

1 SHEPPARD, MULLIN, RICHTER & HAMPTON LLP  
 A Limited Liability Partnership  
 2 Including Professional Corporations  
 CHARLES L. KREINDLER, Cal. Bar No. 119933  
 3 BARBARA E. TAYLOR, Cal. Bar No. 166374  
 MATTHEW LIN, Cal. Bar No. 328852  
 4 333 South Hope Street, 43rd Floor  
 Los Angeles, California 90071-1422  
 5 Telephone: 213.620.1780  
 Facsimile: 213.620.1398  
 6 E mail ckreindler@sheppardmullin.com  
 btaylor@sheppardmullin.com  
 7 mlin@sheppardmullin.com

8 Attorneys for Defendants KAISER  
 FOUNDATION HEALTH PLAN, INC.,  
 9 KAISER FOUNDATION HOSPITALS, THE  
 PERMANENTE MEDICAL GROUP, INC.,  
 10 SOUTHERN CALIFORNIA PERMANENTE  
 MEDICAL GROUP, and COLORADO  
 11 PERMANENTE MEDICAL GROUP, P.C.

12  
 13 UNITED STATES DISTRICT COURT  
 14 EASTERN DISTRICT OF CALIFORNIA  
 15

16 UNITED STATES *et al. ex rel.*  
 17 JEFFREY MAZIK,

18 Plaintiffs,

19 v.

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

22 Defendants.  
 23

Case No. 2:19-cv-0559 JAM-KJN

Judge: Hon. John A. Mendez

**NOTICE OF MOTION AND MOTION TO  
 DISMISS FIRST AMENDED  
 COMPLAINT; MEMORANDUM OF  
 POINTS AND AUTHORITIES**

[Fed. R. Civ. P. 12(b)(1), 12(b)(6)]

*[Filed concurrently with Request for Judicial  
 Notice; [Proposed] Order]*

Hearing Date: October 18, 2022

Time: 1:30 p.m.

Place: Courtroom 6, 14th Floor

Complaint Filed: April 1, 2019

First Amended Complaint Filed: April 2, 2021

Trial Date: None Set

1           **TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD: PLEASE TAKE**  
2 **NOTICE** that on October 18, 2022, at 1:30 p.m. (or as soon thereafter as the matter may be  
3 heard), in the above-entitled court, located at Courtroom 6, 14th Floor, Robert T. Matsui U.S.  
4 Courthouse, 501 I Street, Sacramento, CA 95814, Defendants Kaiser Foundation Health Plan, Inc.,  
5 Kaiser Foundation Hospitals,<sup>1</sup> The Permanente Medical Group, Inc., Southern California  
6 Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (collectively  
7 “Defendants”)<sup>2</sup> will and hereby do move, pursuant to Rules 12(b)(1) and 12(b)(6) of the Federal  
8 Rules of Civil Procedure, to dismiss Relator Jeffrey Mazik’s First Amended Complaint (“FAC”)  
9 on the following grounds:

10           Count I, for alleged violations of the federal False Claims Act (“FCA”), must be dismissed  
11 because it is based on the same material facts as an earlier-filed *qui tam* complaint and therefore is  
12 jurisdictionally barred by the FCA’s first-to-file bar, 31 U.S.C. § 3730(b)(5). Count I must also be  
13 dismissed because Mazik fails to allege both falsity and materiality and improperly relies on group  
14 pleading. His conspiracy claim in Count I fails for the additional reason that Mazik does not allege  
15 an agreement between Defendants to violate the FCA.

16           Counts II–V, VII, and VIII, for alleged violations of various state FCAs, must be dismissed  
17 because they are based on the same facts as the federal FCA claims and so Mazik similarly fails to  
18 allege materiality and falsity. Additionally, Mazik fails to allege facts critical to his state FCA  
19 claims, including information about the state programs at issue and facts about Defendants’  
20 operations in each state.

21           Finally, Counts IX–XII, for alleged retaliation, must be dismissed because Mazik fails to  
22 identify which Defendant employed him and fails to allege that Defendants were aware that he  
23 was engaged in any protected activity.

24 \_\_\_\_\_  
25 <sup>1</sup> The FAC names “Kaiser Foundation Hospitals, Inc.,” which Defendants have interpreted as a  
reference to “Kaiser Foundation Hospitals.”

26 <sup>2</sup> The FAC names Kaiser Foundation Health Plan, Inc. (“KFHP”), Kaiser Foundation Hospitals  
27 (“KFH”), and The Permanente Medical Groups (“PMGs”), referring to them collectively as  
28 “Defendants’ and/or or ‘Kaiser.’” FAC ¶1. Pursuant to stipulation and order (Dkt. 69), the FAC’s  
references to “The Permanente Medical Groups,” which is not an entity, have been replaced with  
The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and  
Colorado Permanente Medical Group, P.C. These three entities are referred to herein as “PMGs.”

1 This motion is made following the conference of counsel pursuant to the Court's standing  
2 order which took place on July 8, 2022. This motion is based on this Notice of Motion and  
3 Motion, the attached Memorandum of Points and Authorities, all other pleadings and papers on  
4 file in this action, any oral argument at the hearing on the Motion, and any further matters of  
5 which this Court may take judicial notice.

6 Dated: July 13, 2022

7 SHEPPARD, MULLIN, RICHTER & HAMPTON LLP

8  
9 By

/s/ Charles L. Kreindler

CHARLES L. KREINDLER

10 Attorneys for Defendants KAISER FOUNDATION  
11 HEALTH PLAN, INC., KAISER FOUNDATION  
12 HOSPITALS, THE PERMANENTE MEDICAL  
13 GROUP, INC., SOUTHERN CALIFORNIA  
14 PERMANENTE MEDICAL GROUP, and  
15 COLORADO PERMANENTE MEDICAL GROUP,  
16 P.C.  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

|   | <b>Page</b> |
|---|-------------|
| 1 I. INTRODUCTION.....  | 1           |
| 2   |             |
| 3 II. BACKGROUND.....   | 3           |
| 4 A. The Medicare Advantage Program.....                                      | 3           |
| 5 B. Dr. Taylor’s External-Provider Allegations .....                         | 4           |
| 6 C. Mazik’s Allegations .....  | 5           |
| 7 III. LEGAL STANDARDS.....   | 6           |
| 8 IV. ARGUMENT .....  | 7           |
| 9 A. The Federal FCA’s First-to-File Bar Bars Mazik’s Federal FCA Claim ..... | 7           |
| 10 B. Mazik Fails to Plead a Federal or State FCA Fraud Claim Under Rule      |             |
| 11 12(b)(6).....  | 10          |
| 12 1. The FAC Fails to Plead a Fraudulent Scheme .....                        | 10          |
| 13 2. The FAC Fails to Plead Materiality .....                                | 12          |
| 14 3. The FAC Fails to Plead Conspiracy .....                                 | 13          |
| 15 4. The FAC Fails to Plead a Fraud Claim Under State FCAs .....             | 13          |
| 16 5. The FAC Impermissibly Groups Defendants.....                            | 14          |
| 17 C. The Court Should Dismiss Mazik’s Retaliation Claims .....               | 15          |
| 18 V. CONCLUSION .....  | 15          |
| 19  |             |
| 20  |             |
| 21  |             |
| 22  |             |
| 23  |             |
| 24  |             |
| 25  |             |
| 26  |             |
| 27  |             |
| 28  |             |

