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 13 P.C.

12 **UNITED STATES DISTRICT COURT**  
 13 **EASTERN DISTRICT OF CALIFORNIA**

14 UNITED STATES OF AMERICA et al. ex  
 15 rel. JEFFREY MAZIK,

16 Plaintiffs,

17 v.

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

20 Defendants.

Case No. 2:19-cv-0559-DAD-JDP

Judge: Hon. Dale A. Drozd

Courtroom 4, 15th Floor

**DEFENDANTS' OPPOSITION TO  
 RELATOR'S MOTION FOR A  
 TEMPORARY STAY, MODIFICATION  
 OF SCHEDULE AND ORDER OF  
 REFERENCE**

**Date: May 18, 2026**

**Time: 1:30 PM**

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1 **I. Introduction**

2 Relator’s motion to stay and modify the scheduling order is both moot and  
3 premature. While the motion recounts procedural history and speculates about the filing of  
4 future motions, these arguments do not support a stay or a modification of the Court’s scheduling  
5 order. The motion should be denied in its entirety.

6 Relator’s request for a “temporary stay of discovery” is moot because fact discovery is  
7 now closed and there are no pending discovery obligations. At the time Relator filed this  
8 motion, he sought to avoid sitting for his deposition and responding to written discovery. Since  
9 then, however, Relator served written responses on April 13, sat for his deposition on April 14,  
10 and fact discovery closed for all parties on April 15. In short, there is no fact discovery to stay  
11 because it has already been completed.

12 Relator’s request to amend the scheduling order fares no better. That request is  
13 predicated on Relator’s stated intention to seek leave to amend the complaint. But Relator has  
14 not filed any such motion, and no amendment has been granted. The request to modify the  
15 Court’s schedule is therefore premature, and, in any event, any such amendment would face  
16 substantial obstacles given the age of this case and Relator’s lack of diligence in prosecuting his  
17 claims to date. As the Court has already made clear, “the filing of motions and/or stipulations  
18 requesting leave to amend the pleadings does not imply good cause to modify the existing  
19 schedule.” ECF No. 123 at 2. Here, Relator has not even taken that step.

20 Relator also seeks additional time to conduct discovery but has not shown the required  
21 good cause to do so. This case has been pending since 2019, and discovery has been open for  
22 years. The Court ordered the completion of fact discovery by July 15, 2025, a date that was later  
23 extended by stipulation to April 15, 2026. Relator had ample opportunity to pursue discovery  
24 during that period. Any failure to do so reflects a lack of diligence, not good cause to reopen or  
25 extend discovery.

26 Finally, there is no basis to order a settlement conference before a magistrate judge. The  
27 parties have already engaged in settlement discussions and remain free to do so. If they  
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1 determine that third-party assistance would be helpful, they may jointly seek a referral or retain a  
2 private mediator. Relator identifies no basis to compel such a referral here.

3 **II. The Request for a Temporary Stay of Discovery Is Moot**

4 Relator’s request for a temporary stay of discovery is moot because the discovery he  
5 sought to delay has already been completed. Relator moved to stay discovery shortly before his  
6 scheduled deposition and while written discovery served by Defendants remained outstanding.  
7 Since then, however, Relator has served written responses, appeared for his deposition, and fact  
8 discovery has closed for all parties. *See* Declaration of Aaron M. May (“May Decl.”) ¶¶ 14-17;  
9 Exs. I-J; Dkt. No. 128. There is no ongoing discovery to stay.

10 Courts routinely deny requests to stay discovery where the discovery at issue has already  
11 occurred. *See United States v. Phu Tan Luong*, No. SA CV 07-00202-CJC(MLGx), 2007 WL  
12 9753000, at \*2 (C.D. Cal. June 5, 2007) (request to stay deposition moot where deposition had  
13 already occurred); *see also Besing v. Taylor*, No. 13-CV-3159-CAB (DHB), 2014 WL 7409554,  
14 at \*1 (S.D. Cal. Dec. 31, 2014) (denying motion as moot where requested relief was no longer  
15 available). Because Relator has now completed the discovery he sought to delay, his request for  
16 a temporary stay presents no live controversy and should be denied as moot. *See Already, LLC*  
17 *v. Nike, Inc.*, 568 U.S. 85, 91 (2013).

18 Even if the request were not moot, Relator has not met the standard required to justify a  
19 stay. A stay is an extraordinary remedy that requires a clear showing of hardship or inequity.  
20 *See Landis v. N. Am. Co.*, 299 U.S. 248, 255 (1936); *Dependable Highway Express, Inc. v.*  
21 *Navigators Ins. Co.*, 498 F.3d 1059, 1066–67 (9th Cir. 2007). A mere preference for delay or  
22 strategic convenience is insufficient. *Lockyer v. Mirant Corp.*, 398 F.3d 1098, 1112 (9th Cir.  
23 2005). Relator has not made that showing here.

24 **III. The Motion to Modify the Scheduling Order Should Be Denied**

25 Relator cannot show good cause to modify the Court’s scheduling order. First, Rule 16’s  
26 good-cause inquiry turns primarily on diligence, and Relator has not acted diligently in pursuing  
27 discovery or developing the claims he now says require additional time. *See Johnson v.*  
28 *Mammoth Recreations, Inc.*, 975 F.2d 604, 609 (9th Cir. 1992). Second, the motion is premature

1 because it is predicated on a possible future motion for leave to amend that Relator has not filed,  
2 and no leave has been granted or likely will ever be granted. *See Dependable Highway Express*,  
3 498 F.3d at 1066–67; ECF No. 123 at 2. Third, Relator’s recent substitution of counsel does not  
4 constitute good cause to reopen discovery or extend deadlines. *See Zivkovic v. S. Cal. Edison*  
5 *Co.*, 302 F.3d 1080, 1087 (9th Cir. 2002). For all of these reasons, the motion should be denied.

6 **A. Legal Standard**

7 Relator’s request to modify the Court’s scheduling order and re-open fact discovery and  
8 extend case deadlines is governed by Federal Rule of Civil Procedure 16. Under Rule 16(b)(4), a  
9 scheduling order “may be modified only for good cause and with the judge’s consent.” The  
10 “good cause” inquiry focuses primarily on the diligence of the party seeking modification; if that  
11 party was not diligent, the inquiry should end. *Johnson*, 975 F.2d at 609.

12 As set forth below, Relator cannot meet that standard. To the extent Relator’s request is  
13 based on his assertion that he will file an amended complaint at some unspecified future date, it  
14 is premature. More fundamentally, he has not shown he used the *years* he had to take discovery  
15 wisely or exercised diligence in the prosecution of this case under the schedule agreed to by the  
16 parties and approved by the Court.

17 **B. Procedural History of the Scheduling Order and Discovery**

18 On August 23, 2024, the Court issued a Rule 16(b) Scheduling Order governing all  
19 subsequent proceedings in the case. *See* ECF No. 123. That order established a comprehensive  
20 schedule, including a fact discovery cutoff of July 15, 2025, expert discovery through March  
21 2026, and dispositive motion deadlines in June 2026. *See id* at 3-4.

22 Critically, the Court expressly warned that the schedule could not be modified absent a  
23 showing of good cause under Rule 16(b), citing *Johnson v. Mammoth Recreations, Inc.*, and  
24 further advising that:

- 25
- 26 • “No further ... amendments to pleadings [are] permitted without leave of court, good  
cause having been shown,” and
  - 27 • “the filing of motions ... requesting leave to amend the pleadings does not imply  
28 good cause to modify the existing schedule.”

1 *See id.* at 2.

2 Thus, from the outset, the parties were on clear notice that diligence, not convenience,  
3 would govern any later request to modify deadlines.

4 Following entry of the Scheduling Order, the parties proceeded with discovery under its  
5 terms. They exchanged written discovery, served responses, and produced documents. *See* ECF  
6 No. 127 at 2. The parties also negotiated and entered into a detailed protocol governing  
7 electronically stored information (“ESI”). *See* ECF No. 126.

8 In July 2025, the parties submitted a joint stipulation to extend the fact discovery  
9 deadline by nine months. In connection with that stipulation, Relator informed the court “he  
10 intends to serve additional requests for certain categories of data” and “has not yet completed his  
11 document production.” ECF No. 127 at 2. Defendants waited to conduct depositions until after  
12 that document production was made. Based on those representations, the Court granted that  
13 request, finding good cause and resetting the schedule to extend fact discovery to April 15, 2026  
14 and pushing back trial and all other deadlines. *See* ECF No. 128.

15 Despite that extensive history, and despite having already obtained an extension of the  
16 discovery deadlines, Relator now seeks yet another modification after the close of fact discovery  
17 based on purported new theories of liability and his incomplete investigation of the relevant  
18 facts. Rule 16 does not permit that result, especially in a case that is over seven years old.

19 **C. Relator’s Motion to Modify the Scheduling Order Is Premature**

20 Relator’s request to modify the scheduling order based on the potential filing of a motion  
21 to amend the complaint for a third time is premature and should be denied on that basis alone.  
22 As Relator explains, “Relator is preparing a motion for leave to file an amended complaint on his  
23 state law claims, and that amended complaint will serve as the foundation for discovery needs for  
24 the remainder of the case.” *See* ECF No. 137 at 1. To date, Relator has not filed a motion for  
25 leave to amend, and the Court has not granted such relief. Defendants will oppose any such  
26 motion if and when it is filed. Unless and until the Court allows Relator to file an amended  
27 complaint that requires new discovery, there is no basis to modify the Scheduling Order. As this  
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1 Court already made clear, “the filing of motions ... requesting leave to amend the pleadings does  
2 not imply good cause to modify the existing schedule.” *See* ECF No. 123 at 2.

3 Without a proposed amended pleading from Relator, the Court cannot evaluate whether  
4 any amendment would be permitted under Rule 15, much less whether such a hypothetical  
5 amendment would justify modifying the existing schedule under Rule 16. Nor can Relator  
6 justify modification of the schedule based on the assumption that any future motion to amend  
7 will be granted. *See id.* Whether amendment would be permitted under Rule 15 is a separate  
8 question that has not been presented to the Court and would be subject to its own standards,  
9 including considerations of delay, prejudice, and futility. Relator’s request thus depends on  
10 multiple contingencies—first that he will seek amendment, second that such amendment will be  
11 allowed, and third that such amendment will require new discovery. Courts routinely deny  
12 requests to alter case schedules where the asserted basis for modification is speculative or  
13 contingent on future events that may or may not occur. *See Dependable Highway Express*, 498  
14 F.3d at 1066–67; *Lockyer*, 398 F.3d at 1112.

15 Relator also contends that the settlement between the U.S. Department of Justice, the  
16 Kaiser defendants, and different relators in the *Osinek* case “will have a profound impact on the  
17 course and scope of this case.” ECF No. 137 at 6. According to Relator, he intends “to seek  
18 leave of the Court to amend the complaint to dismiss the federal claim against defendants based  
19 on the *Osinek* settlement, and to develop the remaining state law claims consistent with the core  
20 facts already identified in Mazik’s initial pleadings.” *Id.* at 17.

21 In addition to being premature, this argument is flawed in at least two ways. *First*, the  
22 dismissal of Relator’s federal *qui tam* claims, while warranted, *narrows* the issues to be tried and  
23 should streamline the case going forward. Accordingly, if anything, the *Osinek* settlement—and  
24 the corresponding dismissal of Relator’s federal claims in this action—means the parties need  
25 *less* time to prepare this case for trial, not more time. To the extent there needs to be motion  
26 practice in this Court to determine the effect of the *Osinek* settlement, that can be addressed  
27 under the existing schedule as the motion deadline in this case is not until June 19, 2027.  
28 Nothing about the *Osinek* settlement requires this Court to extend discovery and delay trial.

1 *Second*, his state law claims are not new. Indeed, Relator alleged the same state law claims in  
2 his original 2019 complaint. ECF No. 1, ¶¶ 366-521. That Relator failed to investigate or seek  
3 discovery in pursuit of those claims demonstrates his lack of diligence; it is not a reason for  
4 further delays.

5 Critically, Relator identifies no concrete discovery that is newly required as a result of the  
6 *Osinek* proceedings. He does not point to any newly discovered facts, unavailable evidence, or  
7 third-party information that could not have been obtained during the discovery period. Instead,  
8 he asserts only that he may wish to “refocus” his claims or pursue different theories. *See* ECF  
9 No. 137 at 1, 7, and 17. That is not a basis to modify the Court’s schedule. As discussed below,  
10 Rule 16 does not permit a party to reopen discovery simply because it wishes to pursue a  
11 different litigation strategy after the close of fact discovery.

12 In short, Relator seeks to extend the case based on hypothetical future developments, not  
13 present necessity. Because no amendment has been sought, no new claims have been identified,  
14 and no additional discovery has been shown to be required, the motion to modify the scheduling  
15 order is premature and should be denied.

16 **D. Relator’s Lack of Diligence Does Not Support Modification of the Scheduling**  
17 **Order**

18 Relator cannot establish the diligence required to modify the Court’s scheduling order  
19 under Rule 16. *See Johnson*, 975 F.2d at 609. To the contrary, the record shows that Relator had  
20 ample time to pursue discovery and develop his claims but failed to do so. The Rule 16 inquiry  
21 focuses primarily on the “diligence of the party seeking the amendment,” and where that party  
22 was not diligent, “the inquiry should end.” *Id.* Although prejudice to the opposing party may  
23 also be considered, it cannot supply good cause where diligence is lacking. *Id.* Here, both the  
24 absence of diligence and the resulting prejudice to Defendants confirm that modification is  
25 unwarranted.

26 This case has been pending for years, and the Court entered a comprehensive scheduling  
27 order allowing the parties until July 15, 2025 to complete fact discovery. *See* ECF No. 123 at 3.  
28 The parties thereafter conducted discovery over an extended period. In July 2025, Relator stated

1 he needed more time to issue additional discovery requests and complete his document  
2 production. The parties jointly stipulated to a nine-month extension, representing that it would  
3 allow them to “complete the outstanding discovery,” including depositions and additional written  
4 discovery. *See* ECF No. 127 at 2. Having obtained that substantial extension based on those  
5 representations, Relator cannot now seek a further extension based on his failure to complete that  
6 same work within the extended period.

7 Despite that lengthy discovery period and substantial extension, Relator did not diligently  
8 pursue discovery. He served written discovery beginning in 2022 and continuing through 2024,  
9 including requests expressly directed to the Medicaid and state-law issues. *See* May Decl. ¶¶ 4-  
10 7, Exs. A-C (Pl.-Relator’s First Set of Interrogatories; Pl.-Relator’s Third and Fourth Sets of  
11 Requests for Production). But he did not follow through with basic discovery necessary to  
12 develop those theories, including depositions, third-party subpoenas, or any discovery-related  
13 motions. Defendants also repeatedly sought clarification of Relator’s Medicaid and state-law  
14 theories through written correspondence, but Relator did not meaningfully narrow or develop  
15 those claims during the discovery period. *See id.* ¶¶ 8-13, Exs. D-H (Mar. 25, 2024 Letter re  
16 Medi-Cal Allegations; July 15, 2024 Letter re Medi-Cal Allegations; Aug. 12, 2024 Letter re  
17 Medicaid Theories; May 15, 2025 Letter re Multi-State Medicaid Claims; May 30, 2025 Letter re  
18 Medicaid Claims).

19 Relator’s own discovery responses confirm that he has not used the seven years while this  
20 case was pending to complete his factual investigation. He admits that he “has not completed his  
21 investigation of the facts relating to this case” and reserves the right to “amend, supplement, or  
22 otherwise change” his responses. *See id.* ¶ 15, Ex. I at 2 (Pl.-Relator’s Responses & Objections  
23 to Defendants’ Requests for Admission (Set One)). He likewise acknowledges that his analysis  
24 was limited to “system-level compliance” and did not include claim-level review, and that he has  
25 not performed any analysis quantifying alleged damages. *See id.* ¶ 16, Ex. J (Pl.-Relator’s  
26 Responses & Objections to Defendants’ Interrogatories (Set Two), as amended, Nos. 15, 18, 21).

27 These admissions underscore that Relator seeks additional time not because of any newly  
28 arising issue, but to complete work he did not undertake during the pendency of this case.

1 Relator’s request instead rests on his assertion that the *Osinek* settlement changes the posture of  
2 his claims and requires him to “refocus[.]” his case. *See* ECF No. 137 at 6–7, 9–13. But the  
3 issues he now seeks to pursue arise from the same alleged risk adjustment fraud underlying this  
4 action—matters that were presumably known to him when he filed the case in 2019 and  
5 throughout the lengthy discovery period. That is not diligence.

6 The lack of diligence is compounded by the prejudice that would result from reopening  
7 discovery at this stage. According to Relator’s allegations, the underlying events in this case  
8 date back to 2008. *See* ECF No. 107 ¶ 49. With the passage of time, Defendants’ ability to  
9 defend against those allegations is further diminished as memories fade and witnesses retire,  
10 move, or otherwise become unavailable. Delay “inherently increases the risk that witnesses’  
11 memories will fade and evidence will become stale” and enhances the prejudice caused by  
12 additional continuances. *See Blue Cross & Blue Shield of Ala. v. Unity Outpatient Surgery Ctr.,*  
13 *Inc.*, 490 F.3d 718, 724 (9th Cir. 2007) (citation modified).

14 Defendants have also already completed written discovery, taken Relator’s deposition,  
15 and prepared their case in reliance on the case deadlines and the theories pled in the operative  
16 complaint. Reopening discovery now would require Defendants to revisit and potentially  
17 duplicate those efforts, including re-engaging in written discovery, preparing for additional  
18 depositions, and reassessing expert and dispositive motion strategy based on newly asserted  
19 theories. Courts routinely deny requests to delay proceedings or reopen discovery where, as  
20 here, the case has progressed through discovery and is ready to proceed. *See Stafford v. Rite Aid*  
21 *Corp.*, No. 3:17-CV-1340-AJB-JLB, 2019 WL 3818019, at \*1 (S.D. Cal. Aug. 14, 2019)  
22 (denying defendant’s motion to stay where it was filed two years into litigation and after  
23 extensive discovery has already been completed); *see also Kilopass Tech. Inc. v. Sidense Corp.*,  
24 No. C 10-02066 SI, 2011 WL 13153233, at \*3 (N.D. Cal. Feb. 8, 2011) (denying stay where  
25 delay risked faded memories and evidentiary loss). That type of disruption to the orderly  
26 progression of the case constitutes prejudice and weighs strongly against modification of the  
27 schedule. *See Robles v. Domino's Pizza, LLC*, No. 2:16-CV-06599-SJO-FFM, 2019 WL  
28 6482232, at \*5 (C.D. Cal. July 30, 2019) (finding that “delaying an action that has already been

1 pending for several years is prejudicial,” as the parties have a “strong interest in the timely  
2 resolution of litigation”); *Nat’l Rural Telecomms. Coop. v. DIRECTV, Inc.*, 319 F. Supp. 2d  
3 1094, 1108 (C.D. Cal. 2003) (“[T]he Court finds that the issuance of a stay may substantially  
4 injure NRTC and DIRECTV who have been involved in this litigation since 1999 and are  
5 entitled to an expeditious resolution of the NRTC Actions.”).

6 In substance, Relator’s motion seeks a do-over. Having had years to pursue discovery,  
7 and having already obtained a substantial extension of the schedule, Relator now asks the Court  
8 to reopen discovery and extend the trial date based on his intention to bring new claims that he  
9 has not even identified for the Court. Rule 16 does not permit modification of a scheduling order  
10 under those circumstances. *See Johnson*, 975 F.2d at 609; *Zivkovic*, 302 F.3d at 1087.

11 Accordingly, Relator’s lack of diligence independently warrants denial of the motion.

12 **E. Relator’s Change in Counsel Does Not Constitute Good Cause**

13 Relator also suggests that modification of the schedule is warranted based on changes in  
14 one of his counsel’s circumstances. That argument does not establish good cause under Rule 16.

