigate all identified overpayments within 60 days. (*Id.* at ¶¶ 63, 64.) His superiors did not request a root cause analysis, did not investigate further, and "even took overt steps to prevent Relator from investigating any further himself." (*Id.* at ¶ 66.)

On June 30, 2016, relator participated in a call with Marita Janiga, "Executive Director of Investigations in Kaiser's National Compliance, Ethics & Integrity Office," and the U.S. Department of Health and Human Services' Office of the Inspector General ("OIG"). (*Id.* at ¶¶ 54, 76.) The purpose of the call was to discuss issues surrounding claims accuracy and claims recovered through fraud reduction efforts. (*Id.* at ¶ 76.) Janiga made several false statements during the call related to compliance issues, such as claiming that "Kaiser and its regional offices were 'fully integrated,' so there was no need for the OIG to inquire into its claims processes." (*Id.* at ¶ 79.) Worried that relator would speak up to correct her or to discuss his overpayment

[4] Relator's allegations in the FAC are ambiguous as to whether or not these overpayments were also due to defendants tampering with compliance software.

findings, Janiga messaged him "[not] to say a word." (*Id.* at ¶¶ 78–81.) Relator obeyed this command and remained silent during the call. (*Id.* at ¶ 82.)

In September 2016, relator performed an audit of claims data from all regional offices dating from August 3, 2010 through July 30, 2016. (*Id.* at ¶ 86.) He found that unsupported diagnosis codes had led to over $209 million in Medicare Advantage overpayments, $181 million in Medi-Cal overpayments, and $181 million in overpayments relating to "other Medicaid programs during that six-year period."[5] (*Id.*)

Despite all of relator's findings, defendants certified that their risk adjustment data was accurate and truthful and failed to correct the overpayments. (*Id.* at ¶¶ 90, 91.) All defendants profited from the overpayments and the inflated capitation rates. (*Id.* at ¶ 93.)

Eventually, defendants retaliated against relator for his activities. (*Id.* at ¶ 96.) The more that relator spoke up about unsupported diagnosis codes and overpayments, and the more that he "tried to steer Kaiser in the direction of full compliance," the more he was "sidelined and closed out from data and documents." (*Id.*) On October 12, 2016, relator approached Lauren Sutcliffe, "a Senior Manager in the Special Investigations Unit," regarding an analysis relator had performed uncovering approximately $380,000 in overpayments. (*Id.* at ¶¶ 54, 98.) Sutcliffe severely criticized relator for performing the analysis without her approval and placed him on a performance improvement plan. (*Id.* at ¶ 98.) Several times in October 2016, relator was denied access to "every data repository necessary to perform his compliance job." (*Id.* at ¶¶ 99, 100.) Because claims data review was relator's central focus on the compliance team, he was thereby stripped of his duties and responsibilities. (*Id.* at ¶ 101.) In an attempt to prevent whistleblowing, Sutcliffe also prohibited relator from meeting with anyone above Sutcliffe's level without her prior approval. (*Id.* at ¶ 102.) On November 3, 2016, Sutcliffe forbade relator from communicating with other employees by phone or instant messaging; he was instructed instead to use only email and to copy Sutcliffe on all outgoing emails. (*Id.* at ¶ 106.) On January 5, 2017, relator was fired. (*Id.* at ¶ 111.) Throughout his time working for defendants, relator's

[5] Again, relator does not specify whether or not the overpayments were due to defendants tampering with auditing software.

performance reviews were consistently "successful" or "excellent," and it was only after his presentations on overpayments that he received his first "performance needs improvement" review. (*Id.* at ¶ 112.)

Based on the above allegations, relator asserts the following eleven claims in his FAC[6]: (1) violation of the federal False Claims Act ("federal FCA"), 31 U.S.C § 3279(a)(1); (2) violation of the California FCA, California Government Code §§ 12650, *et seq.*; (3) violation of the Colorado Medicaid FCA, Colorado Revised Statutes §§ 25.5-4-303.5, *et seq.*; (4) violation of the Georgia Taxpayer Protection Against False Claims Act ("TPAFCA"), Georgia Code §§ 23-3-120, *et seq.*; (5) violation of the Hawai'i FCA, Hawai'i Revised Statutes §§ 661-21, *et seq.*; (6) violation of the Virginia Fraud Against Taxpayers Act, Virginia Code §§ 8.01-216.1, *et seq.*; (7) violation of the Washington Medicaid Fraud FCA, Washington Revised Code §§ 74.66.005, *et seq.*; (8) unlawful retaliation in violation of the federal FCA, 31 U.S.C. § 3730(h); (9) unlawful retaliation in violation of the California FCA, California Government Code § 12653; (10) unlawful retaliation in violation of California Labor Code § 1102.5(b); and (11) retaliatory common law termination in violation of public policy.

On December 1, 2021, the United States filed a notice informing the court of its decision to decline to intervene; the plaintiff states filed a similar notice on December 6, 2021. (Doc. Nos. 62, 66.) The court unsealed relator's FAC on the same day that the plaintiff states declined to intervene, December 6, 2021. (Doc. No. 67.)

On July 13, 2022, defendants filed their pending motion to dismiss relator's FAC. (Doc. No. 78.) On August 29, 2022, relator filed his opposition to the pending motion. (Doc. No. 85.) Defendants filed their reply thereto on September 27, 2022. (Doc. No. 91.)

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[6] In his FAC, relator also asserted a claim for violation of the Maryland False Claims Against State Health Plans and Programs Act. (Doc. No. 48 at ¶¶ 159–67.) This claim has already been dismissed with prejudice because the state of Maryland declined to intervene as required by the aforementioned Act. (Doc. No. 67.)

LEGAL STANDARD

A. Motion to Dismiss Under Rule 12(b)(6)

The purpose of a motion to dismiss pursuant to Rule 12(b)(6) is to test the legal sufficiency of the complaint. *N. Star Int'l v. Ariz. Corp. Comm'n*, 720 F.2d 578, 581 (9th Cir. 1983). "Dismissal can be based on the lack of a cognizable legal theory or the absence of sufficient facts alleged under a cognizable legal theory." *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1990). A plaintiff is required to allege "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

In determining whether a complaint states a claim on which relief may be granted, the court accepts as true the allegations in the complaint and construes the allegations in the light most favorable to the plaintiff. *Hishon v. King & Spalding*, 467 U.S. 69, 73 (1984). However, the court need not assume the truth of legal conclusions cast in the form of factual allegations. *U.S. ex rel. Chunie v. Ringrose*, 788 F.2d 638, 643 n.2 (9th Cir. 1986). While Rule 8(a) does not require detailed factual allegations, "it demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *Iqbal*, 556 U.S. at 678. A pleading is insufficient if it offers mere "labels and conclusions" or "a formulaic recitation of the elements of a cause of action." *Twombly*, 550 U.S. at 555; *see also Iqbal*, 556 U.S. at 678 ("Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice."). It is inappropriate to assume that the plaintiff "can prove facts that it has not alleged or that the defendants have violated the . . . laws in ways that have not been alleged." *Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 526 (1983).

In ruling on a motion to dismiss brought under Rule 12(b)(6), the court is permitted to consider material that is properly submitted as part of the complaint, documents that are not physically attached to the complaint if their authenticity is not contested and the plaintiffs'

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complaint necessarily relies on them, and matters of public record. *Lee v. City of Los Angeles*, 250 F.3d. 668, 688–89 (9th Cir. 2001).

B. Heightened Pleading Standard Under Rule 9(b)

"When an entire complaint, or an entire claim within a complaint, is grounded in fraud and its allegations fail to satisfy the heightened pleading requirements of Rule 9(b), a district court may dismiss the complaint or claim." *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1107 (9th Cir. 2003). Under Rule 9(b), the "circumstances constituting the alleged fraud [must] be specific enough to give defendants notice of the particular misconduct . . . so that they can defend against the charge and not just deny that they have done anything wrong." *Kearns v. Ford Motor Co.*, 567 F.3d 1120, 1124 (9th Cir. 2009) (internal quotation marks omitted) (quoting *Bly-Magee v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001)). To satisfy the particularity standard of Rule 9(b), "a pleading must identify the who, what, when, where, and how of the misconduct charged, as well as what is false or misleading about the purportedly fraudulent statement, and why it is false." *Moore v. Mars Petcare US, Inc.*, 966 F.3d 1007, 1019 (9th Cir. 2020) (quotations omitted) (quoting *Davidson v. Kimberley-Clark Corp.*, 889 F.3d 956, 964 (9th Cir. 2018)). However, "[m]alice, intent, knowledge, and other conditions of a person's mind may be alleged generally." *Irving Firemen's Relief & Ret. Fund v. Uber Techs., Inc.*, 998 F.3d 397, 404 (9th Cir. 2021) (quoting Fed. R. Civ. P. 9(b)); *see also Klaehn v. Cali Bamboo LLC*, No. 21-55738, 2022 WL 1830685, at *2 (9th Cir. 2022)[7] ("Under Fed. R. Civ. P. 9(b), a plaintiff must plead circumstances from which a court can plausibly infer the defendant's knowledge.").

ANALYSIS

A. Federal FCA Claim

Relator's first cause of action alleges a violation of 31 U.S.C. § 3279(a)(1), which subjects a person to liability who "knowingly presents . . . a false or fraudulent claim for payment," "knowingly makes . . . a false record or statement material to a false or fraudulent claim," "knowingly makes . . . a false record or statement material to an obligation to pay or transmit

[7] Citation to the unpublished Ninth Circuit opinions such as those cited here and elsewhere in this order is appropriate pursuant to Ninth Circuit Rule 36-3(b).

money or property to the Government," or "conspires to commit" any of the previously listed violations.

1. First-to-File Bar

"When a person brings [a *qui tam* action under the federal FCA], no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). "[T]he facts underlying the later-filed complaint need not be 'identical' to those underlying the earlier-filed complaint for the later complaint to be barred." *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015). Rather, complaints that allege the same "material facts" as an earlier-filed complaint will be barred. *Id.* at 1123. "As a practical matter, the material facts test often has a court consider 'whether the [later-filed] complaint alleges a fraudulent scheme the government already would be equipped to investigate based on the [first-filed] complaint.'" *United States ex rel. Osinek v. Permanente Med. Grp., Inc.*, 601 F. Supp. 3d 536, 552 (N.D. Cal. 2022) ("*Osinek I*") (quoting *United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011)); *see also Hartpence*, 792 F.3d at 1131 (holding that the district court erred in finding a later complaint barred in part because the Ninth Circuit "disagree[d] that [the later relator's] action provided no additional benefit to the government").

In their pending motion, defendants argue that relator's federal FCA claim is barred by the first-to-file rule and the first amended complaint filed by the relator, Dr. James Taylor, in *United States ex rel. Taylor v. Kaiser Permanente*, No. 21-cv-03894-EMC (N.D. Cal.) ("the Taylor Complaint").[8] (Doc. No. 78 at 14–17.) Below, the court will therefore compare the allegations in

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[8] Defendants request that the court take judicial notice of the Taylor Complaint. (Doc. No. 79.) Courts "may take notice of proceedings in other courts . . . if those proceedings have a direct relation to matters at issue." *United States ex rel. Robinson Rancheria Citizens Council v. Borneo, Inc.*, 971 F.2d 244, 248 (9th Cir. 1992) (quoting *St. Louis Baptist Temple, Inc. v. FDIC*, 605 F.2d 1169, 1172 (10th Cir. 1979); *see also id.* (taking notice of another court's "final judgment" and "related filings"). Accordingly, the court takes judicial notice of the Taylor Complaint.

the Taylor Complaint with relator's allegations in his FAC.[9]

The relevant allegations from the Taylor Complaint are as follows. Defendant "Kaiser Permanente" is a nonprofit managed-care consortium consisting of "three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups." (Taylor Complaint ¶ 16.) "Kaiser routinely conducted . . . audits to determine the accuracy of its risk adjustment claims submissions," and these audits regularly identified categories of claims that had high rates of falsity. (*Id.* ¶ 60.) In particular, the "audits have identified significant error rates in risk adjustment claims Kaiser submitted to CMS based on diagnoses provided by external providers." (*Id.* ¶ 81.) Despite the results of the audits, "Kaiser rarely took even minimal steps" to prevent the future submission of false claims or to audit prior submissions to find previously submitted false claims. (*Id.* ¶ 60.)[10]

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[9] Defendants argue that the appropriate comparison is between relator's original complaint and the Taylor Complaint, i.e., Taylor's first amended complaint. (Doc. No. 78 at 15); *see also Osinek I*, 601 F. Supp. 3d at 551 (holding that courts should compare the original complaint in the later-filed action with the operative complaint in the first-filed action at the time the later-filed action was filed). If the court were to follow the reasoning underpinning the district court's decision in *Osinek I*, the appropriate comparison would indeed be between relator Mazik's original complaint and Taylor's first amended complaint. However, a recent unpublished decision by the Ninth Circuit reviewing the district court's decision in *Osinek I* casts doubt on this approach and suggests courts should instead compare "all pending amended complaints, *i.e.* all operative complaints at the time of the first-to-file analysis." *United States ex rel. Stein v. Kaiser Found. Health Plan, Inc.*, No. 22-15862, 2024 WL 107099, at *1 (9th Cir. 2024); *see also Hartpence*, 792 F.3d at 1125 n.2 ("For purposes of determining jurisdiction, we look to the allegations in the amended complaints."). Ultimately, the resolution of this question does not affect the outcome of the first-to-file analysis in this case, because the relevant allegations in Taylor's original and amended complaints are virtually identical, as are the relevant allegations in relator Mazik's. *See Stein*, 2024 WL 107099, at *1 ("Without deciding whether the district court erred in selecting the proper comparators in applying the first-to-file bar, we conclude any error would be harmless because the district court considered in the alternative the allegations Relators added in their amended complaint. Moreover . . . there were no material differences in the amended *Osinek* and *Taylor* complaints.").

[10] The Taylor Complaint describes the audits, and the defendants' failure to act on those audits, in considerable detail. These more detailed allegations are omitted because they are not ultimately necessary to decide the first-to-file issue in this case for the reasons discussed below.

Defendants argue that Taylor and relator have both alleged fraudulent schemes wherein external providers supply erroneous diagnosis codes to defendants, who then knowingly submit the erroneous codes to CMS to reimbursement. (Doc. No. 78 at 15–16.) In particular, defendants argue that Taylor and relator describe the same three specific practices: (1) audits revealing that the diagnosis codes supplied by external providers had high error rates; (2) defendants' failure to take appropriate corrective action in response to the audits revealing high error rates; and (3) defendants' failure to use oversight tools that would have allowed defendants to identify the high error rates. (*Id.* at 16–17.) Consequently, defendants argue, the Taylor Complaint "gave 'the government grounds to investigate all that is in' Mazik's FAC, and the first-to-file bar requires dismissal of Mazik's federal FCA claim." (*Id.* at 17) (quoting *Batiste*, 659 F.3d at 1210).

In his opposition, relator acknowledges that:

> [t]here are, of course, similarities between the two cases. Like *Taylor*, the allegations in *Mazik* generally pertain to a 'nationwide or corporate-wide fraud' to increase the payments that Defendants received from various government entities by knowingly submitting false, fraudulent, and/or unsupported diagnostic codes in its risk adjustment data. And like *Taylor*, Mazik also alleges that Kaiser's failure to correct 'improper coding by external providers' was a central component of that fraud."