**TABLE OF AUTHORITIES**

|  | <b>Page</b> |
|--|-------------|
| 1 <b><u>CASES</u></b>  |             |
| 2 <i>Bell Atl. Corp. v. Twombly</i> ,                                  |             |
| 3     550 U.S. 544 (2007) .....  | 6           |
| 4 <i>Cafasso, U.S. ex rel. v. Gen. Dynamics C4 Sys., Inc.</i> ,        |             |
| 5     637 F.3d 1047 (9th Cir. 2011) .....                              | 15          |
| 6 <i>California v. Altus Fin.</i> ,                                    |             |
| 7     36 Cal. 4th 1284 (2005) .....                                    | 13          |
| 8 <i>Ebeid ex rel. United States v. Lungwitz</i> ,                     |             |
| 9     616 F.3d 993 (9th Cir. 2010) .....                               | 11          |
| 10 <i>Hausauer v. City of Mesa</i> ,                                   |             |
| 11     2020 WL 2735970 (D. Ariz. May 26, 2020) .....                   | 14, 15      |
| 12 <i>Hawaii ex rel. Torricer v. Liberty Dialysis-Hawaii LLC</i> ,     |             |
| 13     512 F. Supp. 3d 1096 (D. Haw. 2021) .....                       | 13          |
| 14 <i>In re Nat. Gas Royalties Qui Tam Litig.</i> ,                    |             |
| 15     566 F.3d 959 (10th Cir. 2009) .....                             | 9           |
| 16 <i>Killgore v. Specpro Pro. Servs., LLC</i> ,                       |             |
| 17     2019 WL 6911975 (N.D. Cal. Dec. 19, 2019) .....                 | 15          |
| 18 <i>Knudsen v. Sprint Commc'ns Co.</i> ,                             |             |
| 19     2016 WL 4548924 (N.D. Cal. Sept. 1, 2016) .....                 | 13          |
| 20 <i>McVeigh v. Recology S.F.</i> ,                                   |             |
| 21     213 Cal. App. 4th 443 (2013) .....                              | 15          |
| 22 <i>Murray v. Cmty. Health Sys. Prof. Corp.</i> ,                    |             |
| 23     811 S.E.2d 531 (Ga. Ct. App. 2018) .....                        | 14          |
| 24 <i>Sepehry-Fard v. Countrywide Home Loans, Inc.</i> ,               |             |
| 25     2014 WL 2707738 (N.D. Cal. June 13, 2004) .....                 | 9           |
| 26 <i>Swartz v. KPMG LLP</i> ,   |             |
| 27     476 F.3d 756 (9th Cir. 2007) .....                              | 14          |
| 28 <i>U.S. ex rel. Batiste v. SLM Corp.</i> ,                          |             |
| 659 F.3d 1204 (D.C. Cir. 2011) .....                                   | 7, 10       |
| <i>U.S. ex rel. Branch Consultants v. Allstate Ins. Co.</i> ,          |             |
| 560 F.3d 371 (5th Cir. 2009) .....                                     | 7           |
| <i>U.S. ex rel. Campie v. Gilead Scis., Inc.</i> ,                     |             |
| 862 F.3d 890 (9th Cir. 2017) .....                                     | 15          |
| <i>U.S. ex rel. Dahlstorm v. Sauk-Suiattle Indian Tribe of Wash.</i> , |             |
| 2019 WL 4082944 (W.D. Wash. Aug. 29, 2019) .....                       | 13          |
| <i>U.S. ex rel. Dresser v. Qualium Corp.</i> ,                         |             |
| 2016 WL 3880763 (N.D. Cal. July 18, 2016) .....                        | 12, 13      |

**TABLE OF AUTHORITIES**

(continued)

|  | <b>Page</b> |
|--|-------------|
| 1 <i>U.S. ex rel. Hampton v. Columbia/HCA Healthcare Corp.</i> ,   |             |
| 2 318 F.3d 214 (D.C. Cir. 2003) .....                              | 9           |
| 3 <i>U.S. ex rel. Lee v. Corinthian Coll.</i> ,                    |             |
| 4 655 F.3d 984 (9th Cir. 2011).....                                | 10          |
| 5 <i>U.S. ex rel. Lovato v. Kindred Healthcare, Inc.</i> ,         |             |
| 6 2020 WL 9160872 (D. Colo. Dec. 14, 2020).....                    | 13          |
| 7 <i>U.S. ex rel. Lujan v. Hughes Aircraft Co.</i> ,               |             |
| 8 243 F.3d 1181 (9th Cir. 2001).....                               | 6, 7, 9     |
| 9 <i>U.S. ex rel. Marion v. Heald Coll., LLC</i> ,                 |             |
| 10 2015 WL 4512843 (N.D. Cal. July 24, 2015).....                  | 13          |
| 11 <i>U.S. ex rel. Osinek v. Kaiser Permanente</i> ,               |             |
| 12 Case No. 13-cv-3891 (N.D. Cal.).....                            | 4           |
| 13 <i>U.S. ex rel. Osinek v. Permanente Med. Grp., Inc.</i> ,      |             |
| 14 2022 WL 1422944 (N.D. Cal. May 5, 2022) .....                   | 4, 7, 8, 9  |
| 15 <i>U.S. ex rel. Silingo v. WellPoint, Inc.</i> ,                |             |
| 16 904 F.3d 667 (9th Cir. 2018).....                               | 3           |
| 17 <i>U.S. ex rel. Sirls v. Kindred Healthcare, Inc.</i> ,         |             |
| 18 517 F. Supp. 3d 367 (E.D. Pa. 2021) .....                       | 13          |
| 19 <i>United States v. Comstor Corp.</i> ,                         |             |
| 20 308 F. Supp. 3d 56 (D.D.C. 2018) .....                          | 12          |
| 21 <i>United States v. NDUTIME Youth &amp; Fam. Servs., Inc.</i> , |             |
| 22 2020 WL 5507217 (E.D. Va. Sept. 11, 2020).....                  | 13          |
| 23 <i>United States v. Somnia, Inc.</i> ,                          |             |
| 24 2018 WL 684765 (E.D. Cal. Feb. 2, 2018) .....                   | 15          |
| 25 <i>United States v. United Healthcare Ins. Co.</i> ,            |             |
| 26 848 F.3d 1161 (9th Cir. 2016).....                              | 14          |
| 27 <i>UnitedHealthcare Ins. Co. v. Becerra</i> ,                   |             |
| 28 16 F.4th 867 (D.C. Cir. 2021) .....                             | 3, 4        |
| <i>Universal Health Servs., Inc. v. United States</i> ,            |             |
| 579 U.S. 176 (2016) .....  | 12          |
| <b><u>STATUTES</u></b>   |             |
| 31 U.S.C. § 3730(b)(5).....  | 1, 6, 7     |
| 42 U.S.C. § 1395w-23(a)(1)(C)(i).....                              | 3           |
| 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3).....                      | 3           |
| Ga. Code Ann. § 23-3-127 .....                                     | 14          |

