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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor
UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor
UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

NOTICE OF MOTION AND MOTION

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

PLEASE TAKE NOTICE that on March 31, 2022, at 1:30 p.m., or as soon thereafter as counsel may be heard, in the courtroom of the Honorable Edward M. Chen (Courtroom 5) of the above-entitled Court, located at 450 Golden Gate Avenue, San Francisco, California 94102, Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and The Permanente Federation, LLC (collectively, "Defendants") will and hereby do move this Court to dismiss all or portions of the following complaints under Federal Rule of Civil Procedure 12(b)(1):

- *United States ex rel. Taylor v. Kaiser Permanente*, Case No. 3:21-cv-03894-EMC (N.D. Cal.);
- *United States ex rel. Arefi v. Kaiser Foundation Health Plan, Inc.*, Case No. 3:16-cv-01558-EMC (N.D. Cal.);
- *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, Case No. 3:16-cv-05337-EMC (N.D. Cal.);
- Counts 1 through 4, *United Sates ex rel. Bryant v. Kaiser Permanente*, Case No. 3:18-cv-01347-EMC (N.D. Cal.); and
- Counts 1 and 2, *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, Case No. 3:21-cv-03124-EMC (N.D. Cal.).

Defendants bring this Motion on the grounds that the above-listed complaints and causes of action are barred under the False Claims Act's first-to-file bar, 31 U.S.C. § 3730(b)(5). The first-to-file bar is jurisdictional and provides that once a relator brings a *qui tam* action, "no

person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5); *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186-87 (9th Cir. 2001). Each of the above-captioned *qui tam* complaints alleges virtually the same fraudulent scheme—that Defendants (or some combination of Defendants) knowingly submitted or caused to be submitted false diagnosis codes to the U.S. Centers for Medicare and Medicaid Services ("CMS") for purposes of obtaining higher reimbursement relating to health insurance coverage that certain Defendants offered their Medicare Advantage members. Because the fraudulent scheme alleged in all five complaints is related to the same fraudulent scheme alleged in Ronda Osinek's earlier-filed *qui tam* complaint, the first-to-file bar precludes the later-filed actions. Defendants therefore respectfully request that the Court dismiss the above-listed causes of action and *qui tam* complaints.

The Motion is based on this Notice of Motion, the accompanying Memorandum of Points and Authorities, the Request for Judicial Notice, the Declaration of David Deaton in support of the Request for Judicial Notice, any reply memorandum, and such other written and oral argument as may be presented to the Court.

Dated: January 18, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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DAVID J. LEVISS
STEPHEN M. SULLIVAN
CAITLIN M. BAIR
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I. INTRODUCTION

Eight years ago, Ronda Osinek filed a *qui tam* action under the False Claims Act ("FCA"), alleging that Kaiser Permanente[1] knowingly presented false claims for payment to the Medicare Advantage program. Specifically, she contends that Kaiser Permanente engaged in an unlawful "upcoding" scheme in which it reported diagnosis codes for Medicare Advantage members[2] to the U.S. Centers for Medicare and Medicaid Services ("CMS") that Kaiser Permanente knew did not comply with CMS coding and documentation requirements and that these diagnosis codes resulted in overpayments from the Medicare Advantage program. Alerted to an allegedly fraudulent, enterprise-wide scheme, the U.S. Department of Justice ("DOJ") commenced an investigation of Osinek's allegations in 2013. In the subsequent seven years, a stampede of other individuals seeking to cash in on the FCA's bounty system filed *qui tam* complaints of their own against various healthcare organizations operating under the Kaiser Permanente trade name, all alleging a similar "upcoding" scheme to defraud the Medicare Advantage program. Despite the first-filed *Osinek* complaint having already given the United States notice of the alleged fraud on the Medicare Advantage program, ***five more*** FCA suits (the "Later-Filed Complaints") now plead duplicative theories based on the same essential facts. The FCA's first-to-file bar compels the Court to dismiss all or portions of these five subsequent *qui tam* complaints.[3]

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[1] Kaiser Permanente is not a legal entity, *see* Request for Judicial Notice ("RJN"), Ex. F, but rather a trade name that refers to the nationwide collaboration among nonprofit health plans, nonprofit hospitals, and provider-directed medical groups to render healthcare services to their members, including millions of Medicare Advantage members, *see United States ex rel. Taylor v. Kaiser Permanente*, Case No. 3:21-cv-03894-EMC (N.D. Cal.), Dkt. No. 1 ¶¶ 16–17.