(Doc. No. 85 at 11) (internal citations omitted). However, relator argues that the allegations of his FAC describe an entirely different mechanism by which this alleged fraud operates, a mechanism not hinted at in the Taylor Complaint. (*Id.*) That is, relator asserts that his allegations here focus "almost exclusively on Kaiser's defunct compliance operations, including but not limited to its intentional manipulation of fraud detection software . . . ." (*Id.*) Relator also argues that he "is the first to put the government on notice about Kaiser's practice of acquiring and utilizing recognized fraud-detecting programs to make it appear as though it has a robust compliance operation, but purposefully configuring those programs to overlook readily identifiable instances of fraud . . . ." (*Id.* at 13.)

The court concludes that relator's FCA claim is barred by the first-to-file rule except to the extent relator alleges that defendants deliberately tampered with compliance software to ensure that it did not identify erroneous diagnosis codes. As relator acknowledges, the Taylor

Complaint and relator's FAC both broadly allege schemes wherein defendants knowingly requested CMS reimbursements premised on erroneous diagnosis codes. Consequently, the government was "already . . . equipped to investigate" the broader scheme alleged by relator here. *Batiste*, 659 F.3d at 1209. Relator's allegations as to this general scheme "have no additional benefit for the government," which was already on notice of the alleged fraud from the Taylor Complaint. *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1189 (9th Cir. 2001). Accordingly, relator's federal FCA claim is barred insofar as it alleges a general fraudulent scheme wherein defendants knowingly requested CMS reimbursements premised on erroneous diagnosis codes. *See Osinek I*, 601 F. Supp. 3d at 567 ("Based on *Osinek*, the government had grounds to investigate all that is in the Taylor Complaint which points to the same basic problem. . . . [A]t bottom, Dr. Taylor's broader claim is that high-value conditions were diagnosed without following the practices required by Medicare regulations. This is fundamentally the same charge that Ms. Osinek makes.").

However, plaintiff is correct that there is one aspect of his federal FCA claim that does not appear in the Taylor Complaint, namely defendants' alleged tampering with compliance software. With respect to these allegations, "the nature of wrongdoing claimed by [relator Mazik] here involves different 'material elements' from" the wrongdoing alleged in the Taylor Complaint. *Osinek I*, 601 F. Supp 3d at 569; *see also id.* at 568 ("Here, the Court agrees with Dr. Taylor that this specific aspect of his case is not related to *Osinek*."). The Taylor Complaint describes various Kaiser entities discovering errors in the diagnosis codes via audits and then failing to act on those discoveries. (*See, e.g.*, Taylor Complaint ¶¶ 60, 63, 71, 160); *see also Osinek I*, 601 F. Supp. 3d at 565–69 (describing how Taylor's theories of fraud all rely on allegations that "Kaiser failed to act even after audits revealed high error rates"). By contrast, here relator's allegations in his FAC describe defendants' decision to disable compliance software so that the audits would *not* identify erroneous codes and defendants would not discover the errors in the first place. (Doc. No. 48 at ¶¶ 48, 49, 57, 59.) In contrast, the Taylor Complaint alleges that the audits were "relatively successful," "showed that Kaiser continued to have a high error rate," and "identified not only specific [categories of codes] that had high error rates, but also the individual diagnosis

codes that were problematic." (Taylor Complaint ¶¶ 156, 157.) There is nothing in these allegations that would have prompted the government to question the validity of the audits. Relator Mazik's allegations that the audits were themselves compromised would therefore "provide[] [some] additional benefit to the government." *Hartpence*, 792 F.3d at 1131.

Accordingly, relator's federal FCA claim will be dismissed without leave to amend, except to the extent it is premised on defendants' alleged tampering with compliance software. *See Osinek I*, 601 F. Supp. 3d at 569 (holding that "[t]he *Taylor* case is not dismissed in its entirety but only in part" because "*Taylor* differs materially from *Osinek* in three ways"); *id.* at 574 ("*Taylor* is dismissed except to the extent that it pleads (1) a nationwide or corporate-wide fraud; (2) a fraud based on improper coding by external providers; and (3) a fraud based on True Positive results from the NLP program."); *see also United States ex rel. Jahr v. Tetra Tech EC, Inc.*, 2022 WL 2317268, at *6 (N.D. Cal. June 28, 2022) (holding that certain "allegations [were] dismissed under the first-to-file bar" where the prior complaint "would plausibly have provided the government with notice of the material facts of similar claims," but also concluding that other allegations appearing in the earlier filed complaint "are much too general to preclude [the relator's] allegations about soil sampling").

2. Falsity

A "claim for payment can be factually false or legally false." *United States ex rel. Osinek v. Permanente Med. Grp., Inc.*, 640 F. Supp. 3d 885, 897 (N.D. Cal. 2022) ("*Osinek IV*"). "A factually false claim is one in which the claim for payment is itself literally false or fraudulent, such as when the claim involves an incorrect description of goods or services provided or a request for reimbursement for goods or services never provided." *United States ex rel. Anita Silingo v. WellPoint, Inc.*, 904 F.3d 667, 675 (9th Cir. 2018) (internal citations omitted). A legally false claim can take one of two forms: express false certification or implied false certification. *Id.* "Express false certification involves an entity's representation of compliance with the law as part of the process for submitting a claim when it is actually not compliant." *Id.* at 675–76. "By contrast, implied false certification occurs when an entity has previously undertaken to expressly comply with a law, rule, or regulation, and that obligation is implicated

by submitting a claim for payment even though a certification of compliance is not required in the process of submitting the claim." *Id.* at 676 (citations, brackets, and internal quotation marks omitted). "Although the circumstances of a fraud must be pleaded with particularity, knowledge may be pleaded generally." *Id.* at 679 (citing Fed. R. Civ. P. 9(b)).

Defendants argue that relator has failed to allege falsity or any fraudulent scheme with the particularity required by Rule 9(b). (Doc. No. 78 at 18.) Defendants offer a laundry list of details that they argue relator has failed to allege. (*See id.* at 18–19) (arguing that relator has failed to allege, among other things, "the purpose of those 25 [deactivated] rules, how deactivating those rules could result in inaccurate diagnosis codes," or whether "he reviewed any actual medical records"). In his opposition, relator directs the court's attention to more than 40 paragraphs in his FAC which he contends clearly allege a fraudulent scheme with the required particularity. (Doc. No. 85 at 16, 17 & n.9) (citing Doc. No. 48 at ¶¶ 2–6, 19–23, 40–74).

The court concludes that relator has sufficiently alleged a fraudulent scheme in his FAC. Relator has alleged the "who" (defendants), the "what" (tampering with auditing software), the "when" ("since at least 2008"), the "why" (to decrease the chance of identifying errors in claims), and "how" the alleged scheme is fraudulent ("Kaiser repeatedly provided expressly false certifications that its risk adjustment data submissions to CMS were 'accurate, complete, and truthful,' while knowing that the data were, in fact, plagued with errors, and despite knowing that those errors would cause CMS to pay unjustifiably and falsely higher capitation rates."). (Doc. No. 48 at ¶¶ 44, 48, 55, 57–61, 73.) Moreover, relator alleges that defendants "decided to de-activate 25 of the 54 editing rules or features in ClaimsXten—the principal software program that they were supposedly relying on [to] detect such billing fraud." (*Id.* at ¶ 57.) He further alleges that when he used similar auditing software from another company, Verisk, to double-check the results of the ClaimsXten program, he identified $5.3 million in overpayments "for the Georgia region alone" resulting directly from defendants' decision to deactivate the relevant ClaimsXten features. (*Id.* at ¶¶ 57–59.) Despite relator allegedly presenting his findings to several authorities within defendants' corporate structure, defendants never implemented "the most obvious . . . corrective action" of "simply re-activat[ing] these built-in editing features . . . ." (*Id.* at ¶¶ 60,

61.) Relator has thereby sufficiently alleged falsity, as well as defendants' knowledge of the falsity. *See United States ex rel. Swoben v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1175 (9th Cir. 2016) ("[W]hen, as alleged here, Medicare Advantage organizations design retrospective reviews of enrollees' medical records deliberately to avoid identifying erroneously submitted diagnosis codes that might otherwise have been identified with reasonable diligence, they can no longer certify, based on best knowledge, information and belief, the accuracy, completeness and truthfulness of the data submitted to CMS.").

3. Materiality

"Under the [federal] False Claims Act, the term 'material' means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." *United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1018 (9th Cir. 2018). "[T]here is not a bright-line test for determining whether the [federal] FCA's materiality requirement has been met." *United States ex rel. Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1212 (9th Cir. 2019). "No single fact or occurrence determines materiality"; indeed, even "the Government's decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive." *United States ex rel. Winter v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1121 (9th Cir. 2020) (internal quotation marks omitted).

Defendants argue that relator's allegations regarding materiality are conclusory and that he has failed to allege "any specific facts to show that the government would not have paid Defendants had it known about the purported fraud . . . ." (Doc. No. 78 at 19.) Relator argues in response that CMS would not have paid such high capitation rates but for the falsely inflated risk adjustment data that defendants deliberately failed to discover through sham audits. (Doc. No. 85 at 17.)

The court concludes that relator has sufficiently alleged materiality. Relator has alleged that CMS pays capitation rates to defendants based on a risk adjustment formula that considers plan beneficiaries' demographics and health status, that health status is in turn based on diagnosis codes that defendants receive from healthcare providers, and that defendants have purposefully disabled features of their compliance software in order to avoid discovering certain errors in

diagnosis codes that would reduce the capitation rates they receive. (Doc. No. 48 at ¶¶ 4, 5, 21, 57); *see also United States ex rel. Osinek v. Kaiser Permanente*, No. 13-cv-03891-EMC, 2023 WL 4053797, at *4 (N.D. Cal. June 15, 2023) ("*Osinek V*") ("For example, materiality is supported by allegations that CMS makes risk-adjustment payments based directly on the diagnosis codes submitted by health plans."); *cf. Silingo*, 904 F.3d at 673 ("The importance of accurate data certifications and effective compliance programs is obvious: if enrollee diagnoses are overstated, then the capitation payments to Medicare Advantage organizations will be improperly inflated."). Moreover, relator has alleged that defendants' scheme led to $5.3 million in overpayments "for the Georgia region alone." (Doc. No. 48 at ¶ 59); *see also Osinek IV*, 640 F. Supp. 3d at 910 ("[T]he magnitude of the noncompliance weighs in favor of materiality, as the government has asserted that Kaiser has 'reap[ed] thousands of dollars for each inaccurate diagnosis code and hundreds of millions of dollars for its scheme.'"); *cf. Rose*, 909 F.3d at 1022 ("[W]ere a school to offer admissions representatives cups of coffee or $10 gift cards for recruiting higher numbers of students, there would be no viable claim under the False Claims Act. That is not the case here. Under Defendant's 2006–2008 compensation scheme, admissions representatives stood to gain as much as $30,000 and a trip to Hawaii . . . . [These] tremendous bonuses . . . also counsel against a finding that Defendant's noncompliance was immaterial."). Relator has additionally alleged that defendants must certify the truthfulness of the data provided to CMS as a condition of receiving payment. (Doc. No. 48 at ¶ 29) (citing 42 C.F.R. § 422.504). Lastly, relator alleges that defendants must submit an annual attestation certifying that the risk adjustment data is truthful, acknowledging that risk adjustment data "directly affects the calculation of CMS payments," and recognizing that "misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution." (*Id.* at ¶ 29.) *Cf. Rose*, 909 F.3d at 1020 (affirming the denial of the defendant's motion for summary judgment and concluding that "the government condition[ing] the payment of Title IV funds on compliance with . . . statute, regulation, and contract" is "certainly probative evidence of materiality").

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4. Lumping

Defendants next argue that relator's allegations in the FAC impermissibly lump defendants together in violation of Rule 9(b). (Doc. No. 78 at 21); *see also Swartz v. KPMG LLP*, 476 F.3d 756, 764–65 (9th Cir. 2007) ("Rule 9(b) does not allow a complaint to merely lump multiple defendants together but require[s] plaintiffs to differentiate their allegations when suing more than one defendant . . . and inform each defendant separately of the allegations surrounding [their] alleged participation in the fraud."). Defendants argue that relator has failed to allege what role each defendant played in the alleged scheme and that it is not "plausible" that all defendants engaged in precisely the same conduct. (Doc. No. 78 at 21–22); *see also Swoben*, 848 F.3d at 1184 (noting that while lumping is prohibited, "[t]here is no flaw in a pleading, however, where collective allegations are used to describe the actions of multiple defendants who are alleged to have engaged in precisely the same conduct"). In his opposition to the pending motion, relator argues that "the Ninth Circuit has rejected nearly identical arguments in at least two other FCA actions against other Medicare Advantage organizations." (Doc. No. 85 at 18) (citing *Swoben*, 848 F.3d at 1184; *Silingo*, 904 F.3d at 677).

The court concludes that relator's federal FCA claim need not be dismissed due to the lumping of defendants together in violation of Rule 9(b). At the outset, the court notes it has already concluded that relator's federal FCA claim survives only to the extent it is premised on defendants' alleged tampering with compliance software. In his FAC, relator provides allegations detailing each defendant's role in the general fraudulent scheme.[11] More importantly, relator provides allegations regarding each defendant's role in the specific fraudulent scheme to tamper

[11] Relator alleges as follows. The PMG defendants are groups of physicians that "contract with the other Kaiser entities" to provide medical services and are primarily funded by reimbursements from their respective regional KFHP entities. (Doc. No. 48 at ¶ 14.) Defendant KF Hospitals operates hospitals and medical centers that provide infrastructure and facilities for use by the PMG defendants. (*Id.*) Defendant KF Hospitals receives its funding from defendant KFHP. (*Id.*) Lastly, defendant KFHP enrolls members in health insurance plans, provides hospital and medical services for its members through contracts with defendant KF Hospitals and the regional PMGs, and collects its members' diagnosis codes. (*Id.* at ¶¶ 14, 41.) Defendant KFHP then provides data based on the diagnosis codes to CMS regarding its members' health status and collects the corresponding capitated rates. (*Id.* at ¶ 41.) All defendants then profit from these higher reimbursement rates. (*Id.* at ¶ 45.)

with the auditing software: All defendants "work in cooperation with each other," "act in concert," and, crucially, "mak[e] centralized decisions with respect to CMS compliance, claim making, [and] responsibility for tracking and reporting information that goes into claims for Medicare reimbursements . . . ."[12] (Doc. No. 48 at ¶¶ 15, 16.) In doing so, relator has sufficiently alleged that each defendant decided, or acquiesced in the decision, to tamper with defendants' auditing software and disable some of its key features. *See Silingo*, 904 F.3d at 677 ("[A] complaint need not distinguish between defendants that had the exact same role in a fraud."); *United States ex rel. Osinek v. Kaiser Permanente*, No. 13-cv-03891-EMC, 2023 WL 4054279, at *10 (N.D. Cal. June 15, 2023) ("*Osinek VI*") (finding the relator had not improperly lumped the defendants together in part because "[t]he FAC provides sufficient details" as to "the general roles played by the health plans and the physician medical groups with respect to risk adjustment" and because the relator's "allegations that Kaiser's risk adjustment operations were integrated and/or involved collaboration" substantiated the relator's allegations that "the various Kaiser entities have allegedly engaged in the same basic conduct").