**TABLE OF AUTHORITIES**  
**(continued)**

|                                   | <b>Page</b>  |
|-----------------------------------|--------------|
| 1 <b><u>RULES</u></b>             |              |
| 2 Fed. R. Civ. P. 12(b)(1).....   | 6            |
| 3 Fed. R. Civ. P. 12(b)(6).....   | 6            |
| 4 Fed. R. Civ. P. 8 .....         | 1, 12        |
| 5 Fed. R. Civ. P. 9(b).....       | 2, 6, 10, 12 |
| 6 <b><u>REGULATIONS</u></b>       |              |
| 7 42 C.F.R. § 422.308(c)(2) ..... | 3            |
| 8 42 C.F.R. § 422.504(l).....     | 4            |
| 9                                 |              |
| 10                                |              |
| 11                                |              |
| 12                                |              |
| 13                                |              |
| 14                                |              |
| 15                                |              |
| 16                                |              |
| 17                                |              |
| 18                                |              |
| 19                                |              |
| 20                                |              |
| 21                                |              |
| 22                                |              |
| 23                                |              |
| 24                                |              |
| 25                                |              |
| 26                                |              |
| 27                                |              |
| 28                                |              |

1 **MEMORANDUM OF POINT AND AUTHORITIES**

2 **I. INTRODUCTION**

3 Relator Jeffrey Mazik was terminated by “Kaiser”<sup>1</sup> in 2017 for deficient performance.  
4 While he was employed, he expressed no intent to report potential fraud to the government.  
5 Instead, he took two years to file a lawsuit against Defendants<sup>2</sup>—a range of entities affiliated with  
6 the Kaiser Permanente brand that he lumps together as “Kaiser.” His original Complaint, 117  
7 pages of unfocused and rambling allegations, revolved around Defendants’ alleged failure to  
8 adequately monitor claims for reimbursement submitted by “external providers,” a theory already  
9 alleged by Dr. James Taylor five years earlier in a different *qui tam* action under the federal False  
10 Claims Act (“FCA”). To salvage his case, Mazik retained new counsel and spent another two  
11 years revising his complaint, a process that resulted in a First Amended Complaint (“FAC”),  
12 which is deficient for some of the same reasons and for additional reasons of its own.

13 To start, the FCA’s first-to-file bar requires dismissal of Mazik’s FCA fraud claim. The  
14 first-to-file bar, 31 U.S.C. § 3730(b)(5), prohibits duplicative suits that add nothing to the United  
15 States’ investigation of fraud claims. Because Dr. Taylor alleged essentially the same scheme as  
16 Mazik years earlier, the United States *already* had notice of any purported fraud related to KFHP  
17 and other Kaiser Permanente-affiliated entities’ submission of diagnosis codes based on external-  
18 provider data at the time Mazik filed his complaint.

19 The FAC fails in its entirety for multiple other independent reasons. While the FAC seems  
20 to center Mazik’s claims on the mechanics of Medicare Advantage, particularly how risk-  
21 adjustment data submitted to the U.S. Centers for Medicare and Medicaid Services (“CMS”)  
22 factors into CMS’s payment model, Mazik still fails to allege the most basic elements of an FCA  
23 violation, including the “who, what, when, where, and how” of the alleged fraud. With only vague  
24 allegations and Mazik’s own hypotheses for factual support, the FAC lacks the plausibility and  
25 particularity necessary to state a claim under either Rule 8, or the more stringent pleading

26 \_\_\_\_\_  
27 <sup>1</sup> Mazik does not allege which Defendant, if any, employed him. *See* FAC ¶¶ 10–11.

28 <sup>2</sup> “Defendants” means Kaiser Foundation Health Plan (“KFHP”), Kaiser Foundation Hospitals (“KFH”), The Permanente Medical Group, Southern California Permanente Medical Group, and Colorado Permanente Medical Group (collectively, the “PMGs”).

1 standards of Rule 9(b) applicable to fraud claims. Indeed, the FAC is even *less specific* than the  
2 original Complaint, given the FAC drops the only alleged examples of actual overpayments.<sup>3</sup>

3 Mazik’s FAC seeks to establish a “fraudulent capitation rate scheme” based on his opinion  
4 that “Kaiser’s” compliance program was inadequate and conclusions he reached from self-  
5 generated “audits” and data review. But Mazik’s leap—from perceiving some potential for  
6 overpayment to concluding that false claims were in fact submitted to the government—falls flat.  
7 Nowhere in the FAC does he allege that (1) false claims were actually submitted to government  
8 payers, (2) false certifications were actually made to the government for risk-adjustment data, or  
9 (3) overpayments were actually made to any Defendants that were not reported and returned. And  
10 for good reason—he had no basis for such knowledge. Even though Mazik held a compliance  
11 position, FAC ¶¶ 10–12, he does not allege he was in a position to connect his hunches to the  
12 larger picture—he does not allege he was involved in compiling and submitting risk-adjustment  
13 data to CMS or any other government payer, reporting and recovering overpayments to external  
14 providers, or returning overpayments by government payers. And he does not allege he actually  
15 reviewed external-provider claims or acted to verify diagnoses or diagnosis codes.

16 It is telling that Mazik seeks to sustain a federal FCA claim based on Medicare Advantage  
17 risk adjustment without even identifying any diagnosis codes that were false or explaining how  
18 they were false. He makes no effort to allege the requisite materiality—that any purportedly false  
19 claims actually affected the amount of government payments. The same flaws foreclose his  
20 boilerplate state FCA claims, which lack any factual allegations showing overpayments were  
21 received from Medicaid programs.

22 Finally, the FAC’s employment retaliation claims fail because Mazik does not even allege  
23 who his employer was or that he engaged in “protected activity” of which his employer was  
24 aware. For all these reasons, the FAC should be dismissed in full.

25  
26 \_\_\_\_\_  
27 <sup>3</sup> The original Complaint alleged specific examples of false claims. *See* Compl. ¶ 168 (identifying  
28 ten patients who allegedly received excessive diabetes test strips). It also alleged a specific  
procedure code that was misused and allegedly led to \$3,800 in inflated claims. *See id.* ¶¶ 146–47.  
These allegations (or anything as detailed) are missing in the FAC. Even so, Defendants do not  
concede that the original Complaint would have satisfied the requisite pleading standards.

1 **II. BACKGROUND**

2 **A. The Medicare Advantage Program**

3 Mazik alleges that Defendants knowingly engaged in a scheme to submit false claims to  
4 Medicare Advantage, Special Needs Plans (“SNPs”), and state-administered Medicaid programs.  
5 He alleges the SNPs and Medicaid programs operate on “substantially the same” payment model  
6 as Medicare Advantage, FAC ¶ 33, without material description of them.