[2] "Members" refers to the individual Medicare beneficiaries who are enrolled in the Medicare Advantage program and receive their healthcare coverage through a private insurer known as a Medicare Advantage Organization ("MAO"). Members become patients when they receive medical care covered by the Medicare Advantage program. Thus, for purposes of this Motion, the terms "members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

[3] This Motion seeks dismissal of the Later-Filed Complaints—*Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca*—in their entirety except for the retaliation causes of action in the operative *Bryant* complaint (Counts 5 through 8) and the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4), as those claims are not subject to dismissal under the FCA's first-to-file bar.

The FCA incentivizes private individuals, called "relators," to alert the United States to potential fraud by bringing a *qui tam* complaint. But Congress understood that only a single complaint is needed to serve this purpose—where two suits raise "essentially the same claims, permitting the second suit to go forward [i]s not necessary to alert the government to the underlying facts of a fraudulent scheme." *Campbell v. Redding Med. Ctr.*, 421 F.3d 817, 821 (9th Cir. 2005). Congress sought to preclude duplicative *qui tam* suits when it amended the FCA in 1986 to add the so-called "first-to-file bar." This jurisdictional bar provides that after a relator brings a *qui tam* action, "no person other than the Government may intervene or bring a related action ***based on the facts underlying the pending action***." 31 U.S.C. § 3730(b)(5) (emphasis added). The first-to-file bar not only eliminates repetitive lawsuits that needlessly drain judicial and party resources, but also creates a virtuous race to the courthouse with incentives for would-be whistleblowers to quickly file their complaints.

This case is an extreme illustration of why Congress enacted the first-to-file bar. It features not just one repetitive suit alleging the same fraudulent scheme as the original complaint—but ***six separate qui tam actions brought by ten relators*** alleging the same essential elements of fraud on the Medicare Advantage program. As originally pleaded, Relators' complaints total over 300 pages, not to mention amendments and exhibits.[4] But all six complaints allege essentially the same wrongdoing: that Defendants knowingly upcoded diagnosis codes for Medicare Advantage members and that improper practice caused CMS to remit overpayments to health plans sponsored by some of the Defendants.[5]

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[4] "Relators" are (i) Ronda Osinek (complaint filed in 2013); (ii) James Taylor (complaint filed in 2014); (iii) Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc. (complaint filed in 2015); (iv) Marcia Stein and Rodolfo Bone (complaint filed in 2016); (v) Gloryanne Bryant and Victoria Hernandez (complaint filed in 2018); and (vi) Michael Bicocca (complaint filed in 2020).

[5] "Defendants" are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic

The first-filed *Osinek* complaint alleged an enterprise-wide fraud that put the United States on notice of the Medicare Advantage upcoding schemes subsequently alleged in the Later-Filed Complaints, and DOJ actively investigated those allegations for years. The upcoding schemes alleged in the Later-Filed Complaints do nothing to serve the policy goals of the FCA, as the *Osinek* complaint put the United States on notice of the alleged fraud in 2013. Allowing these duplicative allegations to continue would only further complicate this litigation, burden the Court's docket unnecessarily, and waste the parties' resources. This Court should therefore dismiss all or portions of the Later-Filed Complaints under the FCA's first-to-file bar.[6]

II. BACKGROUND

A. The Medicare Advantage Program

Medicare is a federal health insurance program for older adults and individuals with disabilities. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 872 (D.C. Cir. 2021). CMS, an agency within the U.S. Department of Health and Human Services, administers the Medicare program. *Id.* The traditional Medicare program consists of Medicare Part A, which covers inpatient hospital care, and Medicare Part B, which covers outpatient medical care. *Id.* CMS also administers Medicare Part C, which is known as Medicare Advantage, through which Medicare Advantage beneficiaries receive healthcare coverage from private insurers known as MAOs. *Id.* All of the *qui tam* complaints at issue in this Motion allege a scheme to defraud the Medicare Advantage program.

Under the traditional Medicare program, CMS compensates healthcare providers directly for all services rendered to Medicare beneficiaries. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under the Medicare Advantage program, however,

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Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and The Permanente Federation, LLC. Because the various complaints do not name all of the same defendants, "Defendants" or "Kaiser" refers to the defendants named in the complaint(s) referenced in the relevant portion of the Motion, unless otherwise indicated. Although Kaiser Permanente is not a legal entity, *supra* note 1, "Defendants" and "Kaiser" include Kaiser Permanente where named in the complaint at issue.

[6] To assist the Court in its evaluation of this Motion, Appendix A includes a chart comparing the allegations of the *qui tam* complaints.

private health insurance plans "provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage." *Becerra*, 16 F.4th at 872. CMS determines this flat monthly rate through an annual bidding process, and then CMS applies a risk-adjustment payment model, which adjusts the payment rate based on various demographic and health factors that can affect healthcare expenses, including age, gender, and medical diagnoses. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).