Defendants argue that it is not "plausible" that "a nonprofit health plan that provides healthcare coverage (KFHP), a nonprofit hospital that provides hospital services [KF Hospitals], and privately run medical groups that provide other medical care (the PMGs) engaged in precisely the same conduct." (Doc. No. 78 at 21–22.) But defendants do not argue that relator's allegations regarding centralized decision-making with respect to CMS compliance are conclusory.[13] Because relator's allegations are indeed not conclusory, they are to be taken as true

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[12] Defendants argue that relator has conceded that defendants did not engage in precisely the same conduct because relator "admits that not all regions where Defendants operated were 'fully integrated' in terms of processing claims." (Doc. No. 78 at 22) (quoting Doc. No. 48 at ¶ 79). In fact, relator has alleged that defendants' employee represented "that Kaiser and its regional offices were 'fully integrated'" even though "that was only partly true in certain regions." (Doc. No. 48 at ¶ 79.) Taken in its proper context, this allegation does not undercut, but rather supports, relator's claim for two reasons. First, relator is alleging that defendants' own employee described defendants as "fully integrated." Second, there is nothing contradictory in theory about the named defendants being fully integrated while, hypothetically, KFHP was only partly integrated with other regional PMGs that were not named as defendants.

[13] Nor would the court agree with such an argument were it advanced.

at this stage of the litigation. *See Iqbal*, 556 U.S. at 678. The court therefore understands defendants' argument to be an invitation to judge the credibility of the allegations in relator's FAC and the likelihood that they are true, which is of course improper at the pleading stage.

5. Conspiracy

"General civil conspiracy principles apply to conspiracy claims under the False Claims Act." *United States ex rel. Calisesi v. Hot Chalk, Inc.*, No. 13-cv-01150-PHX-NVW, 2015 WL 1966463, at *13 (D. Ariz May 1, 2015). "Thus, 'to prove a False Claims Act conspiracy, a relator must show (1) the existence of an unlawful agreement between defendants to get a false or fraudulent claim allowed or paid by [the Government] and (2) at least one act performed in furtherance of that agreement.'" *Osinek VI*, 2023 WL 4054279, at *8 (quoting *United States ex rel. Grubbs v. Ravikumar Kanneganti*, 565 F.3d 180, 193 (5th Cir. 2009)).

Defendants argue that relator has failed to allege an agreement among defendants to violate the law. However, as described above, relator has alleged that defendants engaged in centralized decision-making with respect to CMS compliance and that defendants tampered with the auditing software despite, and indeed because of, the decreased ability to identify claims errors that would result. It is plausible from these allegations that defendants agreed "to get a false or fraudulent claim allowed or paid by [the Government]." *Grubbs*, 565 F.3d at 193.

Accordingly, defendants' motion to dismiss relator's federal FCA claim, to the extent that claim is premised on defendants' alleged tampering with compliance software, will be denied.

B. State FCA Claims

1. Georgia TPAFCA

Defendants argue that relator's Georgia TPAFCA claim must be dismissed because it is premised on fraud purportedly perpetrated against a state-administered Medicaid program and must therefore be brought instead under the Georgia False Medicaid Claims Act. (Doc. No. 78 at 21 n.11.) Relator does not respond to this argument in his opposition brief.

The final section of the Georgia TPAFCA states: "If a civil action can be commenced pursuant to . . . the 'State False Medicaid Claims Act,' the claimant shall proceed under [that Act]." Ga. Code Ann. § 23-3-127; *see also* Ga. Code Ann. § 49-4-168.1 ("Any person who . . .

knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval . . . shall be liable to the State of Georgia for a civil penalty consistent with the civil penalties provision of the federal False Claims Act . . . .").

Relator alleges that defendants submitted false claims to "Medicaid programs with the various states." (Doc. No. 48 at ¶ 2.) Consequently, relator must bring this claim under the Georgia False Medicaid Claims Act.

Accordingly, relator's Georgia TPAFCA claim will be dismissed without leave to amend. *See United States ex rel. Miller v. Reckitt Benckiser Grp. PLC*, __ F. Supp. 3d __, 2023 WL 6849436, at *19 (W.D. Va. 2023) (dismissing the relator's claim "as it pertains to the Georgia Taxpayer Protection False Claims Act but allow[ing] Miller to proceed under the Georgia False Medicaid Claims Act").

2. All Other States

Relator brings claims under several states' false claims statutes. State FCAs are generally modeled on the federal FCA, and violations of each of the state Acts relevant here are analyzed similarly to violations of the federal FCA.[14] That is, each state Act requires relator to allege a fraudulent scheme with particularity. *See* Fed. R. Civ. P. 9(b).

[14] *See State v. Altus Fin., S.A.*, 36 Cal. 4th 1284, 1299 (2005) ("[T]he CFCA 'is patterned on similar federal legislation' and it is appropriate to look to precedent construing the equivalent federal act.") (quoting *Laraway v. Sutro & Co., Inc.*, 96 Cal. App. 4th 266, 274 (2002)); *United States ex rel. Lovato v. Kindred Healthcare, Inc.*, No. 15-cv-02758-CMA-NYW, 2020 WL 9160872, at *8 n.5 (D. Colo. Dec. 14, 2020) (finding that the relator's CMFCA claim "rise[s] and fall[s] on the adequacy of the relator's [federal] FCA claims"), *adopted by Colorado ex rel. Lovato v. Kindred Healthcare, Inc.*, No. 15-cv-02759-CMA, 2021 WL 1085423 (D. Colo. Mar. 22, 2021); *United States ex rel. Lockyer v. Hawaii Pac. Health*, 490 F. Supp. 2d 1062, 1072 (D. Haw. 2007) ("Hawaii's False Claims Act extends liability in situations nearly identical to the federal FCA."); *United States ex rel. Forunatè v. Ndutime Youth & Fam. Servs., Inc.*, No. 16-cv-00653, 2020 WL 5507217, at *15 (E.D. Va. Sept. 11, 2020) ("'[T]he VFATA is based on the federal civil False Claims Act' . . . . Because the [federal] FCA and the VFATA contain similar provisions, federal courts in Virginia apply the same standard to VFATA claims.") (quoting *Lewis v. City of Alexandria*, 756 S.E.2d 465, 469 (Va. 2014)); *United States ex rel. Siegel v. Novo Nordisk, Inc.*, No. 15-cv-00114-PRW, 2022 WL 16716299, at *8 (W.D. Okla. Nov. 4, 2022) ("For the reasons explained with respect to Plaintiffs' claims . . . based upon alleged violations of the [federal] FCA, the Court concludes that Plaintiffs' claims related to alleged violations of the [Washington Medicaid Fraud FCA] . . . satisfy Rule 9(b)'s heightened pleading standard for fraud-based claims.").

Defendants argue that relator has failed to allege violations of the state FCAs with the required particularity. (Doc. No. 78 at 20–21.) For instance, defendants argue that relator has failed to allege how he determined that overpayments had been made to state programs, whether the state programs used risk-adjustment models based on diagnosis codes such that incorrect codes caused any overpayments, or even which state programs were presented with false claims. (*Id.*) Defendants further argue that relator has failed to allege falsity and materiality with respect to his state FCA claims. (*Id.*) Relator argues in response that because he has sufficiently alleged a federal FCA claim, and because the state FCAs mirror the federal FCA in relevant parts, he has also sufficiently alleged his state FCA claims.

The court concludes that relator has failed to allege all but one of his state FCA claims with sufficient particularity. With the exception of California and Medi-Cal, discussed below, he does not specifically identify any of the state programs to which he alleges defendants presented false claims. This failure alone renders relator's allegations insufficient under the heightened standards of Rule 9(b), with the exception of those allegations relating to California. *See United States ex rel. Everest Principals, LLC v. Abbott Lab'ys, Inc.*, 622 F. Supp. 3d 920, 935 (S.D. Cal. 2022) (dismissing the relator's state FCA claims because "Relator has not alleged with particularity how any false claims were submitted to each state identified in the FAC"); *cf. United States ex rel. Nowak v. Medtronic, Inc.*, 806 F. Supp. 2d 310, 357 (D. Mass. 2011) (dismissing the relator's state FCA claims because she "fails to identify any specific fraudulent or false claim submitted to any state"). Accordingly, relator's claims brought under the Colorado, Hawai'i, Virginia, and Washington false claims statutes will be dismissed. Nonetheless, because these deficiencies can "possibly be cured by the allegation of other facts," leave to amend will be granted as to these claims. *Cook, Perkiss & Liehe, Inc. v. N. Cal. Collection Servs.*, 911 F.2d 242, 247 (9th Cir. 1990).

The California FCA imposes civil liability on "any person who . . . knowingly presents or causes to be presented a false or fraudulent claim for payment or approval" or is "a beneficiary of an inadvertent submission of a false claim, subsequently discovers the falsity of the claim, and fails to disclose the false claim to the state or the political subdivision within a reasonable time

after discovery of the false claim." Cal. Gov. Code § 12651(a). Relator alleges that, "[a]t a minimum," defendants were the beneficiaries of false claims, subsequently discovered those claims' falsity, and failed to disclose the falsity of the claims to the state of California. Defendants argue that relator has failed to allege falsity, materiality, or a fraudulent scheme with sufficient particularity. (Doc. No. 78 at 20.)

The court finds that relator has sufficiently alleged falsity and knowledge as to his California FCA claim. Relator alleges that he conducted an audit in September 2016 of claims data from August 3, 2010 through July 30, 2016 and that this audit revealed $181 million in overpayments from Medi-Cal[15] arising from unsupported diagnosis codes.[16] (Doc. No. 48 at ¶ 86.) Relator has thereby alleged the "who, what, when, where, and how" of the fraudulent scheme with sufficient particularity. *Silingo*, 904 F.3d at 677 (quoting *United States ex rel. Cafasso v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1055 (9th Cir. 2011)). Moreover, relator alleges that defendants approved these claims for overpayments despite their knowledge of their falsity. (Doc. No. 48 at ¶ 86.) Relator further alleges that the more he "spoke up about Kaiser's improper processes for handling unsupported diagnostic codes and the resulting overpayments . . . the more he was sidelined" and denied access to defendants' compliance data. (*Id.* at ¶ 96.) Instead of taking corrective action, relator alleges that defendants "continued to resist, obstruct, and dismiss" his efforts, "especially" after relator began reporting to Sutcliffe in approximately July 2016. (*Id.*) Relator's allegations are therefore also sufficient to permit the court to draw the reasonable inference of defendants' knowledge, which need only be alleged generally. *See* Fed.

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[15] Relator also alleges that the same audit uncovered $181 million in overpayments from "other Medicaid programs," but he again does not specify which programs or states were involved.

[16] Relator does not specify whether the unsupported diagnosis codes were overlooked because defendants allegedly tampered with the auditing software and disabled its key features, or whether the unsupported codes were submitted due to some different reason. However, this is not fatal to relator's claim. Defendants do not argue that relator's California FCA claim is barred by any first-to-file doctrine, nor do they provide the court with an earlier-filed complaint that would support such an argument. Consequently, for his California FCA claim, relator may allege a fraudulent scheme arising from all of his allegations in the FAC. That is, unlike for his federal FCA claim, relator is not restricted to alleging a fraudulent scheme based only on defendants tampering with auditing software.

R. Civ. P. 9(b). Lastly, relator alleges that all defendants profited from the overpayments. (Doc. No. 48 at ¶ 45.) In sum, relator has sufficiently alleged, at minimum, that defendants were the "beneficiaries" of false claims, "subsequently discover[ed] the falsity of the claim[s], and fail[ed] to disclose the false claim[s] to the state or the political subdivision within a reasonable time . . . ." Cal. Gov. Code § 12651(a).

The court finds that relator has also adequately alleged materiality. Defendants argue that relator has failed to allege that any of the state programs used risk-adjustment models based on diagnosis code data, making it unclear how the codes could affect any purported overpayments. (Doc. No. 78 at 20–21.) But in the court's view, relator expressly alleges exactly this information: "Although the above-described risk adjustment model is primarily used in conjunction with Medicare Advantage (Medicare Part C) plans, there are several other government-funded capitation rate plans that rely upon substantially the same model . . . such as Medi-Cal in California . . . ." (Doc. No. 48 at ¶ 33.) Given this allegation and the enormous size of the alleged overpayments, the court finds that relator has alleged materiality. *See Osinek IV*, 640 F. Supp. 3d at 910 ("[T]he magnitude of the noncompliance weighs in favor of materiality, as the government has asserted that Kaiser has 'reap[ed] thousands of dollars for each inaccurate diagnosis code and hundreds of millions of dollars for its scheme.'"); *cf. Silingo*, 904 F.3d at 673 ("The importance of accurate data certifications and effective compliance programs is obvious: if enrollee diagnoses are overstated, then the capitation payments . . . will be improperly inflated."). Defendants' motion to dismiss relator's California FCA claim will therefore be denied.

C. Retaliation Claims

Relator also asserts claims for retaliation under the federal FCA, 31 U.S.C § 3730(h); the California FCA, California Government Code § 12653; California Labor Code § 1102.5(b); and California common law.

To state "claims for retaliation under the [federal] FCA and CFCA[, a relator] must allege that (1) she was engaged in protected conduct; (2) [the defendant] knew she engaged in such conduct; and (3) [the defendant] retaliated against her because of the conduct." *Mendiondo v.*

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Centinela Hosp. Med. Ctr., 521 F.3d 1097, 1104 (9th Cir. 2008).[17] Retaliation claims under the California Labor Code and common law have similar elements. *See* Cal. Lab. Code § 1102.5(b) ("An employer . . . shall not retaliate against an employee for disclosing information . . . to a person with authority over the employee . . . if the employee has reasonable cause to believe that the information discloses a violation of . . . or noncompliance with" a state or federal statute or regulation); *McVeigh v. Recology S.F.*, 213 Cal. App. 4th 443, 472 (2013) (collecting cases describing how a California common law retaliation claim is analogous to one brought under the California FCA). "Protected conduct" under the federal FCA requires "an objectively reasonable, good faith belief that [the defendant] was possibly committing fraud against the government." *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 908 (9th Cir. 2017); *see also McVeigh*, 213 Cal. App. 4th at 456, 469, 472 (noting that a relator must have "reasonably based suspicions" of false claims or illegal activity under the California FCA, California Labor Code § 1102.5(b), and California common law).

1. Against PMG Defendants

Defendants argue that relator's retaliation claims must be dismissed because he has failed to identify his employer. (Doc. No. 78 at 22.) Relator also does not respond to this argument in his opposition brief.

Relator alleges that he was employed by "Kaiser," meaning all named defendants. (Doc. No. 48 at ¶ 11.) But the court "need not accept Relator's conclusory allegation that [he] was [a defendant's] employee for the purposes of a motion to dismiss." *United States ex rel. O'Neill v. Somnia, Inc.*, No. 1:15-cv-00433-DAD-EPG, 2018 WL 684765, at *11 (E.D. Cal. Feb. 2, 2018).

Relator also alleges as follows. He was employed first "as an Information Technology Audit Specialist," later as "Senior Practice Leader in the Fraud Control Program," and eventually as "Senior Practice Leader for Kaiser's *National* Compliance Office . . . ." (*Id.* at ¶¶ 10, 11) (emphasis added). He alleges that "he reported to . . . the Vice President of the *National*

[17] "[U]nlike a [federal] FCA violation claim, a [federal] FCA retaliation claim 'does not require a showing of fraud and therefore need not meet the heightened pleading requirements of Rule 9(b).'" *Mendiondo*, 521 F.3d at 1103 (quoting *United States ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220, 238 n.23 (1st Cir. 2004)).