7 Medicare is a federal health insurance program for older adults and individuals with  
8 disabilities administered by CMS. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 872 (D.C.  
9 Cir. 2021). Traditional Medicare consists of Medicare Part A, which covers inpatient hospital care,  
10 and Medicare Part B, which covers outpatient medical care. *Id.* Medicare Part C, also called  
11 Medicare Advantage, allows beneficiaries to receive healthcare coverage from private insurers  
12 known as Medicare Advantage Organizations (“MAOs”), such as KFHP. *Id.*

13 MAOs “provide Medicare benefits in exchange for a fixed monthly fee per person enrolled  
14 in the program—regardless of actual healthcare usage.” *Id.* at 872. CMS determines this flat  
15 monthly rate through an annual bidding process and then applies a risk-adjustment payment  
16 model, which adjusts the payment rate based on demographic and health factors that can affect  
17 healthcare expenses, including age, gender, and medical diagnoses. *See* 42 U.S.C. § 1395w-  
18 23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2). MAOs “obtain diagnosis codes from healthcare  
19 providers” after providers have medical visits with members.<sup>4</sup> *U.S. ex rel. Silingo v. WellPoint,*  
20 *Inc.*, 904 F.3d 667, 672 (9th Cir. 2018); *see also* 42 U.S.C. § 1395w-23(a)(1)(C)(i). The MAOs  
21 report the codes to CMS, which uses the codes to calculate payment rates for each member. *See* 42  
22 U.S.C. § 1395w-23(a)(1)(C)(i). CMS compensates MAOs based on only those medical conditions  
23 reported for service dates occurring in the previous calendar year. *Silingo*, 904 F.3d at 672.

24 CMS’s risk-adjustment payment model groups diagnosis codes into Hierarchical Condition  
25 Categories (“HCCs”). 42 U.S.C. § 1395w-23(a)(1)(C)(i). Each HCC is assigned a different  
26

27 <sup>4</sup> “Members” refers to the individual Medicare beneficiaries who are enrolled in the Medicare  
28 Advantage program and receive their healthcare coverage through an MAO. Members become  
patients when they receive medical care covered by the Medicare Advantage program. For  
purposes of this Motion, the terms “members,” “beneficiaries,” and “patients” are synonymous.

1 “relative factor,” which corresponds to that HCC’s relative effect on the payment amount to the  
2 MAO. *Becerra*, 16 F.4th at 874-75. The risk score is then used to compute the adjustment to the  
3 flat monthly payment for that member. *Id.* Not all diagnosis codes are assigned HCCs, and thus  
4 not all diagnosis codes will impact the risk score and eventual payment.

5 CMS also requires MAOs to submit attestations to CMS representing that the risk-  
6 adjustment data they submitted were accurate, complete, and truthful based on the MAOs’ “best  
7 knowledge, information, and belief.” 42 C.F.R. § 422.504(l).

### 8 **B. Dr. Taylor’s External-Provider Allegations**

9 Dr. James Taylor is a physician and former employee of Colorado Permanente Medical  
10 Group. *See* Request for Judicial Notice, Exh. 1, ¶ 12 (“*Taylor* FAC”). On October 22, 2014, he  
11 filed a *qui tam* complaint, alleging violations of the FCA. *U.S. ex rel. Taylor v. Kaiser*  
12 *Permanente*, Case No. 21-cv-3894 (N.D. Cal.), Dkt. No. 1. He filed the *Taylor* FAC on November  
13 3, 2014.<sup>5</sup> Like his original complaint, Dr. Taylor’s FAC named as defendants KFHP and other  
14 Kaiser Permanente-affiliated MAOs that provide healthcare coverage to members in various parts  
15 of the country. *Id.* ¶¶ 18, 21–24. He also named “Kaiser Permanente,” which is a trade name, not a  
16 legal entity. *U.S. ex rel. Osinek v. Permanente Med. Grp., Inc.*, 2022 WL 1422944, at \*18 (N.D.  
17 Cal. May 5, 2022).

18 Dr. Taylor’s FAC alleged that KFHP and the other defendants knowingly submitted false  
19 diagnosis codes to CMS that were “based on diagnoses from external providers”—*i.e.*, healthcare  
20 providers who typically are not part of a Kaiser Permanente-affiliated medical group, but are  
21 contracted to provide medical care to members of a Kaiser Permanente-affiliated Medicare  
22 Advantage plan. *See Taylor* FAC ¶ 76. He claimed that “external providers submit claims to  
23 [defendants] for services provided to [defendants’] members,” and the defendants “then use[] the  
24 diagnoses from these claims as the basis for risk adjustment claims” submitted to CMS. *Id.* ¶ 79.  
25 The defendants named in Dr. Taylor’s complaint, including KFHP, purportedly learned that these  
26 external-provider diagnosis codes were false when they conducted audits of external-provider data

27 <sup>5</sup> Dr. Taylor’s case was consolidated with five other *qui tam* actions alleging FCA violations  
28 against various Kaiser Permanente-affiliated entities on June 25, 2021. *See U.S. ex rel. Osinek v.*  
*Kaiser Permanente*, Case No. 13-cv-3891 (N.D. Cal.), Dkt. No. 61.

1 that “identified significant error rates.” *Id.* ¶ 81. But despite allegedly knowing that the external-  
2 provider diagnosis data contained high error rates, the defendants purportedly failed to “conduct  
3 any routine targeted audits of claims submitted by external providers.” *Id.* ¶ 91.

#### 4 C. Mazik’s Allegations

5 Five years after Dr. Taylor filed his complaint, Mazik filed his own *qui tam* action, *see*  
6 *generally* Dkt. No. 1 (“Compl.”), which he amended last year. Mazik names five Kaiser  
7 Permanente-affiliated Defendants. KFHP is a nonprofit health maintenance organization that  
8 contracts with CMS to provide healthcare coverage for its Medicare Advantage members. *See*  
9 FAC ¶¶ 14(a), 18, 29. KFHP “operates hospitals and medical centers” to provide hospital services  
10 to members. *Id.* ¶ 14(b). The PMGs are private medical groups run by healthcare providers and  
11 that provide medical services to members. *Id.* ¶ 14(c). Mazik alleges that he worked for  
12 Defendants starting in 2008 as an Information Technology Audit Specialist and transitioning in  
13 2012 to a compliance role. *Id.* ¶¶ 10–11. He was terminated in 2017, with his Termination Memo  
14 citing his failure to maintain “consistent and satisfactory performance.” *Id.* ¶ 111.

15 While Mazik’s original Complaint fails to allege any coherent fraud claims, the scheme it  
16 attempted to allege is based on essentially the same facts that Dr. Taylor previously alleged. Like  
17 Dr. Taylor, Mazik named KFHP and non-entity Kaiser Permanente as defendants. And like Dr.  
18 Taylor, Mazik alleged a scheme that he asserts could have resulted in the submission of false  
19 diagnosis codes to CMS based on diagnoses from external providers, which allegedly resulted in  
20 Medicare Advantage overpayments. Compl. ¶ 210.

21 The FAC addresses the same alleged fraudulent scheme that Mazik described in his  
22 original Complaint—again, echoing the scheme described by Dr. Taylor: that Defendants  
23 “knowingly allow[ed] false and fraudulent diagnosis codes submitted in claims for payment by  
24 non-Kaiser providers” and incorporated “those false data into [Defendants’] own electronic data  
25 for Medicare Advantage and Medicaid program” members. FAC ¶ 3. Mazik alleges Defendants  
26 “allow[] non-Kaiser providers to submit to it . . . false claims for payment.” *Id.* ¶ 40. Defendants  
27 allegedly “willingly overlook[] these overpayments because subsequent submission of these  
28 unsupported diagnos[is] codes to CMS serve[s] to increase the capitation rates that [Defendants]

1 received from the government.” *Id.* ¶ 45.

