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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

UNITED STATES, STATE OF CALIFORNIA, STATE OF COLORADO, STATE OF GEORGIA, STATE OF HAWAI'I, COMMONWEALTH OF VIRGINIA, STATE OF WASHINGTON, *ex rel.* JEFFREY MAZIK, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HOSPITALS, INC., and THE PERMANENTE MEDICAL GROUPS, Defendants.	No.: 2:19-cv-00559 (DAD) (KJN) **SECOND AMENDED *QUI TAM* COMPLAINT** **JURY DEMANDED**

INTRODUCTION

1. This is a civil action by *qui tam* Plaintiff-Relator Jeffrey Mazik, who files this action on behalf and in the name of the United States of America, and California,

1 Colorado, Georgia, Hawai'i, Virginia, and Washington (the "State Plaintiffs"), against
2 the Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, Inc., and the
3 regional Permanente Medical Groups (collectively, "Defendants" and/or "Kaiser") for
4 damages and civil penalties arising from violations of the False Claims Act, 31 U.S.C.
5 §§ 3729–3733 and the corresponding statutes of the State Plaintiffs.

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

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

21 4. The Medicare Advantage program (also known as Medicare Part C) is a
22 "managed care" program funded by the federal government and administered by
23 private health insurance companies. Under this model, CMS pays a monthly per-
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1 member rate, known as a capitation rate, to Kaiser for each individual beneficiary
2 enrolled in its Medicare Advantage plans, which Kaiser then uses to "manage" all costs
3 associated with the plan. Under Medicaid (Title XIX), several states fund portions of
4 enrollees' medical costs, through Dual Eligible Special Needs Plans (D-SNPs), when
5 enrolled individuals are entitled to Medicare and medical assistance from a state
6 Medicaid plan.

7 5. CMS calculates the capitated monthly payments to Kaiser's plans using a
8 "base rate" for each plan's Part C beneficiaries and then applies adjustments based on
9 each beneficiary's "risk score." To determine the "base rate" in a given contract year,
10 CMS uses a bidding process that considers, *inter alia*, data on the plan's per-enrollee
11 costs from the two preceding years. Next, the capitation rate for each individual
12 beneficiary enrolled in Kaiser's Medicare Advantage plans (and similar plans of the
13 State Plaintiffs) is determined according to a "risk adjustment" formula that considers
14 each individual beneficiary's particular demographics and health status. Thus, CMS
15 and the State Plaintiffs make substantially higher capitation payments to Kaiser's
16 plans if Kaiser reported higher per-enrollee costs in prior year and/or one or more
17 serious medical diagnoses for some of the enrollees.

18 6. While this may have caused Kaiser to overpay outside providers on
19 certain claims at its own expense in the short term, Kaiser knowingly ignored this
20 pattern of upcoding because it ultimately increased the amounts that Kaiser received
21 for each participant in its Medicare Advantage plans and plans of the State Plaintiffs.

22 7. Relatedly, Kaiser also knowingly and improperly ignored its obligation to
23 refund Medicaid overpayments to the State Plaintiffs that its plans had received.
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1 Specifically, even though Kaiser was required by law to return Medicaid overpayments
2 within 60 days of identifying such overpayments, and even though Kaiser had
3 identified more than $360 million such overpayments through audits in 2016, Kaiser
4 knowingly and improperly avoided fulfilling its repayment obligation.

5 **JURISDICTION AND VENUE**

6 8. This is an action brought pursuant to the False Claims Act, 31 U.S.C.
7 §§ 3729, *et seq.*, and subject matter jurisdiction is invoked pursuant to 28 U.S.C. § 1331.
8 This case arises from the wrongful conduct of Defendants incident to obtaining funds
9 from the federal government. This Court also has subject matter jurisdiction under 31
10 U.S.C. § 3732(a) and supplemental jurisdiction over the state law causes of action
11 under 28 U.S.C. § 1367 and 31 U.S.C. § 3732(b).

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

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

20 **PARTIES AND ENTITIES**

21 ***A. Relator Jeffrey Mazik***

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

12. Relator was employed by Kaiser Foundation Health Plan, Inc., working for Kaiser for almost a decade, from 2008 to 2017. He first joined Kaiser Foundation Health Plan, Inc. in May 2008 as an Information Technology Audit Specialist, and eventually transitioned to the role of Senior Practice Leader in the Fraud Control Program, in or around March 2012.

13. In that role, Relator's duties and responsibilities 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—particularly for areas including medical claims, accounts payable, inventories, cash handling, durable medical equipment, IT and payroll; and overseeing Board reporting and mandatory regulatory reporting for the fraud control program.

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

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

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

(a) Kaiser Foundation Health Plan, Inc. is a nonprofit corporation, licensed as a health care service plan, headquartered in Alameda County, California. It enrolls members in individual and group plans, and provides hospital and medical services for its members through separate contracts with

1 the Kaiser Foundation Hospitals, Inc., and the regional Permanente Medical
2 Groups. As is relevant here, the Kaiser Foundation Health Plan, Inc. operates
3 several Medicare Advantage health plans—and various other government-
4 funded capitated rate plans—including certain Special Needs Plans ("SNPs") and
5 state-administered Medicaid plans through regional subsidiaries in California,
6 Georgia, Colorado, Hawai'i, Maryland, Virginia, and Washington.

7 (b) Kaiser Foundation Hospitals, Inc. is a nonprofit corporation that is
8 also headquartered in Alameda County; it operates hospitals and medical
9 centers that receive their funding from the Kaiser Foundation Health Plan and
10 provides infrastructure and facilities for the benefit of the regional Permanente
11 Medical Groups.

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

20 16. The three aforementioned entities work in cooperation with each other to
21 form the largest managed care organization in the United States, which does business
22 under the trade name "Kaiser Permanente" in at least eight states (California,
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Colorado, Georgia, Hawai'i, Maryland, Oregon, Virginia, and Washington) and the District of Columbia.

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

18. For purposes of the California labor law, the Kaiser entities collectively constitute an integrated "single employer."

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

RELEVANT LEGAL FRAMEWORK

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

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

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

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

23. Broadly speaking, capitation rates are determined based on past and expected future medical expenses, the location of the plan's actual and expected members, the health status and demographics of those members, and whether the plan will include any additional benefits. As is relevant here, to determine the "base rate" for a Kaiser plan in a given contract year, CMS uses a bidding process that considers, inter alia, data on the plan's per-enrollee costs from the two preceding years. CMS then applies a risk-adjustment factor to this base rate based upon diagnosis codes for Kaiser's plan enrollees that Kaiser receives from healthcare providers, which are then transmitted to CMS for the purpose of calculating the appropriate capitation rates. *See generally* Medicare and Medicaid Servs., Pub. No. 100-16, Medicare Managed Care Manual, ch. 7, § 40 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c07.pdf). These diagnosis codes contribute to an enrollee's risk score, which is used to adjust the base payment rate.