Compliance Office" and later to the "Executive Director of Investigations in Kaiser's *National* Compliance, Ethics & Integrity Office," and that he focused on "integrating regional and national departments . . . ." (*Id.* at ¶ 50, 54) (emphasis added). Lastly, relator alleges that he detected overpayments in "all" regions, not just one. (*Id.* at ¶ 63.)

It is plausible from relator's allegations recounted above that he was the employee of defendants KFHP and KF Hospitals, two nationwide entities. *See O'Neill*, 2018 WL 684765, at *11 (finding it plausible that the relator was an employee of the defendants because she "goes on to allege specific facts about the nature of her employment"). However, the court cannot draw the reasonable inference from relator's descriptions of his job functions, which all revolved around nationwide compliance programs, that he was employed by the PMG defendants, each a regional collection of physicians. Accordingly, relator's retaliation claims against the PMG defendants will be dismissed. Because this deficiency can "possibly be cured by the allegation of other facts," leave to amend will also be granted as to those claims. *Cook*, 911 F.2d at 247.

2. Against Defendants KFHP and KF Hospitals

Defendants KFHP and KF Hospitals (collectively, "the employer defendants") argue that relator's retaliation claims must be dismissed because relator has failed to allege that he was engaged in protected activity or that defendants knew of his alleged activity. (Doc. No. 78 at 22.) Relator argues in response that he has alleged support for "an objectively reasonable, good faith belief that Kaiser's sham compliance operation was resulting in fraud," and that he has also alleged that he "engaged in protected conduct by reporting his concerns internally, to supervisors and others, on multiple occasions." (Doc. No. 85 at 14.)

The court finds that relator has adequately alleged that he was engaged in protected activity.[18] "An employee engages in a protected activity by investigating matters which are calculated or reasonably could lead to a viable [False Claims Act] action." *Campie*, 862 F.3d at 907 (internal quotation marks omitted). Relator's investigation actually led to a viable FCA action, and his allegations certainly support the reasonable inference that he had "an objectively

[18] The court notes that defendants' single-sentence argument on this point is conclusory and foreclosed by the very decisions cited by defendants in their pending motion.

reasonable, good faith belief that [his employer] was possibly committing fraud against the government." *Id.* at 908.

The court further concludes that relator has alleged that the employer defendants knew of his engagement in protected activity. Defendants cite the Ninth Circuit's decision in *Campie*, 862 F.3d 890, which suggested that "when an employee is tasked with [monitoring and reporting activities and] such investigations, it takes more than an employer's knowledge of that activity to show that an employer was on notice of a potential *qui tam* suit." *Id.* at 908. However, the court's decision in *Campie* actually supports relator's retaliation claims here. The Ninth Circuit held in that case that the relator sufficiently alleged that the defendant had knowledge of his engagement in protected activity because he had alleged that he "was told it was 'none of his concern' when he discussed contamination and adulteration problems on multiple occasions" and that he had "explicitly complained that [his employer] was violating FDA regulations." *Id.* Here, relator similarly alleges that his supervisors "took overt steps to prevent [him] from investigating any further himself" and that he "pointed out that, pursuant to applicable regulations, Kaiser was required to review and investigate all identified overpayments within 60 days." (Doc. No. 48 at ¶¶ 66, 64.) The Ninth Circuit also stressed that the relator in *Campie* had alleged that "he was selectively circumvented and excluded from the regulatory review process in which he was meant to take part . . . ." *Campie*, 862 F.3d at 908 (brackets and internal quotation marks omitted). Similarly, relator here alleges that he was denied access to the software and databases necessary for his job in order to "sideline" him, "even though claims data review was the central role assigned to Relator on the compliance team." (Doc. No. 48 at ¶¶ 99–101.) Lastly, the Ninth Circuit highlighted the relator's allegation that he had threatened to inform the FDA if his employer continued its fraudulent conduct. *Campie*, 862 F.3d at 908. Here, relator alleges that his employer was so fearful that he would disclose information about fraudulent billing practices during a call with HHS OIG that his employer preemptively told him "[not to] say a word." (Doc. No. 48 at ¶ 81.) Taken as a whole, relator's allegations are similar to or even stronger than those found to be sufficient by other district courts to allege a defendant's knowledge of a relator's engagement in protected activity. *See United States ex rel. Osinek v. Permanente Med.*

Grp., Inc., 2022 WL 16934763, at *9 (N.D. Cal. Nov. 14, 2022) ("*Osinek II*") (finding that the relator had adequately alleged the defendant's knowledge in part because she "was not just reporting a coding problem but trying to remediate it, implicitly raising the point that the coding was not legally permissible"); *United States ex rel. Garrett v. Kootenai Hosp. Dist.*, No. 17-cv-00314-CWD, 2020 WL 3268277, at *10 (D. Idaho June 17, 2020) (finding that the relator had sufficiently alleged the defendant's knowledge where she had alleged that she made reports "to correct alleged illegal fraudulent practices, not simply to report regulatory compliance issues in the course of her employment" and that her employer had "responded by openly and actively resisting her efforts").

Accordingly, defendants' motion to dismiss relator's retaliation claims brought against defendants KFHP and KF Hospitals will be denied. [19]

CONCLUSION

For the reasons explained above,

1. Defendants' motion to dismiss relator's complaint is granted in part and denied in part as follows:
   a. Relator's claim for violation of the federal False Claims Act ("FCA") is dismissed without leave to amend, except to the extent that claim is premised on defendants alleged tampering with compliance software;
   b. Defendants' motion to dismiss relator's claim for violation of the federal FCA, to the extent that claim is premised on defendants alleged tampering with compliance software, is denied;
   c. Relator's claim brought pursuant to the Georgia Taxpayer Protection Against False Claims Act is dismissed without leave to amend;

/////

[19] In contrast to the federal FCA, California Labor Code § 1102.5(b) prohibits retaliating against employees for disclosing information "regardless of whether disclosing the information is part of the employee's job duties." Cal. Lab. Code § 1102.5. "Thus, if anything, an argument could be made that a § 1102.5 retaliation claim is more easily proven than a [federal] FCA retaliation claim. In any event, the § 1102.5 claim survives for the reasons stated above." *Osinek II*, 2022 WL 16934763, at *9.

d. Relator's claims brought pursuant to the Colorado Medicaid FCA, Hawai'i FCA, Virginia Fraud Against Taxpayers Act, and Washington Medicaid Fraud FCA are dismissed, with leave to amend;

e. Defendants' motion to dismiss relator's claim brought pursuant to the California FCA is denied;

f. Relator's retaliation claims brought against defendants The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. are dismissed, with leave to amend;

g. Defendants' motion to dismiss relator's retaliation claims brought against defendants Kaiser Foundation Health Plan and Kaiser Foundation Hospitals is denied;

2. Within twenty-one (21) days from the date of entry of this order, relator shall file either a second amended complaint, or a notice of his intent not to file a second amended complaint and to proceed only on the claims found to be cognizable in this order; and

3. Pursuant to the court's order (*see* Doc. No. 100), the parties shall file a joint status report regarding the scheduling of this action within 30 days from the date of entry of this order. The court will thereafter issue a scheduling order.

IT IS SO ORDERED.

Dated: **February 13, 2024**

Dale A. Drozd

DALE A. DROZD
UNITED STATES DISTRICT JUDGE

EXHIBIT D

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:13-cv-03891-EMC **NOTICE OF MOTION AND MOTION OF CLAIMANT JEFFREY MAZIK FOR A SHARE OF SETTLEMENT PROCEEDS UNDER 31 U.S.C. § 3730(c)(5); MEMORANDUM OF POINTS AND AUTHORITIES** Date: April 2, 2026 Time: 1:30 pm Courtroom: 5 Hon. Edward M. Chen

(Caption continued on next page)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:18-cv-01347-EMC
UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants	Case No. 3:21-cv-03894-EMC

NOTICE OF MOTION

TO ALL PARTIES, AND THE ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE THAT on April 2, 2026, at 1:30 p.m. in Courtroom 5 on the 17th floor at 450 Golden Gate Avenue, San Francisco, California, claimant Jeffrey Mazik will and hereby does move the Honorable Edward M. Chen for a share of settlement proceeds in this action under the False Claims Act, 31 U.S.C. § 3730(c)(5).

More specifically, claimant seeks an order recognizing Mazik's statutory share of settlement proceeds under the alternate remedy provision of the Act. For his allocation, Mazik requests that the Court award him 8% of the amounts recovered by the United States from the Kaiser defendants under the terms of the January 14, 2026, settlement agreement (Exh. A), said allocation being paid in addition to, and will not diminish, the existing 17% relator's share for relators Osinek and Taylor. To the extent further proceedings are necessary, Mazik renews his request that he gain access to all settlement and share agreements between the parties of this consolidated action.

This motion is grounded on the following:

1. Mazik is the relator and *qui tam* plaintiff in a related action styled United States *ex rel.* Mazik v. Kaiser Foundation Health Plan, *et al.*, pending in the Eastern District of California, Case No. 2:19-cv-00559-DAD.
2. In his *qui tam* action, Mazik alleged, *inter alia*, that Kaiser defendants violated the False Claims Act by submitting false claims to Medicare for capitated payments on its Medicare Advantage enrollees, using inflated risk adjustment factors (RAFs) that were based on false diagnoses codes.
3. This motion was anticipated by Congress when it amended the False Claims Act in 1986 and turned it into the government's primary litigative tool for combating fraud. As the Senior Practice Leader for the Fraud Control Program in Kaiser's National Compliance Office, Mazik exposed an internal sham compliance program, including the deliberate tampering with data analytic tools designed to expose false and inflated diagnoses codes.

When he exposed the fraud and tried to stop it, defendants terminated his employment. Mazik was the first and only relator to allege defendants deliberately tampered with compliance software to ensure Kaiser did not identify and document erroneous diagnoses codes.

4. After Mazik filed his amended complaint, the United States elected to pursue remedies for injuries to it caused by the submission of false claims for capitated payments in an alternate proceeding. Specifically, it moved here to consolidate six other *qui tam* actions, all **also** involving Kaiser's false claims for capitated payments based on inflated RAFs, and then it filed a complaint-in-intervention.

5. Although it could have pursued the remedies for those same injuries by intervening in Mazik's action as well, the government chose not to, leaving Mazik to pursue his action on his own under 31 U.S.C. § 3730(c)(3).

6. On January 14, 2026, the government announced a settlement of this consolidated action, whereby defendants paid the United States $556,000,000, plus interest at a rate of 4.250% per annum from October 15, 2025, until and including the day of payment. The settlement resolved the United States' amended complaint-in-intervention and the remaining *qui tam* claims of relators Osinek and Taylor.[1]

7. The government and relators Osinek and Taylor reached an agreement on a 17% relator's share out of a potential 25%, resulting in the payment of approximately $95 million to those relators.[2]

---

[1]The settlement agreement, the Department of Justice's press release (Exh. B), and the dismissal requests filed in this action indicate that there were other settlement agreements between defendants and relators in this action. Mazik has not been informed of the terms of those settlements, including whether additional funds were recovered by the United States as a result of the settlements or dismissals.

[2]Mazik has not been informed whether additional relator's shares were recovered by any of the relators in this action.

8. Because the government recovered remedies for the injuries alleged by Mazik, and because the one-recovery rule precludes Mazik from recovering in his *qui tam* action for the same injury or alleged damages again, Mazik's right to share in the settlement proceeds is respectfully protected by the alternate remedy provision of the False Claims Act, 31 U.S.C. § 3730(c)(5).

9. Because the government declined to intervene in Mazik's action, Mazik is entitled to recover a statutory minimum of 25% of the settlement proceeds.

10. The 8% share requested by Mazik from the government is the difference between this statutory floor and the share amounts already agreed upon by the United States and relators Osinek and Taylor. As such, the request made by this motion complies with § 3730(c)(5) while also not diluting the relator's share paid to Osinek and Taylor.

This motion is based on this notice, the attached memorandum of points and authorities, the declaration and exhibits filed concurrently herewith, the pleadings and orders in this action and Mazik's action, and any further evidence and argument submitted on the motion.

Respectfully submitted,

Dated: February 25, 2026

Law Office of Jeremy L. Friedman
Mendenhall Law Group

By: /s/Jeremy L. Friedman
Jeremy L. Friedman

Attorneys for relator Jeffrey Mazik

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Legislative History

MEMORANDUM OF POINTS AND AUTHORITIES

The United States, Kaiser defendants and relators Ronda Osinek and Dr. James M. Taylor have reached a settlement that recovers hundreds of millions of dollars to the federal fisc for injury caused by Kaiser's fraud – the same fraud scheme relator Jeffrey Mazik exposed when he filed his *qui tam* action under seal in the Eastern District of California and made his extensive disclosures to the government.

Mr. Mazik is entitled to a share of these settlement proceeds under the False Claims Act's alternate remedy provision, 31 U.S.C. § 3730(c)(5). That provision exists for precisely this situation: where the government learns of material facts of fraud through the relator's filings and disclosures, elects to pursue its remedy through a separate proceeding rather than intervening in the relator's case, and then settles the dispute to recover a remedy on the same injury identified by the relator. Congress included the alternate remedy provision to prevent the government from depriving a relator of his rightful share of proceeds recovered on claims he brought to the government's attention. Any other outcome would defeat the statutory design, and discourage relators from coming forward to face the risks of prosecuting a declined case only to be left out in the cold when the United States recovers its remedy through alternate means.

Mr. Mazik requests an award of 8% of the proceeds of the settlement, or approximately $44.5 million. This award does not dilute the 17% share of settling relators Osinek and Taylor, while keeping with the 25% statutory minimum for a relator's share in a non-intervened case.

STATEMENT OF FACTS

A. At great risk to his career, Mazik exposed Kaiser's sham fraud detection program and pursued his *qui tam* claims over risk adjustment fraud

Jeffrey Mazik is the former Senior Practice Leader for Kaiser's National Compliance Office, with over 25 years of experience in fraud control, auditing, and compliance. Second Amended Complaint ("SAC"), Exh. C, at ¶ 11. He was employed by Kaiser from 2008 until Kaiser fired him in 2017, first joining as an Information

Technology Audit Specialist in May 2008 and transitioning to the role of Senior Practice Leader in the Fraud Control Program in March 2012. *Id.* ¶ 12.

In his final role at Kaiser, Mr. Mazik's duties included working closely with regional compliance leadership to implement compliance and fraud control initiatives; leading comprehensive risk assessments, using data analytics to drive compliance, fraud control focus-areas, and fraud mitigation initiatives; investigating cases of potential fraud, waste, and abuse; developing corrective action plans to address root causes of fraud risks; and overseeing board reporting and mandatory regulatory reporting for the fraud control program. *Id.* ¶ 13. His role inside Kaiser provided access to high-level, data-driven analyses of claims submissions – all of which he disclosed to the government. Indeed, his ability to understand data-driven fraud detection software clued him in to the fraudulent scheme at issue in this litigation.