2 Echoing Dr. Taylor again, Mazik alleges that Defendants “fail[] to properly utilize fraud  
3 detection tools to monitor and track potential claims errors” and “lack[] enforcement of proper  
4 compliance mechanisms.” *Id.* ¶ 46. And, just like Dr. Taylor, Mazik also alleges that the  
5 preliminary audits showed high error rates that were ignored. *Id.* ¶¶ 63, 65–66.

6 Despite his broad claims of fraud, Mazik provides few specific factual details of the  
7 alleged scheme. He asserts that Defendants disabled “claims-editing functionalities” in certain  
8 auditing tools, including data review tools provided to Defendants by outside vendors. *Id.* ¶¶ 49,  
9 57. But he does not describe what functionalities Defendants disabled, why disabling these  
10 functionalities was improper, or how such disabling led to overpayments. Mazik instead simply  
11 asserts that he identified “overpayments” that resulted from such alleged misuse of vendors’  
12 review tools or other unspecified reasons.

13 Mazik also brings state FCA claims on behalf of several states. And though he fails to  
14 identify which of the five Defendants employed him, Mazik alleges he was retaliated against and  
15 wrongfully terminated on January 5, 2017, after he made a “presentation on overpayments” in  
16 2016. *Id.* ¶¶ 94–112.

### 17 **III. LEGAL STANDARDS**

18 Defendants’ Motion is premised on Rules 12(b)(1) and 12(b)(6). A Rule 12(b)(1) motion  
19 challenges the court’s subject-matter jurisdiction. The FCA’s first-to-file bar, 31 U.S.C.  
20 § 3730(b)(5), is jurisdictional and provides that once a relator brings a *qui tam* action, “no person  
21 other than the Government may intervene or bring a related action based on the facts underlying  
22 the pending action.” 31 U.S.C. § 3730(b)(5); *see also U.S. ex rel. Lujan v. Hughes Aircraft Co.*,  
23 243 F.3d 1181, 1186–87 (9th Cir. 2001).

24 A Rule 12(b)(6) motion challenges whether the complaint in question “state[s] a claim to  
25 relief that is plausible on its face.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). And  
26 because Mazik’s FAC centers on allegations of fraud, it also must satisfy the heightened  
27 requirements of Rule 9(b), which requires a party to “state with particularity the circumstances  
28 constituting fraud or mistake.” Fed. R. Civ. P. 9(b).

1 **IV. ARGUMENT**

2 **A. The Federal FCA’s First-to-File Bar Bars Mazik’s Federal FCA Claim**

3 The FCA’s first-to-file bar requires dismissal of Mazik’s federal FCA claim (Count I). The  
4 FCA encourages private citizens to promptly alert the government to alleged fraud while also  
5 prohibiting duplicative suits that benefit neither the public nor the government’s investigation of  
6 the original fraud claims. To advance this purpose, the first-to-file bar creates a race to the  
7 courthouse by permitting only the first *qui tam* action to proceed through litigation. Once a relator  
8 brings an action, “no person other than the Government may intervene or bring a related action  
9 based on the facts underlying the pending action.” 31 U.S.C. § 3730(b)(5). The reason for this  
10 prohibition is simple: the first-filed action gives “the government notice of the essential facts of an  
11 alleged fraud, while the first-to-file bar stops repetitive claims.” *See Lujan*, 243 F.3d at 1186–87.  
12 Accordingly, § 3730(b)(5) provides “incentives for whistle-blowing insiders” to file suit early. *Id.*

13 The first-to-file bar is broad. It prohibits *qui tam* suits that allege “the ***same material***  
14 ***elements*** of fraud” as an earlier *qui tam* suit, even if the allegations “incorporate somewhat  
15 different details.” *Id.* at 1189 (emphasis added). The focus of the analysis under § 3730(b)(5) is  
16 whether the United States “has enough information to discover related frauds” once it “knows the  
17 essential facts of a fraudulent scheme.” *Id.* (quotations omitted); *see U.S. ex rel. Batiste v. SLM*  
18 *Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011) (first-to-file bar applied where “the allegations of the  
19 first complaint [gave] the government grounds to investigate all that is in the second”).

20 Because the first-to-file bar is so broad, “simply adding factual details . . . to the essential  
21 or material elements of a fraud claim” will not save a subsequent *qui tam* suit from dismissal. *U.S.*  
22 *ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009). Recently, Judge  
23 Chen of the Northern District applied the first-to-file bar to Dr. Taylor’s complaint and four other  
24 related *qui tam* actions. *Osinek*, 2022 WL 1422944, at \*29. All five complaints alleged a Medicare  
25 Advantage upcoding scheme and were filed after an earlier complaint alleging a similar scheme.  
26 *Id.* at \*1. Judge Chen dismissed all five later-filed *qui tam* complaints in whole or in part, making  
27 clear that the Ninth Circuit’s “material facts” test warrants dismissal of similar allegations in later-  
28 filed complaints where the allegations are “based on the same ‘underlying facts’”—even where the

1 structure of the alleged scheme differs. *Id.* at \*22–24.

2 For example, Judge Chen held that Dr. Taylor’s allegations that the defendants had failed  
3 to act on high error rates revealed by “audits” of internal providers were barred by the first  
4 relator’s allegations that the defendants intentionally upcoded high-value medical conditions. *Id.*  
5 The court reasoned that “[a]lthough Dr. Taylor is correct that his claim here is about Kaiser  
6 ignoring an upcoding problem (as revealed by error rates) rather than actively creating upcoding,”  
7 the first-to-file bar applied because “both *Taylor* and [the first-filed *qui tam* action] are ultimately  
8 based on the same ‘underlying facts’: . . . that the high-level condition that was diagnosed did not  
9 have documentation or proper support and/or did not affect patient care.” *Id.* at \*22. Because “the  
10 government was put on notice that high-value conditions often did not have proper support,” Dr.  
11 Taylor’s audit claims were barred, even though the details of the alleged scheme were not exactly  
12 the same as the earlier-filed complaint. *Id.* at \*23.<sup>6</sup>

13 Given that Dr. Taylor first brought FCA claims based on Kaiser Permanente-affiliated  
14 entities’ response to alleged “problematic coding by external providers,” *id.*—and those claims are  
15 currently proceeding elsewhere—the first-to-file bar requires the Court to dismiss Mazik’s  
16 overlapping federal FCA claim.<sup>7</sup> Dr. Taylor alleges that the defendants named in his complaint,  
17 including KFHP, failed to correct erroneous diagnoses documented by external providers and  
18 instead submitted improper diagnosis codes to CMS for reimbursement. *Taylor* FAC ¶ 76. Mazik  
19 attempts to describe a similar scheme: Defendants, including KFHP, “knowingly accept[] false  
20 claims from non-Kaiser physicians for services rendered to [Defendants’] members [and] submit[]  
21 false and artificially inflated diagnostic coding for [the members] to [CMS].” FAC ¶ 2; *see also*

22  
23 <sup>6</sup> While Judge Chen dismissed claims that were based on the same “underlying facts” as the claims  
24 alleged in the first-filed complaint, he did not dismiss Dr. Taylor’s allegations that “Kaiser failed  
25 to act even after audits revealed high error rates with diagnoses submitted by external providers.”  
*Id.* at \*23. As a result, Dr. Taylor could proceed on his external-provider allegations. *Id.*

26 <sup>7</sup> The first-to-file analysis compares “the operative complaint in the first-filed action at the time  
27 the later-filed action was filed” with “the original complaints in the later-filed actions.” *Osinek*,  
28 2022 WL 1422944, at \*11. Because Dr. Taylor’s FAC was filed on November 3, 2014, it was  
operative when Mazik filed his original complaint. But the analysis would not change even if  
performed in relation to Dr. Taylor’s original Complaint, which is virtually identical to his FAC in  
its relevant allegations for purposes of this Motion. Nor would it change if the Court evaluated  
Mazik’s FAC, which also alleges an external-provider fraud claim.