24. The process of adjusting the capitation rate to reflect a member's health status is known as "risk adjustment," and relies upon diagnosis classifications set forth in the International Classification of Diseases, 9th or 10th Edition, Clinical Modification ("ICD-9-CM" or "ICD-10-CM") system. *See* Report to Congress: Risk

1 Adjustment in Medicare Advantage (Dec. 2018), at 14, https://www.cms.gov/Medicare/
2 Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf. These
3 individual diagnosis codes are then organized into groups, called Hierarchical Condition
4 Categories ("HCCs"), upon which the capitation rates are based. *Id*. at 16–19. Every
5 HCC consists of several diagnosis codes that are clinically related and are expected to
6 require a similar level of resources to treat. Thus, for example, a patient who receives
7 ICD-10-CM diagnosis codes for conditions including diabetes, congestive heart failure,
8 acute myocardial infarction (AMI), angina pectoris, cough, contusions and sprains, over
9 the course of several hospital and physician visits, would be considered to have three
10 higher level conditions, or HCCs—(1) diabetes with chronic complications, (2)
11 congestive heart failure, and (3) acute myocardial infarction—for the purpose of
12 determining the appropriate capitation rate. *Id*. at 20.

13 25. Consequently, if the diagnosis codes that Kaiser receives from health care
14 providers are erroneous, false, or fraudulent, and Kaiser fails to identify or correct
15 those errors through an effective internal compliance program before submitting them
16 to CMS, then the capitation rates upon which they are based will also be wrong. *See*
17 *U.S. ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 673 (9th Cir. 2018) ("The
18 importance of accurate data certifications and effective compliance programs is obvious:
19 if enrollee diagnoses are overstated, then the capitation payments to Medicare
20 Advantage organizations will be improperly inflated.").

21 26. Unfortunately, this system tends to provide improper incentives for
22 Medicare Advantage organizations like Defendants to over-report diagnoses codes or
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1 engage in the practice of "upcoding" to increase their revenues by improperly inflating
2 their enrollees' capitation rates.

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

14 28. In order to counteract the potential temptation that Medicare Advantage
15 organizations may have to submit unsupported diagnoses, Medicare regulations require
16 risk adjustment data to be produced according to certain best practices; specifically,
17 every diagnosis code submitted to CMS must be based on a "face-to-face" visit (with the
18 exception of certain pathology services), and medical records must be validated by
19 qualifying physician/practitioner signatures and credentials. *See generally* Medicare
20 Managed Care Manual, ch. 7, §§ 40, 120.1.1. Further, electronic medical records must
21 meet special signature requirements and use software that is protected against
22 modification. *Id.* (citing Ctrs. for Medicare and Medicaid Servs., Pub. No. 100-08,
23 Medicare Program Integrity Manual, ch. 3, § 3.3.2.4 (2018), https://www.cms.gov/
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1 Regulations-and-Guidance/Guidance/Manuals/downloads/PIM83c03.pdf (last visited
2 Feb. 9, 2021)).
3 29. CMS sets risk scores based on risk adjustment data submitted for services
4 provided during the year preceding the payment year. 42 C.F.R. §§ 422.310(g),
5 423.329(b)(3). The annual deadline for submitting risk adjustment data to CMS is in
6 early September. *Id.* The data submitted by the September deadline determines
7 members' preliminary risk scores for the following year. Thereafter, CMS continues to
8 accept risk adjustment data submissions through a reconciliation process that triggers
9 additional payments or adjustments, to account for codes submitted after the
10 September deadline.
11 30. Because this process determines capitation rates, Medicare Advantage
12 organizations must carefully monitor risk adjustment claims to ensure the
13 completeness and accuracy of their submissions. Thus, Medicare Advantage
14 organizations are required to "[a]dopt and implement an effective compliance program,
15 which must include measures that prevent, detect, and correct non-compliance with
16 CMS' program requirements as well as measures that prevent, detect, and correct
17 fraud, waste, and abuse." 42 C.F.R. § 422.503 (b)(4)(vi).
18 31. Importantly, Medicare Advantage organizations must certify the
19 accuracy, completeness and truthfulness of the data they provide to CMS, including
20 risk adjustment data, as a condition to receiving payment. 42 C.F.R. § 422.504.
21 Specifically, CMS requires Medicare Advantage organizations to submit annual
22 attestations, each signed by the CEO or CFO (or their authorized, direct subordinate),
23 certifying that the risk adjustment data they submit annually to CMS are "accurate,
24

complete, and truthful" according to their "best knowledge, information and belief." The attestation acknowledges that risk adjustment information "directly affects the calculation of CMS payments … and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution."

32. CMS also provides strict requirements governing Medicare Advantage plans' contractual relationship with external providers, affiliates, vendors, and other entities—also known as First Tier, Downstream, and Related Entities ("FDRs"), which are defined by CMS as any party that enters into a written arrangement with a Medicare Advantage organization to provide certain healthcare services—that the Medicare Advantage plan will rely upon to provide services to its members. For example, applicable regulations provide, *inter alia*, that:

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

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

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

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

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

1 (f) the Plan must have a system for "promptly responding to
2 compliance issues as they are raised, investigating potential compliance
3 problems as identified in the course of self-evaluations and audits, correcting
4 such problems promptly and thoroughly to reduce the potential for recurrence,
5 and ensure ongoing compliance with CMS requirements per 42 C.F.R. §
6 422.503(b)(4)(vi)(G);
7 (g) the Plan "must conduct a timely, reasonable inquiry into" any
8 "evidence of misconduct related to payment … under the contract" per 42 C.F.R.
9 § 422.503(b)(4)(vi)(G)(1); and
10 (h) the Plan must have "a policy of … non-retaliation for good faith
11 participation in the compliance program, including but not limited to reporting
12 potential issues, investigating issues, conducting self-evaluations, audits and
13 remedial actions, and reporting to appropriate officials" per 42 C.F.R.
14 § 422.503(b)(4)(vi)(A)(7).
15 33. CMS also imposes certain obligations to undertake corrective actions
16 where necessary to ensure compliance with other applicable laws and regulations,
17 which includes the obligation to perform a root cause analysis to identify the source of
18 any potential errors or issues. Such corrective actions must be tailored to address the
19 particular fraud, problem or deficiency identified, and must include timeframes for
20 specific achievements. *See* 42 C.F.R. § 422.504(i)(1). Medicare Advantage organizations
21 must also ensure that FDRs correct deficiencies and provide documentation of all
22 identified deficiencies and corrective actions taken. *Id.*
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34. Medicare Advantage organizations know that they are required to ensure the integrity of the data they submit to CMS, and that they are subject to various audits that could lead to the repayment of improper claims. In 2005, CMS implemented a pilot Medicare Recovery Audit Contractor (RAC) Program applicable to Medicare Parts A and B, which successfully corrected more than $1.03 billion in improper payments to Medicare providers. Then, following the Patient Protection and Affordable Care Act ("ACA"), enacted in March 2010, CMS expanded the Recovery Audit program to the Medicare Part C programs. As a result of these statutes and associated regulations, Medicare Advantage organizations are subject to various health plan audits, including:

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

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

(c) DRG Payment Integrity Reviews, which are ongoing comprehensive review of hospital claims that have been submitted to plans for payment, including the diagnosis related groups (DRGs) – the diagnosis codes used to calculate risk adjustment scores – to make sure cases are properly coded and sequenced, and that billed information matches the patient record.