15 It is well established that changes in counsel, whether due to substitution, withdrawal, or  
16 personal circumstances, do not constitute good cause to modify a scheduling order. *See*  
17 *Zivkovic*, 302 F.3d at 1087; *Johnson*, 975 F.2d at 609. A party remains responsible for  
18 complying with the Court’s schedule, regardless of changes in representation.

19 That principle applies here. Relator has changed attorneys and law firms multiple times,  
20 including the recent addition of the Mendenhall Law Group as counsel in January 2026. *See*  
21 ECF Nos. 129, 132–134. Relator continues to be represented by multiple attorneys, including  
22 longstanding counsel Jeremy Friedman, who has appeared in this action since at least March  
23 2021. *See* ECF No. 45. Relator therefore has not been deprived of representation or the ability  
24 to litigate this case.

25 Defendants are mindful of counsel’s reported medical circumstances and do not minimize  
26 those concerns. But those circumstances do not alter the Rule 16 analysis, particularly when a  
27 case is this old and Relator is assisted by multiple attorneys. The question is whether Relator  
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1 acted diligently in pursuing his claims within the time provided. The record demonstrates that he  
2 did not.

3 **F. There Is No Basis to Refer the Case to a Magistrate Judge**

4 Relator also requests that the Court refer this matter to a magistrate judge for settlement  
5 purposes. That request should be denied.

6 As an initial matter, Relator cites no authority requiring or favoring referral under these  
7 circumstances. Nor does he identify any reason why referral is necessary, as opposed to the  
8 ordinary course of party-driven settlement discussions. The absence of any supporting authority  
9 or case-specific justification is itself sufficient to deny the request.

10 In any event, referral is unnecessary. The parties are fully capable of conducting  
11 settlement discussions without Court intervention, whether directly or through the use of a  
12 private mediator. The decision whether to refer a case for a settlement conference is committed  
13 to the Court's discretion, and courts deny such requests where they are unnecessary. *See Daniels*  
14 *v. Aguillera*, No. 2:16-CV-0996 JAM CKD P, 2019 WL 95510, at \*3 (E.D. Cal. Jan. 3, 2019).

15 Relator's request appears to be premised on the same considerations underlying his  
16 broader motion—namely, his desire to extend the case schedule and revisit his claims in light of  
17 the *Osinek* proceedings. But those considerations do not justify referral. Settlement discussions  
18 can proceed, if appropriate, under the existing schedule and without delaying the progress of the  
19 case. Moreover, the parties have already engaged in prior settlement discussions. *See* ECF No.  
20 137 at 13. The fact that those efforts did not result in resolution does not establish that court-  
21 ordered referral is now warranted.

22 Relator has not shown that referral would promote efficiency, conserve judicial  
23 resources, or materially advance resolution of this case. The request should therefore be denied.

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**IV. Conclusion**

For the foregoing reasons, Relator’s motion should be denied in its entirety.

Dated: April 22, 2026

HALPERN MAY YBARRA GELBERG LLP

*/s/ Aaron M. May*

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Aaron M. May

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 12 Group; and Colorado Permanente Medical Group,  
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12 **UNITED STATES DISTRICT COURT**  
 13 **EASTERN DISTRICT OF CALIFORNIA**

14 UNITED STATES OF AMERICA et al. ex  
 15 rel. JEFFREY MAZIK,

16 Plaintiff,

17 v.

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

20 Defendants.

Case No. 2:19-cv-0559-DAD-JDP

Judge: Hon. Dale A. Drozd

Courtroom 4, 15th Floor

**DECLARATION OF AARON M. MAY IN  
 SUPPORT OF DEFENDANTS'  
 OPPOSITION TO RELATOR'S MOTION  
 FOR A TEMPORARY STAY,  
 MODIFICATION OF SCHEDULE AND  
 ORDER OF REFERENCE**

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**DECLARATION OF AARON M. MAY**

I, Aaron M. May, declare as follows:

1. I am a partner at Halpern May Ybarra Gelberg LLP and counsel for Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (collectively, “Defendants”) in this action. I am over the age of eighteen. Unless otherwise stated, I have personal knowledge of the facts set forth herein and, if called as a witness, I could and would competently testify thereto.

2. Plaintiff-Relator Jeffrey Mazik is referred to herein as “Relator.”

3. I submit this declaration in support of Defendants’ Opposition to Relator’s Motion for a Temporary Stay, Modification of Schedule and Order of Reference.

**Relator’s Written Discovery Requests**

4. During the course of discovery, Relator served written discovery requests, including interrogatories and requests for production directed to issues relating to Medicaid and state-law claims.

5. A true and correct copy of Relator’s First Set of Interrogatories is attached hereto as Exhibit A.

6. A true and correct copy of Relator’s Third Set of Requests for Production is attached hereto as Exhibit B.

7. A true and correct copy of Relator’s Fourth Set of Requests for Production is attached hereto as Exhibit C.

**Defendants’ Meet-and-Confer Efforts**

8. Defendants sent multiple written communications to Relator seeking clarification of Relator’s Medicaid and state-law theories and identifying perceived deficiencies in Relator’s discovery responses.

9. A true and correct copy of the March 25, 2024 letter, not including the exhibits thereto, from Dimitri D. Portnoi (OMM) to Adam Pollock (Pollock Cohen) regarding Medi-Cal allegations is attached hereto as Exhibit D.

1 10. A true and correct copy of the July 15, 2024 letter from Adam Pollock (Pollock  
2 Cohen) to Kyle M. Grossman (OMM) regarding Medi-Cal allegations is attached hereto as  
3 Exhibit E.

4 11. A true and correct copy of the August 12, 2024 letter from Dimitri D. Portnoi  
5 (OMM) to Adam Pollock (Pollock Cohen) regarding Medi-Cal and Medicaid allegations is  
6 attached hereto as Exhibit F.

7 12. A true and correct copy of Defendants' May 15, 2025 letter from Dimitri D.  
8 Portnoi (OMM) to Adam Pollock (Pollock Cohen) regarding Medi-Cal and Medicaid allegations  
9 is attached hereto as Exhibit G.

10 13. A true and correct copy of the May 30, 2025 letter from Adam Pollock (Pollock  
11 Cohen) to Dimitri D. Portnoi (OMM) regarding Medicaid allegations is attached hereto as  
12 Exhibit H.

13 **Discovery Status and Completion**

14 14. On April 13, 2026, Relator served written responses to Defendants' outstanding  
15 written discovery requests.

16 15. A true and correct copy of Relator's Responses and Objections to Defendants'  
17 Requests for Admission (Set One) is attached hereto as Exhibit I.

18 16. A true and correct copy of Relator's Responses and Objections to Defendants'  
19 Interrogatories (Set Two) is attached hereto as Exhibit J.

20 17. On April 14, 2026, Relator appeared for and completed his deposition.

21  
22 I declare under penalty of perjury under the laws of the United States that the foregoing is  
23 true and correct. Executed this 22nd day of April, 2026.

24  
25 /s/ Aaron M. May  
26 Aaron M. May

# **EXHIBIT A**

POLLOCK COHEN LLP  
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Adam Pollock (*pro hac vice*)  
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San Francisco, CA 94105  
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Email: adam@pollockcohen.com

LAW OFFICE OF JEREMY L. FRIEDMAN  
Jeremy L. Friedman, CA Bar No. 142659  
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Email: jlfried@comcast.net

*Counsel for Plaintiff-Relator, Jeffrey Mazik*

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF CALIFORNIA**

UNITED STATES OF AMERICA *et al.*,  
*ex rel.* JEFFREY MAZIK,

Plaintiffs,

v.

KAISER PERMANENTE, INC. *et al.*,

Defendants.

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

**PLAINTIFF-RELATOR'S FIRST SET OF INTERROGATORIES**

Pursuant to the Federal Rules of Civil Procedure, Fed. R. Civ. P. 26 and 33, the Local Rules of Practice of the United States District Court for the Eastern District of California, L.R. 250.2, and consistent with the preliminary discovery plan entered by the parties to this action on September 13, 2022 (ECF. No. 88), Plaintiff-Relator Jeffrey Mazik ("Plaintiff") hereby submits the following interrogatories to Defendants Kaiser Foundation Health Plan, Inc., Kaiser

Foundation Hospitals, Inc., and the Permanente Medical Groups (collectively, “Defendants” and/or “Kaiser”).

### **DEFINITIONS AND INSTRUCTIONS**

1. The definitions, instructions, and rules of construction set forth in the Federal Rules and Local Rule 250.2 are hereby incorporated and shall apply to Plaintiff-Relator’s First Set of Interrogatories to Defendants. These definitions shall apply throughout the Requests without regard to capitalization.

2. The term “communication” means the transmittal of information (in the form of facts, ideas, inquiries or otherwise).

3. The term “document” is defined to be synonymous in meaning and equal in scope to the usage of the term “documents or electronically stored information” in Fed. R. Civ. P. 34(a)(1)(A). A draft or non-identical copy is a separate document within the meaning of this term.

4. When referring to a person, “to identify” means to give, to the extent known, the person’s full name, present or last known address, and when referring to a natural person, additionally, the present or last known place of employment. Once a person has been identified in accordance with this subparagraph, only the name of that person need be listed in response to subsequent discovery requesting the identification of that person.

5. When referring to documents, “to identify” means to give, to the extent known, the (i) type of document; (ii) general subject matter; (iii) date of the document; and (iv) author(s), addressee(s) and recipient(s). In the alternative, the responding party may produce the documents, together with identifying information sufficient to satisfy Fed. R. Civ. P. 33(d).

6. The terms “plaintiff” and “defendant” as well as a party’s full or abbreviated name or a pronoun referring to a party mean the party and, where applicable, its subsidiaries, affiliates,

officers, directors, employees, partners, or corporate parent. This definition is not intended to impose a discovery obligation on any person who is not a party to the litigation.

7. The term “person” is defined as any natural person or any legal entity, including, without limitation, any business or governmental entity or association.

8. The term “concerning” means relating to, referring to, describing, evidencing or constituting.

9. The terms “all,” “any,” and “each” shall each be construed as encompassing any and all.

10. The connectives “and” and “or” shall be construed either disjunctively or conjunctively as necessary to bring within the scope of the discovery request all responses that might otherwise be construed to be outside of its scope.

11. The use of the singular form of any word includes the plural and vice versa.

12. The term “you” or “yours” refers to Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, Inc., and the Permanente Medical Groups, and any subsidiaries, affiliates, predecessors or successors-in-interest, corporate parent(s), controlling entity, and each of their agents, officials, officers, employees, or any other person acting or authorized to act on its behalf.

13. The term “Plaintiff States” refers to the State of California, the State of Colorado, the State of Georgia, the State of Hawaii, the State of Maryland, the Commonwealth of Virginia, and the State of Washington.

14. The term “government-funded healthcare plan” means any health insurance plan that is paid for, in whole or in part, by the federal Centers for Medicare and Medicaid Services and/or state government agencies or programs.

15. The masculine includes the feminine and neuter genders. The past tense includes the present tense where the clear meaning is not distorted by change of tense.

16. If you object to any interrogatory or any portion of an interrogatory based on a claim of privilege or would reveal the substance of a privileged communication, you shall identify:

- (a) the nature of the privilege which is being claimed and, if the privilege is governed by state law, indicate the state's privilege rule being invoked;
- (b) the type of document;
- (c) the subject matter of the document;
- (d) the date of the document;
- (e) the author of the document, the addressees of the document, and any other recipients, and, where not apparent, the relationship of the author, addressees, and recipients to each other; and
- (f) the present custodian of the document.

17. Answer each interrogatory fully, separately, in writing, and under oath. If you object to any interrogatory, state the reasons for objection and answer to the extent the interrogatory is not objectionable. If you are unable to answer an interrogatory fully, submit as much information as is available, explain why your answer is incomplete, and identify or describe all other sources of more complete or accurate information.

18. For any record or document responsive or relating to these interrogatories which is known to have been destroyed or lost, or is otherwise unavailable, identify each such document by author, addressee, date, number of pages, and subject matter; and explain in detail the events leading to the destruction or loss, or the reason for the unavailability of such document.

19. The grounds for any objection to these Interrogatories must be stated with specificity. An objection to part of an interrogatory must specify the part and the interrogatory is to be otherwise answered in full.

20. If, in responding to an interrogatory, you claim any ambiguity in interpreting either the Interrogatory or a definition or instruction applicable thereto, such claim shall not be utilized by you as a basis to refuse to respond, but there shall be set forth as part of the response the language deemed to be ambiguous and the interpretation chosen or used in responding to the Interrogatory.

21. In answering these Interrogatories, you shall furnish all information, however, obtained, including hearsay, which is available to you, and information known by you or in your possession or the possession of your agents and/or attorneys.

22. For the convenience of the court and counsel, it is requested that each Interrogatory be set forth immediately preceding the answer thereto.

23. The following Interrogatories are of a continuing nature so that if, after responding, additional and new information becomes available to you prior to the completion of the trial of this suit and such information would alter, amplify, amend, or complete a previously made response, then you are required to promptly supplement your answers to these Interrogatories to provide any such new information in accordance with the Federal Rules of Civil Procedure.

### **INTERROGATORIES**

1. Identify all the relevant government-funded healthcare plans that Defendants operated and/or managed in each of the Plaintiff States, either directly, or through a subsidiary, affiliate, or partner entity, from 2007 to present.

2. Identify the total amount of risk-adjusted capitation-rate based payments that Defendants received as compensation from each of the Plaintiff States for each year, from 2007 to

present, for providing managed care insurance services through the government-funded healthcare plans that Defendants operated and/or managed either directly, or through a subsidiary, affiliate, or partner entity, during the same period.

Dated: October 25, 2022

POLLOCK COHEN LLP  
LAW OFFICE OF JEREMY L. FRIEDMAN

*/s/ Adam Pollock*

---

Adam Pollock

*Counsel for Plaintiff-Relator, Jeffrey Mazik*

# **EXHIBIT B**

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*Counsel for Plaintiff-Relator, Jeffrey Mazik*

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF CALIFORNIA**

UNITED STATES OF AMERICA *et al.*,  
*ex rel.* JEFFREY MAZIK,

Plaintiffs,

v.

KAISER PERMANENTE, INC. *et al.*,

Defendants.

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

**PLAINTIFF-RELATOR'S THIRD SET OF DOCUMENT REQUESTS**

Pursuant to the Federal Rules of Civil Procedure, Fed. R. Civ. P. 26 and 34, the Local Rules of Practice of the United States District Court for the Eastern District of California, L.R. 250.3, Plaintiff-Relator Jeffrey Mazik ("Plaintiff") hereby submits the following document requests to Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, Inc., and the Permanente Medical Groups (collectively, "Defendants" and/or "Kaiser").

## DEFINITIONS AND INSTRUCTIONS

1. The rules of construction and definitions set forth in Fed. R. Civ. P. 34 are hereby incorporated by reference as applicable to all requests herein, without regard to capitalization. In addition, the following definitions shall apply:

- (a) The terms “all,” “any,” and “each” shall each be construed as encompassing any and/or all.
- (b) The terms “and” and “or” shall be construed either disjunctively or conjunctively as necessary to bring within the scope of the discovery request all responses that might otherwise be construed to be outside of its scope.
- (c) The term “communication” refers to every manner or means of disclosure, transfer, or exchange of information or attempted disclosure, transfer, or exchange of information, and/or any record thereof.
- (d) The term “concerning” means relating to, referring to, describing, evidencing or constituting.
- (e) The term “document” is defined to be synonymous in meaning and equal in scope to the usage of the term “documents or electronically stored information” in Fed. R. Civ. P. 34(a)(1)(A), and shall be construed broadly to include, without limitation, writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations stored in any medium from which information can be obtained. A draft or non-identical copy is a separate document within the meaning of this term.
- (f) The term “government-funded healthcare plan” means any health insurance plan that is paid for, in whole or in part, by the federal Centers for Medicare and Medicaid Services or by any state government agency or program.
- (g) The terms “you” or “yours” and/or “Kaiser” shall refer to the Defendants in this action and any applicable subsidiaries, affiliates, predecessors or successors-in-interest, corporate parent(s), controlling entity, and each of their agents, officials, officers, employees, or any other person acting or authorized to act on its behalf.

2. Unless otherwise defined, all other words and phrases used herein shall be accorded their usual meanings and shall be interpreted in their common, ordinary sense.

The use of the singular form of any word includes the plural and vice versa; the masculine includes the feminine and neutral genders; the past tense includes the present tense where the clear meaning is not distorted by change of tense, etc.

3. Unless otherwise specified in a specific document request, the relevant time period for this particular set of document requests spans from 2007 to the present.

4. All electronically stored information (“ESI”) shall be produced in a format mutually agreed upon by the parties or ordered by the Court.

5. If no responsive documents are within your possession, custody, or control, state so in writing in your response to the specific document request.

6. If any responsive document has been lost, destroyed, or otherwise is no longer in your possession, custody, or control, provide for reach such document:

- (a) the author, addressees, and any other recipients of the document;
- (b) the date of the document (or state that it is not dated);
- (c) a description in reasonable detail of the document;
- (d) the reason the document is no longer in your possession, custody, or control and, if it was destroyed or otherwise disposed of, the reason it was destroyed or otherwise disposed of; and
- (e) the full name and contact information for any person(s) who may have knowledge of information relating to the document.

7. If you withhold under a claim of privilege any information covered by these Requests, you shall furnish a list identifying each document or communication for which privilege is claimed, together with the following information:

- (a) the nature of the privilege which is being claimed and, if the privilege is governed by state law, indicate the state’s privilege rule being invoked;
- (b) the type of document;
- (c) the subject matter of the document;

- (d) the date of the document;
- (e) the author of the document, the addressees of the document, and any other recipients, and, where not apparent, the relationship of the author, addressees, and recipients to each other; and
- (f) the present custodian of the document.

8. If you object to any document request on any ground other than privilege, you must:

- (a) specify the part of the request that is objectionable, and response and allow inspection of materials responsive to the remainder of the request; and
- (b) state whether any responsive materials are being withheld on the basis of an objection.

9. The grounds for any objection to these Requests must be stated with specificity and any objection must state whether any responsive materials are being withheld on the basis of that objection. An objection to part of a request must specify the part and permit inspection of the rest.

10. The following Requests are of a continuing nature so that if, after responding, additional and new information becomes available to you prior to the completion of the trial of this suit and such information would alter, amplify, amend, or complete a previously made response then you are required to produce additional documents to counsel as soon as practicable after discovery of any such new information in accordance with the Federal Rules of Civil Procedure.

### **REQUESTS FOR PRODUCTION OF DOCUMENTS**

1. Relator's 2015 presentation of the comparative analysis between the functionalities provided by the claims data vendors McKesson and Verisk, as described in paragraphs 60 to 67 of the Second Amended Complaint ("SAC").

2. All documents and communications related to Relator's 2015 presentation of the comparative analysis between the functionalities provided by the claims data vendors McKesson and Verisk, as described in paragraphs 60 to 67 of the SAC.

3. Relator's 2016 presentation of his findings regarding overpayments due to erroneous error codes, as described in paragraphs 68 to 71 of the SAC.

4. All documents and communications related to Relator's 2016 presentation of his findings regarding overpayments due to erroneous error codes, as described in paragraphs 68 to 71 of the SAC.

5. All documents and communications related to the June 30, 2016 phone call between Kaiser and the U.S. Department of Health & Human Services: Office of Inspector General, including any messages sent by employees during the call, as described in paragraphs 80 to 86 of the SAC.

6. The 2013 audit with respect to Easterseals, as described in paragraph 90 of the SAC.

7. All documents and communications related to the 2013 audit with respect to Easterseals, as described in paragraph 90 of the SAC.