1 Compl. ¶ 210 (alleging that the defendants “failed to correct [] overpayments, and allowed [an  
2 external provider] to continue overbilling that resulted in massive overpayments”).<sup>8</sup> Both Dr.  
3 Taylor and Mazik base the alleged external-provider schemes on allegations of false diagnosis  
4 codes generated from external-provider data, so their complaints share the same underlying  
5 material facts. This similarity alone is enough to trigger the first-to-file bar, which applies when  
6 the government “knows the essential facts of a fraudulent scheme.” *Lujan*, 243 F.3d at 1189.

7 Dr. Taylor and Mazik also describe many of the same practices when alleging the external-  
8 provider scheme, confirming the first-to-file bar applies:

9 **First**, both allege that “audits” revealed that external-provider data contained high error  
10 rates. Dr. Taylor describes “audits [that] have identified significant error rates in risk adjustment  
11 claims [the defendants] submitted to CMS based on diagnoses provided by external providers.”  
12 *Taylor* FAC ¶ 81. Similarly, referring to an example of such an audit, Mazik explains in his  
13 original complaint that “the audit” of one particular external provider “revealed a 50% billing error  
14 resulting in 40% claims payment inaccuracies.” Compl. ¶ 202. He seems to return to that  
15 allegation in his FAC, alleging “a broader audit of claims data . . . [which] found that unsupported  
16 diagnos[is] codes had led to over \$209 million in overpayments for services provided to members  
17 of [Defendants’] Medicare Advantage program.” FAC ¶ 86.

18 **Second**, both Dr. Taylor and Mazik contend that the defendants failed to take appropriate  
19 corrective action in response to external-provider “audit” results. Dr. Taylor claims audits revealed  
20 high error rates in diagnosis codes submitted by external providers, yet the defendants “rarely took  
21 even minimal steps” to prevent submission of false claims or identify previously submitted false  
22 claims based on these codes. *Taylor* FAC ¶¶ 81, 60. Similarly, Mazik alleges generally that even

23 \_\_\_\_\_  
24 <sup>8</sup> That Mazik’s FAC names defendants that were not named in the *Taylor* FAC does not save  
25 Mazik’s FCA claim from dismissal. A plaintiff cannot cure jurisdictional defects through  
26 amendment. *Sepehry-Fard v. Countrywide Home Loans, Inc.*, 2014 WL 2707738, at \*3 (N.D. Cal.  
27 June 13, 2004). So the addition of new defendants in an amended complaint cannot save claims  
28 that § 3730(b)(5) would otherwise bar. *See Osinek*, 2022 WL 1422944, at \*26 (amendment would  
be “futile” to cure first-to-file defects). Courts also have held that a second-in-time relator cannot  
avoid the first-to-file bar by naming “different members of the same corporate family,” *In re Nat.*  
*Gas Royalties Qui Tam Litig.*, 566 F.3d 959, 962 (10th Cir. 2009), especially where the first-filed  
complaint alleges a “corporate-wide problem” that would give the government grounds to  
investigate all related corporate entities, *U.S. ex rel. Hampton v. Columbia/HCA Healthcare*  
*Corp.*, 318 F.3d 214, 218 (D.C. Cir. 2003).

1 after audits revealed high external-provider error rates, “no follow-through or further audits were  
2 conducted” nor was any “corrective action taken to curb future overpayments.” Compl. ¶ 206. In  
3 the FAC, Mazik asserts that “even after the identification of widespread overpayments to outside  
4 providers, [Defendants] refused to take appropriate corrective actions, and refused to address  
5 known compliance lapses that were facilitating continuous billing and claims errors.” FAC ¶ 68.

6 **Third**, Dr. Taylor and Mazik both allege that the defendants declined to use oversight tools  
7 that would have allowed them to identify erroneous external-provider diagnoses. Dr. Taylor  
8 alleges that the defendants in his FAC, including KFHP, failed to use an existing “coder review  
9 [of] each hospital stay at an external provider” to look for erroneous diagnoses. *Taylor* FAC ¶ 91.  
10 Similarly, Mazik alleges that KFHP failed to utilize “monitoring and tracking tools” to avoid  
11 submitting false claims and identifying overpayments. *See* Compl. ¶¶ 312–13.

12 Dr. Taylor put the government on notice of purported errors in diagnosis codes submitted  
13 by Defendants that originated from external-provider data. Both Mazik’s original Complaint and  
14 FAC describe virtually the same alleged scheme involving external providers. Taylor’s FAC thus  
15 gave “the government grounds to investigate all that is in” Mazik’s FAC, and the first-to-file bar  
16 requires dismissal of Mazik’s federal FCA claim. *Batiste*, 659 F.3d at 1209.

17 **B. Mazik Fails to Plead a Federal or State FCA Fraud Claim Under Rule 12(b)(6)**

18 Mazik cannot proceed on any of his federal or state FCA fraud claims<sup>9</sup> because he fails to  
19 plead falsity and materiality—two critical elements of these claims.

20 **1. The FAC Fails to Plead a Fraudulent Scheme**

21 Even if the first-to-file bar did not preclude Mazik’s FCA fraud claim, it must be dismissed  
22 because he does not adequately allege that Defendants engaged in a fraudulent course of conduct.  
23 “The essential elements of an FCA claim are (1) a false or fraudulent course of conduct, (2) made  
24 with requisite scienter, (3) that was material, causing (4) the government to pay out money or  
25 forfeit moneys due.” *U.S. ex rel. Lee v. Corinthian Coll.*, 655 F.3d 984, 993 (9th Cir. 2011). As to  
26 the first element, under Rule 9(b)’s heightened standard, Mazik must state with particularity “the  
27

28 <sup>9</sup> Mazik dismissed Count VI after Maryland declined to intervene, reducing his state FCA fraud claims to Counts II–V, VII & VIII. *See* Dkt. No. 67.

1 who, what, when, where, and how of the misconduct charged,” and “set forth what is false or  
2 misleading about a statement, and why it is false.” *Ebeid ex rel. United States v. Lungwitz*, 616  
3 F.3d 993, 998 (9th Cir. 2010).