B. Medicaid and Dual Eligibility Special Needs Plans ("SNP")

35. 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—

1 including Special Needs Plans ("SNPs"), which are focused on coordinating care for
2 persons with disabilities and other special needs—and various state-administered
3 Medicaid programs—such as Medi-Cal in California, Med-QUEST program
4 (administered by the Department of Human Services of the State of Hawai'i), Virginia's
5 Department of Medical Assistance Services (which administers Virginia Medicaid), and
6 the Washington State Health Care Authority (which administers Washington's
7 Medicaid program, known, since 2014, as "Apple Health," in which Kaiser participates
8 through Molina healthcare).

9 36. Kaiser also participates, as a provider, in certain state-administered
10 Medicaid programs, such as Medi-Cal in California; the Colorado Medicaid program
11 (which became known, as of summer 2016, as "Health First Colorado") and Colorado's
12 Child Health Plan Plus ("CHP+"); the Georgia Department of Community Health
13 (which administers the Medicaid program in Georgia); and Virginia's Medicaid
14 program.

15 37. A Special Needs Plan ("SNP") is a Medicare Advantage coordinated care
16 plan specifically designed to provide targeted care and limit enrollment to special needs
17 individuals. These plans were first authorized by Congress in the Medicare
18 Modernization Act of 2003, which identified "special needs individuals," including (1)
19 "dual eligible" individuals – those qualifying for both Medicare and Medicaid coverage;
20 (2) individuals with chronic conditions; and (3) institutionalized individuals. Plans
21 covering such individuals are called D-SNPs, C-SNPs and I-SNPs, respectively.
22 Because of the overlap with state Medicaid programs, the various states that
23 implement such programs will pay part of the costs associated with SNPs.
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1 38. Since the initial enactment in 2003, the program has been extended by
2 Congress repeatedly, including by the Medicare, Medicaid, and State Children's Health
3 Insurance Program (SCHIP) Extension Act of 2007 (extending the SNP program to
4 December 31, 2009); The Medicare Improvements for Patients and Providers Act of
5 2008 (MIPPA) (extending the SNP program through December 31, 2010); The Patient
6 Protection and Affordable Care Act ("ACA") effective in 2011 (extending the SNP
7 program through December 31, 2013); The American Taxpayer Relief Act of 2012
8 (ATRA) (extending the SNP program through December 31, 2014); the Bipartisan
9 Budget Act of 2013 (Pub. L. 113-67) (extending the SNP program through December 31,
10 2015); the Protecting Access to Medicare Act of 2014 (extending the SNP program
11 through December 31, 2016) and the Medicare Access and CHIP Reauthorization Act of
12 2015 (MACRA) (extending the SNP program through December 31, 2018).
13 39. SNPs are expected to follow existing Medicare Advantage program rules,
14 including Medicare Advantage regulations at 42 C.F.R. § 422, as modified by guidance,
15 with regard to Medicare-covered services and Prescription Drug Benefit program rules.
16 Under CMS rules, SNPs should assume that, if no modification is contained in
17 guidance, existing Part C and D rules apply. Payment procedures for SNPs mirror the
18 procedures that CMS uses to make payments to non-SNP Medicare Advantage plans.
19 SNPs must prepare and submit bids like other Medicare Advantage plans, and are paid
20 in the same manner as other Medicare Advantage plans based on the plan's enrollment
21 and risk adjustment payment methodology. All SNPs must abide by current CMS
22 guidance on cost sharing requirements.
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1 ***C. The False Claims Act ("FCA")***

2 40. The U.S. Court of Appeals for the Ninth Circuit has explicitly held that
3 "the Medicare Advantage capitation payment system is subject to the False Claims
4 Act." *Silingo*, 904 F.3d at 673–74.

5 41. As is relevant here, the FCA prohibits, *inter alia*: (a) knowingly
6 presenting (or causing to be presented) to the federal government a false or fraudulent
7 claim for payment or approval; (b) knowingly making or using, or causing to be made or
8 used, a false or fraudulent record or statement material to a false or fraudulent claim;
9 (c) knowingly making, using, or causing to be made or used, a false record or statement
10 material to an obligation to pay or transmit money or property to the government, or
11 knowingly concealing or knowingly and improperly avoiding or decreasing an obligation
12 to pay or transmit money or property to the government; and (d) conspiring to violate
13 any of these three sections of the FCA. *See* 31 U.S.C. §§ 3729(a)(1)(A)-(C), and (G). The
14 FCA also imposes an independent duty to correct known errors that will cause, or have
15 caused, a government overpayment. Accordingly, Medicare Advantage plans not only
16 have a duty to submit correct data to CMS, but also, for data they have already
17 submitted, must delete records known to be incorrect from CMS's database using a
18 "delete code."

19 42. The FCA also defines "obligation" in section 3729(a)(1)(G) – the reverse
20 false claims provision – to include any "established duty, whether or not fixed, arising
21 from an express or implied contractual … relationship, from a fee-based or similar
22 relationship, from statute or regulation, or from the retention of an overpayment." Id.
23 § 3729(b)(3). This broad definition reflects Congress's intent for the reverse false claims
24

1 provision to apply to non-fixed duties to pay or repay the Government. See S. Rep.
2 111-10 at 14 (2009).

3 43. In 2010, Congress further reinforced the duty on Medicaid and Medicare
4 program participants like Kaiser to return overpayments in a timely manner.
5 Specifically, as part of the Patient Protection and Affordable Care Act of 2010, see 124
6 Stat. 119, 753–56 (2010), Congress added a provision to the Social Security Act that
7 obligates Kaiser to report and return overpayments made by Medicare within 60 days
8 of the identification of the overpayments. *See* 42 U.S.C. § 1320a–7k(d)(2). The
9 regulations created a six-year lookback period, requiring refund of any overpayment
10 identified within those six years.

11 44. Any person who violates the FCA is liable for a civil penalty of up to
12 $27,894 for each violation, plus three times the amount of the damages sustained by
13 the United States. 31 U.S.C. § 3729(a)(1); 28 C.F.R. § 85.5.

14 **FACTUAL ALLEGATIONS**

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

17 ***1. Defendants' Scheme to Allow False Claims by Outside Providers***

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

maintained for each of its members. It then submits those data to CMS and the State Plaintiffs in order to falsely inflate risk adjustment factors used to calculate its capitation rates.

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

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

48. Because provider claims are submitted to Kaiser rather than directly to Medicare, Kaiser acts as the gatekeeper for fraudulent claims. Specifically, Kaiser has

1 the obligation under Medicare regulations to undertake "internal monitoring and
2 audits" to evaluate providers' "compliance with CMS requirements." Further, if Kaiser
3 "discovers evidence of misconduct related to payment[,] it must conduct a timely,
4 reasonable inquiry into that conduct."