1. Kaiser knew it had a problem with false diagnoses data

Participants in the Medicare Advantage program have an inherent "incentive to over-report diagnosis codes in order to raise beneficiary risk scores and, in turn, increase the amount that CMS pays them." *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010, 1020 (N.D. Cal. 2020). Mr. Mazik uniquely gave the government a roadmap showing Kaiser's fraud was necessarily deliberate. After CMS expanded its Recovery Audit program to Medicare Part C following the Affordable Care Act, Kaiser recognized its diagnosis coding would be subject to governmental scrutiny. As part of his extensive disclosures to the Department of Justice, Mr. Mazik provided a 2013 internal report on Reimbursement Compliance, where Kaiser's Audit and Compliance Committee noted "extrapolatable" audits conducted by the government might result in a "take back" of Medicare Advantage capita payments and subject Kaiser to fines and penalties, threatening "gross income for our risk adjustment payments [of] roughly $11 Billion." Friedman Decl., ¶ 5, Exhibit D.

Similarly, Mr. Mazik provided the government with the results of a Hierarchical Condition Category (HCC) audit probe in 2012 using 2011 data. Friedman Decl., ¶ 6,

Exh. E. These results showed a total accuracy rate for Part C at a dismal 89%, with only 2 regions showing accuracy rates at 95% or better, and 3 regions showing accuracy at 85% or below. Kaiser's National Compliance, Ethics & Integrity Office identified "key issues" with respect to false or fraudulent diagnosis data, including two important risks: "coding of historical conditions as acute" and "record submitted in support of condition not documented to be present." *Id*.

Despite these red flags, Kaiser focused its compliance efforts exclusively on "encounters" data – diagnosis coding from care provided by internal Kaiser providers – rather than "claims" data from outside providers. This was done because Kaiser had much greater control over clinical services furnished by network physicians and thus could hide behind its self-audit and self-improvement responsibilities. This deliberate plan allowed Kaiser to intentionally disregard fraud control measures, even though it was obligated to review and adjudicate claims pursuant to CMS standards, and undertake measures to protect the integrity of the diagnosis code data reported to CMS.

2. Mazik worked with data analytic tools used for fraud control

When Mr. Mazik joined Kaiser's compliance office in 2012, he reported to Mia Okinaga, who was then Vice President of the National Compliance Office. SAC ¶ 55. Ms. Okinaga personally recruited Mr. Mazik to join the compliance team and focus on integrating regional and national departments for better monitoring and tracking of fraud control. *Id.* Mr. Mazik worked closely with Ms. Okinaga, who actively pushed initiatives to direct Kaiser and the regional offices to effectively utilize various diagnostic compliance and fraud detection tools. *Id.* ¶ 56. Such tools were developed by vendors such as Verisk Health, McKesson and FICO – data analytics companies that work with clients to identify fraud and abuse in various financial sectors. *Id.* CMS's own Medicare Advantage Fraud Handbook identifies the use of such analytics tools as critical measures that are "especially productive in trying to uncover fraud: scrutiny of beneficiary enrollment data and provider contract information, and surveillance of billing and claims patterns." Friedman Decl., ¶7, Exh F, at p.67.

Mr. Mazik also worked with Jay Loden, Assistant Director of Information Analytics and Compliance Technology, on tools and analytical studies; Judy Sarles, Senior Director, on compliance systems; and Daren Pursche, Director of Government Audit & Reimbursement, on external and internal compliance standards. SAC ¶ 57.

3. Data analytics showed Kaiser's fraud scheme was nationwide

In his *qui tam* action, Mr. Mazik revealed that since 2008, Kaiser engaged in a scheme to defraud the United States by providing inflated risk adjustment factors derived from invalid diagnosis coding for Medicare Advantage enrollees. SAC ¶¶ 2, 6-7. Through his own audits, Mr. Mazik discovered that Kaiser was able to conceal its risk adjustment fraud by deploying a sham compliance program.

In September 2016, Mr. Mazik employed the data analytic tools that were at Kaiser's disposal to audit claims data from all regional offices using Kaiser's proprietary Audit Recovery Information System (ARIS) database. *Id.* ¶ 86. The audit covered the period from August 3, 2010 through July 30, 2016. *Id.* Mr. Mazik created Excel pivot tables that summarized the data and found that unsupported diagnosis codes led to over $209 million in Medicare Advantage overpayments. *Id.* Such overpayments not only represented a dramatic failure of the organization to review and adjudicate claims as was required of it. The overpayments were a necessary step in Kaiser's plan to submit monthly claims for billions of dollars in falsely inflated capitated payments.

For example, applied to data from 2010 to 2013, Verisk software identified $11,690,149 in overpayments in Georgia alone. SAC ¶ 92. A snapshot of Kaiser's claims metrics from April 2015 reveals the scope of the problem: Kaiser reported approximately 900,000 Medicare claims and paid out a total of $2.0 billion in claims across all strata. Although 32% of the financials had been audited, **only 1% of paid claims had been audited.** And while several outside vendors recovered high seven-figure dollars in claims overpayments, the two vendors who flagged claims for "fraud and abuse" (CSC and HCI) recovered $0. Friedman Decl., ¶ 8, Exh. G.

Ms. Okinaga's position was eliminated on August 21, 2015, after she prioritized Mr. Mazik's initiatives that uncovered problems with Kaiser's data integrity – problems Kaiser intentionally concealed. *Id.* ¶ 58. Thereafter, Mr. Mazik reported to Marita Janiga, Executive Director of Investigations in Kaiser's National Compliance, Ethics & Integrity Office, for about a year—and then to Lauren Sutcliffe, a Senior Manager in the Special Investigations Unit. *Id*. In effect, Kaiser shut down the audit efforts of Ms. Okinaga and Mr. Mazik.

4. Mazik discovered that Kaiser accomplished its fraud scheme by tampering with data analytic compliance software

Through his *qui tam* action, Mr. Mazik brought unique insight to the government into the key component of Kaiser's risk adjustment fraud scheme: to conceal the results of its one-way data-mining effort to find "missing" diagnoses, Kaiser had to deactivate the compliance filters of its data analytics.

Kaiser would contract with data analytics vendors to review claims data for each region. SAC ¶ 47. These vendors – including McKesson, Verisk and FICO – each provided Kaiser with software applications that performed various types of Medicare Advantage billing reviews. *Id.* ¶ 61. Mr. Mazik discovered that Kaiser intentionally failed to use these fraud-detection tools, thus allowing its offensive data-mining practices to move forward unchallenged. Specifically, Kaiser intentionally misused these programs by setting them at minimum capacity and disabling key features to purposely reduce the chances of detecting false diagnoses data errors. *Id.* ¶¶ 48, 49.

Mr. Mazik uncovered this software tampering in late 2015 when he was tasked with conducting a comparative analysis between the functionalities provided by McKesson and Verisk. *Id.* ¶¶ 55, 56, 60.

McKesson's software, ClaimsXten, detects fraudulent billing practices using a robust set of rules. *Id.* ¶ 61. ClaimsXten applies automated rules based on CMS's Correct Coding Initiative, including the detection of invalid, inconsistent and unsupported diagnoses codes. Friedman Decl., ¶ 9; Exh. H. Mr. Mazik learned that Kaiser had

deactivated 25 of the 54 rules in ClaimsXten – **the principal software program Kaiser relied on to detect billing fraud**. SAC ¶ 62.

Kaiser refused to buy or turn on the full set of McKesson or Verisk rules, and it delayed implementation of FICO, an advanced predictive modeling software that Mr. Mazik used to detect anomalous billing patterns in Kaiser's electronic health records and identify providers who used improper coding. SAC ¶ 117.

When Mr. Mazik and his colleagues used a Verisk program to double-check data from the Georgia region produced by the neutered ClaimsXten, the group found $5.3 million in overpayments stemming directly from Kaiser's decision to deactivate nearly half the rules in ClaimsXten. *Id.* ¶ 59, 64. The most obvious solution would have been for Kaiser to simply re-activate these built-in editing features. Instead, in furtherance of its fraud, Kaiser never reactivated the disabled rules nor take steps to audit the consequences. *Id*. ¶¶ 60, 61, 65.

Indeed, when Mr. Mazik, Mr. Kelly, and Mr. Loden presented their findings to Ms. Janiga and Ms. Sarles, neither expressed any interest in correcting this problem. *Id.* ¶ 66. The findings were also brought before Sean Killeen, Executive Director of Payment Integrity in the Claims-Cost Containment Department. *Id*. ¶ 67. Mr. Killeen's response was also indifferent. In short, nothing was ever done at the national or regional level to rectify the easily correctable non-compliance. *Id.*

Mr. Mazik also used a Verisk-based program to run a shadow audit across all other regions, detecting some $209 million in overpayments for Medicare Advantage enrollees due to erroneous coding. *Id*. ¶ 68. He then prepared a Webex presentation to report his findings to Ms. Janiga and Mr. Pursche of the Government Audit & Reimbursement division. *Id.* In this presentation, Mr. Mazik pointed out that, pursuant to applicable regulations, Kaiser was required to review and investigate all identified overpayments within 60 days. *Id*. ¶ 69. The purpose of his analysis was to put his superiors on notice and lay out various options for the necessary corrective action. *Id.*

Kaiser's executives demonstrated a complete lack of interest in this audit. No one at Kaiser – including Ms. Sarles, Mr. Pursche or Ms. Janiga – asked for any follow-up by Mr. Mazik. *Id.* ¶ 71. They made no request for his data, and they did not ask for any root-cause analysis. Instead, Kaiser dismissed, ignored, and hid Mr. Mazik's findings. Not only did his superiors refuse to investigate any further, they took overt steps to prevent Mr. Mazik from investigating any further himself. *Id.* Kaiser never even executed the contract with Verisk to include it from its new "Anti-Fraud Alliance." *Id*. ¶ 99.

Kaiser's one-sided data mining efforts could only have succeeded long term with the compliance software tampering uncovered by Mr. Mazik. If the tools flagged the false diagnoses coding, the compliance officers were legally obligated to delete it. By turning the tools off, Kaiser prevented internal compliance officers from creating a paper trail for the fraud, and it also allowed the false diagnoses codes in the electronic health records to inflate the risk adjustment factors which led to the higher capitated payments.

5. Kaiser silenced and retaliated against Mr. Mazik, but now OIG uses Mazik-style data analytics to combat the same risk adjustment fraud

Mr. Mazik not only uncovered the key mechanism by which Kaiser committed the risk adjustment fraud, he witnessed the misrepresentations to the government that hid this fraud. During a phone call with the U.S. Department of Health & Human Services: Office of Inspector General (HHS OIG) on June 30, 2016, Kaiser silenced Mazik and made sure that his information would not be disclosed. SAC ¶ 80.

The call was a kick-off call held by HHS OIG with Kaiser to discuss medical loss ratio reporting and audits, addressing issues surrounding claims accuracy and claims recovered through fraud reduction efforts. *Id*. ¶ 81. During the call, OIG asked Kaiser about its general stance on claims operations, informing Kaiser that part of OIG's initiative was to address potential problems. *Id*. ¶ 82. Ms. Janiga falsely claimed that OIG's questions regarding claims auditing were irrelevant because "claims were not [Kaiser's] business." *Id*. ¶ 83. This statement ignored that Kaiser processed outside medical claims of at least $7 billion annually. *Id*. Kaiser's misrepresentations to OIG were

intended to preclude the OIG from inquiring into Kaiser's claims audit process. *Id*.

Ms. Janiga was concerned that if he spoke during the OIG call, Mr. Mazik might contradict her and correct her misrepresentations. *Id*. ¶ 85. She was also concerned that Mr. Mazik might raise his compliance and audit findings with the OIG. *Id*. To that end, in the middle of the phone call with OIG, Ms. Janiga messaged Mr. Mazik on intercompany messaging and instructed him to "[not] say a word." *Id*. ¶ 86.

The more Mr. Mazik raised concerns regarding Kaiser's suspect coding and overpayments, or steer Kaiser toward full compliance, the more he was sidelined and closed out from data and documents. *Id*. ¶ 96. This was especially true after Mr. Mazik began reporting to Ms. Sutcliffe in or around July 2016. *Id*. ¶ 114.

On October 12, 2016, Mr. Mazik approached Ms. Sutcliffe about an analysis he had performed that uncovered approximately $380,000 in suspected overpayments relating to a single procedure code error. *Id*. ¶¶ 54, 98, 116. Rather than acknowledge Mr. Mazik's efforts, or proceed to correct the systematic overpayments, Ms. Sutcliffe criticized him for performing the analysis without obtaining her prior approval, and she placed him on a Performance Improvement Plan ("PIP"). *Id*. ¶¶ 98, 116.

Mr. Mazik was also denied access to the software tools that were necessary for his job. *Id*. ¶¶ 99, 100, 117. On October 15, 2016, Mr. Mazik was denied access to the Claims Data Warehouse, Kaiser's internal data repository system to collect and analyze claims information. *Id.* ¶ 117(a).

On October 16, 2016, he was denied access to Kaiser Permanente HealthConnect, Kaiser's internal electronic health record (EHR) database system. *Id*. ¶ 117(b). HealthConnect is a massive multi-year EHR database, built at a cost of approximately $4 billion, and considered one of the largest non-governmental health information technology projects in the world. This EHR database combines diagnoses codes from outside providers with codes provided by Kaiser encounters, weaving a unified data stream used by Kaiser to provide CMS to back up its monthly claims for capitated payments.

By denying him access to every data repository necessary to perform his job, Kaiser effectively prevented Mr. Mazik from performing any audit activity. *Id*. ¶¶ 101, 118 119. Ms. Sutcliffe also forbade Mr. Mazik from holding any meetings with anyone at Kaiser that was above her level without her express, prior approval. *Id*. ¶¶ 102, 120. This directive restricted Mr. Mazik's access to communicating with key people at Kaiser, purposefully disincentivized internal complaints and whistleblowing, and directly hindered him from accomplishing the PIP objectives. *Id*. ¶ 120.

On November 3, 2016, Ms. Sutcliffe further forbade Mr. Mazik from communicating with other employees via phone or internal instant messaging. *Id.* ¶¶ 106, 124. Instead, Mr. Mazik was told he could only use email communications, and he was instructed to copy Ms. Sutcliffe on all such outgoing emails. *Id*. On December 13, 2016, Mr. Mazik met with Ms. Janiga, and summarized the retaliatory actions taken against him, but Ms. Janiga ignored his complaints. *Id*. ¶ 127.

On December 23, 2016, Mr. Mazik sought a meeting with Jacqueline Thomas in Human Resources to discuss Kaiser's harassing efforts at stymying his attempt to correct Kaiser's audit problems. *Id*. ¶ 128. No such meeting ever took place.

On January 5, 2017, Mr. Mazik was instead fired. *Id*. ¶ 111, 129. Throughout his prior nine years working for Kaiser, Mr. Mazik's performance reviews were consistently "successful" or "excellent." *Id*. ¶¶ 112, 130. Between 2012 and 2016, he performed exceedingly well. *Id*. ¶ 130. It was not until he first presentated his audits findings that he suddenly received his very first, below-level "performance needs improvement" review. *Id*. ¶¶ 112, 130. The Honorable Judge Dale A. Drozd relied on these facts when ruling on February 13, 2024, that Mr. Mazik's action could continue despite the "first-to-file" bar set forth in 31 U.S.C. § 3730(b)(5). Exh. I.

After being silenced during the OIG call, stripped of his responsibilities, denied access to the Kaiser's systems, barred from speaking internally and ultimately fired, Mazik filed his *qui tam* action. Soon thereafter, CMS made a sea change in its auditing of Medicare Advantage Organizations for risk adjustment fraud.