8. All documents and communications related to the improper claims for payment to State healthcare agencies in Georgia, Washington, and Virginia that were identified by the Verisk system, as described in paragraph 92 of the SAC.

9. The 2016 internal audit of claims data dating from 2010 through 2016 for all of the regional offices, as described in paragraph 110 of the SAC.

10. All documents and communications related to the 2016 internal audit of claims data dating from 2010 through 2016 for all of the regional offices, as described in paragraph 110 of the SAC.

11. Documents sufficient to show the date(s) on which Kaiser implemented the FICO system to review claims and the region(s) in which Kaiser implemented such review.

Dated: May 24, 2024

POLLOCK COHEN LLP  
LAW OFFICE OF JEREMY L. FRIEDMAN

*/s/ Adam Pollock*

---

Adam Pollock

*Counsel for Plaintiff-Relator, Jeffrey Mazik*

# **EXHIBIT C**

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*Counsel for Plaintiff-Relator, Jeffrey Mazik*

**UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF CALIFORNIA**

UNITED STATES OF AMERICA *et al.*,  
*ex rel.* JEFFREY MAZIK,

Plaintiffs,

v.

KAISER PERMANENTE, INC. *et al.*,

Defendants.

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

**PLAINTIFF-RELATOR'S FOURTH SET OF DOCUMENT REQUESTS**

Pursuant to the Federal Rules of Civil Procedure, Fed. R. Civ. P. 26 and 34, the Local Rules of Practice of the United States District Court for the Eastern District of California, L.R. 250.3, Plaintiff-Relator Jeffrey Mazik ("Plaintiff") hereby submits the following document requests to Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, Inc., and the Permanente Medical Groups (collectively, "Defendants" and/or "Kaiser").

## DEFINITIONS AND INSTRUCTIONS

1. The rules of construction and definitions set forth in Fed. R. Civ. P. 34 are hereby incorporated by reference as applicable to all requests herein, without regard to capitalization. In addition, the following definitions shall apply:

(a) The terms “all,” “any,” and “each” shall each be construed as encompassing any and/or all.

(b) The terms “and” and “or” shall be construed either disjunctively or conjunctively as necessary to bring within the scope of the discovery request all responses that might otherwise be construed to be outside of its scope.

(c) The term “communication” refers to every manner or means of disclosure, transfer, or exchange of information or attempted disclosure, transfer, or exchange of information, and/or any record thereof.

(d) The term “concerning” means relating to, referring to, describing, evidencing or constituting.

(e) The term “document” is defined to be synonymous in meaning and equal in scope to the usage of the term “documents or electronically stored information” in Fed. R. Civ. P. 34(a)(1)(A), and shall be construed broadly to include, without limitation, writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations stored in any medium from which information can be obtained. A draft or non-identical copy is a separate document within the meaning of this term.

(f) The term “government-funded healthcare plan” means any health insurance plan that is paid for, in whole or in part, by the federal Centers for Medicare and Medicaid Services or by any state government agency or program.

(g) The terms “you” or “yours” and/or “Kaiser” shall refer to the Defendants in this action and any applicable subsidiaries, affiliates, predecessors or successors-in-interest, corporate parent(s), controlling entity, and each of their agents, officials, officers, employees, or any other person acting or authorized to act on its behalf.

2. Unless otherwise defined, all other words and phrases used herein shall be accorded their usual meanings and shall be interpreted in their common, ordinary sense. The use of the singular form of any word includes the plural and vice versa; the masculine includes the feminine and neutral genders; the past tense includes the present tense

where the clear meaning is not distorted by change of tense, etc.

3. Unless otherwise specified in a specific document request, the relevant time period for this particular set of document requests spans from 2007 to the present.

4. All electronically stored information (“ESI”) shall be produced in a format mutually agreed upon by the parties or ordered by the Court.

5. If no responsive documents are within your possession, custody, or control, state so in writing in your response to the specific document request.

6. If any responsive document has been lost, destroyed, or otherwise is no longer in your possession, custody, or control, provide for each such document:

- (a) the author, addressees, and any other recipients of the document;
- (b) the date of the document (or state that it is not dated);
- (c) a description in reasonable detail of the document;
- (d) the reason the document is no longer in your possession, custody, or control and, if it was destroyed or otherwise disposed of, the reason it was destroyed or otherwise disposed of; and
- (e) the full name and contact information for any person(s) who may have knowledge of information relating to the document.

7. If you withhold under a claim of privilege any information covered by these Requests, you shall furnish a list identifying each document or communication for which privilege is claimed, together with the following information:

- (a) the nature of the privilege which is being claimed and, if the privilege is governed by state law, indicate the state’s privilege rule being invoked;
- (b) the type of document;
- (c) the subject matter of the document;
- (d) the date of the document;

(e) the author of the document, the addressees of the document, and any other recipients, and, where not apparent, the relationship of the author, addressees, and recipients to each other; and

(f) the present custodian of the document.

8. If you object to any document request on any ground other than privilege, you must:

(a) specify the part of the request that is objectionable, and response and allow inspection of materials responsive to the remainder of the request; and

(b) state whether any responsive materials are being withheld on the basis of an objection.

9. The grounds for any objection to these Requests must be stated with specificity and any objection must state whether any responsive materials are being withheld on the basis of that objection. An objection to part of a request must specify the part and permit inspection of the rest.

10. The following Requests are of a continuing nature so that if, after responding, additional and new information becomes available to you prior to the completion of the trial of this suit and such information would alter, amplify, amend, or complete a previously made response then you are required to produce additional documents to counsel as soon as practicable after discovery of any such new information in accordance with the Federal Rules of Civil Procedure.

#### **REQUESTS FOR PRODUCTION OF DOCUMENTS<sup>1</sup>**

20. All documents contained within the National Compliance Office (“NCO”) department file share system containing any of the following keywords:

- Claims

---

<sup>1</sup> Starting now, Plaintiff is numbering his requests sequentially, without repeating numbers from previous sets of requests. Plaintiff has made 19 prior requests.

- FICO
- Verisk
- McKesson
- IFM
- Fraud
- Glucose Test Strip
- Diabetic Test Strip
- GTS
- DTS
- Easterseals
- Easter Seals

21. All documents contained within the NCO department SharePoint containing any of the following keywords:

- Claims
- FICO
- Verisk
- McKesson
- IFM
- Fraud
- Glucose Test Strip
- Diabetic Test Strip
- GTS
- DTS
- Easterseals
- Easter Seals

22. All communications, including but not limited to emails, letters, memoranda, and instant messages contained in the Lotus Notes, SameTime, or Microsoft Outlook systems, sent to or from, or via CC or BCC, the email address Jeffrey.Mazik@kp.org, for the period January 1, 2013, to present.

23. All communications, including but not limited to emails, letters, memoranda, and instant messages, contained in the Lotus Notes, SameTime, or Microsoft Outlook systems, between the following persons, as listed in Plaintiff-

Relator's Initial Disclosures, Persons Reasonably Likely to Have Discoverable Information, for the period January 1, 2013, to present:

- Rob Belch
- Derric Gregory
- Claudia Herrera
- Derek Ho
- Marita Janiga
- Sean Kelly
- Sean Killeen
- Jay Loden
- Lorrie Marwick
- Luz McCullough
- Brian Messaris
- Timothy Molloy
- Gloria Napue
- Remedios P. Osorio
- Sue Preston
- Daren Pursche
- Rick Reynolds
- Judy Sarles
- Alice Stolz
- Laurel Sutcliffe
- Jacqueline Thomas
- Judy Lee Warford
- Bill Withers
- Blaine Yanabu
- Andrea Allmon
- Eileen Guiney

24. All calendar records, contained in the Lotus Notes or Microsoft Outlook systems, of the following persons, as listed in Plaintiff-Relator's Initial Disclosures, Persons Reasonably Likely to Have Discoverable Information, for the period January 1, 2013, to present:

- Jeffrey Mazik

- Rob Belch
- Derric Gregory
- Claudia Herrera
- Derek Ho
- Marita Janiga
- Sean Kelly
- Sean Killeen
- Jay Loden
- Lorrie Marwick
- Luz McCullough
- Brian Messaris
- Timothy Molloy
- Gloria Napue
- Remedios P. Osorio
- Sue Preston
- Daren Pursche
- Rick Reynolds
- Judy Sarles
- Alice Stolz
- Laurel Sutcliffe
- Jacqueline Thomas
- Judy Lee Warford
- Bill Withers
- Blaine Yanabu
- Andrea Allmon
- Eileen Guiney

25. All documents contained in the Audit Reporting Information System (“ARIS”) database for the period January 1, 2010, to present.

26. All documents regarding the analyzed Kaiser claim and provider data contained within the FICO insurance fraud manager, McKesson claims review, or Verisk claims review applications, for the period January 1, 2010, to present.

27. All documents regarding Kaiser overpayments reported to the Centers for Medicare and Medicaid Services, for the period January 1, 2010, to present.

28. All communications, including but not limited to emails, presentations, and memoranda, regarding Diversified Compliance Group (also known as DiMaggio Consulting Group) meetings, for the period January 1, 2010, to present.

29. A set or collection of documents which identifies, summarizes and explains any and all information technology available to Defendants and/or outside vendors that could be used to conduct data analytics of information contained in ClaimsConnect, Claims Data Warehouse, Health Connect, and/or any other database systems which contain information on patient or enrollee encounters that might refer or relate to compliance with Medicare and Medicaid rules and regulations. Documents produced pursuant to this request should include identification of systems configurations and interconnections, data fields architecture, explanatory statements, categorical lists or other writings which provide an understanding of the assembly and analysis of electronic data related to patient or enrollee health and/or medical care.

Dated: July 11, 2024

POLLOCK COHEN LLP  
LAW OFFICE OF JEREMY L. FRIEDMAN

*/s/ Adam Pollock*

---

Adam Pollock

*Counsel for Plaintiff-Relator, Jeffrey Mazik*

# **EXHIBIT D**



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March 25, 2024

**Dimitri D. Portnoi**  
D: +1 213 430 7699  
dportnoi@omm.com

**VIA EMAIL**

Adam Pollock  
Pollock Cohen LLP  
111 Broadway, Suite 1804  
New York, NY 10006

**Re: United States ex rel. Mazik v. Kaiser Foundation Health Plan, Inc., Case No. 19-cv-559-DAD-KJN (E.D. Cal.)**

Dear Mr. Pollock:

I am writing on behalf of Defendants Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Southern California Permanente Medical Group, and Colorado Permanente Medical Group (collectively, “Defendants”) to address certain allegations made in the above-captioned matter. As you know, on February 13, 2024, the Court granted in part and denied in part Defendants’ Motion to Dismiss Relator Jeffrey Mazik’s First Amended Complaint (“FAC”).<sup>1</sup> The Court did not dismiss Relator’s claim under the California False Claims Act, which alleged a fraud on California’s Medi-Cal program (the “Medi-Cal Claim”).<sup>2</sup> But the Medi-Cal Claim is factually baseless, and we request that Relator voluntarily dismiss the Medi-Cal Claim immediately.

Relator premises the Medi-Cal Claim on the unfounded assumption that California’s Medi-Cal program operated “*substantially the same*” as the federal Medicare Advantage program—specifically, that Medi-Cal used a risk-adjustment methodology factoring in diagnosis codes to calculate payments to health plans.<sup>3</sup> Relator alleges that the “capitation rate for each individual beneficiary enrolled in Kaiser’s Medicare Advantage plans (and similar plans of the State Plaintiffs) is determined according to a ‘risk adjustment’ formula that considers each individual beneficiary’s particular demographics and health status.”<sup>4</sup> According to Relator, “the health status of [beneficiaries] *is based upon diagnosis codes* that Kaiser receives from healthcare providers following medical encounters.”<sup>5</sup> The submission of “unsupported *diagnostic codes* to CMS” allegedly increased capitation rates that Defendants received from the

<sup>1</sup> See Dkt. No. 104.

<sup>2</sup> See Dkt. No. 48 (“FAC”) ¶¶ 121-30.

<sup>3</sup> *Id.* ¶ 33 (emphasis added).

<sup>4</sup> *Id.* ¶ 5.

<sup>5</sup> *Id.* ¶ 21 (emphasis added).

government under Medicare Advantage.<sup>6</sup> Relator contends that “Medi-Cal in California” relies on “*substantially the same model*” as Medicare Advantage.<sup>7</sup> Relator alleges that the submission of “unsupported diagnostic codes” resulted in “\$181 million in overpayments for services provided to members of Kaiser’s Medi-Cal program.”<sup>8</sup> Other than contending that Medi-Cal operates substantially the same as Medicare Advantage, Relator provides no specific facts about how the Medi-Cal program operates.

Medi-Cal has never operated “substantially the same” as Medicare Advantage. With a recent, limited exception discussed below, Medi-Cal has not adjusted risk based on diagnosis codes from healthcare providers—instead, it has used pharmacy data to do so. Approximately 15 years ago, the State’s Department of Health Care Services (“DHCS”) contracted with Mercer Consulting (“Mercer”) to assist with studying “the Medi-Cal capitation rate development and reimbursement structure” and to recommend how to develop “a mechanism to make risk adjustments to the rates paid to health plans.”<sup>9</sup> DHCS started implementing Mercer’s recommendations and “used a risk adjustment mechanism to develop managed care rates for the first time for the 2009-10 rate year.”<sup>10</sup> Prior to this, “rates were based on information the department collected about the use of *services* by patients enrolled in fee-for-service and the rates paid to those providers.”<sup>11</sup>

Most relevant here, the risk-adjustment methodology that DHCS adopted did not adjust risk based on diagnosis codes. Because of “a lack of reliable and complete encounter data,” DHCS used “an alternative tool” “to assess the relative medical risk of Medi-Cal beneficiaries participating in the health plans”—Medicaid Rx.<sup>12</sup> Mercer, serving as DHCS’s actuary in calculating risk-adjusted payments to health plans,<sup>13</sup> has described the model as follows: “This model uses *pharmacy data* to classify individuals into disease conditions. The pharmacy data were determined to be the most accurate and complete source of claims-level information for the Medi-Cal managed care program. The pharmacy data were used in conjunction with member

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<sup>6</sup> *Id.* ¶ 45 (emphasis added).

<sup>7</sup> *Id.* ¶ 33; *see also id.* ¶ 92 (alleging that “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 *State Plaintiffs according to their risk adjustment frameworks*” (emphasis added)).

<sup>8</sup> *Id.* ¶¶ 45, 86.

<sup>9</sup> Ex. A, California Legislative Analyst’s Office, *Medi-Cal Rate Setting Methodology for Two Plan Model* (May 5, 2010) (“2010 LAO Report”), available at <https://lao.ca.gov/Recommendations/Details/236#:~:text=%20New%20Medi-Cal%20Managed%20Care%20Rate%20Methodology%20Includes,Adjustment%20Factors%20Determined%20With%20Medicaid%20Rx...%20More%20>.

<sup>10</sup> *Id.*

<sup>11</sup> Ex. B, California Legislative Analyst’s Office, *Analysis of the 2002-03 Budget Bill*, available at [https://lao.ca.gov/analysis\\_2002/health\\_ss/healthss\\_07\\_4260\\_anl02.htm](https://lao.ca.gov/analysis_2002/health_ss/healthss_07_4260_anl02.htm).

<sup>12</sup> *See* 2010 LAO Report, *supra* note 9 (explaining that the Medicaid Rx tool “relies mainly on pharmacy data to assess an individual’s health risks, which are combined for its beneficiaries to calculate a risk factor. Each plan’s risk factor is applied to the countywide average rate to establish a risk-adjusted rate for each plan.”).

<sup>13</sup> Ex. C, Mercer, *Two-Plan, Geographic Managed Care, Whole Child Model, Regional, and County Organized Health System Models: Capitation Rate Development and Certification January 1, 2021-December 31, 2021* at 1 (Jan. 28, 2021) (explaining that DHCS “contracted with Mercer ... to develop actuarially sound Medicaid capitation rates”).

demographics (age and gender categories) to measure a population’s anticipated health risk. The model assigns each member to zero, one or more of the 45 medical condition categories based on the *prescription drugs used by each member*, and to one of 11 age/gender categories.”<sup>14</sup>

In other words, the model uses pharmacy data based on prescription drugs that Medi-Cal beneficiaries *actually used* to risk adjust—not diagnosis codes reported to DHCS. Pharmacy data inherently provide a strong indication that a patient has a diagnosed medical condition that a physician is actively treating. The physician had to prescribe medication, demonstrating active treatment of a medical condition, and the patient had to obtain the medication at a pharmacy. Pharmacy data therefore directly link diagnosed medical conditions that affect patient health with treatment for those conditions. For the vast majority of the relevant period in the FAC, Medi-Cal used pharmacy data—not diagnosis-code data—to adjust rates.<sup>15</sup>

In the last two years, Medi-Cal has transitioned to a new risk-adjustment model called the Chronic Illness and Disability Payment System and Medicaid Rx (“CDPS+Rx”) health-based payment model, which does consider diagnosis data in conjunction with pharmacy data in calculating risk-adjusted payments.<sup>16</sup> As Mercer has explained, CDPS+Rx “uses diagnosis codes from professional, institutional, and pharmacy data to classify members into disease categories, while the Medicaid Rx model uses pharmacy data alone.”<sup>17</sup> But Relator, who was terminated in 2017, was not employed by any Defendant at the time this model was implemented. He has no personal knowledge of how Defendants report diagnosis data to DHCS or how that data is even used in this model. And in any event, the CDPS+Rx model—which bases risk adjustment on diagnosis codes from healthcare providers and institutions *as well as* prescription-drug data from pharmacies—is not “substantially the same” as the Medicare Advantage risk-adjustment model given its hybrid structure. Relator’s allegations simply do not apply to the CDPS+Rx model.

Relator’s theory of liability for his Medi-Cal Claim does not depend on pharmacy data, does not discuss risk adjustment under Medi-Cal, and does not recognize the fundamental differences between Medi-Cal and Medicare Advantage. His theory of liability appears to be meritless, and we do not understand what factual basis Relator had for making the allegations underlying the Medi-Cal Claim. We seriously question what basis Relator has to continue to

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<sup>14</sup> Ex. H, Mercer, *FINAL Medi-Cal CY 2022 Two-Plan, Geographic Managed Care and Regional Model Risk-Adjustment Methodology* at 2 (Dec. 15, 2021).

<sup>15</sup> Attached as Exhibits D-H are letters from Mercer describing the risk-adjustment methodology from 2016-2022 under the Medicaid Rx model. It is our understanding that DHCS has not maintained prior letters. But the Medicaid Rx model was used until the 2023 calendar year, when a new risk-adjustment model was implemented, as discussed *infra*. Not a single one of these letters refers to the use of diagnosis-code data for risk adjusting rates.

<sup>16</sup> Ex. I, Mercer, *Two-Plan, Geographic Managed Care, Regional, and County Organized Health Systems Models: Capitation Rate Development and Certification* at 77-78 (Dec. 21, 2022) (explaining the CDPS+Rx risk-adjustment model used for the 2023 calendar year).

<sup>17</sup> Ex. J, Mercer Letter to DHCS re: Medi-Cal CY 2022 Two-Plan, Geographic Managed Care and Regional Model CDPS+Rx Dry Run Risk-Adjustment Methodology at 2 (Jun. 3, 2022) (explaining the CDPS+Rx model methodology).



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assert the Medi-Cal Claim that would satisfy your and Relator's obligations under Federal Rule of Civil Procedure 11. We request that Relator dismiss the Medi-Cal Claim immediately.

If you have any questions, please feel free to contact me to discuss.

Sincerely,

*/s/ Dimitri D. Portnoi*

Dimitri D. Portnoi  
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# **EXHIBIT E**

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July 15, 2024

VIA EMAIL

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Re: *U.S. et al. ex rel Mazik v. Kaiser Foundation Health Plan, Inc. et al.*,  
E.D.Ca. No. 2:19 Civ. 00559

Dear Kyle:

As you know, we represent Relator in the above-referenced action. We write to respond to your March 25, 2024 letter ("Letter") regarding the First Amended Complaint (ECF no. 48, Apr. 2, 2021).