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

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

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

23 51. Kaiser consistently and intentionally fails to properly utilize fraud-
24 detection tools to monitor and track potential claims errors, lacks enforcement of proper

1 compliance mechanisms, and lacks transparency with regional offices on implementing
2 corrective actions for identified defects and misrepresentations.

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

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

16 54. For instance, Kaiser intentionally disabled certain claims-editing
17 functionalities in these auditing tools, so as to avoid the identification of certain types
18 of errors. In other words, Kaiser used standard compliance tools, but turned on very few
19 of those features that were designed to detect claim anomalies and overpayments. In
20 doing so, Kaiser outwardly appeared to be engaging in efforts to utilize monitoring and
21 tracking tools to be compliant, when in fact, Kaiser was actively working to avoid
22 detecting and correcting the fraud.

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1 55. When Relator joined Kaiser's compliance office in 2012, he reported to
2 Mia Okinaga, who was then the Vice President of the National Compliance Office. Ms.
3 Okinaga personally recruited Relator to join the compliance team. She considered
4 Relator a valuable addition to the team, announcing that his role would focus on
5 integrating regional and national departments to enhance the effectiveness of
6 monitoring and tracking fraud control.
7 56. Relator worked closely with Ms. Okinaga, who actively pushed her
8 initiative to direct Kaiser and the regional offices to effectively utilize various
9 diagnostic compliance and fraud detection tools. Such tools were developed by vendors
10 such as Verisk Health ("Verisk") and FICO, both of which are data analytics companies
11 that work with clients to identify fraud and abuse in various financial sectors. Ms.
12 Okinaga and Relator believed that such vendors and their tools could be used to
13 substantially reduce losses from health care billing error, abuse, and fraud.
14 57. Relator also worked closely with Jay Loden, Assistant Director of
15 Information Analytics and Compliance Technology, on tools and analytical studies,
16 Judy Sarles, Senior Director, on compliance systems, and Daren Pursche, Director of
17 Government Audit & Reimbursement, on external and internal compliance standards.
18 58. Ms. Okinaga was eventually pushed out because she lacked the full
19 support from senior management in the compliance office to prioritize those initiatives--
20 and because she was detecting and uncovering significant overpayments that had
21 previously been intentionally concealed.
22 59. Kaiser made the announcement that Ms. Okinaga's position was
23 eliminated on August 21, 2015. Thereafter, Relator reported to Marita Janiga,
24

1 Executive Director of Investigations in Kaiser's National Compliance, Ethics &
2 Integrity Office, for about a year—and then to Lauren Sutcliffe, a Senior Manager in
3 the Special Investigations Unit.

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

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

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

15 63. Relator, Mr. Loden, and Project Manager Sean Kelly worked on this
16 project with a Verisk employee, Strategic Account Manager Dave Bohnenstingel, using
17 claims data only from the Georgia region.

18 64. Relator's and Mr. Loden's efforts, in collaboration with Verisk, identified
19 $5.3 million in overpayments for the Georgia region alone, which stemmed directly from
20 the Kaiser's previous decision to deactivate various features in McKesson ClaimsXten.

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

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1 66. When Relator, Mr. Kelly, and Mr. Loden presented their findings to Ms.
2 Janiga and Ms. Sarles, neither supervisor expressed an intent to address or rectify the
3 identified overpayments in the Georgia region.
4 67. The findings were also brought before Sean Killeen, Executive Director of
5 Payment Integrity in the Claims-Cost Containment Department and Mike Wathen,
6 Vice President of Georgia Claims Administration. Mr. Killeen's response to the
7 overpayments was indifferent. Mr. Wathen was interested in learning more about the
8 issue, but Mr. Killeen got in the way of any follow-up with the matter by acknowledging
9 his receipt of the issue. In short, nothing was ever done about these issues, either by
10 the national compliance leadership or the regional claims management in Georgia.
11 68. A few months later, in mid-February 2016, Relator detected significant
12 amounts of overpayments due to erroneous codes from all other regions, discovering
13 that they had not been recorded or included in any claims adjustment, credit balance,
14 or self-reported refund. He then prepared a Webex presentation to report his findings to
15 Ms. Janiga, Relator's supervisor, and Mr. Pursche of the Government Audit &
16 Reimbursement division.
17 69. In this presentation, Relator also pointed out that, pursuant to applicable
18 regulations, Kaiser was required to review and investigate all identified overpayments
19 within 60 days. The purpose of Relator's analysis was to put his superiors on notice and
20 lay out various options for the necessary corrective action.
21 70. The presentation was received with a lack of interest from Ms. Janiga and
22 Mr. Pursche. They admitted that compliance had "never done this before." Indeed, this
23 very basic level review that Relator conducted to detect unsupported diagnostic codes
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and resulting overpayments had never been done before Relator took it upon himself in 2016.

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

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

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

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

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

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

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

78. Kaiser's claims for payment were also false because 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.

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

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

80. Relator subsequently discovered that Kaiser was also misrepresenting its structure and operations to the government, including during a phone call with the U.S.

Department of Health & Human Services: Office of Inspector General (HHS OIG) on June 30, 2016.

81. 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. Several people participated on the call including: Relator, Ms. Janiga, Brian Mesaris, OPM-OIG Auditor, Stephanie Oliver, OPM-OIG Manager, and Robin Richardson, OPM-OIG counsel.

82. 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 and raise additional concerns that prevented Kaiser from maintaining accuracy and consistency of claims payments.

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

84. Ms. Janiga also misrepresented that Kaiser and its regional offices were "fully integrated," so there was no need for the OIG to inquire into its claims process. These misrepresentations were intended to preclude the OIG from inquiring into Kaiser's claims process.

85. Ms. Janiga was aware that Relator knew that her statements were untrue. She was concerned that if he spoke during the OIG call, Relator might contradict Ms. Janiga and correct her misrepresentations to the OIG. She was also

1 concerned that Relator might raise his compliance and overpayments findings with the
2 OIG.

3 86. So in the middle of the phone call with the OIG, Ms. Janiga messaged
4 Relator on intercompany messaging and instructed him to "[not] say a word."

5 87. Relator understood this as a direct order not to correct or contradict
6 anyone on the call, especially Ms. Janiga's misrepresentations to the OIG. He did as
7 instructed and stayed quiet on the call.

8 88. This episode had the intended chilling effect on Relator, confirming his
9 worries that Kaiser was not interested in compliance on this issue, let alone fraud
10 detection and correction.

11 ***4. Kaiser's scheme results in false claims.***

12 89. As a result of the scheme as described herein, Kaiser has allowed,
13 approved and made false claims for payment in violation of the False Claims Act and
14 the false claims acts of the State Plaintiffs. *First*, when Kaiser allows false or
15 fraudulent claims for overpayment by outside physicians, those approvals cause false
16 claims as defined under § 3729(b)(2)(A)(ii) and the corresponding provisions of the false
17 claims acts of the State Plaintiffs.