By way of background, in the April 2016 report by the Government Accountability Office, GAO-16-76, CMS was criticized for its weak audit selection process, noting that $14.1 billion was improperly paid to Medicare Advantage Organizations in 2013 alone. Between 2019 and 2021, OIG launched and reported on a targeted review series, indicating 20 Medicare Advantage organizations were using chart reviews to disproportionately drive payments. *See* Office of Inspector General Report in Brief (September 2021), OEI-03-17-00474.

By 2023, CMS finalized technical details of risk adjustment data validation, whereby CMS would extrapolate audit findings across plan revenue. *See* 2023 Risk Adjustment Data Validation Rule Fact Sheet (CMS-4185-F2). OIG then released a definitive "Toolkit to Help Decrease Improper Payments in Medicare Advantage," which became the industry standard for internal auditing in 2024. This toolkit follows form of the shadow audits that Mr. Mazik performed. New OIG Compliance Guidance, issued in February 2026, now mandates exactly what Mr. Mazik found missing at Kaiser: two-way auditing, NPI-level monitoring and audit finding extrapolation.

B. The United States elected to pursue Mazik's claim and seek remedies for the same injuries alleged by Mazik through an alternate proceeding

1. The government was informed of Mazik's allegations, declined to intervene and elected to pursued this action without joining Mazik

On April 1, 2019, Mr. Mazik filed his original complaint under seal, and the sealed complaint and disclosure statement were served on the government. On February 25, 2021, Mr. Mazik's counsel provided the government confidentially with a final draft of an amended complaint. Friedman Decl., ¶ 11. An application to file under seal was made on March 31, 2021, and after the application was granted, Mr. Mazik's amended complaint was filed under seal on April 2, 2021. Subsequently, after discussions with the government's attorneys, two supplemental disclosure statements were served, on April 19, 2021, and on May 21, 2021. *Id*. At those times, Mr. Mazik and his counsel were unaware of any pending related actions against Kaiser under the False Claims Act. *Id*.

Through Mr. Mazik's filings and disclosures, the government learned of Mr. Mazik's allegations regarding Kaiser's RAF fraud scheme, and the software tampering that allowed the fraud to exist undetected. Mr. Mazik's disclosures went far beyond the complaint itself. He provided compelling documentary evidence, including: internal presentations showing that use of data analytics tools was supposed to be a key component in Kaiser's compliance risk-mitigation strategy; evidence that Kaiser had at its disposal various data analytics-based fraud detection tools which, if used properly, would have effectively identified the false or invalid diagnoses coding in Kaiser's EHRs; evidence that Kaiser knowingly disabled critical features and functionalities in those software applications; and Mr. Mazik's contemporaneous handwritten notes and calculations from his September 2016 ARIS database analysis revealing $209 million in Medicare Advantage overpayments. *Id*., ¶ 12.

In his supplemental disclosures, Mr. Mazik articulating his legal theories in detail – explaining the precise mechanism of Kaiser's fraudulent scheme: running a sham fraud compliance program over claims, effectively disabling Kaiser's defenses that led to the submission of false data for its members' health status and inflated RAFs. He identified specific categories of documents the government should seek through Civil Investigative Demands, including Kaiser's ARIS database, FICO Insurance Fraud Manager data, McKesson claims review data, and documentation of Kaiser's database architecture. He even suggested methodologies the government could use to analyze data and determine whether false or improper claims diagnosis code data caused Kaiser to receive higher per capita payments. *Id*., ¶ 13.

After receiving the filings and disclosures, the government chose to pursue alternate remedies here for the injuries Mr. Mazik identified – which was its right. Pursuant to the government's motion, the Court ordered consolidation of sealed cases on June 25, 2021 (ECF 61). On July 27, 2021, while the consolidated cases were sealed, the government noticed its intent to intervene (ECF 64). The Court, on July 29, 2021, ordered unsealing of the relators' complaints and the government's notice of election (ECF 65).

On October 25, 2021, the government filed a complaint-in-intervention (ECF 110), listing six consolidated actions and 10 relators, but not Mr. Mazik.

Subsequently, on December 1, 2021, the government filed a notice declining to intervene in Mazik's amended complaint. In an order issued on December 2, 2021, the Eastern District of California, Hon. John A. Mendez, directed that Mr. Mazik's amended complaint be unsealed and served upon defendants. Friedman Decl., ¶ 14.

2. The government's initial and amended complaints-in-intervention sought remedies for the same injuries identified in Mazik's claims.

In its initial complaint-in-intervention, the government elected to pursue the same causes of action alleged by Mr. Mazik, *i.e.,* the submission of monthly claims for capitated payments for Medicare Advantage enrollees using falsely inflated RAFs based on invalid or improper diagnoses codes. ECF 110, ¶¶ 2, 3, 348-351 (First Claim for Relief), 353-355 (Second Claim for Relief), and 360 (Fourth Claim for Relief). The government's complaint-in-intervention alleged the same basis for the inflated risk adjustment factors as that alleged by Mr. Mazik. *See*, *e.g., id*., at ¶¶ 137 ("the inevitable result was the widespread submission of invalid diagnosis codes for conditions that did not require or affect patient care treatment or management and whose very existence many times was contradicted by the patient's medical record"), 174 ("Kaiser often failed to alert physicians to information that directly contradicted the existence of the condition, leading to the addition of many inaccurate diagnoses via addenda, and the resulting submission of inaccurate diagnosis codes to CMS for risk-adjustment payments"). In the original complaint-in-intervention, the United States focused on Kaiser's use of addenda to manufacture false records of diagnoses coding – facts that were not part of Mr. Mazik's complaint. But the United States alleged the same core fraudulent scheme that Mr. Mazik alleged: Kaiser knowingly submitted false diagnosis codes to CMS to unlawfully and fraudulently inflate risk adjustment payments on its enrollees.

In the original complaint-in-intervention, the government also made multiple allegations that Kaiser engaged in data mining of EHRs to identify and add diagnosis

codes only when they resulted in higher payments by CMS. *Id*., ¶¶ 133-150. These facts become material when understood through the lens provided by Mr. Mazik: by turning off the data analytic tools in its compliance software, the consistent effort to insert conditions with higher reimbursement rates internally was one-sided, as the tools would have flagged claims for procedures and lab testing that were inconsistent with that patient's coding, triggering an obligation to delete the claims and audit the patient's records. Kaiser's data mining was only one-way by virtue of its deliberate tampering with the software that would have detected the scheme and precluded Kaiser from engaging in it.

On December 12, 2022, the government filed an amended complaint-in-intervention (ECF 240), maintaining the same claims for relief based upon the same RAF fraud scheme alleged by Mr. Mazik. *See* ¶¶ 378-384. Moreover, the government greatly expanded on the allegations of the widespread submission of inaccurate diagnosis codes that were contradicted by the medical records. In fact, whereas such allegations were sparse in the original pleading, in the amended pleading illuminated by Mr. Mazik's voluminous disclosures the government introduced these concepts in the second paragraph and the last paragraph before the causes of action (¶ 376), and it repeated them some 20 times throughout. Kaiser's tampering with the compliance software as revealed by Mr. Mazik was thus crucial and well understood by the government as necessary for the facilitation of the fraudulent scheme alleged by the government.

C. Following this Court's decision, Judge Drozd denied Kaiser's motion to dismiss, finding Mazik's action survived the first-to-file rule

Between the time the original and amended complaints-in-intervention were filed in this action, Kaiser defendants on January 1, 2022, filed a motion to dismiss (ECF 141) pursuant to the False Claims Act's first-to-file rule, 31 U.S.C. § 3730(b)(5). In light of the filing of the first-to-file motion here, Kaiser defendants and Mazik on January 28, 2022, agreed to stay briefing in the Eastern District of California action until 30 days after this Court ruled on the motion. Judge Mendez granted the stay on January 31, 2022.

On May 5, 2022, this Court entered an order (ECF 171), granting in part and denying in part defendants' first-to-file motion. Pursuant to the temporary stay order in the Eastern District, after this Court's ruling, the parties then briefed Kaiser defendants' motion to dismiss the *Mazik* action. On July 13, 2022, Kaiser filed a motion to dismiss relator Mazik's action, predicated in part on the first-to-file rule. Mr. Mazik opposed the motion on August 29, 2022, arguing that this Court's ruling on the first-to-file rule provided a "blueprint" for resolution of Defendants' motion to dismiss.

The Eastern District case was then reassigned to Judge Drozd. After briefing, on February 13, 2024, Judge Drozd issued an order granting in part and denying in part Kaiser defendants' motion to dismiss Mazik's complaint. (A copy of that order is included as Exhibit I, and can be found at: *Mazik v. Kaiser Permanente, Inc*., No. 19-cv-00559-DAD-KJN, 2024 U.S. Dist. LEXIS 25397 (E.D. Cal. Feb. 13, 2024)). Relevant for purposes of this motion, the court compared the allegations by Mr. Mazik to the allegations made by relator Taylor. The court concluded that Mr. Mazik's federal False Claims Act claim is "barred by the first-to-file rule except to the extent relator alleges that defendants deliberately tampered with compliance software to ensure that it did not identify erroneous diagnosis codes." Order, at 12:26-28. Because Mazik was the first relator to allege Kaiser had tampered with compliance software to achieve their unlawful ends, "'the nature of the wrongdoing claimed by [relator Mazik] here involves different "material elements" from' the wrongdoing in the Taylor Complaint" (*id*., at 13:16-19) (quoting this Court's ruling, 601 F. Supp 3d at 569). Accordingly, Judge Drozd followed this Court's ruling in the Consolidated action, and it dismissed the Mazik complaint only in part. See Order, at 14:5-16.

Importantly, Judge Drozd recognized that Mr. Mazik's allegations revealed material facts about Kaiser's fraudulent scheme that could not be learned from the relators' in this action. He wrote: "[t]here is nothing in these [Taylor] allegations that would have prompted the government to question the validity of the audits. Relator Mazik's allegations that the audits were themselves compromised would therefore

'provide[] [some] additional benefit to the government.'" Order, at 14 (quoting *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1131 (9th Cir. 2015)). Indeed, the conduct uncovered by Mr. Mazik and revealed to the government would have been difficult to uncover but for Mr. Mazik stepping forward, given that no other relator brought forth any claim based on Kaiser's throttling of compliance software – the very software intended to prevent the exact massive fraud perpetrated by Kaiser.[3]

Judge Drozd also denied Kaiser defendants' motion under Rules 9(b) and 12(b)(6). He concluded that Mr. Mazik "has sufficiently alleged a fraudulent scheme" in his amended complaint.

> Relator has alleged the "who" (defendants), the "what" (tampering with auditing software), the "when" ("since at least 2008"), the "why" (to decrease the chance of identifying errors in claims), and "how" the alleged scheme is fraudulent ("Kaiser repeatedly provided expressly false certifications that its risk adjustment data submissions to CMS were 'accurate, complete, and truthful,' while knowing that the data were, in fact, plagued with errors, and despite knowing that those errors would cause CMS to pay unjustifiably and falsely higher capitation rates."). [Order, at 15:14-19.]

Judge Drozd also found the conduct alleged by Mr. Mazik potentially "material" under the Act because it could influence the government's payment of money: "Relator has alleged . . . defendants have purposefully disabled features of their compliance software in order to avoid discovering certain errors in diagnosis codes that would reduce the capitation rates they receive." *See id.*, at 16:24-17:27.

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[3]Tellingly, of the Kaiser employees deposed by the government in its civil investigation, not one was a "Data Quality Trainer" such as Relator Ms. Osinek; they were compliance and IT audit professionals like Mr. Mazik, including: Nancy Andersen, Senior Compliance Manager with Kaiser's National Compliance Office (CID Testimony, October 1, 2020); Dr. David Bliss, Regional Director of Documentation and Coding (CID Testimony, October 2, 2020); Janet Franklin, Compliance Manager with Kaiser's National Compliance Office (CID Testimony, October 7, 2020); Karen Graham, Managing Director for Encounter Information Operations (CID Testimony, October 5, 2020); Jeremy Walsleben, Senior Manager of Risk Adjustment (CID Testimony, September 29, 2020); Teresa Welsh, Director of Coding (CID Testimony, October 2, 2020). See Stipulation and Order Regarding Admissibility of Prior Deposition and Examination Transcripts (ECF 401 at 2-3).

Pursuant to Judge Drozd's order, Mr. Mazik filed his second amended complaint (Exh. C) on March 26, 2024. He then proceeded in his *qui tam* action under § 3730(c)(3) ("If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action").

D. Under the terms of the January 14, 2026, settlement agreement, the government recovered $556 million and broadly released its claims

In the settlement announced on January 14, 2026, the government recovered $556 million, plus interest at a rate of 4.250% per annum from October 15, 2025, until and including the day of payment. *See* Exh. A. This is the largest recovery in history to date in a False Claims Act involving Medicare Part C. It results in the release and dismissal of all "covered conduct" claims – as defined by the broad scope of the government's amended complaint-in-intervention. According to the press release, relators Osinek and Taylor shall received approximately $95 million, a 17% share.

E. Mazik gave notice of his claim and filed this motion

On January 15, 2026 – one day after learning of the settlement – Mr. Mazik gave notice to the Court and the parties of his claim to a share of the settlement proceeds under the alternate remedy provision of the Act (ECF 422). On January 30, 2026, Mr. Mazik and the parties filed a joint response confirming their agreement that the settlement remains valid (ECF 429).

Mr. Mazik filed administrative motions seeking an extension of time to file his motion (ECF 430) and for a special conference or an order granting access to the settlement and share agreements (ECF 435). The Court denied without prejudice the request for access to the agreements, directing Mr. Mazik at this juncture to address entitlement to any share (ECF 438).[4] The Court extended the time for filing the motion to February 25, 2025. Mr. Mazik now files this motion seeking an order recognizing his right to a share, and requesting an 8% share of the settlement proceeds.

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[4]As argued below, the Court may award Mr. Mazik his requested share of the settlement without further proceedings. However, Mr. Mazik will renew his request if the Court desires further briefing, or if any opposition so warrants it.

ARGUMENT

I. Mazik is entitled to a share under the clear wording of the statute

"The FCA, which Congress originally enacted in 1863, is the government's 'primary litigative tool for combatting fraud' against the federal government." *United States ex rel. Kelly v. Boeing Co.*, 9 F.3d 743, 745 (9th Cir. 1993) (citing Senate Judiciary Committee, False Claims Amendments Act of 1986, S. Rep. No. 345, 99th Cong., 2d Sess. 2 (1986), reprinted in 1986 U.S.C.C.A.N. 5266). Congress queried "why fraud in Government programs is so pervasive yet seldom detected and rarely prosecuted." S. Rep. No. 99-345, at 4. It found "69 percent of those who believed they had direct knowledge of illegalities failed to report the information. Those employees who chose not to report fraud were then asked why they failed to come forward. The most frequently cited reason given (53 percent) was the belief that nothing would be done to correct the activity even if reported. Fear of reprisal was the second most cited reason (37 percent)." *Id*.

Relevant for our purposes, Congress made two changes to overcome this hurdle. First, § 3730(c)(3) now allows a relator to pursue a *qui tam* case even if the government declines to intervene. This provision gave Mr. Mazik reassurance that, even if the Department of Justice declined to do something about the fraud he saw inside Kaiser, he could still move forward. Accordingly, when the government declined to intervene in his action, he persevered, knowing that if he were to recover a remedy for the United States, he would be entitled to a minimum of 25% of the proceeds.