Healthcare providers typically record member diagnoses after member visits using "diagnosis codes" and send those codes to the members' Medicare Advantage plans. *Silingo*, 904 F.3d at 672; *see also* 42 U.S.C. § 1395w-23(a)(1)(C)(i). The plans then report the codes to CMS, which uses them to calculate payment rates for each Medicare Advantage member. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i). CMS compensates Medicare Advantage plans based on only those medical conditions diagnosed in the previous payment year. *Silingo*, 904 F.3d at 672.

CMS's risk-adjustment payment model groups diagnosis codes into Hierarchical Condition Categories ("HCCs"). *Id.* Each HCC is assigned a different "relative factor," which corresponds to that HCC's relative effect on the payment amount to the Medicare Advantage plan. *Becerra*, 16 F.4th at 874–75. During the period at issue, CMS determined the relative factors for each HCC through its statistical analysis of the average costs of treating members with those reported conditions in traditional Medicare. *Id.* Because the relative factors differ among HCCs, some HCCs have a larger effect on the payment amount to Medicare Advantage plans. *Id.* CMS uses the relative factors associated with each HCC applicable to a given Medicare Advantage member to calculate what it calls a "risk score," and this risk score is then used to compute the risk adjustment to the flat monthly payment for that member. *Id.*

The D.C. Circuit recently offered this example of how the HCC payment model works: "a 72-year-old woman living . . . with diabetes without complications (relative factor 0.118), and multiple sclerosis (relative factor 0.556)" has a particular risk score keyed to her age, gender, other demographic factors, and medical diagnoses. *Id.* at 875. Both medical conditions raised her risk score by a "relative factor," but multiple sclerosis resulted in a higher increase in that score because CMS had previously determined that treating that condition costs the traditional

Medicare program more than treating ordinary diabetes without complications. *See id.* In other words, under the HCC-payment model, some medical conditions will result in higher risk scores and, in turn, higher CMS payments to Medicare Advantage plans because those conditions are associated with comparatively higher average medical costs than other conditions.

B. The First-Filed *Osinek* Complaint

Ronda Osinek filed the first of the *qui tam* complaints on August 22, 2013. Osinek was a medical coder employed by The Permanente Medical Group, which operates in Northern California. Dkt. No. 1 ¶¶ 5, 23.[7] Osinek's original complaint names a single defendant, Kaiser Permanente. She distinguishes Kaiser Permanente from regional entities operating within Kaiser Permanente and alleges that it directed these entities to engage in various documentation and diagnosis coding practices. *See, e.g.*, *id.* ¶¶ 5–6, 23, 37–38 (alleging that Kaiser exerted "competitive pressure" "between regions").

The crux of Osinek's complaint is that Kaiser "defrauded the United States through a sophisticated scheme to upcode diagnoses to ensure Medicare [Advantage] payments for reimbursable, high-value [medical] conditions." *Id.* ¶ 2. She defines "upcoding" as using diagnosis codes to make Medicare Advantage members "appear less healthy than they actually are." *Id.* ¶ 25. The alleged fraud implicates a range of Kaiser's purported business practices—referred to below as Data Mining/Algorithms, Refresh, Addenda, Boilerplate Phrases, Pressure to Diagnose Risk-Adjusting Medical Conditions, and Guidance & Policies—which subsequent Relators also cited in their *qui tam* complaints.

Data Mining/Algorithms. Osinek alleges that around 2007, Kaiser began a process called "data mining." *Id.* ¶¶ 24–25. Through data mining, Kaiser allegedly identified "higher value HCCs and then determined the diagnoses its [healthcare providers] would need to make to

[7] Unless otherwise indicated, docket references are to the docket in *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-03891-EMC (N.D. Cal.), under which the Later-Filed Complaints have been consolidated. References to dockets in the other consolidated cases are indicated by case name. Defendants dispute the factual allegations and legal assertions in all of the *qui tam* complaints. The characterization of the complaints in this Motion is for the sole purpose of explaining that the complaints allege the same fraudulent scheme—a scheme that Defendants deny. Nothing herein constitutes an admission of any allegation in those complaints.