In your letter, you request that Relator voluntarily dismiss claims raised under the California False Claims Act as allegedly unsupported given the manner in which Defendants gets paid under the California Medi-Cal Program. Specifically, you assert that, until recently, Defendants were paid *per capita* for Medi-Cal enrollees on the basis of claims-level information derived from pharmacy data, as opposed to risk-adjustment methodology used to determine capitated payments as a Medicare Advantage Organization.

We appreciate the opportunity to correspond with you regarding any aspect of Relator's claims, but we must decline your suggestion that we voluntarily dismiss these claims at this time. This is for several reasons.

While your letter raises the question whether capitated payments for Medi-Cal enrollees were based on false risk adjustment factors, you do not address the other ways in which alleged misconduct by Defendants case resulted in false claims. *See* ECF no. 107 (Second Amended Complaint) ¶¶ 76–79. Falsified risk adjustments are a component of Relator's Medicare claims, but they are *not* the only aspect of the damages alleged.

Indeed, we understand your March 25, 2024 Letter to address the state False Claims Act presented in the First Amended Complaint, but we do not believe that Defendants' argument would apply to continuing violations on the state Medicaid program, nor that it applies with respect to previous violations set forth in the

Kyle M. Grossman, Esq.

July 15, 2024

Page 2 of 2

operative complaint. As amended in the Second Amended Complaint (ECF no. 107, Mar. 26, 2024), which was filed *after* your letter, the risk-adjustment methodology is not the only theory of damages for Medi-Cal claims. Specifically, the Second Amended complaint 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 from the other Plaintiff States. (This audit also found \$209 million in overpayments from CMS to Kaiser’s Medicare Advantage plans due to unsupported diagnostic data.)

ECF no. 107 ¶¶ 109–10 (emphasis added).

From your letter, you admit that Defendants were paid capitated amounts from state funds based on “claims-level” information on Medi-Cal enrollees. To the extent that the State determined payments to Defendants based on such claims-level information, and to the extent that such data were inflated through Defendants’ allowance of false claims, the conduct alleged not only resulted in false claims, it resulted in higher payments from the Medi-Cal program.

In the example noted in paragraph 110 above, Kaiser knew about the false claims and failed to remedy approximately \$181 million in overpayments. Kaiser’s liability is clear.

Should you wish to further meet and confer on any of these issues, I am always happy to connect with you.

Sincerely,

*/s/ Adam Pollock*

Adam Pollock

# **EXHIBIT F**



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August 12, 2024

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**VIA EMAIL**

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**Re: United States ex rel. Mazik v. Kaiser Foundation Health Plan, Inc., Case No. 19-cv-559-DAD-KJN (E.D. Cal.)**

Dear Mr. Pollock:

I am writing on behalf of Defendants Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Southern California Permanente Medical Group, and Colorado Permanente Medical Group (collectively, “Defendants”) in response to your July 15, 2024 letter (the “July 15 Letter”).

In Defendants’ March 25, 2024 letter (the “March 25 Letter”), we explained that Relator Jeffrey Mazik’s fraud claim under California’s Medi-Cal program (the “Medi-Cal Claim”) is factually baseless, and requested that Relator voluntarily dismiss the Medi-Cal Claim. In particular, we explained that the Medi-Cal Claim is premised “on the unfounded assumption that California’s Medi-Cal program operated ‘*substantially the same*’ as the federal Medicare Advantage program—specifically, that Medi-Cal used a risk-adjustment methodology factoring in diagnosis codes to calculate payments to health plans.” March 25 Letter at 1 (emphasis in original). Medi-Cal has never operated substantially the same as Medicare Advantage; indeed, until 2023, diagnosis codes did not factor into Medi-Cal’s payment methodology at all, which is long after Relator was terminated from his employment with Defendant Kaiser Foundation Health Plan in 2017. *Id.* at 1-3. In your July 15 Letter, you refused to dismiss the Medi-Cal Claim and stated that “the risk-adjustment methodology is not [Relator’s] only theory of damages for Medi-Cal claims” in the Second Amended Complaint (“SAC”), which was filed after we sent our March 25 Letter. *See* July 15 Letter at 2.

To be clear, while Relator’s SAC identifies with more specificity the Medicaid programs at issue in each Plaintiff State<sup>1</sup> compared to the First Amended Complaint (“FAC”), the fraud claims in the SAC are virtually identical to those alleged in the FAC. Specifically, all of Relator’s fraud claims still depend on the core allegation that Medicaid programs in each state operate “substantially the same” as Medicare Advantage in that they use diagnosis codes as a

<sup>1</sup> The “Plaintiff States” include California, Colorado, Georgia, Hawaii, Virginia, and Washington.

basis to risk-adjust payments to health plans, and that Defendants submitted false diagnosis codes to the Centers for Medicare and Medicaid Services (“CMS”) and the Plaintiff States. *See, e.g.*, SAC ¶ 3 (“Kaiser accomplishes this fraudulent scheme by knowingly allowing false and fraudulent **diagnosis codes** submitted in claims for payment by non-Kaiser providers ... incorporating those false data into its own electronic data for its Medicare Advantage **and Medicaid program enrollees**, and thereby making those individuals appear sicker or significantly less healthy than they actually are.” (emphasis added)), ¶ 35 (alleging that Medicaid programs operate on “**substantially the same model**” as Medicare Advantage (emphasis added)). The Court also recognized Relator’s singular focus on the submission of diagnosis codes in its order on Defendants’ Motion to Dismiss the FAC. *See* Dkt. No. 104, Mot. to Dismiss Order at 3-4 (noting that Relator alleges a scheme “to defraud the federal government by allowing external, i.e., ‘non-Kaiser,’ healthcare providers to **submit false diagnosis codes**, which defendants in turn submit to CMS” and recognizing that Relator alleges that Medicaid programs operate on “substantially the same” model as Medicare Advantage (emphasis added)); *see also id.* at 6 (noting that Relator alleges that “**unsupported diagnosis codes**” resulted in the retention of “overpayments” from the Medicare Advantage and state Medicaid programs (emphasis added)).

In addition, the SAC focuses solely on diagnostic data from **external providers** used to calculate alleged risk-adjusted payments, not data from any other source. *See id.* ¶ 3 (focusing on “non-Kaiser providers”), ¶ 74 (“even after the identification of widespread **overpayments to outside providers**, Kaiser refused to take appropriate corrective actions” (emphasis added)), ¶ 76 (“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...” (emphasis added)).<sup>2</sup>

In your July 15 Letter, you point to an allegation about a purported audit that found “approximately \$181 million in overpayments from the Medi-Cal program,” *see* SAC ¶ 110, to incorrectly argue that “[f]alsified risk adjustments” are “*not* the only aspect of the damages alleged,” *see* July 15 Letter at 1-2 (emphasis in original). The earlier version of this allegation that was included in the FAC made clear that Relator alleged the overpayments were based on “unsupported diagnostic codes.” FAC ¶ 86. And in its order on Defendants’ Motion to Transfer Venue, which considered the operative SAC, the Court characterized these same allegations as pertaining to “unsupported diagnosis codes.” Dkt. No. 122, Order Denying Defs.’ Mot. Transfer Venue at 6.<sup>3</sup>

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<sup>2</sup> Relator also has represented to the Court that his case is focused only on diagnostic data from external providers, and contends that the data was false because of Defendants’ alleged tampering with compliance software. *See* Dkt. No. 85, Opp’n to Defs.’ Mot. to Dismiss at 1 (“The gravamen of the Complaint is that, in an effort to ‘make the company appear as though it was engaged in comprehensive and meaningful fraud-prevention efforts,’ Kaiser procured various compliance software programs designed to detect fraud, waste, and abuse **in claims data submitted by external providers**—but then purposefully configured those programs to function at minimum capacity and/or disabled key features so as to systematically overlook errors and anomalies in claims data that was then submitted to government healthcare programs for payment.” (emphasis added)).

<sup>3</sup> The Court has noted that Relator has not specified whether these alleged Medicaid overpayments “were allegedly due to defendants tampering with auditing software.” *See id.* at 6 n.3. Instead, Relator has alleged that Defendants had knowledge of Medicaid overpayments from an internal audit. SAC ¶¶ 109-11. Nonetheless, the Court has made clear that Relator’s overpayment claims center on allegations concerning “unsupported diagnosis codes”



In short, the SAC—like the FAC before it—focuses on an alleged fraud premised on the assumption that Medicaid programs in the Plaintiff States used diagnostic data from external providers to calculate risk-adjusted payments to health plans in a manner substantially similar to the Medicare Advantage program. Discovery regarding Relator’s fraud claims must therefore be limited to that theory, as Defendants’ concurrently served Responses and Objections to Relator’s Fourth Set of Requests for Production make clear. To the extent Medicaid programs in the Plaintiff States did not use diagnosis codes from external-provider data to calculate risk-adjusted payments in this way, as was the case in California, Relator’s Medicaid claims are meritless.

Accordingly, we reiterate our request that you articulate the factual basis for Relator to assert the Medi-Cal Claim that would satisfy your client’s obligations—as well as your own obligations—under Federal Rule of Civil Procedure 11. Otherwise, Relator should dismiss his Medi-Cal Claim immediately.

Sincerely,

*/s/ Dimitri D. Portnoi*

Dimitri D. Portnoi  
Partner  
of O’MELVENY & MYERS LLP

cc: (via email only)  
Jeremy L. Friedman, Esq.  
Kyle M. Grossman, Esq.

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purportedly revealed through that audit, *see* Dkt. No. 122 at 6, not some other unspecified and unpled inaccuracies in “claims-level information” as you now contend, *see* July 15 Letter at 2.

# EXHIBIT G



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May 15, 2025

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**VIA EMAIL**

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**Re: United States ex rel. Mazik v. Kaiser Foundation Health Plan, Inc., Case No. 19-cv-559-DAD-KJN (E.D. Cal.)**

Dear Mr. Pollock:

In connection with my March 25, 2024 and August 12, 2024 letters addressing Relator's Medi-Cal claim ("Medi-Cal Letters"), I am now writing on behalf of Defendants Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Southern California Permanente Medical Group, and Colorado Permanente Medical Group (collectively, "Defendants") to address certain allegations about the Medicaid programs in Colorado, Georgia, Virginia, and Washington made in the above-captioned matter.

Relator brings claims for the alleged submission of false diagnosis code data to the Medicaid programs of these states along with claims for the submission of false diagnosis code data to the federal Medicare Advantage program. Though he targets different government programs, Relator's theory of fraud and underlying allegations are identical for each: Defendants submitted false diagnosis code data and were paid inflated amounts based on that data.<sup>1</sup>

Defendants previously explained why the scheme Relator alleges could not apply to California's Medicaid program—his claims about submissions to the Medicaid programs of Colorado, Georgia, Virginia, and Washington fare no better. Those claims fail for two key reasons: **First**, none of the Defendants contracted directly with any of these four state Medicaid programs during the relevant time period. And no entity associated with the "Kaiser Permanente" brand name contracted directly with the state Medicaid programs of Colorado, Georgia, or Washington. **Second**, none of the Defendants were paid based on diagnosis code data they submitted to the Medicaid programs of Colorado, Georgia, Virginia, and Washington.

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<sup>1</sup> Relator contends that Defendants have engaged in a fraudulent scheme by "knowingly allowing false and fraudulent diagnosis codes [to be] submitted in claims for payment by non-Kaiser providers ('outside providers'), incorporating those false data into its own electronic data for its Medicare Advantage and Medicaid program enrollees," which leads to "false and artificially increased per-capita amounts that Kaiser receives as payment for each enrollee in its Medicare Advantage and Medicaid programs." See Dkt. No. 107 ("SAC") ¶¶ 2–3.

And no entity associated with the “Kaiser Permanente” brand name was paid based on diagnosis code data submitted to these four state Medicaid programs. Because Defendants neither contracted with these various state Medicaid programs nor were paid by those programs based on diagnosis code data they submit, none could be liable pursuant to the theory of fraud Relator alleges.

**I. Defendants Do Not Contract Directly with the State Medicaid Programs of Colorado, Georgia, Virginia, and Washington**

**Colorado.** No Defendant contracted directly with Colorado’s State Medicaid Program (i.e., Health First Colorado). And no entity associated with the “Kaiser Permanente” brand name did either. Instead, Kaiser Foundation Health Plan of Colorado contracted with Regional Accountable Entities such as Colorado Access and Colorado Community Health Alliance.<sup>2</sup> Similarly, no Defendant contracted with Colorado’s CHP+ program. Kaiser Foundation Health Plan of Colorado contracted with the state of Colorado to provide services to the CHP+ program.<sup>3</sup>

**Georgia.** No Defendant contracted directly with Georgia’s State Medicaid Program. And no entity associated with the “Kaiser Permanente” brand name did either. Instead, Kaiser Foundation Health Plan of Georgia, Inc. and the Southeast Permanente Medical Group, Inc. contracted with managed care plans such as Peach State Health Plan, Inc. and WellCare.<sup>4</sup>

**Virginia.** No Defendant contracted directly with Virginia’s State Medicaid Program. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. previously contracted with the Commonwealth of Virginia, Department of Medical Assistance Services.<sup>5</sup>

**Washington.** No Defendant contracted directly with Washington’s State Medicaid Program. And no entity associated with the “Kaiser Permanente” brand name did either. Instead, Kaiser Foundation Health Plan of Washington contracted with Molina Healthcare of Washington, Inc.<sup>6</sup> During Relator’s employment, Group Health Cooperative contracted with Molina Healthcare of Washington, Inc.<sup>7</sup>

**II. Defendants Are Not Paid By the State Medicaid Programs of Colorado, Georgia, Virginia, and Washington Based on Diagnosis Data**

**Colorado.** No Defendant was paid for services provided to Health First Colorado beneficiaries using diagnosis-based risk adjustment. And no entity associated with the “Kaiser Permanente” brand name was either. Kaiser Foundation Health Plan of Colorado was paid under its contracts with Regional Affiliated Entities on a per-member-per-month and fee-for-service

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<sup>2</sup> Exhibit A (CO Medicaid – Colorado Access); Exhibit B (CO Medicaid – Colorado Community Health Alliance)

<sup>3</sup> Exhibit C (CO CHP+)

<sup>4</sup> Exhibit D (GA – Peach State); Exhibit E (GA—Well Care)

<sup>5</sup> Exhibit F (Commonwealth of Virginia Medallion 3.0 Data Book and Capitation Rates Fiscal Year 2017)

<sup>6</sup> Exhibit G (WA – KP)

<sup>7</sup> Exhibit H (WA – GH)

basis—i.e., not based on diagnosis-based risk adjustment.<sup>8</sup> Similarly, no Defendant was paid for services provided to CHP+ beneficiaries using diagnosis-based risk adjustment. Kaiser Foundation Health Plan of Colorado shared experience data with the State of Colorado, who blends that data with data from other Managed Care Organizations to determine the ultimate rates.<sup>9</sup>

**Georgia.** No Defendant was paid for services provided to Georgia Medicaid beneficiaries using diagnosis-based risk adjustment. And no entity associated with the “Kaiser Permanente” brand name was either. Kaiser Foundation Health Plan of Georgia, Inc. and the Southeast Permanente Medical Group, Inc. were paid by the managed care plans on a fee-for-service basis.<sup>10</sup>

**Virginia.** No Defendant was paid for services provided to Virginia Medicaid beneficiaries using diagnosis-based risk adjustment. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. was previously paid for services provided to Virginia Medicaid beneficiaries based on capitated rates.<sup>11</sup> The Commonwealth of Virginia does use the Chronic Illness and Disability Payment System to determine the capitated amounts, however, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. did not submit data for use in rate development until the 2016 rate development.<sup>12</sup>

**Washington.** No Defendant is paid for services provided to Washington Medicaid beneficiaries using diagnosis-based risk adjustment. And no entity associated with the “Kaiser Permanente” brand name was either. Both Group Health Cooperative and Kaiser Foundation Health Plan of Washington were paid by Molina Healthcare of Washington, Inc. on a fee-for-service basis.<sup>13</sup>

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<sup>8</sup> Exhibit A (“[C]ompensation is based on a Per Member per Month basis”); Exhibit B (providing for per-member-per-month compensation); *see also* Colorado Department of Health Care Policy & Financing, 2020-2021 Annual Report, available at <https://hcpf.colorado.gov/sites/hcpf/files/HCPFAnnualReport2020-21.pdf> (explaining that Health First Colorado’s “[p]roviders are paid fee-for-service for the health care they provide and also receive a per-member-per-month (PMPM) payment from the RAEs [Regional Accountable Entities] for their medical home services.”).

<sup>9</sup> Exhibit B (CO CHP+)

<sup>10</sup> Exhibit C (GA); *see also* Georgia Medicaid, Types of Medicaid Plans, available at <https://medicaid.georgia.gov/how-apply/types-medicaid-plans> (“Under the FFS model, Georgia pays providers directly for each covered service received by a Medicaid beneficiary... In general, Georgia set provider payments under fee-for-service.”).

<sup>11</sup> Commonwealth of Virginia Medallion 3.0 Data Book and Capitation Rates Fiscal Year 2017

<sup>12</sup> *Id.* (“As a new plan it submitted encounter data for the first time for the FY 2016 rate development.”)

<sup>13</sup> Exhibit H (“All Covered Services rendered by Provider shall be reimbursed by Health Plan according to the lesser of billed charges or . . . applicable Member co-payments, amounts paid or to be paid by other liable third parties.”).



\* \* \*

Based on the above, we request that Relator dismiss his claims related to the state programs at issue here immediately. If you have any questions, please feel free to contact me to discuss.

Sincerely,

*/s/ Dimitri D. Portnoi*

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# **EXHIBIT H**

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May 30, 2025

**VIA EMAIL**

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Re: *United States ex rel. Mazik v. Kaiser Foundation Health Plan, Inc.*,  
No. 19-cv-559-DAD-KJN (E.D. Cal.)

Dear Mr. Portnoi:

We write to respond to your letter dated May 15, 2025 regarding Defendants' frauds on Colorado, Georgia, Virginia, and Washington ("Ltr."). Relatedly, we write to address the serious deficiencies in Defendants' document production to date.

**Colorado**

In your letter, you assert that: "No Defendant contracted directly with Colorado's State Medicaid Program (i.e., Health First Colorado). And no entity associated with the 'Kaiser Permanente' brand name did either." (Ltr. at 2, emphasis added.)

Your letter seems to hang on the issue of whether Kaiser "directly" contracted with Colorado's Medicaid program. But, of course, liability under the False Claims Act does not depend on a direct contractual relationship between the state entity and the fraudster. For example, subcontractors too may be held liable for *causing* false claims. See 31 U.S.C. § 3729(a)(1)(A); *United States v. Bornstein*, 423 U.S. 303 (1976).

We are certain that Kaiser is involved in claims made for state Medicaid funds for services provided to qualifying individuals. Indeed, as Kaiser's website notes, "In Colorado, Kaiser Permanente serves more than 63,000 assigned patients in Health First Colorado (Medicaid)."<sup>1</sup>

If your contention is instead a technical defect – that Relator named Colorado Permanente Medical Group instead of the Kaiser Foundation Health Plan of Colorado –

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<sup>1</sup> Kaiser Permanente, Institute for Health Policy, "At a Glance: Kaiser Permanente's Participation in Health First Colorado (Colorado)" (Feb. 24, 2025), <https://www.kpihp.org/blog/co-at-a-glance-kaiser-permanentes-participation-in-health-first-colorado/>.

Dimitri D. Portnoi, Esq.

May 30, 2025

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then we can correct the caption to include this additional entity. (However, we had understood through discussions with Kaiser’s prior counsel that the caption already reflects the correct entities.)