Second, the 1986 amendments added § 3730(c)(5): "Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action **shall have the same rights** in such proceeding as such person would have had if the action had continued under this section" (emphasis supplied). This provision reassured Mr. Mazik that his "same right" to a share would be protected if the government pursued remedies for the same injuries he identified.

As the Ninth Circuit stated:

> the purpose of the statutory scheme is clear. The FCA is designed to help fight fraud against the government by encouraging private individuals to come forward with information about fraud that might otherwise remain hidden. The encouragement is provided by giving these individuals a relator's share of any recovery obtained using the relator's information in an FCA action, or an equivalent share of a recovery obtained using that same information to procure an "alternative remedy." [*United States ex rel. Barajas v. United States*, 258 F.3d 1004, 1012 (9th Cir. 2001).]

"It is entirely consistent with this purpose to read the "any alternative remedy" language of § 3730(c)(5) to mean what it says." *Id*.

The Court in *Barajas* went on:

> It can be quite difficult for private individuals – particularly for "whistleblowers" like Barajas – to come forward with damaging information about their employers. In some instances, the whistleblowers have participated in the wrongdoing (as Barajas did), and in some instances, the whistleblowers are fired because of their whistleblowing (as Barajas may have been). It would be inconsistent not only with the plain meaning of the broad language employed in the statute, but also with the purpose of the statute, to allow the government to obtain from a *qui tam* defendant a remedy that **could have been obtained** in an already-filed FCA action, and then to argue that the proceeds of that remedy need not be shared with the whistleblower because the remedy was not an "alternate remedy" within the meaning of the FCA. [*Id*. (Emphasis supplied).]

Application of § 3730(c)(5) to Mr. Mazik's claim is straightforward. Mr. Mazik was always an important insider with knowledge of key essential facts proving the massive RAF fraud that Kaiser committed. While relators Osinek and Taylor also brought important information to the government's attention, and they were first to file with those pieces in place, Mr. Mazik provided material information no other relator (or government investigator) had before he acted. No different than Leocadio Barajas, Mr. Mazik too faced significant personal risks for his whistleblowing efforts. It was the deliberate deactivation of the fraud detection software tools, however, that ultimately allowed Kaiser to hide its fraud, and without Mr. Mazik's filings and disclosures the United States would have been unable to articulate the one-way data mining set forth in its amended complaint-in-intervention.

This point is worth expanding upon. Whether or not Mr. Mazik could theoretically continue in the Eastern District with his software tampering claims and use such claims to prove how Kaiser's fraud was perpetuated, that could only lead to the same remedies the United States recovered through the settlement agreement. In other words, the material elements found in both the consolidated cases and in Mr. Mazik's action necessarily only provides the government a single remedy because there are no two Kaiser frauds – only one, even though there were several paths towards proving it: one by way of the consolidated cases and one using Mr. Mazik's fraud roadmap. *See*, *c.f., United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1131 (9th Cir. 2015) ("[A]llowing claims for related but distinct fraud claims encourages broader investigation and increases the total potential for recovery").

As in *Barajas*, "It would be inconsistent not only with the plain meaning of the broad language employed in the statute, but also with the purpose of the statute, to allow the government to obtain from [Kaiser] a remedy that could have been obtained in [Mr. Mazik's] already-filed [False Claims Act] action, and then to argue that the proceeds of that remedy need not be shared with the whistleblower." 258 F.3d at 1012. Under the clear wording of the Act, the Court should recognize Mr. Mazik's entitlement to a share of the settlement proceeds.[5]

In addition to its plain reading of the statute, *Barajas* is helpful to understand two related underlying doctrines: **claim preclusion** and **damage credit** as applied to this case. Both doctrines – and the alternate remedy provision itself – are grounded in an underlying "**one-remedy" rule**. Mr. Barajas brought two separate *qui tam* actions against Northrop

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[5] *See also United States ex rel. Bledsoe v. Community Health Systems, Inc.*, 342 F.3d 634, 649 (6th Cir. 2003) ("We therefore hold that a settlement pursued by the government in lieu of intervening in a *qui tam* action asserting the same FCA claims constitutes an 'alternate remedy' for purposes of 31 U.S.C. § 3730(c)(5)"); *In Re Pharmaceutical Industry Ave. Wholesale Price*, 892 F. Supp. 2d 341, 344 (D. Ma. 2012) ("The government effectively settled Relators' claims by approving the settlement between Ven-A-Care and Baxter, and such a separate settlement constitutes an 'alternate remedy'").

for injuries caused to the United States. The first, in which the government intervened, sought damages for test falsifications; and after that action ended in settlement, Barajas filed a second action, in which the government did not intervene, alleging defective dampening fluid. Northrop successfully moved to dismiss the second *qui tam* action on the grounds of claims preclusion, arguing that the settlement of the first *qui tam* action, concerning the falsified and incomplete tests foreclosed the second action, concerning the defective damping fluid. In an earlier appeal, the Ninth Circuit affirmed the dismissal, holding that the damping fluid complaint was precluded by claim preclusion because it arose out of the "same transactional nucleus" as the test falsification complaint.

> Application of "same transactional nucleus of fact," is quite clear here. While Barajas is plainly correct that it is one thing to have fluid that gums up in the cold, and another to lie about whether the fluid was tested for gumming up, **both wrongful acts arise out of the same attempt to get paid** for flight data transmitters not up to specifications. **The recovery in a qui tam case is not for each false statement or bad act done to the government; it is for "a false or fraudulent claim for payment or approval."** 31 U.S.C. § 3729(a)(1). [*United States ex rel. Barajas v. Northrop Corp.*, 147 F.3d 905, 910 (9th Cir. 1998) (emphasis supplied).]

The same is true here. As in *Barajas*, the transactional nucleus of facts in this case involves claims for capitated payments based on falsely inflated RAFs, which in turn are based on invalid diagnoses codes. Kaiser could therefore successfully argue that the government's settlement in this case for false RAF claim submissions extinguishes Mazik's claims for false RAF claim submissions. Even if causing internal physicians to submit false diagnostic codes through improper addenda is distinct from tampering with the software tools which would have exposed invalid coding, the recovery is for the false claims for capitated payment – which is the same underlying fraud in both the settled actions and in Mr. Mazik's suit. The settlement in this Court thus impairs Mazik's action, entitling him to a share of the proceeds.[6] *See United States v. Bisig*, 2005 U.S. Dist. LEXIS 38316, at *6 (S.D. Ind. Dec. 21, 2005) (government acknowledges that a remedy is an alternate remedy when it "precludes the continuance of a *qui tam* action").

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[6]For these reasons, relator Taylor also recovered a share and dismissed his claims.

With equal force, the *Barajas* decision exemplifies the related basis for share entitlement: the damage credit. There, the Ninth Circuit held that the relator was entitled to a share of the government's recovery of a remedy through a debarment proceeding. Although the Ninth Circuit noted the differences between a False Claims Act action and a suspension or debarment proceeding, it recognized that the government can, and sometimes does, seek a remedy in such proceedings that "effectively takes the place" of a False Claims Act remedy. Because Northrop was entitled to receive an "appropriate credit for funds paid or value received" in any separate civil proceeding – specifically, the relator's *qui tam* action – the relator in that *qui tam* action was entitled to a share. *Barajas*, 258 F.3d at 1011.

The government, the Ninth Circuit, and several other courts now recognize this well-founded rule: when the *qui tam* defendant would be entitled to claim a damage credit against the relator's action based upon money paid in an alternate proceeding, the relator is entitled to a share out of that alternate recovery. *See United States v. Van Dyck*, 866 F.3d 1130, 1135 n.3 (9th Cir. 2017) (government acknowledges that relator is entitled to claim a share to the extent that *qui tam* defendant "is entitled to a damage credit"); *United States v. Couch*, 906 F.3d 1223, 1228-29 (11th Cir. 2018) (citing *Van Dyck*).

In this case, Kaiser's settlement with the government resulted in a broad release of all covered conduct claims, meaning all claims encompassed within the government's expansive amended complaint-in-intervention. Those claims encompass the same remedy sought in Mr. Mazik's *qui tam* action. Whether under the clear terms of the statute, the force of claim preclusion, the defendants' right to a damage credit, or all three bases, the government is only entitled to recover its damages one time – effectively barring Mr. Mazik from pursuing his action in the Eastern District.

Even if Mr. Mazik *could* theoretically continue his federal *qui tam* False Claims Act claims against Kaiser, he would have to recover one dollar more than the largest settlement in the history of Part C False Claims Act recoveries before he obtained that one dollar for the federal fisc, and 25 cents for himself. No logical interpretation of the

Act would require either Mr. Mazik or the Eastern District to continue such a futile effort. Under these circumstances, the Court should hold Mr. Mazik is entitled to a share of the government's recovery.

II. No further proceedings are necessary on Mazik's request for an award of 8% of the settlement proceeds

It is no surprise that Kaiser's multi-billion dollar fraud scheme involved complex factual issues where several independent relators brought material information to the government on essential elements of its claims. When multiple relators claim entitlement to an allocation of a share, and when the relators and the government are unable to reach agreement amongst themselves on the amount of the share or its allocation, the statute entrusts those determinations to the courts. In some cases, there has been no first-to-file adjudication, and courts will take up that determination in the first instance in determine shares. In others, multiple relators are first-to-file on some aspect of the recovery, and the Courts must make an allocation determination. And, in still others, the relators' share agreements can impact who is entitled to what among the shares. *See e.g., United States ex rel. Allstate Ins. Co. v. Millenium Labs., Inc*., 464 F. Supp. 3d 449, 453 (D. Mass. 2020) (only one relator was entitled to a share under § 3730(d)(1)); *United States ex rel. Bledsoe v. Community Health Systems, Inc*., 501 F.3d 493 (6th Cir. 2007) (multiple relators were entitled to attorneys' fees in light of their sharing agreements).

In this case, however, no further proceedings are necessary to determine the amount or the apportionment of a share.

A. The Court need not conduct another first-to-file analysis

In extensive proceedings in this Court and the Ninth Circuit, it has already been determined that Ms. Osinek and Dr. Taylor survived the motions to dismiss under the first-to-file bar. Under the law of the case doctrine, that decision may not be revisited. To that end, the settlement agreement with defendants note that only those two relators in this consolidated action will share in the settlement agreements. Moreover, it was reported that, under the side-letter agreement with the government, relators Osinek and

Taylor receive a total share of $95 million. Any apportionment between themselves, or with other relators in the action, need not be reviewed by the Court.

As set forth herein, Judge Drozd already determined that Mr. Mazik's federal False Claims Act claims survived the first-to-file bar. That determination was based on this Court's ruling with respect to relator Taylor, and it was predicated on a sound and correct scrutiny of the pleadings. As such, no further proceedings are needed to apply the first-to-file bar in this action.

B. Congress set the 25% statutory floor applicable to Mazik's share

Under the express terms of the alternate remedies provision, Mr. Mazik is entitled to the same rights as if the recovery was made in his *qui tam* action. *See* § 3730(c)(5) (relator "shall have the same rights . . . as such person would have had if the action had continued"). Because the government declined to intervene, the total amount of share recovered in his case has a statutory floor of 25% and a maximum of 30%. *See* § 3730(d)(2) ("The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds"); *United States ex rel. Bibby*, 369 F. Supp. 3d 1346, 1349 (N.D. Ga. 2019) (government concedes that a relator in a non-intervened case has a minimum 25% share authorized under § 3730(d)(2)). Affording Mr. Mazik the "same rights" to which he have if the action had continued, the statutory floor for the relator's share is 25%.

C. An award of 8% does not dilute the settling relators' share

This motion does not require apportionment between Mr. Mazik and relators Osinek and Taylor. Mr. Mazik does not seek to reduce what the settling relators agreed to receive. Mr. Mazik is requesting the differential between that agreement and the statutory floor to which he is entitled to claim. As such, relators Osinek and Taylor may recover their agreed-upon $95 million award with all parties knowing this case has resolved.

Although Mr. Mazik's requested award will come from the government's share of the proceeds, such was the determination of Congress when it set the relative ranges of share recoveries for intervened and non-intervened actions, and when it required that Mr.

Mazik receive the "same rights" as he would have in his non-intervened case.

Moreover, while Mr. Mazik reserves for his reply any response to what the government has to say in opposition to this motion, he notes here that these circumstances are of its own making. The government had a right to decline intervention into Mr. Mazik's case, and to pursue its remedies on the same RAF fraud scheme in this Court. Even though he had expended considerable time and effort providing the government with detailed pleadings and disclosure statements on key facts, he was left in the dark regarding the government's progress. When Kaiser moved to have Mr. Mazik's action transferred to the Northern District, the government vigorously opposed it, filing a Statement of Interest against the motion. Mr. Mazik was led to believe he would not be left out in the cold by the government but instead he was left to fight the government's battles for it all the while he was kept out of discovery and settlement proceedings. Mr. Mazik did not even learn of the settlement until the press release on January 14. He had to act fast just to put the Court on notice of his claim – which he did the following day. The goverment should not be rewarded for its conduct by shirking the plain language of 31 U.S.C. § 3730(c)(5) and adding to the federal fisc at Mr. Mazik's significant detriment.

CONCLUSION

For the foregoing reasons, Mr. Mazik respectfully requests that the Court recognize his entitlement to a share of the government's settlement proceeds, and he be awarded 8%, in addition to, and not out of, the 17% award agreed upon for the named settling relators.

Respectfully submitted,

Dated: February 25, 2026

Law Office of Jeremy L. Friedman
Mendenhall Law Group

By: /s/Jeremy L. Friedman
Jeremy L. Friedman

Attorneys for relator Jeffrey Mazik

Exhibit E

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

May 25, 2017

Mr. Nathaniel Oubre
Vice President
Kaiser Permanente
1800 Harrison Street
Oakland, CA 94612

NOTICE OF INTENT TO IMPOSE MONETARY SANCTIONS FOR FAILURE TO COMPLY WITH CORRECTIVE ACTION PLAN

Dear Mr. Oubre:

On April 20, 2016, the Department of Health Care Services (DHCS) notified Kaiser Permanente (Kaiser) and its Plan Partners of the requirement to submit all outstanding encounter data by June 30, 2016, to the Post Adjudicated Claims and Encounters System (PACES). DHCS also notified all Medi-Cal Managed Care Plans that failure to meet the June 30, 2016, deadline for reporting all outstanding encounter data using the PACES submission process would result in the imposition of a Corrective Action Plan (CAP). On June 28, 2016, Kaiser notified DHCS that it was unable to meet the June 30 encounter data submission deadline.

On September 23, 2016, DHCS imposed a CAP on Kaiser for failure to meet its regulatory and contractual obligations for reporting encounter data. DHCS' CAP notification letter informed Kaiser that its inability to submit all retrospective encounter data by January 1, 2017, would result in the imposition of monetary sanctions. Kaiser failed to meet the January 1, 2017, deadline for submitting its retrospective encounter data. On January 13, 2017, DHCS informed Kaiser that it would impose monetary sanctions in the amount of $2,535,500 for:

- Failure to submit encounter data for external medical claims from November 2014 through September 2016 (CAP deficiency number one).
- Failure to submit Physician Administered Drugs (PAD) data from March 2010 to March 2015 (CAP deficiency number four).