4 The FAC fails to meet the Rule 9(b) standard. Mazik does not allege any facts supporting  
5 his conclusions that claims based on external-provider diagnoses were inflated—he does not allege  
6 he reviewed any actual medical records from or contracts with external providers or  
7 communicated with external providers about any claims. He does not allege material details of the  
8 purported fraud, such as what diagnosis codes were allegedly unsupported and their effect on  
9 members’ risk scores. He does not link his conclusory allegations about false diagnosis codes to  
10 specific members or Defendants’ submissions to CMS or other payers. And notably, Mazik fails to  
11 allege how any of the allegedly inflated claims factored into risk-adjustment data submitted to  
12 CMS (or data submitted to any payer), and how that data increased reimbursements. Although  
13 Mazik alleges “Kaiser approved” inflated claims, FAC ¶ 86, he provides no details to support his  
14 allegation, including who approved the purportedly inflated claims, how he was aware they were  
15 “approved,” or whether and how approval resulted in false data submissions to CMS. Instead,  
16 Mazik points to alleged examples of overpayments that raise more questions than they answer:

17 **First**, Mazik alleges that he identified “\$5.3 million in overpayments for the Georgia  
18 region,” due to the decision to deactivate 25 of 54 editing rules in a specific vendor tool. *Id.* ¶¶ 55–  
19 62. But he does not explain the purpose of those 25 rules, how deactivating those rules could result  
20 in inaccurate diagnosis codes or overpayments, or why declining to use the rules lacked a  
21 legitimate basis. Nor does he even name a Georgia-specific entity as a defendant.

22 **Second**, Mazik asserts he detected overpayments “from all other regions,” *id.* ¶ 63, but he  
23 does not explain the nature of these overpayments, including what diagnosis codes were allegedly  
24 erroneous, how the allegedly erroneous codes resulted, or even whether the codes correspond to  
25 risk-adjustment data that were actually submitted to payers and affected any member’s risk score.

26 **Third**, Mazik alleges that a 2013 audit with a specific external provider showed a “50%  
27 billing error rate,” *id.* ¶ 85, but he again does not allege any specifics about the alleged errors, how  
28 they would have affected risk-adjustment payments (if at all), if the alleged errors were the result

1 of a fraudulent scheme, and if so how that scheme operated and who was involved.

2 *Fourth*, Mazik asserts that he conducted his own audit of claims data from 2010 to 2016  
3 that showed hundreds of millions of dollars in overpayments from Medicare Advantage, Medi-  
4 Cal, and other Medicaid programs, *id.* ¶ 86—again without any explanation at all for how these  
5 purported overpayments occurred.

6 *Fifth*, Mazik claims to have discovered \$380,000 in “*suspected* overpayments relating to a  
7 particular procedure code error” based on an “analysis he had performed.” *Id.* ¶ 98 (emphasis  
8 added). But he does not explain what that analysis was, how he “suspected” that analysis revealed  
9 overpayments, or what purported scheme led to the “suspected” overpayments. He does not even  
10 allege the procedure code at issue.

11 Mazik’s vague and conclusory allegations do not allege a fraud scheme that satisfies Rule  
12 8’s plausibility standards, let alone the heightened particularity requirement of Rule 9(b).

## 13 2. The FAC Fails to Plead Materiality

14 Mazik also fails to allege materiality to support his FCA claim. Materiality means “having  
15 a natural tendency to influence, or be capable of influencing, the payment or receipt of money or  
16 property.” *Universal Health Servs., Inc. v. United States*, 579 U.S. 176, 182 (2016). The  
17 “materiality standard is demanding,” *id.* at 194, and the FCA includes “a heightened standard for  
18 pleading materiality,” *United States v. Comstor Corp.*, 308 F. Supp. 3d 56, 85 (D.D.C. 2018).  
19 Although a plaintiff must allege the government would not have paid had it known of alleged  
20 fraudulent conduct, that, by itself, is not sufficient if the allegations do not specifically explain  
21 “why” the government would not have paid. *U.S. ex rel. Dresser v. Qualium Corp.*, 2016 WL  
22 3880763, at \*6 (N.D. Cal. July 18, 2016).

23 Here, Mazik does not allege materiality because he merely incants the legal standard by  
24 alleging that “Kaiser’s false certifications and attestations” were “material” and that government  
25 payers “would not have paid . . . monies to Kaiser had they known that the certifications were  
26 false.” FAC ¶¶ 2, 6, 88. Mazik does not allege any specific facts to show that the government  
27 would not have paid Defendants had it known about the purported fraud, such as an allegation that  
28 the government has refused to reimburse MAOs that have engaged in similar behavior. *See, e.g.*,

1 *Knudsen v. Sprint Commc'ns Co.*, 2016 WL 4548924, at \*12 (N.D. Cal. Sept. 1, 2016) (dismissing  
 2 complaint where relator's "conclusory statement" about materiality was "not sufficient to meet the  
 3 rigorous standard for pleading materiality"); *Dresser*, 2016 WL 3880763, at \*6 (similar).

### 4 **3. The FAC Fails to Plead Conspiracy**

5 Having failed to allege falsity and materiality, Mazik cannot sustain his conspiracy claim.  
 6 That claim also fails for an additional reason: Mazik does not allege facts to show an agreement  
 7 among KFHP, KFH, and the PMGs to violate the law, a necessary element of the claim. *U.S. ex*  
 8 *rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at \*4 (N.D. Cal. July 24, 2015) ("[P]laintiffs  
 9 alleging conspiracy claims under Section 3729(a)(1)(C) must allege the existence of an agreement  
 10 between the defendants to violate the FCA.").

### 11 **4. The FAC Fails to Plead a Fraud Claim Under State FCAs**

12 Mazik's state FCA fraud claims suffer from the same pleading deficiencies as his federal  
 13 FCA claim and should be dismissed. The state statutes Mazik cites are similar to the federal  
 14 FCA,<sup>10</sup> and Mazik similarly fails to allege falsity and materiality under them.

15 Mazik's Medicaid allegations, which are specific to his state-law claims, also do not  
 16 suffice to state a fraud claim. Mazik alleges he performed an "audit" of "claims data" for a six-  
 17 year period that revealed hundreds of millions of dollars of Medi-Cal and Medicaid overpayments.  
 18 FAC ¶ 86. But he does not identify how he determined overpayments had been made. He alleges  
 19 that he conducted audits, without explaining what that process entailed. He does not allege he  
 20 reviewed any actual claims or medical records or communicated with any external providers to  
 21 investigate whether unidentified diagnoses were supported. Although Mazik alleges various states'  
 22 Medicaid programs were "substantially similar" to the Medicare Advantage program, *id.* ¶ 33, he  
 23 does not allege that during the relevant period any of these programs used a risk-adjustment model  
 24 based on member-level diagnosis-code data, so it is not clear how external-provider data even

25 \_\_\_\_\_  
 26 <sup>10</sup> See *California v. Altus Fin.*, 36 Cal. 4th 1284, 1299–300 (2005) (CA); *U.S. ex rel. Lovato v.*  
 27 *Kindred Healthcare, Inc.*, 2020 WL 9160872, at \*8 n.5 (D. Colo. Dec. 14, 2020) (CO); *U.S. ex rel.*  
 28 *Sirls v. Kindred Healthcare, Inc.*, 517 F. Supp. 3d 367, 390–91 (E.D. Pa. 2021) (GA); *Hawaii ex*  
*rel. Torricer v. Liberty Dialysis-Hawaii LLC*, 512 F. Supp. 3d 1096, 1107 n.5 (D. Haw. 2021)  
 (HI); *United States v. NDUTIME Youth & Fam. Servs., Inc.*, 2020 WL 5507217, at \*13 (E.D. Va.  
 Sept. 11, 2020) (VA); *U.S. ex rel. Dahlstorm v. Sauk-Suiattle Indian Tribe of Wash.*, 2019 WL  
 4082944, at \*14 (W.D. Wash. Aug. 29, 2019) (WA).