support the HCCs Kaiser wanted to submit for Medicare reimbursement." *Id.* Then Kaiser allegedly used "algorithms to identify . . . [medical] conditions for data mining" in members' medical records to ensure that it did not fail to report potentially reimbursable medical conditions to CMS. *See id.* Indeed, Osinek contends that Kaiser employed data mining to eliminate instances where a healthcare provider could have recorded a diagnosis for a member but did not, omissions that Kaiser allegedly called "missed opportunities." *See id.* After Kaiser identified "missed opportunities," it allegedly prompted healthcare providers to add the identified medical conditions to member medical records. *Id.* ¶ 33. According to Osinek, the purpose of data mining is to submit diagnosis codes to CMS for "high value [medical] conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue." *Id.* ¶ 25. She alleges that Kaiser would target specific medical conditions for data mining medical records, including chronic kidney disease, congestive heart failure, depression, chronic respiratory failure, cachexia/protein calorie malnutrition, and obesity. *See id.*

Refresh. Because CMS compensates Medicare Advantage plans based on only those medical conditions diagnosed in the previous payment year, *see supra* at 4, plans must record and report chronic medical conditions for members each year. According to Osinek, Kaiser uses the term "refresh" to describe its efforts to re-diagnose chronic conditions each year. *See id.* ¶ 37. She contends that Kaiser implemented organized efforts to refresh members' "chronic [medical] conditions" year over year to eliminate "missed opportunities." *Id.* ¶¶ 33, 37. She further alleges that Kaiser used data mining and this refresh initiative to improperly increase Kaiser's "billings for high value . . . HCCs." *Id.* ¶ 24. According to Osinek, Kaiser directly tied compensation to affiliated medical facilities to "refresh and data mining rates" in order to incentivize healthcare providers to submit more diagnosis codes for reimbursable medical conditions. *Id.* ¶¶ 39–40.

Addenda. Osinek alleges that Kaiser violated CMS guidance about when a healthcare provider can modify or amend a medical record following a member visit. According to Osinek, a provider typically enters relevant information about a member "into a medical record at the time of service." *Id.* ¶ 20. But sometimes a provider will amend a medical record with additional information, including additional medical diagnoses, after the face-to-face visit with the member.

See id. These post-encounter amendments to the medical record are called "addenda." *See id.* ¶¶ 20, 28. Osinek asserts that, under CMS guidelines about addenda, healthcare providers "must verify that they considered a diagnosis or treated a diagnosis during the [patient] encounter, which means a [provider] must address what was contemporaneously considered if he or she addends a diagnosis." *Id.* ¶ 28. She contends, however, that Kaiser's healthcare providers addended medical records "with supporting statements or documentation [for medical conditions] that were not addressed at the time of an encounter." *Id.* After a member visit, Kaiser allegedly instructed healthcare providers "to go back to see what [the] member's previous test results showed to make diagnoses," and "prompted" healthcare providers to addend records with specific diagnoses based on, for example, laboratory tests. *Id.* ¶¶ 29–30. She broadly asserts that Kaiser "also addended and submitted diagnostic codes for complex [medical] conditions without proper support (i.e., not a true causal connection)." *Id.* ¶ 31.

Boilerplate Phrases. Osinek alleges that Kaiser created "boilerplate phrases" for use in documenting a member encounter in the medical record and that these "boilerplate phrases" helped healthcare providers "justify" additions to the medical record. *Id.* ¶ 32. She contends that these phrases allow healthcare providers to "systematically addend [members'] records retroactively—often many months after visits—with cloned or boilerplate language to make the [] record appear to comply with CMS instructions." *Id.* ¶ 28. She further explains that healthcare providers "are expected to use these phrases rather than their own language and discretion based on what they recall from [member] visits." *Id.* ¶ 32.

Pressure to Diagnose Risk-Adjusting Medical Conditions. Osinek also alleges that Kaiser "pressures" healthcare providers "to addend diagnoses and capture the high value HCCs" to eliminate "missed opportunities." *Id.* ¶ 33. As part of this pressure, Kaiser allegedly uses "data mining prompts," which are requests sent to healthcare providers to add diagnoses to medical records when Kaiser discovers "missed opportunities." *Id.* Osinek contends there is an "escalation process" for those healthcare providers who disagree with the prompts and that this escalation process requires healthcare providers to "explain their refusal" to diagnose the prompted medical conditions. *Id.* She also alleges that Kaiser ties healthcare providers'

compensation directly to their performance on data-mining and refresh efforts. *Id.* ¶ 34. And she asserts that Kaiser sponsored so-called "coding parties," created competitions, and awarded cash prizes to encourage healthcare providers to participate in upcoding of diagnosis codes. *Id.* ¶¶ 35–37. As one example, she cites documents that she alleges demonstrate a competition between Kaiser's regional organizations to pressure healthcare providers to increase the number of risk-adjusting diagnoses reported from member visits. *Id.* ¶ 37.