18 90. For example, Kaiser subcontracts with Easterseals, an organization
19 providing healthcare services individuals with disabilities across the country, including
20 in Georgia, California, Colorado, Hawai'i, Virginia, and Washington. Kaiser contracts
21 with Easterseals to provide health care services for members diagnosed with autism. As
22 revealed in 2013 audit with respect to Easterseals, Kaiser knew that there was a 50%
23 billing error rate, resulting in 40% claims payment inaccuracies. Despite knowing that
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1 false claims for payment had been made for Medicare and Medicaid funds, it ignored
2 the violations and approved of the claims.
3 91. This nationwide scheme persisted in other states as well.
4 92. Kaiser's use of the Verisk system identified improper claims for payment
5 to State healthcare agencies in Georgia, Washington, and Virginia. For example, during
6 2010 to 2013, the Verisk software identified $11,690,149 in overpayments in Georgia
7 alone, and additional overpayments in the Northwest region (including Washington)
8 and the Mid-Atlantic States (including Virginia) but Kaiser never took action on it.
9 93. Around this time, Kaiser determined that it preferred ignorance to
10 knowledge of its false claims. It intentionally disabled the Verisk software tool in the
11 Mid-Atlantic States (including Virginia) which, of course, caused it to no longer identify
12 any such overpayments.
13 94. Further, Kaiser failed to activate (or disabled) the Verisk system at all in
14 other states such as Colorado and Hawai'i, intentionally disregarding the
15 recommendations of compliance personnel such as Relator. Because Kaiser never
16 looked for overpayments in those states, it inevitably failed to find any. But such
17 overpayments occurred, as demonstrated by the millions of dollars in overpayments
18 that resulted from similar conduct by Kaiser in Georgia and other states where Verisk
19 had been activated.
20 95. As a consequence, for example, Kaiser could not accurately address
21 inflated and upcoded charges made by over 1,000 Kaiser doctors in Colorado to Health
22 First Colorado and Colorado's Child Health Plan Plus. Further, in Colorado, Kaiser
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1 identified upcoded charges by its doctors using a "filter" tool, but routinely ignored the
2 results and then, in 2012, ended the filter program.

3 96. In Hawai'i, there was a pattern of fraud and overpayments made by
4 Hawai'i's Medicaid program, which resulted in a corporate integrity agreement.
5 Nonetheless, Relator found that Kaiser still did not make necessary corrections.

6 97. Further, Kaiser intentionally disabled the Verisk software tool in Georgia
7 which, again, caused it to no longer identify any such overpayments.

8 98. And then Kaiser also intentionally disabled the Verisk software tool in the
9 Northwest Region (including Washington State), which also caused it to no longer
10 identify any such overpayments in Washington.

11 99. In late 2015, Kaiser and Verisk developed a new contract, to use Verisk's
12 software as part of a new "Anti-Fraud Alliance" to detect healthcare fraud. But Kaiser
13 never executed the contract and the fraud continued.

14 100. By late 2016, for example, Kaiser found $10.7 million of overpayments to
15 56 providers made by Kaiser's Virginia Medicaid plan, but never took action on those
16 payments either.

17 101. As part of its responsibilities under the Medicare Advantage program,
18 Kaiser is paid to conduct meaningful reviews of outside physician claims. When it seeks
19 payment of Medicare and Medicaid funds, the request for payment is a "claim" under
20 the Act, including an explicit and implicit certification that it had performed core
21 functions of the Medicare Advantage organizations. Kaiser, however, did not provide
22 meaningful reviews of outside physician claims, either before paying them, or within a
23 period of time thereafter when the claim approvals could have been corrected.
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1 102. Instead, Kaiser disabled compliance software so that the audits would not
2 identify erroneous codes and defendants would not discover the errors in the first place.
3 In essence, Kaiser simply did not perform reviews, or conducted them in such a fashion
4 that the service provided was worthless. Indeed, as described herein, Kaiser's sham
5 compliance program ensured that such meaningful reviews would not be conducted,
6 protecting the claims from further scrutiny internally or by CMS.
7 103. Kaiser's false certifications and attestations that it had performed the
8 responsibilities of a Medicare Advantage organization, and the analogous certifications
9 and attestations of the Medicaid programs of the State Plaintiffs,[1] were material. The
10 United States and the State Plaintiffs would not have paid these monies to Kaiser had
11 they known that the certifications were false. As a result, Kaiser has knowingly
12 received payments from CMS and the State Plaintiffs, and government payors were
13 damaged in the amounts paid to Kaiser for the performance of its function as a
14 Medicare Advantage organization.
15 104. As a result of this conduct, Kaiser has knowingly received inflated
16 payments from CMS and the State Plaintiffs in the form of capitation rates that were
17 significantly higher than they would have been, if based upon reported per-enrollee
18 costs and patient diagnosis data that were true and accurate. Kaiser repeatedly
19 submitted false certifications and attestations with respect to the accuracy,
20

21 [1] For example, Hawai‘i makes unlawful the misrepresentation or falsification of
22 information provided to the state's Department of Human Services. (Haw. Code R.
§ 17-1735.2-6(b)(4).) Likewise, the managed care contracts of Hawai‘i and Washington
23 incorporate the federal CFR's requirement of certification to the accuracy and
completeness of the data. And Virginia's managed care contract also requires that the
24 managed care organization ensure the accuracy of its data.

1 completeness, and truthfulness of the cost and diagnosis data it provided to CMS and
2 the State Plaintiffs. Kaiser knew it had misused healthcare compliance software and
3 fraud-detection programs necessary to ensure the integrity of the data submitted to
4 CMS and the State Plaintiff, and with a sham compliance program, it could not
5 truthfully certify that the data accurately reflected the health status of its members.
6 Indeed, it knew that an actual compliance program would raise red flags regarding
7 overpayments to outside physicians, and that Kaiser had in fact submitted data that
8 led to artificially inflated capitation rates.

9 105. Kaiser certifies the "accuracy, completeness, and truthfulness of the data"
10 because CMS and the State Plaintiffs have neither the access nor the resources to
11 verify Kaiser's compliance efforts. When Kaiser annually submitted data for its per-
12 enrollee costs and enrollees' preliminary risk scores, and in any subsequent submission
13 of data during the reconciliation process, CMS and the State Plaintiffs relied upon
14 these false data to derive the base rate for Kaiser's plans and risk adjustment scores,
15 which in turn set the capitation rates. Each month after the inflated risk adjustment
16 scores were determined based upon the false record data, Kaiser made false claims for
17 artificially elevated capitated payments for a growing number of its members.

18 106. As a result, Kaiser has continually submitted and caused the submission
19 of false and unsupported per-enrollee cost and diagnosis data to CMS, despite knowing
20 that the cost data was inflated and that the enrollees did not have the claimed
21 diagnoses and/or had not been treated for those diagnoses. Additionally, Kaiser has
22 continually refused to correct previously submitted risk adjustment claims, despite
23 knowing that the information therein was patently false. These false cost and diagnosis
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data and false risk adjustment claims were material as they directly caused the inflated payments.