1 factored into the purported overpayments. Other than the inadequate allegation about Medi-Cal,  
 2 the FAC does not make any factual allegations about any Medicaid programs. Finally, other than  
 3 for California and Colorado, Mazik neither names a state-specific defendant nor describes  
 4 Defendants’ operations in the state, so the FAC also fails to state a claim for those other regions.<sup>11</sup>

### 5                   **5. The FAC Impermissibly Groups Defendants**

6           The Court should dismiss all fraud claims—both federal and state—because Mazik  
 7 engages in impermissible group pleading. “Rule 9(b) does not allow a complaint to merely lump  
 8 multiple defendants together but ‘require[s] plaintiffs to differentiate their allegations when suing  
 9 more than one defendant.’” *Swartz v. KPMG LLP*, 476 F.3d 756, 764 (9th Cir. 2007). A plaintiff  
 10 must “identify the role of each defendant” in the alleged fraud so as to “inform each defendant  
 11 separately of the allegations surrounding his alleged participation in the fraud.” *Id.* at 764–65.  
 12 While courts allow collective allegations where each defendant has allegedly “engaged in  
 13 precisely the same conduct,” *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1184  
 14 (9th Cir. 2016), collective allegations are not permitted where defendants presumably did not  
 15 engage in the same conduct, *see Hausauer v. City of Mesa*, 2020 WL 2735970, at \*3 (D. Ariz.  
 16 May 26, 2020) (dismissing claims where plaintiff “repeatedly lumps [defendants] together as a  
 17 collective whole” but defendants “presumably did not each engage in the exact same conduct”).

18           Here, the FAC impermissibly groups Defendants without differentiating each entity’s  
 19 purported role in the alleged fraud. Mazik defines “Defendants” and “Kaiser” to mean KFHP,  
 20 KFH, and the PMGs. FAC ¶ 1. Other than one generalized paragraph (FAC ¶ 41), Mazik does not  
 21 allege the role of any of the Defendants in the submission of false claims. Nor is it plausible that a  
 22 nonprofit health plan that provides healthcare coverage (KFHP), a nonprofit hospital that provides  
 23 hospital services (KFH), and privately run medical groups that provide other medical care (the

24 \_\_\_\_\_  
 25 <sup>11</sup> Mazik’s claim under the Georgia Taxpayer Protection Against False Claims Act (“TPAFCA”) fails for an additional reason. That claim, which is premised on fraud against a state-administered Medicaid program, must instead be brought under the Georgia False Medicaid Claims Act (“GFMCA”) rather than the TPAFCA. *See* Ga. Code Ann. § 23-3-127 (“If a civil action can be commenced pursuant to Article 7B of Chapter 4 of Title 49, the ‘State False Medicaid Claims Act,’ the claimant *shall* proceed under Article 7B of Chapter 4 of Title 49.”) (emphasis added). Even if Mazik had sued under the correct statute, he would still have failed to state a claim. *See Murray v. Cmty. Health Sys. Prof. Corp.*, 811 S.E.2d 531, 537 (Ga. Ct. App. 2018) (“[C]ourts generally look to federal case law to decide issues under the GFMCA.”).

1 PMGs) engaged in precisely the same conduct. *See id.* ¶ 14(a)–(c); *Hausauer*, 2020 WL 2735970,  
2 at \*3. Mazik even admits that not all regions where Defendants operated were “fully integrated” in  
3 terms of processing claims, *id.* ¶ 79, conceding they did *not* engage in precisely the same conduct.

#### 4 C. The Court Should Dismiss Mazik’s Retaliation Claims

5 Mazik’s own allegations foreclose a retaliation claim. He must show that (1) he engaged in  
6 protected activity (2) about which his employer was aware and (3) for which the employer  
7 retaliated. *Cafasso, U.S. ex rel. v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1060 (9th Cir.  
8 2011). “[W]hen an employee is tasked with [monitoring-and-reporting activities such as]  
9 investigations, it takes more than an employer’s knowledge of that activity to show that an  
10 employer was on notice of a potential *qui tam* suit.” *U.S. ex rel. Campie v. Gilead Scis., Inc.*, 862  
11 F.3d 890, 908 (9th Cir. 2017). Instead, an employer “is put on notice only where [the employee]  
12 has suggested that she intends to use the alleged noncompliance as the basis for an FCA claim, or  
13 else intends to report the misconduct to government officials.” *United States v. Somnia, Inc.*, 2018  
14 WL 684765, at \*10 (E.D. Cal. Feb. 2, 2018). Similar requirements apply under the California  
15 retaliation laws that Mazik cites. *See McVeigh v. Recology S.F.*, 213 Cal. App. 4th 443, 455  
16 (2013); *Killgore v. Specpro Pro. Servs., LLC*, 2019 WL 6911975, at \*7 (N.D. Cal. Dec. 19, 2019).

17 The Court should dismiss Mazik’s retaliation claims because he has not even identified his  
18 employer. Mazik alleges he was employed by “Kaiser”—again, defined collectively as KFHP,  
19 KFH, and the PMGs. FAC ¶¶ 1, 11. He could not plausibly have been employed and terminated by  
20 all of these entities. Nor does Mazik plead that he was engaged in a protected activity. He simply  
21 alleges that, as part of his job duties, he detected what he perceived to be overpayments by  
22 “Kaiser” to external providers, due to an inadequate (in his opinion) compliance program. But *his*  
23 *job was in compliance*, *id.* ¶ 10—that he investigated and reported potential overpayments at work  
24 would not have put his employer on notice that he was “investigating fraud.” He does not  
25 otherwise allege that Defendants had notice that he was going to bring a fraud claim or report  
26 alleged fraud to government officials.

#### 27 V. CONCLUSION

28 For all these reasons, the FAC should be dismissed in its entirety.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

Dated: July 13, 2022

SHEPPARD, MULLIN, RICHTER & HAMPTON LLP

By

/s/ Charles L. Kreindler

CHARLES L. KREINDLER

Attorneys for Defendants KAISER FOUNDATION  
HEALTH PLAN, INC., KAISER FOUNDATION  
HOSPITALS, THE PERMANENTE MEDICAL  
GROUP, INC., SOUTHERN CALIFORNIA  
PERMANENTE MEDICAL GROUP, and  
COLORADO PERMANENTE MEDICAL GROUP,  
P.C.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

At the time of service, I was over 18 years of age and **not a party to this action**. I am employed in the County of Los Angeles, State of California. My business address is 333 South Hope Street, 43rd Floor, Los Angeles, CA 90071-1422.

On July 13, 2022, I served true copies of the following document(s) described as **NOTICE OF MOTION AND MOTION TO DISMISS FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES** on the interested parties in this action as follows:

**BY CM/ECF NOTICE OF ELECTRONIC FILING:** I electronically filed the document(s) with the Clerk of the Court by using the CM/ECF system. Participants in the case who are registered CM/ECF users will be served by the CM/ECF system. Participants in the case who are not registered CM/ECF users will be served by mail or by other means permitted by the court rules.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct and that I am employed in the office of a member of the bar of this Court at whose direction the service was made.

Executed on July 13, 2022, at Los Angeles, California.



---

Angie Sotelo