Guidance & Policies. Finally, Osinek alleges that Kaiser instituted policies and guidance meant to target high-value HCCs. *Id.* ¶¶ 26–30. She insists that, as a general matter, Kaiser instructs its affiliated-healthcare providers "to change diagnoses to upcode to higher value and more complicated forms of diseases" rather than medical conditions that members' symptoms actually reflect. *Id.* ¶ 30. She also alleges that Kaiser's policies caused healthcare providers to "take into consideration HCCs and the Medicare [Advantage] payment system when coding and recording [member] encounters." *Id.* ¶ 26. And she asserts that "when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its [healthcare providers] to change coding practices to reflect new reimbursable [HCCs]." *Id.* ¶ 27.

C. The Later-Filed Complaints

Like *Osinek*, each of the Later-Filed Complaints alleges that Defendants relied on "upcoding" techniques to identify and report to CMS "higher value" HCCs for the purposes of defrauding the Medicare Advantage program. And all five of the Later-Filed Complaints describe the same techniques that allegedly facilitated the scheme that Osinek first described in her initial complaint.

1. *Taylor* (2014)

James Taylor is a physician and former employee of Defendant Colorado Permanente Medical Group. *Taylor* Dkt. No. 1 ¶ 12. On October 22, 2014, he filed a *qui tam* complaint against "Kaiser Permanente" as well as national and regional Kaiser-affiliated entities, including Defendants Kaiser Foundation Health Plan, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest. *Id.* ¶¶ 18, 21–24. His allegations date back to when Kaiser implemented new Medicare Advantage

policies in 2004 following the creation of the risk-adjustment model that is at issue in this litigation. *Id.* ¶ 5.

Like Osinek's complaint the year before, Taylor details a scheme to "upcode" diagnoses submitted to CMS for Medicare Advantage members. *Id.* ¶¶ 61, 101. He alleges that Defendants "submit false claims to CMS when they know, or in the exercise of reasonable care should know, that: (1) the [members] do not have the diagnoses for which a risk adjustment claim was submitted; and/or (2) the diagnosis" did not meet purported CMS requirements—specifically, the diagnosis "a) was neither treated nor affected the treatment provided; b) in a face-to-face visit; c) with an appropriate provider; d) in the year at issue." *Id*. ¶ 5.

Taylor provides examples of allegedly false risk-adjustment data, *id.* ¶ 81, including "examples of diagnoses and HCCs identified as frequently upcoded" in Kaiser's internal audits. *Id.* ¶ 101. He lists many of the same medical conditions that Osinek identifies in her complaint, such as cancer, malnutrition, respiratory conditions, and renal conditions. *Id.* ¶¶ 131, 135, 139, 151. Taylor also alleges that Kaiser engaged in the same types of business practices and techniques that Osinek described in her complaint:

Data Mining/Algorithms. Taylor alleges that Kaiser relied on algorithms and "audits" to identify "certain diagnoses" in member medical records to increase the number and value of the HCCs that Kaiser reported to CMS. *Id.* ¶¶ 62, 177, 191, 197. Like Osinek, Taylor focuses on technology, citing one program called "Natural Language Processing," which he states "uses an algorithm to search [medical records] to find words that, individually or in combination, indicate that a [member] has certain diagnoses." *Id.* ¶ 191.

Refresh. Like Osinek, Taylor asserts that Kaiser improperly used a "program designed to 'refresh' chronic [medical conditions]." *Id.* ¶ 186. He contends that some medical conditions identified via refresh initiatives and reported to CMS "were likely false." *Id.* ¶¶ 186–88. He also contends that a 2009 "refresh" audit concluded that more "data mining" of specific conditions was needed. *See id.*

Addenda. Taylor also contends that, through use of addenda, healthcare providers impermissibly added diagnoses to medical records after face-to-face encounters. *See id.* ¶ 138.

He asserts that "Kaiser routinely submitted [diagnosis codes] where the only documentation to support the diagnosis was a radiologic or lab test, or other non-face-to-face service." *Id.* ¶ 160.