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

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

5. Kaiser's Knowing and Improper Failure to Refund Medicaid Overpayments to the Plaintiff States.

109. As summarized above, Kaiser had an affirmative obligation under the law to report and return overpayments to Medicaid and Medicare within 60 days of the identification of such overpayments. *See* 42 U.S.C. § 1320a–7k(d)(2).

110. Due to Kaiser's practice of not properly assessing claims made to the Medicaid and Medicare programs, it had received hundreds of millions of dollars in overpayments from these programs by 2016. Specifically, an internal audit of claims data dating from August 3, 2010, through July 30, 2016, for all of the regional offices — which was witnessed by Relator in September 2016 — found that Kaiser had obtained approximately $181 million in overpayments from the Medi-Cal program and approximately $181 million in overpayments from other Medicaid programs, including

1 from the other Plaintiff States. (This audit also found $209 million in overpayments
2 from CMS to Kaiser's Medicare Advantage plans due to unsupported diagnostic data.)
3 111. Like Relator, other compliance executives at Kaiser were aware of the
4 overpayment findings of this audit. Those compliance executives also were well aware
5 of Kaiser's obligation under the law to refund overpayments to the Plaintiff States and
6 to Medicare. Yet, instead of fulfilling that obligation, Kaiser knowingly and improperly
7 avoided refunding more than $360 million in Medicaid overpayments that it had
8 identified through audits.
9 ***B. Unlawful Retaliation and Wrongful Termination***
10 112. As recounted above, numerous widespread operational and compliance
11 issues became readily apparent to Relator after Ms. Okinaga left her position at Kaiser
12 in 2015.
13 113. Relator uncovered multiple instances of identified overpayments that
14 were not further investigated, were not disclosed, and were not corrected. Rather than
15 acting on the information given by Relator, Kaiser failed to take proper measures to
16 comply with rules, regulations, and laws on overpayments.
17 114. In fact, the more Relator spoke up about Kaiser's improper processes for
18 handling unsupported diagnostic codes and the resulting overpayments, and the more
19 Relator tried to steer Kaiser in the direction of full compliance and disclosure—the
20 more he was sidelined and closed out from data and documents, which prevented the
21 systemic operational and compliance violations from being corrected going forward.
22 Instead of taking prompt and proper corrective actions, Kaiser continued to resist,
23 obstruct, and dismiss Relator's efforts. This was especially true after Relator began
24 reporting to Ms. Sutcliffe, in or around July 2016.

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

116. For example, on October 12, 2016, Relator approached Ms. Sutcliffe about an analysis he had performed that uncovered approximately $380,000 in suspected overpayments relating to a particular procedure code error. Rather than acknowledge Relator's efforts and the associated cost savings, and proceed to correct the systematic overpayments, Ms. Sutcliffe severely criticized him for performing such an analysis without obtaining her prior approval, and then placed him on a Performance Improvement Plan ("PIP").

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

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

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

(c) On October 17, 2016, Ms. Sutcliffe pushed off, and ultimately never followed up with, Relator's request for access to the Member Complaint's

1 database system. She told Relator that she needed to discuss with Ms. Janiga
2 first, but never approved this request.

3 118. In sum, Relator was denied access to every data repository necessary to
4 perform his compliance job. Given that he had never had any problems with access
5 during his long career at Kaiser, and these tools were necessary for his job, by refusing
6 to allow him access, Kaiser actively stopped or prevented Relator from being able to
7 perform his regular job.

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

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

19 121. These circumstances created an impossible work environment for Relator,
20 who became fearful of speaking up or identifying further instances of overpayments
21 stemming from unsupported diagnostic codes.

22 122. Nevertheless, Relator continued performing his duties proficiently, just as
23 he had done throughout his long career at Kaiser. And although Relator had a strong
24

speculation that he had been placed on a PIP because he had repeatedly spoken up about massive overpayments, Relator made every effort to demonstrate objective and measurable improvement in each of the areas identified by the PIP.

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

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

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

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

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

5 128. On December 23, 2016, Relator also requested a meeting with Jacqueline
6 Thomas in Human Resources. He had planned to complain about the harassing
7 environment that arose from him bringing unwelcomed compliance issues to light. But
8 the meeting schedule was adjusted several times and ultimately, never happened.

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

13 130. Since Relator's start date at Kaiser in 2008, he had received numerous
14 performance reviews, which were consistently "successful" and "excellent" between
15 2012 and 2016, he performed exceedingly; it was not until Relator made his first
16 presentation on overpayments and Ms. Sutcliffe came into the picture in 2016, that he
17 suddenly received his first, below- level "performance needs improvement" performance
18 review—and then was placed on the PIP several months later, before ultimately being
19 terminated from his position.

20 **<u>COUNT I</u>**
Violations of the False Claims Act
21 **31 U.S.C. §§ 3729(a)(1)(A)–(C), (G)**

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

24

1 132. This is a claim for treble damages, civil penalties, and the fees and costs of
2 this action under the False Claims Act, 31 U.S.C. §§ 3279–33, as amended.
3 133. Through the acts described above, Defendants, their agents, employees,
4 and co-conspirators, knowingly presented, or caused to be presented, to the United
5 States false and fraudulent claims, and knowingly failed to disclose material facts, in
6 order to obtain payment or approval from the United States and its contractors,
7 grantees, and other recipients of its funds.
8 134. Through the acts described above, Defendants, their agents, employees,
9 and co-conspirators, knowingly made, used, and caused to be made and used false
10 records and statements, which also omitted material facts, in order to induce the
11 United States to approve and pay false and fraudulent claims.
12 135. Through the acts described above, Defendants, their agents, employees,
13 and co-conspirators, knowingly made, used, and caused to be made and used false
14 records and statements material to an obligation to pay and transmit money to the
15 United States, and knowingly concealed and improperly avoided and decreased an
16 obligation to pay and transmit money to the United States.
17 136. Through the acts described above, Defendants, their agents, employees,
18 and other co-conspirators knowingly conspired to submit false claims to the United
19 States and to deceive the United States for the purpose of causing the United States to
20 pay or allow false or fraudulent claims.
21 137. The United States, unaware of the falsity of the records, statements, and
22 claims made and submitted by Defendants, its agents, employees, and co-conspirators,
23 and as a result thereof, paid money that it otherwise would not have paid.
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1 138. By reason of the payments made by the United States, as a result of
2 Defendants' fraud, the United States has suffered damages and continues to be
3 damaged.