In the January 13, 2017, Notice of Intent to Impose Monetary Sanctions Letter, DHCS informed Kaiser that additional monetary sanctions relating to its continued inability to submit external medical claims from October 2016 to present could result in additional monetary sanctions. DHCS also informed Kaiser that additional monetary sanctions

could be imposed for Kaiser's continued failure to submit PAD data from April 2015 to present.

DHCS and Kaiser have engaged in extensive communications pertaining to Kaiser's encounter data submission deficiencies and the CAP. This communication includes, but is not limited to:

- In person meetings held on October 18, 2016, and January 9, 2017, and April 11, 2017.
- Conference calls held on September 23, 2016, November 10, 2016, November 23, 2016, November 29, 2016, December 2, 2016, and February 27, 2017.
- DHCS' emails confirming Kaiser's CAP submissions on December 7, 2016, which was acknowledged and accepted by DHCS on December 29, 2016, and January 6, 2017, which was acknowledged and accepted by DHCS on March 6, 2017; and
- The aforementioned Notice of Intent to Impose Monetary Sanctions Letter dated January 13, 2017.

Throughout the CAP and sanctioning process, DHCS has maintained that Kaiser would be held to the January 1, 2017, compliance date for submitting missing encounter data. Additionally, DHCS has been consistant in communicating its approach to evaluate monetary sanctions quarterly until Kaiser is compliant with all encounter data submission reporting requirements identified in the CAP.

As of March 31, 2017, Kaiser was out of compliance with the following CAP requirements:

1. Submission of encounter data for external medical claims to DHCS and Kaiser's 13 Plan Partners in the PACES format for 2014, 2015, and 2016 (CAP deficiency number one).
2. Submission of correct paid claim information in the 837 Institutional encounter data format for encounters with dates of service of January 1, 2016, or later (CAP deficiency number two).
3. Submission of all institutional, professional, and pharmacy encounter data that failed to pass Kaiser's internal data quality validation process to DHCS and Kaiser's 13 Plan Partners (CAP deficiency number three).
4. Submission of all PAD data with dates of service from March 2010 through March 2015 to DHCS and Kaiser's 13 Plan Partners (CAP deficiency number four).

Under Title 22, California Code of Regulations, Section 53862, and its contract with DHCS, Kaiser is required to submit encounter data to DHCS on a monthly basis.

Kaiser's inability to submit the required encounter data warrants the imposition of monetary sanctions. Therefore, DHCS submits this Notice of Intent to Impose Sanctions as follows:

- Monetary sanctions in the amount of $99,000 for Kaiser's failure to submit encounter data for external medical claims from October 2016 through December 2016.
- Monetary sanctions in the amount of $379,500 for Kaiser's failure to submit encounter data for correct paid claim information in the 837 Institutional encounter data format from January 2016 through December 2016 (CAP deficiency number two).
- Monetary sanctions in the amount of $940,500 for Kaiser's failure to submit all institutional, professional, and pharmacy encounter data that failed to pass Kaiser's internal data quality validation process from November 2014 through March 2017 (CAP deficiency number three).
- Monetary sanctions in the amount of $792,000 for Kaiser's failure to submit all PAD data with dates of service from April 2015 through March 2017 to DHCS.

The total amount of monetary sanctions to be imposed is $2,211,000, which includes monetary sanctions that DHCS could impose on Kaiser's Plan Partners for encounter data deficiencies caused by Kaiser.

Kaiser informed DHCS that deficiency item number one (for retrospective data and dates of services beginning January 1, 2017, and all prospective data), number two (retrospective and prospective data), and number five (retrospective and prospective data) have been ameliorated. Subject to DHCS validating that these three items have been remediated, DHCS will impose no additional monetary or other sanction or penalty of any type against Kaiser or any of the Plan Partners based on or related to Kaiser's failure to submit the required encounter data as described in CAP deficiency number one, two, and five. However, if DHCS finds that these CAP deficiencies have not been remediated, additional sanctions may be assessed.

DHCS acknowledges that Kaiser is making efforts to resolve all deficiencies and that, to date, Kaiser has complied with the deliverable deadlines set forth in the January 6, 2017, CAP.

DHCS will continue to evaluate Kaiser's progress toward ameliorating its encounter data submission deficiencies related to CAP deficiency numbers three and four on a quarterly basis. The evaluation process includes the potential to impose monetary sanctions on a quarterly basis for any period of time that Kaiser has not been previously sanctioned for the deficiencies.

DHCS reserves the right to claim liquidated damages to the extent that Kaiser's encounter data reporting deficiencies causes DHCS to repay federal financial participation to the Centers for Medicare & Medicaid Services.

If you have any questions, please contact Sarah Brooks at Sarah.Brooks@dhcs.ca.gov or (916) 440-7800.

Sincerely,

Original Signed by Jennifer Kent

Jennifer Kent
Director

Enclosure

Exhibit F

MERCER

AUDITORS REPORT

CALENDAR YEAR 2017 KAISER FOUNDATION HEALTH PLAN RATE DEVELOPMENT TEMPLATE

September 9, 2020

Contents

1
Executive Summary

Pursuant to federal requirements under Title 42 of the Code of Federal Regulations 438.602(e), the California Department of Health Care Services (DHCS) must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of each Managed Care Organization (MCO) [1]. DHCS contracted with Mercer Government Human Services Consulting (Mercer) to fulfill this requirement for the financial data submitted in the Medi-Cal Rate Development Template (RDT) for calendar year (CY) 2017 by the Kaiser Foundation Health Plan (KFHP). Mercer designed and DHCS approved procedures to test the accuracy, truthfulness and completeness of self-reported financial data in the RDT.

The specific financial schedules selected for testing are used by Mercer as a critical part of the base data development process for capitation rate development related to the Bridge Year rating period (July 1, 2019 – December 31, 2020). The RDT tested was the final version, including any revisions stemming from resubmissions as a result of the RDT Q&A discussion guide process with the MCO.

The key schedules subject to testing from the RDT include, but were not limited to:

- Schedule 1 Utilization and Cost Experience
- Schedule 1A – Global Subcontracted Health Plan Information
- Schedule 1C – Base Period Enrollment by Month
- Schedule 5 – Large Claims Report
- Schedules 6a and 6b – Financial Reports
- Schedule 7 – Lag Payment Information

The data collected in the RDT is reported on a modified accrual (incurred) basis for CY 2017 and does not follow Generally Accepted Accounting Principles with regards to retroactivity from prior year activity, including claim or capitation accruals, retroactive enrollment or termination of enrollment of members from prior years. The data provided is designed to report only financial and enrollment activity incurred for the calendar year reported.

The procedures and results of the test work are enumerated in Table 1 of Section 2.

[1] 42 CFR 438.602(e)

2
Procedures and Results

We have performed the procedures enumerated in Table 1 below, which were designed by Mercer and were reviewed and agreed to by DHCS, solely to test the completeness, accuracy and truthfulness of information reported in the Medi-Cal RDT from KFHP for the CY 2017. KFHP's management is responsible for the content of the RDT and responded timely to all requests for information.

Table 1: Procedures

Category	Description	Results
Utilization and Cost Experience	We compared summarized total net cost data from amounts reported in Schedule 1 to Direct Medi-Cal category of service (COS) totals from Schedule 6a and to total incurred claims by COS for Schedule 7 for consistency.	Schedule 1 is overstated by 0.05% when compared to Schedule 6a and no material variance when compared to Schedule 7.
Member Months	We compared MCO reported member months from Schedule 1C to eligibility and enrollment information provided by the State. Our procedures are to request explanations for any member months with greater than 1% variance in total or greater than 2% variance by major category of aid.	Variance: RDT overstated by 0.07% in total.
Capitation Revenue	We discussed how capitation was recorded. KFHP records capitation revenue on an accrual basis using eligibility from the 834 data multiplied by rates established on the most current rate sheet received from DHCS.	Variance: Schedule 6a is understated by 0.47% or $2,382,916, based on estimated revenue calculation using the known capitation rates in place during 2017.
Interest and Investment Income	We requested interest and investment income for the MCO entity as a whole and information regarding how the income provided in Schedule 6a was allocated to the Medi-Cal line of business. Interest and Investment income was not reported on the CY2017 RDT. Per discussion with KFHP, no amount was reported on the RDT due to the losses incurred for KFHP on the Medi-Cal program, therefore no interest/investment income earned on this line of business. However, KFHP provided support for an amount that was applicable to the Medi-Cal line of business, thus this was the amount used by Mercer as the RDT reported variance.	Variance: RDT is understated by 100.00%, $1,448,334, or 0.28% of Net Revenue.

Category	Description	Results
Fee For Service Medical Expense	Using data files (paid claims files) provided by KFHP, we sampled and tested transactions for each major category of service (COS) (Inpatient, Outpatient, Physician, Pharmacy, Facility-Long Term Care (LTC), and All Others) and traced sample transactions through KFHP claims processing system, the payment remittance advice, and the bank statements.	No variance observed.
	We compared detailed lag tables for each major COS (Inpatient, Outpatient, Physician, Pharmacy, Facility- (LTC), and All Others) created from the data files provided by KFHP and compared the information reported in Schedule 7. We compared the paid claims amounts from Schedule 7, line 35 to total paid claims prior to the additional runout detail included in the data files, expecting no changes.	Variance: RDT understated in total by 1.82% of total FFS claims payments reported on Schedule 7, or $9,308,084.
	We compared total final incurred amounts including incurred but not reported (IBNR) estimates from Schedule 7 to total paid amounts from all months reported in the data files to verify the accuracy/reasonableness of IBNR for each COS. Allowable absolute value variances were deemed to be not greater than 2% for inpatient claims and 1% for all other COS.	Variance: RDT over/(understated): Inpatient (7.37%); LTC (15.39%); Outpatient (0.72%); Pharmacy (1.55%); Physician 0.14%; All Other (5.58%); In Total (1.82%), or $9,303,585.
	We confirmed and observed pharmacy benefit manager (PBM) fees were inappropriately recorded as pharmacy expense and included in pharmacy FFS claims expenses in the RDT.	Variance: RDT Pharmacy expense line item was overstated by 2.74%, or $1,859,701.
	We reviewed a sample of claims from each COS to verify control totals, verify eligibility, confirm the COS grouping was correct, and confirm the year reported was correct.	Control totals: No variance noted. Eligibility: Verified for all members selected. COS Map: No variance noted. Service Year: No variance noted.
Sub-capitated Medical Expense	We compared reported sub-capitation payments to amounts reported in Schedule 7.	Variance: RDT overstated by 0.14%, or $361,801.
	We sampled membership from three subcontractors, verified eligibility of members and analyzed claims to verify none of the FFS claims paid should have been paid by the sub-capitated provider.	No variance noted.

Category	Description	Results
	We reviewed subcontract agreements and recalculated payment amounts for reasonableness.	Variance: RDT is overstated by 18.25%, or $24,226,396, based on contracted PMPM rates. Variance attributed to additional dollar-for-dollar reimbursements in contract; detail was not sufficient to validate amount reported.
	We attempted to observe proof of payments for a sample of sub-capitated provider payments.	Variance: We were unable to validate sub-capitated medical expense payments as they are journal entry items only in the KFHP organization rather than actual payments.
Provider Incentive Arrangements	We reviewed incentive arrangements and observed sample calculations for contractual compliance and reasonableness.	Variance: RDT is understated by 100.00% as there was nothing reported on the RDT. However, the net amount was $369 and not material.
Administrative Expenses	We benchmarked administrative expenses as a percentage of capitation across all Two-Plan/GMC plans and compared to the amount reported in Schedule 6a, taking into consideration the membership size of the plan under review when reviewing the results.	The benchmark administrative percentage was 5.50% and KFHP reported 5.57%.
	We compared detailed line items from the plan's trial balance mapped to line items in Schedule 6a for reasonableness. We reviewed allocation methodologies and recalculated for reasonableness.	Variance: The RDT is understated by 7.59%, or $1,859,701. PBM fees were reported in medical expense and should have been reported in administrative expense.
Utilization Management, Quality Assurance, Care Coordination (UM/QA/CC)	We interviewed financial management to determine how health care quality improvement activities such as care coordination are isolated from general administrative expenses in the general ledger. We compared UM/QA/CC costs as a percentage of revenue to benchmark for reasonableness. Confirmed with KFHP management via interview that UM/QA/CC costs were not also included in general administrative expenses.	The benchmark UM/QA/CC percentage was 1.23% and KFHP reported 0.29%.

Category	Description	Results
Pharmacy	We confirmed and observed PBM fees were inappropriately recorded as pharmacy expense and included in pharmacy FFS claims expenses in the RDT.	Variance: As mentioned above, PBM fees of $1,859,701 were incorrectly reported on the pharmacy expense line item in the medical cost section of the RDT.
Other Information	We reviewed the audited financial statements for the plan for the CY 2017 for a clean audit opinion or identification of significant deficiencies or material weaknesses.	No variance noted.
	We compared reported expenses, including IBNR and administrative expenses, to audited financial statements for consistency.	Audited Financials are for Kaiser Foundation Health Plan, Inc. and subsidiaries (Health Plans) and Kaiser Foundation Hospitals and Subsidiaries (Hospitals). Therefore, internal financials were used to complete this test. See results below.
	We compared reported expenses, including IBNR and administrative expenses, to internal financial statements for consistency.	No material variances noted.
	We inquired how hospital-acquired conditions (HACs) were treated in the RDT and policies for payment.	Possible HACs are identified by Quality and Risk, Infection Prevention, or coding teams at Kaiser Hospitals, and billing is stopped pending review, consistent with CDC guidelines. KFHP does not pay any Kaiser hospital or any external hospital for treatment of HACs and no cost to provide HAC care is included in KFHP's RDT.

3 Summary of Findings

Based on the procedures performed, the total amount of gross medical expenditures in the RDT were understated by $6,848,247 or 1.33% of total medical expenditures in the CY 2017 RDT.

Based on the procedures performed, administrative expenditures in the RDT were understated by $1,859,701 or 7.59% of total administrative expenditures in the CY 2017 RDT.

Based on the defined variance threshold, the results of the audit for medical expenditures are determined to be immaterial and do not warrant corrective action.

Based on the defined variance threshold, the results of the audit for administrative expenditures are determined to be a significant variance. The variance is primarily due to the misclassification of PBM fees as medical rather than administrative. KFHP should report these fees correctly in the future to accurately reflect administrative expenses on the appropriate line items in the relevant RDT schedules.

KFHP has reviewed this report and had the following response:

KFHP has reviewed the CY2017 RDT audit findings and note that there were no material differences on medical expense. Although KPHP acknowledges that in CY 2017 we did not reclass any PBM fees to admin expense, we believe that auditor's estimate of $1.9 million is overstated and the actual number is around $0.3 million. Starting with our CY2019 RDTs, KFHP now reclasses estimated PBM-like fees from medical expense to admin. KFHP acknowledges that we sent the auditors our non-operating interest and investment income on a PMPM basis for 2017. However, as we run a large negative cash flow from our Medi-Cal business, none of this can be attributed to our Medi-Cal line of business and it was appropriate for us to exclude it from our CY2017 RDT. For sub-capitated medical expense an overstatement of $24 million was noted related to dollar for dollar reimbursements. This expense was not overstated and KFHP provided the auditors a reconciliation of RDT capitated expense that tied to our audited financial statements as support. It is KFHP's normal practice to reimburse the Permanente Medical Groups through inter-entity accounting and the journal entries referenced in the audit report represent actual payments. Thank you for the many meetings and communications as we worked though this first RDT audit.

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