Pressure to Diagnose Risk-Adjusting Medical Conditions. Taylor, like Osinek, also alleges that Kaiser "pressured" healthcare providers to diagnose "higher-value" medical conditions. *Id.* ¶ 134. As an example, he explains that Kaiser pressured healthcare providers "to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust)." *Id.* He also describes provider "scores" that allegedly were affected by participation in Kaiser's upcoding initiatives. *Id.*

2. *Arefi* (2015)

On September 4, 2015, three more relators—Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc. ("Prime") (collectively, the "*Arefi* Relators")—filed a third *qui tam* complaint against more than ten Kaiser-affiliated entities. *Arefi* Dkt. No. 1. Arefi is a former employee of Defendant The Permanente Medical Group, and he and Kumar are current Prime employees. *Id.* ¶¶ 8–9. Prime owns and operates 35 acute care hospitals across 11 states and treats Medicare Advantage members, including some Kaiser members, for emergency medical conditions. *Id.* ¶ 10. The *Arefi* complaint's allegations date back to 2009. *See Arefi* Dkt. No. 67; Dkt. No. 64.

The *Arefi* Relators follow the familiar pleading pattern evident from the *Osinek* and *Taylor* complaints, alleging that Kaiser perpetrated a "Medicare Advantage diagnosis upcoding scheme" by "reporting false . . . diagnoses to CMS for Medicare Advantage plan enrollees." *Arefi* Dkt. No. 1 ¶¶ 42, 78. Similar to Osinek, the *Arefi* Relators allege that Kaiser used ***addenda*** to "add[] or substitut[e]" medical conditions to members' medical records after encounter dates. *Id.* ¶ 47. The complaint further alleges that Kaiser relied on medical record reviewers to identify and addend HCC-triggering "diagnoses that were not made by the treating [healthcare provider] at the time of the required face-to-face encounter" with the member. *Id.* ¶ 45.

3. *Stein* (2016)

On May 16, 2016, Marcia Stein and Rodolfo Bone (the "*Stein* Relators") brought a fourth *qui tam* action, naming over a dozen national and regional Kaiser-affiliated entities as defendants

along with "Kaiser Permanente." *Stein* Dkt. No. 1. Stein is a Registered Health Information Administrator who was previously employed by Defendants Kaiser Foundation Hospitals and Southern California Permanente Medical Group. *Id.* ¶ 25. Bone is a coder who was formerly employed by Defendant Kaiser Foundation Hospitals. *Id.* ¶ 27. The *Stein* allegations date back to 2010. *Id.* ¶ 36.

Like the previous Relators, the *Stein* Relators allege "a fraudulent scheme to up-code and falsely diagnose" Medicare Advantage members. *Id.* ¶ 50. They also point to the same specific techniques first alleged by Osinek and then again by other Relators:

Data Mining/Algorithms & Refresh. In their *qui tam* complaint, the *Stein* Relators describe "an improper program designed to identify 'missing' [] diagnosis codes and have the [healthcare providers] 'refresh' the missing [diagnosis codes]." *Id.* ¶ 83. They allege that Defendant Kaiser Foundation Health Plan's "contracted medical groups compil[ed] a 'hit-list' of high value HCC[s] . . . and their related . . . diagnosis codes," and that the list included chronic medical conditions. *Id.* ¶ 84. As part of this alleged scheme to refresh previously diagnosed medical conditions, Kaiser would purportedly "data-mine" the members' medical records for medical conditions that correspond to "high value" HCCs to identify members with a history of diagnoses on the "hit-list." *Id.*

Addenda. The *Stein* Relators also contend that Kaiser used addenda and "improper late medical record entries" to amend medical records "without valid face-to-face encounters" between healthcare providers and members. *Id.* ¶¶ 80, 87–91.

Pressure to Diagnose Risk-Adjusting Medical Conditions. The *Stein* Relators allege that Kaiser sent prompts or "queries" to healthcare providers to encourage providers to diagnose medical conditions. They allege that these "leading queries" pressured healthcare providers to "refresh" medical conditions through addenda that would translate into high-value HCCs, and that coders would meet with healthcare providers "to ensure" the conditions were coded for submission to CMS. *Id.* ¶ 84; *see also id.* ¶¶ 80, 89, 91. They also allege that Kaiser "tracked . . . the [healthcare providers] who 'refreshed' the HCC diagnoses" and that "coders then met with the [healthcare providers] to ensure that the hit-list HCC diagnoses were refreshed." *Id.* ¶¶ 83–84.

Guidance & Policies. The *Stein* Relators also allege that Defendants Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and the Permanente Medical Groups imposed "unwritten policies" that prevented coders from querying healthcare providers for additional support when the providers diagnosed sepsis, a "high-value" medical condition that would "increase CMS's capitation payments" to Kaiser. *Id.* ¶¶ 50–51, 68–69. They also allege that Kaiser "instructed" healthcare providers to use inaccurate diagnosis and coding standards that increased Medicare Advantage members' risk scores through over-diagnosing medical conditions that increased CMS's payments to Kaiser. *Id.* ¶¶ 50, 53–54, 60, 68–69.