4 **COUNT II**
Violations of the California False Claims Act
5 **Cal. Gov't. Code §§ 12650, *et seq*.**

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

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

11 141. The California False Claims Act provides liability for any person who (1)
12 knowingly presents, or causes to be presented, to an officer or employee of the state or
13 of any political division thereof, a false claim for payment or approval; (2) knowingly
14 makes, uses, or causes to be made or used a false record or statement to get a false
15 claim paid or approved by the state or by any political subdivision; (3) conspires to
16 defraud the state or any political subdivision by getting a false claim allowed or paid by
17 the state or by any political subdivision; or (8) is a beneficiary of an inadvertent
18 submission of a false claim to the state or a political subdivision, subsequently discovers
19 the falsity of the claim, and fails to disclose the false claim to the state or the political
20 subdivision within a reasonable time after discovery of the false claim. Cal. Gov't Code
21 § 12651(a).

22 142. Through the acts described above, Defendants, their agents, employees,
23 and co-conspirators, knowingly presented, or caused to be presented, to the State of
24 California false and fraudulent claims, and knowingly failed to disclose material facts,

in order to obtain payment or approval from the State of California and its contractors, grantees, and other recipients of its funds.

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

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

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

146. At a minimum, Defendants were the beneficiaries of inadvertent submissions of false claims to the State of California, subsequently discovered the falsity of the claims, and failed to disclose the false claims to the State of California within a reasonable time after discovery of the false claim.

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

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

COUNT III
Violations of the Colorado Medicaid False Claims Act
C.R.S. 25.5-4-303.5, *et seq.*

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

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

151. The Colorado Medicaid False Claims Act provides liability for any person who:

> (a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (b) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
>
> …
>
> (f) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act", or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act";
>
> (g) Conspires to commit a violation of paragraphs (a) to (f) of this subsection (1).

C.R.S. § 25.5-4-305.

1 152. Through the acts described above, Defendants, their agents, employees,
2 and co-conspirators, knowingly presented, or caused to be presented, false and
3 fraudulent claims to the Colorado Medicaid program (which became known, as of
4 summer 2016, as "Health First Colorado") and Colorado's Child Health Plan Plus
5 ("CHP+"), and knowingly failed to disclose material facts, in order to obtain payment or
6 approval from the State of Colorado and its contractors, grantees, and other recipients
7 of its funds.
8 153. Through the acts described above, Defendants, their agents, employees,
9 and co-conspirators, knowingly made, used, and caused to be made and used false
10 records and statements, which also omitted material facts, in order to induce the
11 Colorado Medicaid program and CHP+ to approve and pay false and fraudulent claims.
12 154. Through the acts described above, Defendants, their agents, employees,
13 and co-conspirators, knowingly made, used, and caused to be made and used false
14 records and statements material to an obligation to pay and transmit money to the
15 Colorado Medicaid program and CHP+, and knowingly concealed and improperly
16 avoided and decreased an obligation to pay and transmit money to the Colorado
17 Medicaid and CHP+.
18 155. Through the acts described above, Defendants, their agents, employees,
19 and other co-conspirators knowingly conspired to submit false claims to the Colorado
20 Medicaid program and CHP+ and to deceive the Colorado Medicaid program and CHP+
21 for the purpose of causing the State of Colorado to pay or allow false or fraudulent
22 claims.
23
24

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

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

COUNT IV
Violations of the Georgia False Medicaid Claims Act
Ga. Code §§ 49-4-168, *et seq.*[2]

158. Relator hereby incorporates, by reference, all of the allegations from each of the preceding paragraphs.

159. This is a claim brought by Relator and Georgia to recover treble damages, civil penalties and the fees and cost of this action, under the Georgia False Medicaid Claims Act, Ga. Code §§ 49-4-168 *et seq*.

160. The Georgia False Medicaid Claims Act provides liability for any person who:

> (1) Knowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval;
>
> (2) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;

[2] The Court previously dismissed Relator's Georgia Taxpayer Protection Act ("TPAFCA") without leave to amend on the ground that "relator must bring this claim under the Georgia False Medicaid Claims Act. (ECF no. 104 at 20–21 (citing *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").) Relator now asserts a claim under Georgia's False Medicaid Claims Act.

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4
5

> (3) Conspires to commit a violation of paragraph[s] [1-7] of this subsection;
>
> … or … (7) Knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit property or money to the Georgia Medicaid program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit property or property to the Georgia Medicaid program.

6 Ga. Code § 49-4-168.1(a).

7 161. Through the acts described above, Defendants, their agents, employees,
8 and co-conspirators, knowingly presented, or caused to be presented, false and
9 fraudulent claims to the Georgia Department of Community Health ("GA DCH") (which
10 administers the Medicaid program in Georgia) and knowingly failed to disclose material
11 facts, in order to obtain payment or approval from the GA DCH and its contractors,
12 grantees, and other recipients of its funds.

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

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

22 164. Through the acts described above, Defendants, their agents, employees,
23 and other co-conspirators knowingly conspired to submit false claims to the GA DCH
24

and to deceive the GA DCH for the purpose of causing the State of Georgia to pay or allow false or fraudulent claims.

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

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

COUNT V
Violations of the Hawai'i False Claims Act
Haw. Rev. Stat. §§ 661-21, *et seq.*

167. Relator hereby incorporates, by reference, all of the allegations from each of the preceding paragraphs.

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

169. The Hawai'i False Claims Act provides liability for any person who:

> (1) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (2) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> …
>
> (7) Is a beneficiary of an inadvertent submission of a false claim to the State, who subsequently discovers the falsity of the claim, and fails to disclose the false claim to the State within a reasonable time after discovery of the false claim; or
>
> (8) Conspires to commit any of the conduct described in this subsection.

1 Haw. Rev. Stat. § 661-21(a).

2 170. Through the acts described above, Defendants, their agents, employees,
3 and co-conspirators, knowingly presented, or caused to be presented, false and
4 fraudulent claims to the Med-QUEST program (administered by the Department of
5 Human Services of the State of Hawaiʻi), and knowingly failed to disclose material
6 facts, in order to obtain payment or approval from Med-QUEST and its contractors,
7 grantees, and other recipients of its funds.

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

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

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

21 174. At a minimum, Defendants were the beneficiaries of inadvertent
22 submissions of false claims to Med-QUEST, subsequently discovered the falsity of the
23
24

claims, and failed to disclose the false claims to Med-QUEST within a reasonable time after discovery of the false claim.

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

176. By reason of the payments made by the State of Hawaiʻi, as a result of Defendants' fraud, the State of Hawaiʻi has suffered damages and continues to be damaged.

COUNT VI
Violations of the Virginia Fraud Against Taxpayers Act
Va. Code §§ 8.01-216.1, *et seq.*

177. Relator hereby incorporates, by reference, all of the allegations from each of the preceding paragraphs.

178. This is a claim brought by Relator and the Commonwealth of Virginia to recover treble damages, civil penalties and the fees and cost of this action, under the Virginia Fraud Against Taxpayers Act, Va. Code §§ 8.01-216.1, *et seq*.

179. The Virginia Fraud Against Taxpayers Act provides liability for any person who:

> 1. Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> 2. Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> 3. Conspires to commit a violation of [this] subdivision …;
>
> …
>
> 8. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit

1 money or property to the Commonwealth or knowingly conceals or knowingly and improperly avoids or decreases an obligation to
2 pay or transmit money or property to the Commonwealth.