Second, you contend that Colorado did not pay any Defendant “using diagnosis-based risk adjustment.” But Colorado employs the Chronic Illness and Disability Payment System (“CDPS”) for risk adjustment in its Medicaid program. Further, Relator’s complaint alleges that Kaiser directly made false claims to Colorado, where Kaiser has 6,742 doctors:<sup>2</sup>

94. Further, Kaiser failed to activate (or disabled) the Verisk system at all in other states such as Colorado and Hawai’i....

95. As a consequence, for example, Kaiser could not accurately address inflated and upcoded charges made by over 1,000 Kaiser doctors in Colorado to Health First Colorado and Colorado’s Child Health Plan Plus. Further, in Colorado, Kaiser identified upcoded charges by its doctors using a “filter” tool, but routinely ignored the results and then, in 2012, ended the filter program.

Indeed, Kaiser failed to activate or disabled: a) the appropriate required claim edits in Kaiser’s base claim systems; b) the appropriate required claim edits in Kaiser’s version of the Verisk claim review program; and c) the appropriate required claim edits in Kaiser’s version of the FICO claim review program in all states in which it operated.

The Complaint also alleges that, through its sub-contract with Easterseals, Kaiser made additional false claims in Colorado. (*Id.* ¶ 90.)

Moreover, false inflation of risk adjustment scores is not the only route by which Kaiser’s knowing misconduct resulted in damages to state Medicaid payors. As you know, to the extent (and in the time periods) that payments to Kaiser were *not* based on enrollees’ diagnosis codes, the actual costs incurred by Kaiser for payments of claims were subsumed within Kaiser’s payments structure. The inflated risk adjustments is a now well-developed legal basis for proving damages from false claims by Medicare Advantage Organizations, but it does not displace the older, also well-established basis for holding plans, hospitals, and medical groups liable for falsely inflated cost submissions.

Defendants have failed to produce any documents or data relating to Kaiser’s inflated and upcoded charges made to Colorado’s state-funded healthcare programs. Please produce all documents and correspondence regarding the de-activation or disabling of the a) base claim system edits, b) Verisk program in Colorado, and c) FICO

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<sup>2</sup> Kaiser Permanente, About, Colorado, <https://about.kaiserpermanente.org/commitments-and-impact/healthy-communities/communities-we-serve/colorado-community>.

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program in Colorado. Further, please produce all related claims data. (Of course, we will continue to try to meet and confer with you as to the best form of production and to limit the scope of the fields to be produced.)

### Georgia

We respond similarly with respect to Georgia.

First, your letter states: “No Defendant contracted directly with Georgia’s State Medicaid Program. And no entity associated with the ‘Kaiser Permanente’ brand name did either. Instead, Kaiser Foundation Health Plan of Georgia, Inc. and the Southeast Permanente Medical Group, Inc. contracted with managed care plans such as Peach State Health Plan, Inc. and WellCare.” (Ltr. at 2, emphasis added.)

But, as you note, Kaiser participated in Georgia’s Medicaid MCO plans, which is confirmed by Kaiser’s website: “More than 21,000 patients are assigned to Kaiser Permanente in Georgia Families (Medicaid) through contracts with the current three CMOs.”<sup>3</sup> And, as noted above, there is liability under the False Claims Act for a subcontractor that *causes* false claims.

Further, Kaiser offers a Medicare Medicaid Plan known as Kaiser Permanente Senior Advantage Medicare Medicaid Plan. In addition to contracting with CMS, Kaiser has a separate contract with the Georgia Medicaid program, enabling it to offer coordinated Medicaid-covered services to dual-eligible individuals – those qualified for both Medicare and Medicaid.

Again, if your contention is instead a technical defect – that the caption does not reflect the correct Kaiser entity – then we can correct the caption to include the additional entity.

Next, you contend that Georgia did not pay any Defendant “using diagnosis-based risk adjustment.” (Ltr. at 3.) But Georgia employs acuity-based risk adjustment in its Medicaid program. Further, Relator’s complaint alleges that Kaiser directly made false claims to Georgia, where Kaiser has 643 doctors<sup>4</sup>:

64. Relator’s and Mr. Loden’s efforts, in collaboration with Verisk, identified \$5.3 million in overpayments for the Georgia region alone...

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<sup>3</sup> Kaiser Permanente, Institute for Health Policy, “At a Glance: Kaiser Permanente’s Participation in Georgia Families (Georgia)” (Feb. 27, 2025), <https://www.kpihp.org/blog/ga-at-a-glance-kaiser-permanentes-participation-in-georgia-families-and-childrens-health-insurance-program/>.

<sup>4</sup> Kaiser Permanente, About, “Our impact in Georgia,” [about.kaiserpermanente.org/commitments-and-impact/public-policy/our-impact/news-perspectives-on-public-policy-georgia](https://www.kaiserpermanente.org/commitments-and-impact/public-policy/our-impact/news-perspectives-on-public-policy-georgia).

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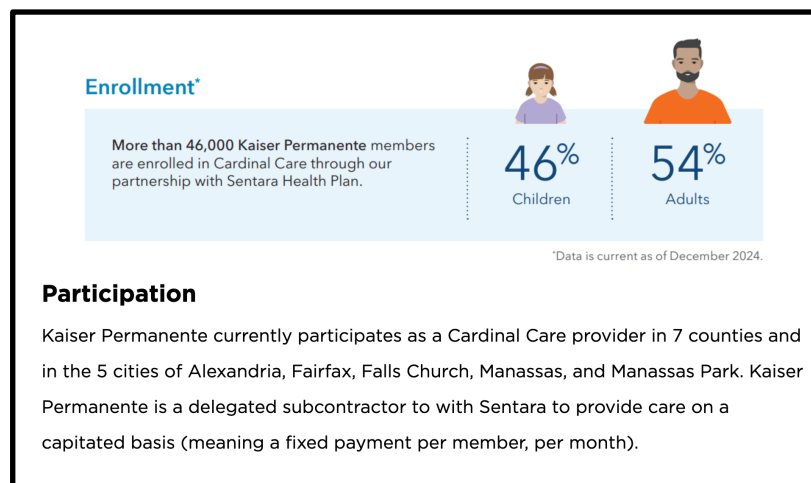
92. ... For example, during 2010 to 2013, the Verisk software identified \$11,690,149 in overpayments in Georgia alone...

Moreover, as noted above, to the extent that Georgia's payments under its Medicaid programs were *not* based on risk adjustment, the actual and projected costs from the false claims would have caused falsely inflated claimed costs. Like for Colorado, Defendants have failed to produce any claims data relating to Kaiser's inflated and upcoded charges made to Georgia's state-funded healthcare programs. (Of course, as noted above, we will continue to try to meet and confer with you as to the best form of production and to limit the scope of the fields to be produced.)

## Virginia

With respect to Virginia, you wrote: "No Defendant contracted directly with Virginia's State Medicaid Program." (Ltr. at 2.) But, as you continue, "Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. previously contracted with the Commonwealth of Virginia, Department of Medical Assistance Services." (*Id.*)

Indeed, Kaiser's website trumpets: "More than 46,000 Kaiser Permanente members are enrolled in Cardinal Care [Virginia's current Medicaid program] through our partnership with Sentara Health Plan. 46% are children and 54% are adults."<sup>5</sup>



Again, if your contention is instead a technical defect, then we can stipulate to correct the caption.

Next, you write that Kaiser "was previously paid ... based on capitated rates," and that Virginia does use diagnosis-based adjustments, but that Kaiser did not submit

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<sup>5</sup>Kaiser Permanente, Institute for Health Policy, "At a Glance: Kaiser Permanente's Participation in Medallion Medicaid (Virginia)" (Feb. 24, 2025), <https://www.kpihp.org/blog/va-at-a-glance-kaiser-permanentes-participation-in-medallion-medicaid/>.

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data until 2016. (Ltr. at 3.) The exhibit indicates: “Kaiser Permanente health plan joined the Medallion [VA state Medicaid] 3.0 managed care program in November 2013 and submitted encounter data for the period November 2013 to June 2015 with run out through October 2015.” (Exh. F at 5.) Thus, at least from 2016 forward, Kaiser’s capitated payments were affected by diagnosis-based risk adjustments, as affected by data back to 2013.

Further, Relator’s complaint alleges that Kaiser directly made false claims to Virginia, where Kaiser has more than 1,800 doctors:<sup>6</sup>

92. Kaiser’s use of the Verisk system identified improper claims for payment to State healthcare agencies in Georgia, Washington, and Virginia. For example, during 2010 to 2013, the Verisk software identified \$11,690,149 in overpayments in Georgia alone, and additional overpayments in the Northwest region (including Washington) and the Mid-Atlantic States (including Virginia) but Kaiser never took action on it.

93. Around this time, Kaiser determined that it preferred ignorance to knowledge of its false claims. It intentionally disabled the Verisk software tool in the Mid-Atlantic States (including Virginia) which, of course, caused it to no longer identify any such overpayments.

...

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

Moreover, as noted above, payments made under Virginia’s Medicaid plan that were *not* based on risk adjustment factors would have been based on Kaiser’s actual and projected costs, and the false claims paid by Kaiser as identified in Relator’s operative complaint would have caused false inflation of those cost submissions. Damages to Virginia as a result of Kaiser’s actions are not limited to risk adjustment inflation.

Defendants have failed to produce any documents or data relating to Kaiser’s inflated and upcoded charges made to Virginia’s state-funded healthcare programs. Please produce all documents and correspondence regarding the activation or disabling of the Verisk system in Virginia. Further, please produce all related claims data. (Of course, we will continue to try to meet and confer with you as to the best form of production and to limit the scope of the fields to be produced.)

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<sup>6</sup> Kaiser Permanente, “Easy to Join,” <https://myhealth.kaiserpermanente.org/commonwealthofvirginia/easy-to-join/>.

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## Washington

With respect to Washington, you assert a similar point: “No Defendant contracted directly with Washington’s State Medicaid Program. And no entity associated with the ‘Kaiser Permanente’ brand name did either. Instead, Kaiser Foundation Health Plan of Washington contracted with Molina Healthcare of Washington, Inc. During Relator’s employment, Group Health Cooperative contracted with Molina Healthcare of Washington, Inc.” (Ltr. at 2.)

This is the same point as Georgia: Kaiser is apparently something like a subcontractor to Molina: “Kaiser Permanente participates in Washington Apple Health through Molina Healthcare of Washington, a Medicaid Managed Care Organization (MCO).”<sup>7</sup> That does not affect Kaiser’s liability under the False Claims Act.

Next, you contend that Kaiser was not paid “using diagnosis-based risk adjustment” and was instead paid “on a fee-for-service basis.” (Ltr. at 3.) But, per Kaiser’s website, Kaiser’s model depends on the location within Washington state:

The majority of our Medicaid clients are served via our partnership with Molina; our contractual agreements with Molina have 2 distinct models: In Clark and Cowlitz counties, Kaiser Permanente participates in a delegated subcontract with Molina to provide care on a **capitated basis** (meaning a fixed payment per client, per month). In the Puget Sound and Spokane metro areas, Kaiser Permanente contracts with Molina as a **fee-for-service** provider for primary and specialty care. Our fee-for-service arrangement with Molina also includes a care coordination fee and annual quality-gated shared savings incentives.<sup>8</sup>

Accordingly, please produce Kaiser’s capitated contract for Clark and Cowlitz counties. Kaiser Permanente’s direct payments are structured on a capitated basis through its partnership with Molina Healthcare, and we understand that these payments are influenced by diagnosis-based risk adjustment methods employed by Washington’s Medicaid program.

Further, Relator’s complaint alleges that Kaiser directly made false claims to Washington, where Kaiser has more than 400 doctors:<sup>9</sup>

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<sup>7</sup> Kaiser Permanente, Shop Plans, “Learn about Medicaid with Kaiser Permanente in Washington State,” <https://healthy.kaiserpermanente.org/washington/shop-plans/medicaid/why-kp>.

<sup>8</sup> Kaiser Permanente Institute for Health Policy, “At a Glance: Kaiser Permanente’s Participation in Apple Health (Washington State)” (Feb. 25, 2025), <https://www.kpihp.org/blog/wa-at-a-glance-kaiser-permanentes-participation-in-apple-health> (emphasis added).

<sup>9</sup> Kaiser Permanente, “More than 100 ‘Top Docs’ recognized in Washington state” (Sept. 18, 2024), <https://about.kaiserpermanente.org/news/more-than-100-top-docs-recognized-in-washington>.

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92. Kaiser's use of the Verisk system identified improper claims for payment to State healthcare agencies in Georgia, Washington, and Virginia. For example, during 2010 to 2013, the Verisk software identified \$11,690,149 in overpayments in Georgia alone, and additional overpayments in the Northwest region (including Washington) and the Mid-Atlantic States (including Virginia) but Kaiser never took action on it.

...

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

Moreover, to the extent that capitated payments were *not* determined by enrollee risk adjustment factors, those payments were inflated by the false inflation of Kaiser's actual and projected costs. Damages to Washington's Medicaid program simply do not depend upon risk adjustments to be recovered under the state Act.

Defendants have failed to produce any documents or data relating to Kaiser's inflated and upcoded charges made to Washington's state-funded healthcare programs. Please produce all documents and correspondence regarding the activation or disabling of the Verisk system in Washington. Further, please produce all related claims data. (Of course, we will continue to try to meet and confer with you as to the best form of production and to limit the scope of the fields to be produced.)

\* \* \*

Thank you for your attention to the matters herein. We would appreciate your response by **June 13, 2025**.

In the meantime, we will write separately to address additional deficiencies in your production (in addition to the issues relating to the four states discussed above).

Sincerely,

/s/ Adam Pollock

Adam Pollock

# **EXHIBIT I**

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9 Attorneys for relator Jeffrey Mazik

10 UNITED STATES DISTRICT COURT  
11 EASTERN DISTRICT OF CALIFORNIA

12 UNITED STATES OF AMERICA, <i>etc., ex rel.</i> )	Case No. 2:19-cv-00559-DAD-JDP
13 JEFFREY MAZIK,	)
14 Plaintiffs,	)
15 v.	)
16 KAISER FOUNDATION HEALTH PLAN, <i>et</i> )	<b>PLAINTIFF-RELATOR JEFFREY MAZIK'S</b>
17 <i>al.</i> ,	<b>RESPONSES AND OBJECTIONS TO</b>
18 Defendants.)	<b>DEFENDANT KAISER FOUNDATION</b>
	<b>HEALTH PLAN, INC.'S FIRST SET OF</b>
	<b>REQUESTS FOR ADMISSION</b>

19 **PROPOUNDING PARTY: DEFENDANT KAISER FOUNDATION HEALTH PLAN, INC.**

20 **RESPONDING PARTY: PLAINTIFF-RELATOR JEFFREY MAZIK**

21 **SET NUMBER: ONE**

22 **PRELIMINARY STATEMENT**

23 Relator has pending a motion for a temporary stay in discovery, and intends to amend or modify  
24 that motion to seek a stay in the entire case until resolution of appellate proceedings in a related case.  
25 One basis for the stay request is the need for relator's counsel to have time to review a substantial body  
26 of case materials recently transferred between attorneys. Relator objected to defendants' propounding of  
27 this discovery at this time, and requested that defendants grant reasonable extensions of time and respect  
28 relator's stay request; but defendants insisted on getting these written responses. In light of these

1 circumstances, as well as those presented in relator’s stay requests, relator provides these responses at  
2 this time, but reserves all rights to amend, supplement, or otherwise change the responses provided  
3 herein.

4 These responses are made solely for the purpose of this action. Each response is subject to all  
5 objections as to competence, relevance, materiality, propriety, and admissibility, and any and all other  
6 objections and grounds which would require the exclusion of any statement herein, all of which  
7 objections and grounds are reserved and may be interposed at the time of trial.

8 Plaintiff-Relator Jeffrey Mazik has not completed his investigation of the facts relating to this  
9 case and has not completed his preparation for trial. The following responses are made without prejudice  
10 to his right to use later discovered facts, or his right to amend or supplement his responses in accordance  
11 with Rule 26(e). Except for explicit facts admitted herein, no incidental or implied admissions are  
12 intended hereby. The fact that Mr. Mazik has responded to any Request for Admission should not be  
13 taken as an admission that Mr. Mazik accepts or admits the existence of any facts set forth or assumed  
14 by such Request, or that such response constitutes admissible evidence.

15 The Preliminary Statement is incorporated into each of the responses set forth below.

### 16 **GENERAL OBJECTIONS**

17 1. Plaintiff-Relator Mazik objects to each Request for Admission to the extent it purports to  
18 impose obligations in excess of, or different from, those imposed by the Federal Rules of Civil  
19 Procedure or other applicable law or rules.

20 2. Plaintiff-Relator Mazik objects to Definition No. 27 (“You,” “Your,” or “Relator”) as vague,  
21 overly broad, unduly burdensome, not proportional to the needs of the case, and contrary to the scope of  
22 Federal Rule 36. Accordingly, Mr. Mazik restricts his responses to answering on behalf of himself and  
23 does not purport to answer on behalf of “any attorneys, agents, representatives, consultants, or other  
24 persons acting or purporting to act on his behalf.”

25 3. Plaintiff-Relator Mazik objects to each Request for Admission to the extent it is vague,  
26 ambiguous, compound, assumes facts not established, or is otherwise susceptible to more than one  
27 reasonable interpretation.

28 4. Plaintiff-Relator Mazik objects to each Request for Admission to the extent it seeks

1 admissions on matters that call for legal conclusions, expert opinions, or the application of law to  
2 disputed facts.

3 5. Plaintiff-Relator Mazik objects to each Request for Admission to the extent it seeks  
4 information that is privileged, including information protected by the attorney-client privilege, work  
5 product doctrine, joint defense privilege, or common interest privilege.

6 6. Plaintiff-Relator Mazik objects to Instruction No. 4 to the extent it purports to extend the  
7 relevant time period from January 1, 2007 through present. Mr. Mazik restricts his responses to the time  
8 period from January 1, 2008 through April 1, 2019, consistent with his responses to Defendant's prior  
9 discovery.

10 7. Plaintiff-Relator Mazik objects to each Request for Admission, each of the subparts, and the  
11 entire set, on the basis that they exceed the limits on interrogatories, and they are no directed to matters  
12 that a properly the subject of admissions.

13 Each General Objection shall be incorporated in full into each of Mr. Mazik's responses, as  
14 though set forth fully therein.

15 **SPECIFIC RESPONSES AND OBJECTIONS**

16 **REQUEST FOR ADMISSION NO. 1:** Admit that You do not contend that any False Claim  
17 alleged in the Complaint involves claims submitted by providers other than External Providers.

18 **RESPONSE:** Denied. Certain claims – including claims for capitated payments on government  
19 programs, claims for payment of premiums and/or to avoid rebates, and other claims associated with the  
20 allegations by relator, are made by Kaiser defendants, in addition to, and other than, external providers.  
21 The Complaint alleges false claims arising from Defendants' systemic misconduct, including the  
22 deliberate disabling and misconfiguration of compliance tools, the submission of false annual  
23 attestations by senior executives, and the submission of inflated cost data during CMS's annual bidding  
24 process. These false claims are not limited to claims submitted by External Providers.

25 **REQUEST FOR ADMISSION NO. 2:** Admit that the False Claims You allege in the  
26 Complaint are limited to claims involving External Providers.

27 **RESPONSE:** Denied. See Response to Request for Admission No. 1.

28 **REQUEST FOR ADMISSION NO. 3:** Admit that You do not allege any False Claims in

1 connection with any state Medicaid program not identified in the Complaint.