4. *Bryant* (2018)

Gloryanne Bryant and Victoria Hernandez (the "*Bryant* Relators") filed a fifth *qui tam* complaint on March 1, 2018, naming eleven national and regional Kaiser-affiliated entities as well as "Kaiser Permanente." *Bryant* Dkt. No. 1. Bryant and Hernandez are coders and former employees of Defendants Kaiser Foundation Health Plan and The Permanente Medical Group, respectively. *Id.* ¶¶ 10, 22–23. Their allegations date back to 2009. *Id.* at 3.

Similar to *Osinek* and the other previously filed *qui tam* actions, the *Bryant* complaint alleges that "Defendants 'upcode' risk adjustment [data]" through various techniques, such as "manipulating the documentation and submitting [risk-adjustment data] to the Medicare Advantage program for diagnoses that the member does not have or for which the member was not treated in the relevant year," or claiming that a member was "treated for a more serious [medical] condition" than the member actually has. *Id.* ¶ 11. The *Bryant* Relators also cite the "upcoding" of specific medical conditions, many of which Osinek also references in her complaint—such as malnutrition, respiratory conditions, depression, obesity, aortic atherosclerosis, and renal conditions. *Id.* ¶¶ 59, 89, 111, 130, 137, 144–45, 148.

The *Bryant* Relators contend that Kaiser implemented the alleged fraud using the same upcoding practices first alleged by Osinek:

Data Mining/Algorithms. The *Bryant* Relators describe Kaiser's alleged efforts to "mine" medical records for "missed opportunities," which resulted in the "systematic over-documenting, over-coding and upcoding of [diagnosis codes corresponding to] certain high value

HCCs." *Id.* ¶¶ 54, 79. The complaint explains that the "'data mining' team . . . used 'algorithms' . . . to identify and capture possible missed [diagnosis codes] . . . referred to as 'missed opportunities.'" *Id.* ¶ 193.

Addenda. Similar to Osinek, the *Bryant* Relators also allege that Kaiser sent "leading" prompts to healthcare providers to "add" diagnosis codes to members' medical records through improper addenda. *Id.* ¶¶ 155, 159–63.

Boilerplate Phrases. The *Bryant* Relators allege the improper use of the same type of boilerplate phrases that Osinek first described in her 2013 complaint: "To provide 'documentation' that would constitute evidence of the clinical significance of [a diagnosis]," Defendant The Permanente Medical Group "developed a 'SMARTPHRASE' to automatically populate the medical record . . . that would . . . falsely state that the diagnosis was significant[.]" *Id.* ¶¶ 62, 69.

Pressure to Diagnose Risk-Adjusting Medical Conditions. The *Bryant* Relators contend that Kaiser employed "leading" queries that encouraged healthcare providers to diagnose medical conditions that corresponded to HCCs in the CMS payment model and would increase Kaiser's reimbursement from CMS. *See id.* ¶¶ 124–25, 134, 137–38, 141–42, 155–59, 161–64, 182–83, 186. The complaint explains that the "queries are always, or almost always, directed toward an HCC diagnosis for maximizing reimbursement capture and not for overall quality documentation . . . ." *Id.* ¶ 162.

Guidance & Policies. According to the *Bryant* Relators, "Kaiser consistently publishes and enforces internal company policies and procedures that contravene coding and diagnostic principles that are widely accepted and enforced within the broader coding community." *Id.* ¶ 151. Like Osinek, the *Bryant* Relators allege that Kaiser relied on diagnosis coding and documentation standards that instructed coders and healthcare providers to report medical conditions that increased Kaiser's reimbursement from CMS where it was not appropriate to do so. *Id.* ¶¶ 59–60, 86–87, 111–13, 131, 137.

5. *Bicocca* (2020)

Michael Bicocca filed the latest *qui tam* action on February 10, 2020, naming Defendants

The Permanente Medical Group; Southern California Permanente Medical Group; and The Permanente Federation. *Bicocca* Dkt. No. 1 ¶¶ 1–24. Bicocca is an anesthesiologist who formerly worked at "Kaiser Hospitals" in California. *Id.* ¶¶ 15–16. His allegations date back to 2015. *Id.* ¶ 91. Bicocca's complaint focuses on the alleged false submission of chronic medical conditions, an alleged practice that Osinek first described in her complaint.

Boilerplate Phrases. Like other Relators, Bicocca describes in his complaint boilerplate phrases that Kaiser supposedly directed healthcare providers to use in medical records. *Id.* ¶¶ 98, 137–45. He contends that these phrases were used to make it appear that CMS guidelines were satisfied when they were not. *Id.* ¶¶ 99–101.