3 Va. Code § 8.01-216.3.

4 180. Through the acts described above, Defendants, their agents, employees,
5 and co-conspirators, knowingly presented, or caused to be presented, false and
6 fraudulent claims to Virginia Medicaid (which is administered by Virginia's
7 Department of Medical Assistance Services), and knowingly failed to disclose material
8 facts, in order to obtain payment or approval from Virginia Medicaid and its
9 contractors, grantees, and other recipients of its funds.

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

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

19 183. Through the acts described above, Defendants, their agents, employees,
20 and other co-conspirators knowingly conspired to submit false claims to Virginia
21 Medicaid and to deceive Virginia Medicaid for the purpose of causing the
22 Commonwealth of Virginia to pay or allow false or fraudulent claims.

23 184. The Commonwealth of Virginia, unaware of the falsity of the records,
24 statements, and claims made and submitted by Defendants, its agents, employees, and

co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

185. By reason of the payments made by the Commonwealth of Virginia, as a result of Defendants' fraud, the Commonwealth of Virginia has suffered millions of dollars in damages and continues to be damaged.

COUNT VII
Violations of the Washington State Medicaid Fraud False Claims Act
Wash. Rev. Code §§ 74.66.005, *et seq*.

186. Relator hereby incorporates, by reference, all of the allegations from each of the preceding paragraphs.

187. This is a claim brought by Relator and Washington to recover treble damages, civil penalties, and the fees and costs of this action, under the Medicaid Fraud False Claims Act, Wash. Rev. Code §§ 74.66.005, *et seq*.

188. The Washington State Medicaid Fraud False Claims Act provides liability for any person who:

> (a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
>
> (b) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
>
> (c) Conspires to commit one or more of the violations in this subsection (1);
>
> … or
>
> (g) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.

Wash. Rev. Code § 74.66.020(1).

1 189. Through the acts described above, Defendants, their agents, employees,
2 and co-conspirators, knowingly presented, or caused to be presented, false and
3 fraudulent claims to the Washington State Health Care Authority ("HCA", which
4 administers Washington's Medicaid program, known, since 2014, as "Apple Health),
5 and knowingly failed to disclose material facts, in order to obtain payment or approval
6 from HCA and its contractors, grantees, and other recipients of its funds.
7 190. Through the acts described above, Defendants, their agents, employees,
8 and co-conspirators, knowingly made, used, and caused to be made and used false
9 records and statements, which also omitted material facts, in order to induce HCA to
10 approve and pay false and fraudulent claims.
11 191. Through the acts described above, Defendants, their agents, employees,
12 and co-conspirators, knowingly made, used, and caused to be made and used false
13 records and statements material to an obligation to pay and transmit money to HCA,
14 and knowingly concealed and improperly avoided and decreased an obligation to pay
15 and transmit money to HCA.
16 192. Through the acts described above, Defendants, their agents, employees,
17 and other co-conspirators knowingly conspired to submit false claims to HCA and to
18 deceive HCA for the purpose of causing the State of Washington to pay or allow false or
19 fraudulent claims.
20 193. The State of Washington, unaware of the falsity of the records,
21 statements, and claims made and submitted by Defendants, its agents, employees, and
22 co-conspirators, and as a result thereof, paid money that it otherwise would not have
23 paid.
24

1 194. By reason of the payments made by the State of Washington as a result of
2 Defendants' fraud, the State of Washington has suffered damages and continues to be
3 damaged.

4 **COUNT VIII**
Unlawful Retaliation Pursuant to the False Claims Act
5 **31 U.S.C. § 3730(h)**

6 195. Relator hereby incorporates, by reference, all of the allegations from each
7 of the preceding paragraphs.
8 196. Through the acts described above, Defendant Kaiser Foundation Health
9 Plan, Inc., and Kaiser's agents, employees, and co-conspirators, unlawfully retaliated
10 against Relator, in violation of the False Claims Act, 31 U.S.C. § 3730(h), which
11 prohibits the discharge, demotion, suspension, threatening, harassment or other
12 discrimination against an employee because of any lawful act done by the employee on
13 behalf of the employee or others in furtherance of an action under the FCA.
14 197. As a direct and proximate result of Defendants' unlawful retaliation,
15 Relator has suffered, and will continue to suffer, economic and non-economic harm for
16 which Kaiser is liable, including but not limited to back pay, interest on the back pay,
17 front pay, compensation for any special damages sustained as a result of the
18 discrimination, punitive damages, and attorneys' fees.

19 **COUNT IX**
Unlawful Retaliation Pursuant to the California False Claims Act
20 **Cal. Gov't Code § 12653**

21 198. Relator hereby incorporates, by reference, all of the allegations from each
22 of the preceding paragraphs.
23 199. Through the acts described above, Kaiser Foundation Health Plan, Inc.,
24 and Kaiser's agents, employees, and co-conspirators, unlawfully retaliated against

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

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

COUNT X
Unlawful Retaliation in Violation of the California Labor Code
Cal. Lab. Code § 1102.5(b)

201. Relator hereby incorporates, by reference, all of the allegations from each of the preceding paragraphs.

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

203. As a direct and proximate result of Defendants' unlawful conduct, Relator has suffered, and will continue to suffer, economic and non-economic harm for which Kaiser is liable, including but not limited to back pay, interest on the back pay, front pay, compensation for any special damages sustained as a result of the discrimination, punitive damages, and attorneys' fees.

COUNT XI
Retaliatory Common Law Termination in Violation of Public Policy

204. Relator hereby incorporates, by reference, all of the allegations from each of the preceding paragraphs.

205. At all times relevant herein, Relator was an employee and Kaiser Foundation Health Plan, Inc. was his employer, as recognized by California common law.

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

207. Kaiser's retaliatory actions against violated clear public policy and are the actual and proximate cause of his injuries, as described herein.

1 **REQUEST FOR RELIEF**

2 WHEREFORE, *qui tam* Relator Jeffrey Mazik respectfully requests that the
3 Court enter judgment against Defendants, as follows:

4 (a) that Defendants cease and desist from violating the federal False
5 Claims Act, 31 U.S.C. §§ 3729–33, and the analogue state versions of the False
6 Claims Act in California, Colorado, Georgia, Hawai'i, Virginia, and Washington;

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

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

19 (d) that Defendant Kaiser Foundation Health Plan, Inc. pay to
20 Plaintiff-Relator front pay compensation in lieu of reinstating Plaintiff-Relator to
21 a position similar to that he would have had, but-for the retaliation; two times
22 back pay, plus interest; and compensation for additional and special damages
23 sustained as a result of the retaliation, including litigation costs and reasonable
24 attorneys' fees.

(e) that Plaintiff-Relator be awarded all costs of this action, including attorneys' fees and expenses; and

(f) any other such relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

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

Dated: March 26, 2024

POLLOCK COHEN LLP

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

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