2       **RESPONSE:** Denied. The fraudulent conduct alleged in the Complaint was systemic and  
3 organization-wide. Kaiser operated in additional states during the relevant time period, potentially  
4 including Maryland, Oregon, and the District of Columbia, among others. Relator reserves the right to  
5 identify additional state Medicaid programs affected by Defendants’ conduct as discovery proceeds.  
6 Relator further responds that False Claims Act violations occurred on state Medicaid programs arising  
7 out of false historical costs submitted to government auditors, false risk adjustments not necessarily tied  
8 to HCCs, and evasion of actuarial reviews, leading to fraud on state Medicaid programs not necessarily  
9 identified in the Complaint, but arising out of the facts alleged.

10       **REQUEST FOR ADMISSION NO. 4:** Admit that the False Claims alleged in the Complaint  
11 are solely based on the alleged misuse of Compliance Tools.

12       **RESPONSE:** Denied. The False Claims alleged in the Complaint are based on multiple  
13 categories of misconduct, including but not limited to: the deliberate disabling and misconfiguration of  
14 compliance tools; the submission of false annual attestations to CMS certifying that risk adjustment data  
15 was “accurate, complete, and truthful”; the submission of inflated cost data during CMS’s annual  
16 bidding process; the knowing retention of overpayments in violation of the 60-Day Overpayment Rule,  
17 42 U.S.C. § 1320a-7k(d); and the knowing approval of claims from Easterseals despite a documented  
18 fifty percent billing error rate. Relator further responds that other False Claims Act violations arose out  
19 of the facts alleged in the complaint, whether or not alleged as identified in this request.

20       **REQUEST FOR ADMISSION NO. 5:** Admit that, as of the date of Your response, You have  
21 not identified a specific False Claim submitted in connection with Medicare Advantage.

22       **RESPONSE:** Plaintiff-Relator objects to this Request as vague and ambiguous as to the  
23 meaning of “specific False Claim.” Subject to and without waiving this objection, denied. Relator  
24 identified systemic false claims through his compliance work at Kaiser, including through internal audits  
25 revealing approximately \$209 million in CMS overpayments from unsupported diagnostic data. The  
26 underlying claim-level data is in Defendants’ exclusive possession, custody, and control. Relator further  
27 responds that relator has identified the submission of claims for payment with respect to capitated  
28 payments, as well as claims for payment that were submitted to, and knowingly overpaid, by Kaiser

1 defendants.

2 **REQUEST FOR ADMISSION NO. 6:** Admit that, as of the date of Your response, You have  
3 not identified a specific False Claim submitted in connection with any Medicaid Program.

4 **RESPONSE:** Plaintiff-Relator objects to this Request as vague and ambiguous as to the  
5 meaning of “specific False Claim.” Subject to and without waiving this objection, denied. Relator  
6 identified systemic false claims through his compliance work at Kaiser, including through internal audits  
7 revealing approximately \$181 million in Medi-Cal overpayments and \$5.3 million in Georgia Medicaid  
8 overpayments. The underlying claim-level data is in Defendants’ exclusive possession, custody, and  
9 control. Relator further responds that relator has identified the submission of claims for payment with  
10 respect to capitated payments, as well as claims for payment that were submitted to, and knowingly  
11 overpaid, by Kaiser defendants.

12 **REQUEST FOR ADMISSION NO. 7:** Admit that You have not identified any exemplar, test  
13 claim, or sample False Claim supporting the allegations in the Complaint.

14 **RESPONSE:** Plaintiff-Relator objects to this Request as vague and ambiguous as to the  
15 meaning of “exemplar, test claim, or sample False Claim.” Subject to and without waiving this  
16 objection, denied. Relator’s compliance work identified categories of false claims through audit results  
17 and compliance tool outputs, as detailed in the Second Amended Complaint. The specific claim-level  
18 data underlying these findings is in Defendants’ exclusive possession, custody, and control. Relator  
19 further responds that relator has identified the submission of claims for payment with respect to  
20 capitated payments, as well as claims for payment that were submitted to, and knowingly overpaid, by  
21 Kaiser defendants.

22 **REQUEST FOR ADMISSION NO. 8:** Admit that You contend identification of specific False  
23 Claims requires expert analysis and/or discovery from Defendants.

24 **RESPONSE:** Denied. Relator identified false claims through his own compliance work at  
25 Kaiser Permanente, including through internal audits and the operation of compliance tools. While  
26 expert analysis and discovery from Defendants may further support and quantify the false claims  
27 identified, Relator does not contend that such analysis or discovery is a prerequisite to identifying the  
28 existence of false claims.

1           **REQUEST FOR ADMISSION NO. 9:** Admit that You have not personally reviewed any CMS  
2 or State Submissions in connection with the allegations in the Complaint.

3           **RESPONSE:** Plaintiff-Relator objects to this Request as vague and ambiguous insofar as the  
4 term “CMS or State Submissions” is susceptible to multiple reasonable interpretations regarding what  
5 constitutes a “submission.” Subject to and without waiving this objection, denied. Based on Relator’s  
6 knowledge and experience in Kaiser’s compliance operations, the information he observed and analyzed  
7 in the course of his employment included data that was submitted to CMS and state Medicaid agencies.

8           **REQUEST FOR ADMISSION NO. 10:** Admit that You have not personally identified any  
9 CMS or State Submissions that You contend contains false or inaccurate diagnosis data.

10           **RESPONSE:** Plaintiff-Relator objects to this Request on the same grounds stated in response to  
11 Request for Admission No. 9. Subject to and without waiving this objection, denied. Relator’s  
12 compliance work identified data containing false or inaccurate diagnosis codes that, based on Relator’s  
13 knowledge of Kaiser’s claims processes, were submitted to CMS and state Medicaid agencies.

14           **REQUEST FOR ADMISSION NO. 11:** Admit that You have not personally compared any  
15 outputs from the Compliance Tools to CMS or State Submissions.

16           **RESPONSE:** Plaintiff-Relator objects to this Request on the same grounds stated in response to  
17 Request for Admission No. 9. Subject to and without waiving this objection, denied. Based on Relator’s  
18 understanding of Kaiser’s claims processes, claims data was routed through compliance tools before  
19 submission to CMS and state Medicaid agencies. The compliance tool outputs identified claims that  
20 should have been corrected or eliminated from the submission process but were not, due to Defendants’  
21 deliberate disabling and misconfiguration of those tools.

22           **REQUEST FOR ADMISSION NO. 12:** Admit that You have not personally reviewed any  
23 medical records or underlying clinical documentation in support of the allegations in the Complaint.

24           **RESPONSE:** Denied. Relator reviewed expert reports that included medical records and clinical  
25 documentation. Specifically, experts were engaged to review the compliance software and related claims  
26 data, and the resulting expert report—which Relator reviewed—included underlying medical records.

27           **REQUEST FOR ADMISSION NO. 13:** Admit that You have not personally reviewed Claim-  
28 Level Data for any specific claim You contend is a False Claim.

1           **RESPONSE:** Denied. Relator reviewed claim-level data in connection with his compliance  
2 work, including through expert reports containing claim-level analyses.

3           **REQUEST FOR ADMISSION NO. 14:** Admit that the Compliance Tools were designed to  
4 identify potential issues for review rather than determine whether fraud occurred.

5           **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for speculation regarding  
6 the design intent of the Compliance Tools, which are products created and configured by third-party  
7 vendors and Defendants. Relator did not design the Compliance Tools and cannot testify as to every  
8 aspect of their intended function. Subject to and without waiving this objection, Plaintiff-Relator can  
9 neither admit nor deny this Request after reasonable inquiry, and therefore denies the request. Relator  
10 states that, based on his experience working with these tools at Kaiser Permanente, he reasonably  
11 believed and perceived that a key function of the Compliance Tools was fraud detection, identification  
12 of overpayments, prevention of wasteful payments, and certification of the accuracy of data submitted to  
13 government agencies and auditors in connection with false or fraudulent claims for capitated payments.

14           **REQUEST FOR ADMISSION NO. 15:** Admit that the Compliance Tools did not determine  
15 whether diagnosis codes submitted to CMS or a state Medicaid agency were false.

16           **RESPONSE:** Plaintiff-Relator objects to this Request as vague, ambiguous, and confusingly  
17 worded in light of Defendant’s own definition of “Compliance Tools,” which encompasses multiple  
18 distinct software products, systems, and processes with different functions and capabilities. Subject to  
19 and without waiving this objection, Plaintiff-Relator can neither admit nor deny this Request as stated.  
20 To the extent a response is required, denied. The Compliance Tools, when properly configured, were  
21 capable of identifying false, inflated, or unsupported diagnosis codes and claims data prior to  
22 submission.

23           **REQUEST FOR ADMISSION NO. 16:** Admit that the Compliance Tools did not validate or  
24 certify the accuracy of diagnosis data submitted in connection with Medicare Advantage or any  
25 Medicaid Program.

26           **RESPONSE:** Plaintiff-Relator objects to this Request as vague, ambiguous, and confusingly  
27 worded insofar as the terms “validate or certify” are undefined and susceptible to multiple reasonable  
28 interpretations. Subject to and without waiving this objection, Plaintiff-Relator can neither admit nor

1 deny this Request as stated. To the extent a response is required, denied. The Compliance Tools served a  
2 gatekeeping function in Defendants' claims processing, and when properly configured, would have  
3 identified and flagged inaccurate data before it was submitted to CMS or state Medicaid agencies.

4 **REQUEST FOR ADMISSION NO. 17:** Admit that You have not identified any instance in  
5 which an output from a Compliance Tool caused Defendants to submit a False Claim.

6 **RESPONSE:** Denied. Relator's contention is that Defendants' deliberate disabling and  
7 misconfiguration of the Compliance Tools—and their systematic refusal to act on the outputs those tools  
8 did generate—caused false claims to be submitted. Relator identified multiple instances in which  
9 compliance tool outputs revealed overpayments and billing anomalies, yet Defendants suppressed or  
10 ignored those outputs, resulting in the continued submission of false claims. Relator further responds  
11 that relator has identified the submission of claims for payment with respect to capitated payments, as  
12 well as claims for payment that were caused by, submitted to, and knowingly overpaid, by Kaiser  
13 defendants.

14 **REQUEST FOR ADMISSION NO. 18:** Admit that You have not identified a direct causal link  
15 between outputs from the Compliance Tools and any payment by CMS or a Medicaid Program to  
16 Defendants.

17 **RESPONSE:** Denied. Internal audits—which constitute outputs of the compliance review  
18 process—identified hundreds of millions of dollars in overpayments from CMS and state Medicaid  
19 programs, establishing a direct link between the compliance tool outputs and payments by CMS and  
20 state Medicaid agencies to Defendants. Relator further responds that relator has identified a causal link  
21 between the deactivation of the Compliance Tools and the submission of claims for payment with  
22 respect to capitated payments, as well as claims for payment that were caused by, submitted to, and  
23 knowingly overpaid, by Kaiser defendants.

24 **REQUEST FOR ADMISSION NO. 19:** Admit that You have not identified any Medi-Cal  
25 statute, regulation, contract provision, or payment guidance providing that diagnosis codes were used to  
26 set or adjust payments to health plans during the relevant time period alleged in the Complaint.

27 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a legal conclusion  
28 regarding the interpretation and application of Medi-Cal statutes, regulations, contract provisions, and

1 payment guidance. Subject to and without waiving this objection, Plaintiff-Relator can neither admit nor  
2 deny this Request after reasonable inquiry, as identification of the specific legal authorities governing  
3 Medi-Cal payment methodologies is a matter for expert analysis and legal research. To the extent a  
4 response is required, denied. Relator further responds that diagnosis codes and other encounter data  
5 subject to the deactivated tools were submitted to Medi-Cal under statutes, regulations, contract  
6 provisions and payment guidance in connection with rate determinations, rebates, medical loss ratios  
7 and other factors impacting capitated payments. Relator further responds that relator has identified the  
8 claims for payment that were caused by, submitted to, and knowingly overpaid, by Kaiser defendants in  
9 connection with its Medi-Cal managed care programs.

10 **REQUEST FOR ADMISSION NO. 20:** Admit that, during the relevant time period alleged in  
11 the Complaint, payments made by Medi-Cal to health plans were not risk-adjusted based on diagnosis  
12 codes submitted by External Providers.

13 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a legal conclusion  
14 regarding the interpretation and application of Medi-Cal statutes, regulations, contract provisions, and  
15 payment guidance. Subject to and without waiving this objection, Plaintiff-Relator can neither admit nor  
16 deny this Request after reasonable inquiry, as identification of the specific legal authorities governing  
17 Medi-Cal payment methodologies is a matter for expert analysis and legal research. To the extent a  
18 response is required, denied. Relator further responds that diagnoses coding and other encounter data  
19 subject to the deactivated software tools involved risk-adjusted payments based on diagnosis codes  
20 under the Chronic Illness and Disability Payment System (CDPS). CDPS relies on 19 major diagnostic  
21 categories that identify chronic, costly illnesses in younger disabled populations. To the extent Medi-Cal  
22 payments were not based on risk adjustment, the Complaint also alleges that Defendants' false claims  
23 inflated actual and projected costs that were reflected in Defendants' submissions to Medi-Cal, thereby  
24 causing damages through unlawfully inflated capitated, or Per Member Per Month (PMPM) payments.

25 **REQUEST FOR ADMISSION NO. 21:** Admit that You did not conduct the "internal audit"  
26 referenced in paragraph 110 of the Complaint.

27 **RESPONSE:** Denied. Relator participated in and reviewed the internal audit referenced in  
28 paragraph 110 of the Complaint, including through his review of ARIS (Audit Reporting and Issue

1 System) data in connection with the audit findings.

2 **REQUEST FOR ADMISSION NO. 22:** Admit that You have not identified any specific claim,  
3 diagnosis code, or beneficiary associated with the alleged \$181 million in Medi-Cal overpayments  
4 referenced in paragraph 110 of the Complaint.

5 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as the specific claims, diagnosis  
6 codes, and beneficiary information underlying the \$181 million figure are in Defendants' exclusive  
7 possession, custody, and control. Subject to and without waiving this objection, denied. Relator  
8 witnessed the internal audit findings reflecting this figure and reviewed the associated ARIS data. The  
9 underlying claim-level detail is maintained in Defendants' systems. Relator further responds that relator  
10 has identified the submission of claims for payment with respect to capitated payments, as well as  
11 specific claims for payment that were caused by, submitted to, and knowingly overpaid, by Kaiser  
12 defendants.

13 **REQUEST FOR ADMISSION NO. 23:** Admit that the figures referenced in paragraphs 64 and  
14 92 of the Complaint (\$5.3 million and \$11,690,149) reflect potential claim review findings or vendor-  
15 generated outputs and do not represent confirmed Overpayments to Defendants.

16 **RESPONSE:** Plaintiff-Relator objects to this Request as compound insofar as it contains two  
17 distinct propositions and as vague insofar as the term "confirmed Overpayments" is undefined. Subject  
18 to and without waiving these objections, Plaintiff-Relator admits that the referenced figures reflect claim  
19 review findings and vendor-generated outputs from the Verisk compliance software. Plaintiff-Relator  
20 denies that these figures do not represent confirmed overpayments. By virtue of being entered into ARIS  
21 (Audit Reporting and Issue System), these findings constituted confirmed overpayments within Kaiser's  
22 own internal audit framework.

23 **REQUEST FOR ADMISSION NO. 24:** Admit that prior to engaging in the Protected Activity  
24 alleged in the Complaint, Your performance evaluations identified areas in which Your supervisors  
25 believed improvement in Your work performance was needed.

26 **RESPONSE:** Relator admits to this request only to the extent that standard practice for virtually  
27 every employee's performance evaluation to identify areas for improvement, and the areas identified in  
28 Relator's evaluations were routine and did not reflect any consequential performance deficiencies. In all

1 other respects, this request is denied.

2 **REQUEST FOR ADMISSION NO. 25:** Admit that prior to the Protected Activity alleged in  
3 the Complaint Your supervisors had communicated concerns regarding aspects of Your work  
4 performance.

5 **RESPONSE:** Plaintiff-Relator objects to this Request as vague and ambiguous insofar as the  
6 term “concerns” is undefined and carries an overly negative connotation suggesting that any discussion  
7 of work performance constitutes a consequential performance deficiency. Subject to and without  
8 waiving this objection, Plaintiff-Relator admits that ways to improve performance were discussed with  
9 his supervisors in the ordinary course, as is the case with nearly every employee. Plaintiff-Relator denies  
10 that, prior to engaging in the Protected Activity alleged in the Complaint, any consequential concern was  
11 ever communicated to Relator regarding his work performance.

12 **REQUEST FOR ADMISSION NO. 26:** Admit that You contend the sole reason for Your  
13 termination was retaliation for Protected Activity.

14 **RESPONSE:** Relator admits that retaliation for Protected Activity was a factually sufficient  
15 reason for his termination. In all other respects, this request is denied.

16 **REQUEST FOR ADMISSION NO. 27:** Admit that You do not contend that any non-  
17 retaliatory performance, conduct, or business-related reason contributed to Defendant’s decision to  
18 terminate Your employment.

19 **RESPONSE:** Plaintiff-Relator objects to this Request to the extent it calls for speculation  
20 regarding what was in the minds of the individuals who made or influenced the termination decision.  
21 Subject to and without waiving this objection, Relator admits that retaliation for Protected Activity was  
22 a factually sufficient reason for his termination. In all other respects, this request is denied, with the  
23 qualification that Relator does not contend that any legitimate, non-retaliatory reason sufficiently  
24 contributed to Defendant’s decision to justify its decision to terminate his employment.

25 **REQUEST FOR ADMISSION NO. 28:** Admit that You filed the Mazik Notice in the Osinek  
26 Action.

27 **RESPONSE:** Denied. The Mazik Notice was filed by Relator’s counsel on his behalf. Relator  
28 did not personally file the document.

1           **REQUEST FOR ADMISSION NO. 29:** Admit that the statements You made in the Mazik  
2 Notice are true and accurate.

3           **RESPONSE:** Plaintiff-Relator objects to this Request to the extent it seeks admissions regarding  
4 the content of a legal filing prepared by counsel, which constitutes attorney work product. Relator  
5 further objects to this request as compound, overbroad and burdensome. Subject to and without waiving  
6 this objection, Plaintiff-Relator can neither admit nor deny this Request. The Mazik Notice was prepared  
7 by Relator’s counsel and contained legal arguments, characterizations, and factual assertions advanced  
8 in the context of litigation strategy. Whether those statements are “true and accurate” in the context  
9 sought by this Request is a matter for the Court.

10           **REQUEST FOR ADMISSION NO. 30:** Admit that Your Complaint and the Government  
11 Complaint in Intervention both allege that defendants submitted false or unsupported diagnosis codes  
12 affecting Medicare Advantage payments.

13           **RESPONSE:** Plaintiff-Relator objects to this Request to the extent it calls for a legal conclusion,  
14 is over broad, burdensome and not proportional to the discovery needs in this case. Without waiver of  
15 these objections, it is admitted that both the Complaint and the Government Complaint in Intervention  
16 contain allegations relating to the submission of false claims for capitated payments, based on inflated  
17 risk adjustment factors and unsupported diagnosis codes affecting Medicare Advantage payments. This  
18 admission is not an admission that the scope, theories of liability, or categories of damages in the two  
19 complaints are coextensive. In all other respects, the request is denied.

20           **REQUEST FOR ADMISSION NO. 31:** Admit that the United States "recovered remedies for  
21 the injuries alleged by Mazik" and that the "one-recovery rule" precludes recovery again for the same  
22 injury or alleged damages.

23           **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a legal conclusion  
24 regarding the application of the one-recovery rule and the scope of remedies recovered by the United  
25 States. Subject to and without waiving this objection, Plaintiff-Relator can neither admit nor deny this  
26 Request after reasonable inquiry. The quoted language was advanced as a legal argument in the context  
27 of Relator’s Motion for a Share of Settlement Proceeds in the Osinek Action. The Court in the Osinek  
28 Action has since ruled on Relator’s motion, the legal conclusions and characterizations advanced therein

1 are subject to the courts' disposition, and the matter is now within the jurisdiction of the Ninth Circuit  
2 on Mr. Mazik's appeal. Whether the one-recovery rule applies to the claims asserted in this Action, and  
3 the scope of its application, are contested legal issues that cannot be resolved through a request for  
4 admission.

5 **REQUEST FOR ADMISSION NO. 32:** Admit that "there are no two Kaiser frauds—only  
6 one."

7 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a legal conclusion  
8 and seeks to take a rhetorical characterization made in the context of legal briefing and convert it into a  
9 binding factual admission. Subject to and without waiving this objection, Plaintiff-Relator can neither  
10 admit nor deny this Request after reasonable inquiry. The quoted language was advanced as a legal  
11 argument in Relator's Motion for a Share of Settlement Proceeds in the Osinek Action, in support of a  
12 specific legal theory regarding Relator's entitlement to a share under the alternate remedy provision. The  
13 Court in the Osinek Action has since ruled on that motion, the legal conclusions and characterizations  
14 advanced therein are subject to the courts' disposition, and the matter is now within the jurisdiction of  
15 the Ninth Circuit on Mr. Mazik's appeal. The legal characterizations and arguments advanced therein  
16 cannot properly be the subject of a request for admission in this separate proceeding.

17 **REQUEST FOR ADMISSION NO. 33:** Admit that the Federal False Claims Act claims You  
18 assert in this Action seek recovery for Medicare Advantage payments that were also the subject of the  
19 Osinek Settlement.

20 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a legal conclusion  
21 regarding the scope and overlap of claims in this Action and the Osinek Settlement, and insofar as it  
22 mischaracterizes the nature and scope of the claims asserted in this Action. Subject to and without  
23 waiving this objection, Plaintiff-Relator can neither admit nor deny this Request after reasonable  
24 inquiry. The scope of the Osinek Settlement, the claims resolved therein, and the extent to which those  
25 claims overlap with the claims asserted in this Action are contested legal issues. Relator further responds  
26 that relator has identified Federal False Claims Act violations in addition to the risk adjustment factor  
27 fraud, including the submission of claims for payment with respect to capitated payments under a false  
28 certification of compliance with core Medicare Advantage obligations, as well as false claims for

1 payment that were caused by, submitted to, and knowingly overpaid, by Kaiser defendants. Moreover,  
2 this Action asserts claims under both the Federal False Claims Act and multiple State False Claims Acts  
3 that extend beyond Medicare Advantage payments, including claims involving state Medicaid programs,  
4 the Easterseals subcontractor relationship, and retaliation. The Court in the Osinek Action has ruled on  
5 Relator's motion, the legal conclusions and characterizations advanced therein are subject to the courts'  
6 disposition, and the matter is now within the jurisdiction of the Ninth Circuit on Mr. Mazik's appeal.  
7 The legal questions implicated by this Request are properly resolved by the Court, not through a request  
8 for admission.

9 **REQUEST FOR ADMISSION NO. 34:** Admit that the Osinek Settlement resolved the same  
10 set of Medicare Advantage payments for which You seek recovery in this Action.

11 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a legal conclusion  
12 regarding the scope of the Osinek Settlement and its preclusive effect, if any, on the claims asserted in  
13 this Action. Subject to and without waiving this objection, Plaintiff-Relator can neither admit nor deny  
14 this Request after reasonable inquiry. The scope of the Osinek Settlement, the specific payments it  
15 resolved, and whether those payments are coextensive with the payments at issue in this Action are  
16 contested legal issues that require interpretation of the settlement agreement and related court orders.  
17 The Court in the Osinek Action has ruled on Relator's motion, the legal conclusions and  
18 characterizations advanced therein are subject to the courts' disposition, and the matter is now within the  
19 jurisdiction of the Ninth Circuit on Mr. Mazik's appeal. The legal questions implicated by this Request  
20 are properly resolved by the Court, not through a request for admission.

21 **REQUEST FOR ADMISSION NO. 35:** Admit the United States cannot recover Federal False  
22 Claims Act damages more than once for the same Medicare Advantage payments.

23 **RESPONSE:** Plaintiff-Relator objects to this Request insofar as it calls for a pure legal  
24 conclusion regarding the interpretation and application of the Federal False Claims Act's damages  
25 provisions. Subject to and without waiving this objection, Plaintiff-Relator can neither admit nor deny  
26 this Request after reasonable inquiry. The legal question of whether and to what extent the Federal False  
27 Claims Act permits recovery, and the application of any one-recovery or double-recovery principles, are  
28 contested legal issues that are properly resolved by the Courts. The Court in the Osinek Action has ruled

1 on Relator’s motion, the legal conclusions and characterizations advanced therein are subject to the  
2 courts’ disposition, and the matter is now within the jurisdiction of the Ninth Circuit on Mr. Mazik’s  
3 appeal. The legal questions implicated by this Request are properly resolved by the Court, not through a  
4 request for admission.

5 Dated: April 13, 2026

Law Office of Jeremy L. Friedman  
Mendenhall Law Group

6  
7 By: /s/Jeremy L. Friedman  
Jeremy L. Friedman

8 Attorneys for relator Jeffrey Mazik  
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**PROOF OF SERVICE**

I, Jeremy L. Friedman, declare as follows:

I have an office in Alameda county. I am over the age of eighteen years. My business address is 2801 Sylhowe Road, Oakland, CA, 94602.

I declare that on this day I served a copy of the attached pleading by electronic transmission on this date to:

Aaron M. May (SBN 207751)  
aaron.may@halpernmay.com  
Grant B. Gelberg (SBN 229454)  
grant.gelberg@halpernmay.com  
Gwendolyn M. Toczko (SBN 255984)  
gwendolyn.toczko@halpernmay.com  
Thomas Rubinsky (SBN 302002)  
thomas.rubinsky@halpernmay.com  
HALPERN MAY YBARRA GELBERG LLP  
550 South Hope Street, Suite 2330  
Los Angeles, California 90071-2604

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. DATED: Oakland, California, April 13, 2026.

/s/ Jeremy L. Friedman  
Jeremy L. Friedman

# EXHIBIT J

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9 Attorneys for relator Jeffrey Mazik

10 UNITED STATES DISTRICT COURT  
11 EASTERN DISTRICT OF CALIFORNIA

12 UNITED STATES OF AMERICA, <i>etc., ex rel.</i> )	Case No. 2:19-cv-00559-DAD-JDP
13 JEFFREY MAZIK,	)
14 Plaintiffs,	)
15 v.	)
16 KAISER FOUNDATION HEALTH PLAN, <i>et</i> )	<b>PLAINTIFF-RELATOR JEFFREY MAZIK'S</b>
17 <i>al.</i> ,	<b>RESPONSES AND OBJECTIONS TO</b>
18 Defendants.)	<b>DEFENDANT KAISER FOUNDATION</b>
	<b>HEALTH PLAN, INC.'S SECOND SET OF</b>
	<b>INTERROGATORIES</b>

19 **PROPOUNDING PARTY: DEFENDANT KAISER FOUNDATION HEALTH PLAN, INC.**

20 **RESPONDING PARTY: PLAINTIFF-RELATOR JEFFREY MAZIK**

21 **SET NUMBER: TWO**

22 **PRELIMINARY STATEMENT**

23 Relator has pending a motion for a temporary stay in discovery, and intends to amend or modify  
24 that motion to seek a stay in the entire case until resolution of appellate proceedings in a related case.  
25 One basis for the stay request is the need for relator's counsel to have time to review a substantial body  
26 of case materials recently transferred between attorneys. Relator objected to defendants' propounding of  
27 this discovery at this time, and requested that defendants grant reasonable extensions of time and respect  
28 relator's stay request; but defendants insisted on getting these written responses. In light of these

1 circumstances, as well as those presented in relator’s stay requests, relator provides these responses at  
2 this time, but reserves all rights to amend, supplement, or otherwise change the responses provided  
3 herein.

4 These responses are made solely for the purpose of this action. Each response is subject to all  
5 objections as to competence, relevance, materiality, propriety, and admissibility, and any and all other  
6 objections and grounds which would require the exclusion of any statement herein if the Interrogatories  
7 were asked of, or any statements contained herein were made by, a witness present and testifying in  
8 Court, all of which objections and grounds are reserved and may be interposed at the time of trial.

9 Plaintiff-Relator Jeffrey Mazik has not completed his investigation of the facts relating to this  
10 case and has not completed his preparation for trial. The following responses are made without prejudice  
11 to his right to use later discovered facts, or his right to amend or supplement his responses in accordance  
12 with Rule 26(e). Except for explicit facts admitted herein, no incidental or implied admissions are  
13 intended hereby. The fact that Mr. Mazik has answered any interrogatories should not be taken as an  
14 admission that Mr. Mazik accepts or admits the existence of any facts set forth or assumed by such  
15 interrogatory, or that such response constitutes admissible evidence. The fact that Mr. Mazik has  
16 answered part or all of any interrogatory is not intended and shall not be construed to be a waiver by Mr.  
17 Mazik of all or any part of any objection to any interrogatory of Defendant Kaiser Foundation Health  
18 Plan, Inc.

19 The Preliminary Statement is incorporated into each of the responses set forth below.

20 **OBJECTIONS TO INSTRUCTIONS AND DEFINITIONS**

21 Plaintiff-Relator Jeffrey Mazik objects to each Instruction and Definition to the extent it purports  
22 to impose obligations in excess of, or different from, those imposed by the Federal Rules of Civil  
23 Procedure or other applicable law or rules.

24 Plaintiff-Relator Mazik objects to Definition No. 16 (“You,” “Your,” or “Relator”) as vague,  
25 overly broad, unduly burdensome, not proportional to the needs of the case, and contrary to the scope of  
26 Federal Rules 26 and 33 insofar as it purports to extend to “any attorneys, agents, representatives,  
27 consultants, or other persons acting or purporting to act on his behalf.” Accordingly, Mr. Mazik restricts  
28 his responses to answering on behalf of himself and does not purport to answer on behalf of any

1 attorneys, agents, representatives, consultants, or other persons acting or purporting to act on his behalf.

2 Plaintiff-Relator Mazik objects to Definition No. 9 (“Identify”) as vague, overly broad, unduly  
3 burdensome, not proportional to the needs of the case, and contrary to the scope of Federal Rules 26 and  
4 33. Accordingly, Mr. Mazik restricts his responses to answers that give, to the extent known, the  
5 person’s full name, present or last known address, and when referring to a natural person, additionally,  
6 the present or last known place of employment.

7 Plaintiff-Relator Mazik objects to Instruction No. 1 as vague, overly broad, unduly burdensome,  
8 not proportional to the needs of the case, and contrary to the scope of Federal Rules 26 and 33.  
9 Accordingly, Mr. Mazik restricts his responses to answers that appropriately consider whether the  
10 Interrogatory seeks discovery “regarding any nonprivileged matter that is relevant to any party’s claim  
11 or defense and proportional to the needs of the case, considering the importance of the issues at stake in  
12 the action, the amount in controversy, the parties’ relative access to relevant information, the parties’  
13 resources, the importance of the discovery in resolving the issues, and whether the burden or expense of  
14 the proposed discovery outweighs its likely benefit.”

15 Plaintiff-Relator Mazik objects to Instruction No. 8 as overly broad, unduly burdensome, not  
16 proportional to the needs of the case, and contrary to the scope of Federal Rules 26 and 33. Accordingly,  
17 Mr. Mazik restricts his responses to answers to the time period from January 1, 2008 through April 1,  
18 2019.

19 Plaintiff-Relator Mazik objects to each interrogatory, each of the subparts, and the entire set, on  
20 the basis that they exceed the limits on interrogatories.

21 Each General Objection shall be incorporated in full into each of Mr. Mazik’s responses, as  
22 though set forth fully therein.

### 23 **SPECIFIC RESPONSES AND OBJECTIONS**

24 **INTERROGATORY NO. 14:** Describe all data, information, materials, analyses, or reports that  
25 You reviewed, relied upon, or analyzed in forming the allegations in the Complaint that Defendants  
26 submitted false or inaccurate diagnosis data in connection with Medicare Advantage or the Medicaid  
27 Programs, including any claim-level data, spreadsheets, exports, audit results, or Compliance Tools  
28 outputs.

1           **RESPONSE:** Plaintiff-Relator objects to this Interrogatory insofar as it is overbroad, unduly  
2 burdensome, and not proportional to the needs of the case. Plaintiff-Relator further objects to this  
3 Interrogatory on the grounds it seeks information that is neither relevant to the subject matter of, or any  
4 claim or defense in, this action nor reasonably calculated to lead to the discovery of admissible evidence.  
5 Mr. Mazik further objects to this Interrogatory as overbroad as to time. Plaintiff-Relator further objects  
6 to this Interrogatory because it calls for information more readily available from another source,  
7 including Defendant's own records. The Complaint references the relevant documentation relied upon in  
8 forming the allegations herein.

9           Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: The  
10 Second Amended Complaint (Dkt. No. 107) references and relies upon the data, information, materials,  
11 analyses, and reports that formed the basis of the allegations. These include, but are not limited to:  
12 internal audit results and findings witnessed by Relator, including the September 2016 internal audit  
13 revealing approximately \$209 million in CMS overpayments and approximately \$181 million in Medi-  
14 Cal overpayments; data analyses performed by Relator and Jay Loden in collaboration with Verisk,  
15 which identified \$5.3 million in overpayments for the Georgia region alone; outputs from the Verisk and  
16 FICO compliance tools run against Kaiser's regional claims data; McKesson ClaimsXten configuration  
17 reports reflecting that 25 of 54 editing rules had been intentionally deactivated; claims data from  
18 Kaiser's regional claims systems, including data from the Georgia, Mid-Atlantic, and Northwest  
19 regions; the Webex presentation Relator prepared in mid-February 2016 to report overpayment findings  
20 to Marita Janiga and Daren Pursche; and internal memoranda and audit findings regarding the  
21 Easterseals billing error rate. Plaintiff-Relator reserves the right to supplement this response as discovery  
22 proceeds.

23           **INTERROGATORY NO. 15:** State whether, as of the date of Your response, You have  
24 identified any specific instance in which false or inaccurate diagnosis data was submitted by any  
25 Defendant to CMS or any state Medicaid agency in connection with Medicare Advantage or a Medicaid  
26 Program. If so, Identify each such instance and state whether You reviewed or analyzed any underlying  
27 medical records, claim files, charts, or other clinical documentation relating to that instance. If not, state  
28 that fact expressly.

1           **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
2 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
3 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
4 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
5 case. Plaintiff-Relator further objects to this Interrogatory because it calls for information more readily  
6 available from another source, including Defendant's own records.

7           Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows:  
8 Relator's work at Kaiser Permanente involved system-level compliance analysis, not individual claim-  
9 level review of medical records or clinical documentation. Relator and his colleagues, including Jay  
10 Loden, analyzed system-level claims data by running it through compliance software tools, including  
11 Verisk and FICO. These tools identified that Kaiser was systematically overpaying for procedures at  
12 rates exceeding what other comparable payors were paying for the same services. Relator further  
13 responds that diagnoses coding and other encounter data subject to the deactivated software tools  
14 involved risk-adjusted payments based on diagnosis codes under the Chronic Illness and Disability  
15 Payment System (CDPS). CDPS relies on 19 major diagnostic categories that identify chronic, costly  
16 illnesses in younger disabled populations. To the extent Medi-Cal payments were not based on risk  
17 adjustment, the Complaint also alleges that Defendants' false claims inflated actual and projected costs  
18 that were reflected in Defendants' submissions to Medi-Cal, thereby causing damages through  
19 unlawfully inflated capitated, or Per Member Per Month (PMPM) payments. Relator further reviewed  
20 the file of an expert that was brought in to review the issues Relator identified, and within the expert's  
21 report were medical records. Relator review the expert's report containing those records. The specific  
22 claims data underlying these analyses is in Defendants' possession, custody, and control. Plaintiff-  
23 Relator reserves the right to supplement this response as discovery proceeds.

24           **INTERROGATORY NO. 16:** Describe how the Compliance Tools identified in the Complaint  
25 allegedly resulted in the submission of false or inaccurate diagnosis data to CMS or any state Medicaid  
26 agency, including: (a) the source of the information analyzed by the Compliance Tools; (b) how the  
27 Compliance Tools analyzed the information; (c) what outputs the Compliance Tools generated; (d) how  
28 those outputs were allegedly used or not used by Defendants; and (e) Identify any statute, regulation,

1 CMS manual provision, guidance, enforcement action, or other authoritative source that You contend  
2 required Defendants to configure or utilize any Compliance Tool in a particular manner.

3 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
4 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
5 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
6 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
7 case. Plaintiff-Relator further objects to this Interrogatory because it calls for information more readily  
8 available from another source, including Defendant's own records, as the architecture, configuration,  
9 and operation of the Compliance Tools are within Defendants' exclusive possession and control.

10 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows:

11 (a) Source of Information: The information analyzed by the Compliance Tools consisted of  
12 claims data originating from Kaiser's regional claims systems. Each Kaiser region used its own claims  
13 processing system. The Compliance Department maintained an ongoing relationship with Kaiser's IT  
14 area to obtain the claims data necessary to perform compliance work. Jay Loden, Assistant Director of  
15 Information Analytics and Compliance Technology, obtained copies of claims data and ran it through  
16 the compliance software tools. A diagram showing the flow of data for claims (the "claims data flow"  
17 diagram) exists in Defendants' records and depicts this process.

18 (b) How the Compliance Tools Analyzed the Information: The primary compliance tools were  
19 Verisk and FICO. Verisk analyzed claims data to determine the appropriate payment amount for a given  
20 procedure—essentially identifying what should be paid. FICO provided comparison data showing what  
21 other payors typically paid for the same procedures. Additionally, McKesson ClaimsXten applied  
22 editing rules designed to detect abusive billing and prevent wasteful payments. Each regional office used  
23 a different configuration of these tools. At a high level, the tools contained settings and editing rules  
24 that, if configured too broadly or deactivated, would fail to catch fraudulent or inflated claims. When  
25 properly configured, these tools would flag overpayments and billing anomalies for review and  
26 correction.

27 (c) Outputs Generated: The Compliance Tools generated reports identifying overpayments,  
28 billing anomalies, and claims flagged for further review. For example, the Verisk software identified

1 \$11,690,149 in overpayments in the Georgia region alone during 2010 to 2013, and additional  
2 overpayments in the Northwest region (including Washington) and the Mid-Atlantic States (including  
3 Virginia). The FICO tools similarly identified overpayments in multiple regions.

4 (d) How Outputs Were Used or Not Used: Defendants systematically ignored, suppressed, or  
5 failed to act on the outputs of these Compliance Tools. Defendants intentionally deactivated 25 of 54  
6 editing rules in their McKesson ClaimsXten software specifically designed to detect abusive billing and  
7 prevent wasteful payments. When Relator and his colleagues demonstrated that reactivating these  
8 features would identify millions in overpayments, Defendants' management refused to implement the  
9 corrective action and instead buried the findings. Defendants also intentionally disabled the Verisk  
10 software tool in the Mid-Atlantic States (including Virginia) and the Northwest Region (including  
11 Washington State), causing it to no longer identify overpayments in those regions. In Colorado, Kaiser  
12 identified upcoded charges using a "filter" tool, but routinely ignored the results and then, in 2012,  
13 ended the filter program entirely. Claims that were not caught by the improperly configured tools passed  
14 through to the CMS and state Medicaid reimbursement processes without correction.

15 (e) Authoritative Sources: Defendants were required to maintain effective compliance programs  
16 under, inter alia, 42 U.S.C. § 1320a-7k(d) (the 60-Day Overpayment Rule); 42 C.F.R. §  
17 422.503(b)(4)(vi) (requiring Medicare Advantage organizations to implement an effective compliance  
18 program); 42 C.F.R. § 422.504 (requiring annual attestations regarding accuracy of risk adjustment  
19 data); the OIG Compliance Program Guidance for Medicare+Choice Organizations; and the terms of  
20 Kaiser's Corporate Integrity Agreement entered into in 2005 in connection with its Hawai'i operations.  
21 Plaintiff-Relator reserves the right to supplement this response as discovery proceeds.

22 Relator further responds that diagnoses coding and other encounter data subject to the  
23 deactivated software tools involved risk-adjusted payments based on diagnosis codes under the Chronic  
24 Illness and Disability Payment System (CDPS). CDPS relies on 19 major diagnostic categories that  
25 identify chronic, costly illnesses in younger disabled populations. To the extent Medi-Cal payments  
26 were not based on risk adjustment, the Complaint also alleges that Defendants' false claims inflated  
27 actual and projected costs that were reflected in Defendants' submissions to Medi-Cal, thereby causing  
28 damages through unlawfully inflated capitated, or Per Member Per Month (PMPM) payments.

1           **INTERROGATORY NO. 17:** State whether You contend that any Compliance Tool was used  
2 to validate, approve, certify, or submit diagnosis data in connection with Medicare Advantage or any  
3 Medicaid Program. If so, Identify each such Compliance Tool and describe all facts supporting Your  
4 contention that the tool was used for that purpose, including how the tool allegedly affected the  
5 submission of diagnosis data to CMS or any state Medicaid agency.

6           **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
7 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
8 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
9 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
10 case. Plaintiff-Relator further objects to this Interrogatory because it calls for information more readily  
11 available from another source, including Defendant's own records.

12           Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: Yes.  
13 To the extent claims data was routed through compliance tools before being submitted to CMS or state  
14 Medicaid agencies, the compliance tools served a validation function. The Compliance Tools—  
15 including Verisk, FICO, and McKesson ClaimsXten—were used to review, validate, and edit claims  
16 data prior to its submission or use in connection with government reimbursement. To the extent those  
17 tools were improperly configured, disabled, or their outputs were ignored by Defendants, false and  
18 inaccurate claims were submitted to CMS and state Medicaid agencies without the corrections that  
19 properly functioning compliance tools would have identified and flagged. Relator further responds that  
20 relator has identified the submission of claims for payment with respect to capitated payments, as well  
21 as claims for payment that were caused by, submitted to, and knowingly overpaid, by Kaiser defendants.  
22 The specific manner in which each tool interfaced with Defendants' claims submission processes is  
23 within Defendants' exclusive knowledge and control. Plaintiff-Relator reserves the right to supplement  
24 this response as discovery proceeds.

25           **INTERROGATORY NO. 18:** Describe all facts supporting Your contention that any alleged  
26 Overpayment occurred, including: (a) the Medicare Advantage or Medicaid Program at issue; (b) the  
27 relevant time period; (c) all data, datasets, spreadsheets, reports, analyses, or systems You reviewed or  
28 relied upon in forming that contention; and (d) the specific amount of damages You attribute to each

1 identified program, separately stating any amounts attributed to Medicare Advantage and to each  
2 individual Medicaid Program.

3 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory insofar as it is overbroad, unduly  
4 burdensome, and not proportional to the needs of the case. Plaintiff-Relator further objects to this  
5 Interrogatory on the grounds it seeks information that is neither relevant to the subject matter of, or any  
6 claim or defense in, this action nor reasonably calculated to lead to the discovery of admissible evidence.  
7 Plaintiff-Relator further objects to this Interrogatory because it calls for information more readily  
8 available from another source, including Defendant's own records and audit results.

9 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: The  
10 facts supporting Relator's contentions regarding overpayments are set forth in the Second Amended  
11 Complaint (Dkt. No. 107) and in Relator's Amended Responses to Defendant's First Set of  
12 Interrogatories, which are incorporated herein by reference. The overpayment contentions are supported  
13 by internal audits witnessed by Relator, compliance tool outputs, and data analyses performed by  
14 Relator and his colleagues. Relator incorporates his responses to Interrogatories Nos. 1 and 2 of  
15 Defendant's First Set of Interrogatories, as amended. The underlying claims data, audit reports,  
16 compliance tool outputs, and datasets from which the overpayment figures were derived are in  
17 Defendants' possession, custody, and control. Plaintiff-Relator reserves the right to supplement this  
18 response, including with specific damage figures attributed to each program, as well as penalties owing  
19 to the United States and plaintiff Medicaid States, as discovery proceeds and expert analysis is  
20 completed.

21 **INTERROGATORY NO. 19:** Describe all facts supporting any contention that any Medicaid  
22 Program payments to Defendants were increased as a result of the conduct alleged in the Complaint,  
23 including identification of any statutes, regulations, contracts, guidance, or payment methodologies You  
24 rely upon, and all facts supporting Your contention that such alleged conduct was material to the  
25 payment decisions of CMS or any state Medicaid agency, including any facts supporting a contention  
26 that payment would have been refused, reduced, suspended, recouped, or otherwise altered had the  
27 alleged conduct been known.

28

1           **RESPONSE:** Plaintiff-Relator objects to this Interrogatory insofar as it calls for a legal  
2 conclusion or expert opinion. Plaintiff-Relator further objects to this Interrogatory on the grounds it is  
3 overbroad, unduly burdensome, and not proportional to the needs of the case. Plaintiff-Relator further  
4 objects to this Interrogatory because it calls for information more readily available from another source,  
5 including Defendant’s own records regarding its Medicaid submissions and payment methodologies.

6           Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: Relator  
7 incorporates his Amended Responses to Interrogatories Nos. 1 and 2 of Defendant’s First Set of  
8 Interrogatories. Medicaid Program payments to Defendants were increased as a result of the conduct  
9 alleged in the Complaint through multiple mechanisms. First, in states employing risk-adjustment-based  
10 payment methodologies, Defendants’ submission of artificially inflated acuity-based encounter risk  
11 adjustment data directly increased capitated payments. Second, in states and time periods where  
12 payments were not based on enrollee diagnosis codes, the actual costs incurred by Kaiser for  
13 overpayments to outside providers were subsumed within Kaiser’s payment structure, causing falsely  
14 inflated actual and projected costs that were reflected in Kaiser’s submissions to state Medicaid  
15 agencies, thereby inflating future payments. The Medicaid submissions from Kaiser reflecting the data  
16 that would have been impacted by Kaiser’s overpayments to providers are in Defendants’ possession,  
17 custody, and control. Relator further responds that relator has identified Federal False Claims Act  
18 violations in addition to the risk adjustment factor fraud, including the submission of claims for payment  
19 with respect to capitated payments under a false certification of compliance with core Medicare  
20 Advantage obligations, as well as false claims for payment that were caused by, submitted to, and  
21 knowingly overpaid, by Kaiser defendants. The relevant statutes and regulations include, inter alia, 42  
22 U.S.C. § 1320a-7k(d) (60-Day Overpayment Rule), 42 U.S.C. §§ 1396a and 1396b (Medicaid payment  
23 requirements), and the applicable state false claims acts. Plaintiff-Relator reserves the right to  
24 supplement this response, including with expert analysis, as discovery proceeds.

25           **INTERROGATORY NO. 20:** Describe the factual basis for each numerical allegation of  
26 overpayments or damages set forth in the Complaint, including but not limited to the alleged \$5.3  
27 million, \$11,690,149, \$209 million, and \$181 million figures referenced in Paragraphs 64, 92, and 110  
28 of the Complaint. For each such figure, Identify all data, analyses, methodologies, audits, datasets, or

1 reports underlying the figure, and state: (a) the program(s) to which the figure relates; (b) the time period  
2 covered; (c) whether the figure was based on claim-level review, sampling, extrapolation, vendor-  
3 generated output, or other methodology; and (d) whether the alleged amount was ever repaid, refunded,  
4 or otherwise confirmed as an Overpayment.

5 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory insofar as it is overbroad, unduly  
6 burdensome, and not proportional to the needs of the case. Plaintiff-Relator further objects to this  
7 Interrogatory because it calls for information more readily available from another source, including  
8 Defendant's own records, audits, and data.

9 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: Relator  
10 incorporates his Amended Responses to Interrogatories Nos. 1 and 2 of Defendant's First Set of  
11 Interrogatories. With respect to the specific figures referenced:

12 The \$5.3 million figure relates to overpayments identified in the Georgia region by Relator and  
13 Jay Loden, in collaboration with Verisk. See Dkt. No. 107, Second Amended Complaint, ¶¶ 63–64. This  
14 figure was generated by running Kaiser's Georgia claims data through the Verisk compliance software.  
15 The \$11,690,149 figure relates to overpayments identified by the Verisk software in Georgia alone  
16 during 2010 to 2013, with additional overpayments identified in the Northwest region (including  
17 Washington) and the Mid-Atlantic States (including Virginia). See Dkt. No. 107, ¶ 92.

18 The \$209 million figure relates to overpayments from CMS identified in an internal audit  
19 witnessed by Relator in September 2016 due to unsupported diagnostic data. See Dkt. No. 107, ¶ 110.  
20 The \$181 million figure relates to overpayments from the Medi-Cal program identified in an internal  
21 audit of claims data dating from August 3, 2010 through July 30, 2016, covering all regional offices,  
22 which was also witnessed by Relator in September 2016. See Dkt. No. 107, ¶ 110.

23 The data, analyses, methodologies, audits, datasets, and reports underlying each of these figures  
24 are in Defendants' possession, custody, and control. To Relator's knowledge, the alleged amounts were  
25 not repaid, refunded, or otherwise confirmed as overpayments by Defendants—indeed, Defendants'  
26 failure to refund known overpayments is central to the allegations in the Complaint. Plaintiff-Relator  
27 reserves the right to supplement this response as discovery proceeds and expert analysis is completed.

28

1 **INTERROGATORY NO. 21:** State whether You have performed, commissioned, or relied  
2 upon any analysis that quantifies: (a) the effect of any allegedly inaccurate diagnosis code on risk-  
3 adjustment payments made by CMS; or (b) the effect of any alleged conduct described in the Complaint  
4 on payments made by CMS or any state Medicaid agency. If so, Identify the analysis. If not, state that  
5 fact expressly.

6 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
7 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
8 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
9 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
10 case. Subject to and without waiving the foregoing objections, Mr. Mazik responds that any analysis that  
11 quantifies the damages caused to government programs are subject to work product privilege. Relator  
12 reserves the right to commission, perform, or rely upon such analyses as discovery proceeds and in  
13 connection with expert disclosures.

14 **INTERROGATORY NO. 22:** Identify each employee You contend was similarly situated to  
15 You but treated more favorably, and describe all facts supporting that contention.

16 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
17 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
18 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
19 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
20 case.

21 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: Relator  
22 does not necessarily rely upon a comparison of any employee was similarly situated to him for purposes  
23 of a comparator analysis. Generally, multiple employees who worked for defendant in various capacities  
24 did not engage in protected activity of the nature engaged by relator, and yet they were not terminated.  
25 Defendants are in possession and control over documents and information related to these individuals.  
26 To relator's knowledge, other members of Relator's team were not terminated. Relator's team consisted  
27 of direct reports to Mia Okinaga, including: Jay Loden (Assistant Director, Information Analytics and  
28 Compliance Technology, who managed a team of data analysts that ran compliance software against

1 claims and other company data); Marita Janiga (who ran Special Investigations, investigating fraud  
2 allegations reported through various channels including the compliance software run by Loden's team  
3 and the compliance whistleblower online portal); and Judy Sarles (Senior Director, who worked on the  
4 team alongside Loden). None of these individuals were fired. Mia Okinaga herself was laid off, but  
5 Defendants paid money for a non-disclosure agreement in connection with her separation, and she was  
6 not technically terminated for cause. Plaintiff-Relator reserves the right to supplement this response as  
7 discovery proceeds.

8 **INTERROGATORY NO. 23:** Describe all facts supporting Your contention that any Adverse  
9 Employment Action was taken because of Protected Activity, including: (a) the identity of each  
10 Decision-Maker; (b) the basis for Your contention as to that Person's knowledge of the Protected  
11 Activity; and (c) all facts supporting a causal connection between the Protected Activity and the Adverse  
12 Employment Action.

13 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
14 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
15 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
16 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
17 case. Relator further objects on the basis that it calls for information within the possession and control of  
18 defendants, and relator is not obligated to conduct research on behalf of, or for the benefit of,  
19 defendants.

20 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows:

21 (a) Identity of Decision-Makers: The individuals Relator contends made, approved,  
22 recommended, influenced, participated in, or ratified the Adverse Employment Actions include Laurel  
23 Sutcliffe (Director and Senior Manager, National Compliance Office, Fraud Control) and Marita Janiga  
24 (Executive Director of Investigations, Claims Cost Containment Administration). After Mia Okinaga  
25 was laid off as head of the Fraud Control Program, Janiga assumed responsibility for the Fraud Control  
26 unit and its approximately 30 employees. Janiga hired Sutcliffe, and Relator contends that Janiga  
27 directed Sutcliffe to take adverse action against Relator.

28 (b) Knowledge of Protected Activity: Both Sutcliffe and Janiga had direct knowledge of

1 Relator's Protected Activity. Relator directly reported his fraud and overpayment findings to Janiga,  
2 including through a Webex presentation in mid-February 2016 to Janiga and Daren Pursche reporting  
3 significant overpayments. See Dkt. No. 107, ¶¶ 68–69. On October 12, 2016, Relator approached  
4 Sutcliffe with \$380,000 of identified overpayments; Sutcliffe did not question the findings but severely  
5 criticized Relator for performing such an analysis without her prior approval and forbade him from  
6 looking into the issue further. See id. ¶ 116. On December 13, 2016, Relator met with Janiga to  
7 summarize the retaliation he had received from Sutcliffe due to his raising overpayments and claims  
8 compliance issues; Janiga failed to take any action. There were also several instances in which Relator  
9 advised his superiors that Kaiser was violating the 60-Day Overpayment Rule requirements, including at  
10 least one instance in writing to Sutcliffe during or immediately following a presentation on the 60-Day  
11 Overpayment Rule.

12 Additionally, one of Relator's responsibilities—and Okinaga's before her departure—was to  
13 deliver quarterly reports to the Board regarding the Fraud Control Program. This reporting requirement  
14 had been in place for years, instituted because a previous issue had not been reported to the Board.  
15 Relator's performance of this reporting function, which included information about compliance failures,  
16 constituted Protected Activity of which management was directly aware.

17 (c) Causal Connection: Relator had worked at Kaiser Permanente for approximately nine years  
18 prior to the Adverse Employment Actions. Throughout his tenure, he consistently received positive  
19 performance reviews and was promoted when he transitioned from Internal Audit, receiving a  
20 significant salary increase. Only after Relator began reporting fraud, overpayments, and compliance  
21 failures did he receive a Performance Improvement Plan (“PIP”). The PIP was a 60-day plan, and  
22 Relator was terminated shortly after its expiration on January 5, 2017. The temporal proximity between  
23 Relator's Protected Activity and the institution of the PIP and subsequent termination supports a causal  
24 connection. During the PIP, Relator had no understanding of why the PIP was being imposed and did  
25 not realize the connection to his compliance reporting until after the fact. Relator prepared a PowerPoint  
26 presentation documenting his efforts to address each point raised in the PIP. At least one member of  
27 Kaiser management, Doyle Litchfield (who worked in IT management), reviewed the PIP and indicated  
28 that it was deficient and unlike any PIP he had seen at the organization. Plaintiff-Relator reserves the

1 right to supplement this response as discovery proceeds.

2 **INTERROGATORY NO. 24:** Identify each Communication that You contend constituted  
3 Protected Activity but was not identified in response to Interrogatory No. 13 of Defendant's First Set of  
4 Interrogatories.

5 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory on the grounds it seeks information  
6 that is neither relevant to the subject matter of, or any claim or defense in, this action nor reasonably  
7 calculated to lead to the discovery of admissible evidence. Mr. Mazik further objects to this  
8 Interrogatory as overbroad as to time and unduly burdensome and not proportional to the needs of the  
9 case. Relator further objects on the basis that it calls for information within the possession and control of  
10 defendants, and relator is not obligated to conduct research on behalf of, or for the benefit of,  
11 defendants.

12 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows:  
13 Relator's Amended Response to Interrogatory No. 13 of Defendant's First Set of Interrogatories is  
14 generally comprehensive in identifying instances of Protected Activity. In addition to those  
15 communications previously identified, Relator's Protected Activity also included email communications  
16 with Laurel Sutcliffe and Marita Janiga regarding overpayment findings and compliance concerns, the  
17 specific content and dates of which are reflected in Relator's email records and Defendants' records.  
18 Additionally, Relator's quarterly Board presentations regarding the Fraud Control Program constituted  
19 Protected Activity, as they included information about compliance failures and fraud findings. Plaintiff-  
20 Relator reserves the right to supplement this response as discovery proceeds, including upon further  
21 review of documentary evidence produced in discovery.

22 **INTERROGATORY NO. 25:** State all facts supporting any contention that CMS or any state  
23 Medicaid agency lacked knowledge of the conduct alleged in the Complaint during the period in which  
24 payments at issue were made, and Identify all documents, communications, audits, or governmental  
25 findings You rely upon in support of that contention.

26 **RESPONSE:** Plaintiff-Relator objects to this Interrogatory insofar as it calls for a legal  
27 conclusion. Plaintiff-Relator further objects to this Interrogatory on the grounds it is overbroad, unduly  
28 burdensome, and not proportional to the needs of the case. Plaintiff-Relator further objects to this

1 Interrogatory because it calls for information more readily available from another source, including  
2 Defendant’s own records and records of CMS and state Medicaid agencies. Relator further objects on  
3 the basis that it calls for information within the possession and control of defendants, and relator is not  
4 obligated to conduct research on behalf of, or for the benefit of, defendants.

5 Subject to and without waiving the foregoing objections, Mr. Mazik responds as follows: The  
6 conduct alleged in the Complaint—including Defendants’ deliberate disabling of compliance tools,  
7 suppression of internal audit findings, refusal to act on identified overpayments, and submission of false  
8 annual attestations—was by its nature concealed from CMS and state Medicaid agencies. Defendants’  
9 false certifications to CMS pursuant to 42 C.F.R. § 422.504, in which senior executives attested that risk  
10 adjustment data submissions were “accurate, complete, and truthful,” were designed to and did conceal  
11 the underlying compliance failures from CMS. Similarly, Defendants’ deliberate disabling of the Verisk  
12 software in the Mid-Atlantic and Northwest regions and deactivation of McKesson ClaimsXten editing  
13 rules ensured that the resulting overpayments would not be identified and therefore not reported to CMS  
14 or state agencies as required by the 60-Day Overpayment Rule, 42 U.S.C. § 1320a-7k(d). The \$556  
15 million settlement subsequently obtained by the government further evidences the materiality and  
16 concealment of the conduct alleged. Relator is not presently aware of any document or communication  
17 in which CMS or any state Medicaid agency indicated awareness of the specific conduct alleged during  
18 the relevant payment periods. Plaintiff-Relator reserves the right to supplement this response as  
19 discovery proceeds.

20 Dated: April 13, 2026

Law Office of Jeremy L. Friedman  
Mendenhall Law Group

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

23 Attorneys for relator Jeffrey Mazik  
24  
25  
26  
27  
28

**PROOF OF SERVICE**

I, Jeremy L. Friedman, declare as follows:

I have an office in Alameda county. I am over the age of eighteen years. My business address is 2801 Sylhowe Road, Oakland, CA, 94602.

I declare that on this day I served a copy of the attached pleading by electronic transmission on this date to:

Aaron M. May (SBN 207751)  
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HALPERN MAY YBARRA GELBERG LLP  
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I declare under penalty of perjury under the laws of the State of California that the above is true and correct. DATED: Oakland, California, April 13, 2026.

/s/ Jeremy L. Friedman  
Jeremy L. Friedman