Pressure to Diagnose Risk-Adjusting Medical Conditions. Bicocca also alleges a fraud scheme based on pressuring healthcare providers. He asserts that Kaiser "pressures" healthcare providers to improperly diagnose chronic medical conditions by certifying that the providers "managed" the member's "chronic [medical] conditions, even though they have not managed the chronic [medical] condition . . . ." *Id.* ¶¶ 2, 142. Like Osinek, he also alleges that Kaiser tracked healthcare provider participation in various diagnosis-coding initiatives. *Id.* ¶ 132. And he alleges that Kaiser encouraged healthcare providers to add diagnosis codes to members' medical records with monetary incentives and disincentives, including a "reduction in bonus" for healthcare providers who did not meet diagnosis-coding requirements. *Id.* ¶ 129.

Guidance & Policies. Like Osinek, Bicocca alleges that Kaiser instructed healthcare providers to apply diagnosis-coding and documentation standards that were inconsistent with CMS guidance: "Defendants do not require, and effectively discourage [healthcare providers] from complying with CMS regulations." *Id.* ¶ 6. He further alleges that Kaiser created "trainings and policy changes" that "contained inaccurate information" directing healthcare providers to fraudulently diagnose chronic medical conditions. *Id.* ¶¶ 91–96.

D. *Qui Tam* Consolidation and Intervention by United States

On June 25, 2021, this Court consolidated *Osinek* and the Later-Filed Complaints at the request of the United States, with no opposition from Relators. Dkt. No. 61. The consolidation order cited the overlapping allegations in the complaints and explained: "The six actions each

allege that Kaiser submitted claims to the Medicare Advantage Program . . . for risk-adjustment payments for diagnoses that [members] did not actually have and/or that were not actually addressed by the treating [healthcare provider] during a [member] encounter as required by Medicare billing rules." *Id.* at 2.

On July 27, 2021, after nearly eight years of investigating the allegations that Osinek first asserted in 2013, the United States filed a notice of its intent to intervene ***partially*** in the consolidated *qui tam* actions. Dkt. No. 64. The intervention applies only to "allegations that [Defendants][8] submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added ***via addenda*** under Medicare [Advantage] from the years 2009 until present." *Id.* at 1 (emphasis added).

On December 30, 2021, the *Arefi* Relators dismissed their claims with prejudice to the extent that the United States did not intervene in their case. *See Arefi* Dkt. Nos. 67 & 68. Thus, only their post-2008 allegations pertaining to addenda practices remain for litigation. All other causes of action in *Osinek* and the other Later-Filed Complaints remain to be litigated.

III. ARGUMENT

A. The FCA's First-to-File Bar Prohibits Additional *Qui Tam* Actions Alleging the Same Material Elements of Fraud as an Earlier-Filed *Qui Tam*

The FCA's first-to-file bar encourages private citizens to promptly alert the government to alleged fraud while also prohibiting duplicative suits that benefit neither the public nor DOJ's investigation of the original fraud allegations. To advance this dual purpose, the first-to-file bar creates a race to the courthouse by permitting only the first *qui tam* action containing related fraud allegations to proceed through litigation. Once a relator brings a *qui tam* action, "no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). The policy reason for this prohibition is simple: the first-filed action gives "the government notice of the essential facts of an alleged fraud, while the

[8] The United States' intervention applies only to Defendants Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.

first-to-file bar stops repetitive claims." *See United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186–87 (9th Cir. 2001). Accordingly, § 3730(b)(5) provides "incentives for whistle-blowing insiders" to file suit early. *Id.*

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

The Ninth Circuit has rejected a more narrow test under § 3730(b)(5) that asks whether the two actions share "identical facts." *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015). Indeed, the statute speaks of "related," not "identical," actions. *Lujan*, 243 F.3d at 1189 (citing 31 U.S.C. § 3730(b)(5)). In *Lujan*, the Ninth Circuit found that a bar only of "identical" actions would "decrease incentives to promptly bring qui tam actions," allow "recovery for the same conduct," and permit FCA claims to proceed that "have no additional benefit for the government" since the first-filed action already gave DOJ grounds to investigate the alleged fraud. *Id.*

Because the first-to-file bar is so broad, "simply adding factual details . . . to the essential or material elements of a fraud claim" will not save a subsequent *qui tam* suit from dismissal. *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009); *see also United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *3 (N.D. Cal. July 24, 2015). For example, in *Marion*, the relator was one of several whistleblowers who alleged that a for-profit college had defrauded the U.S. Department of Education. 2015 WL 4512843, at *2. The relator argued that the first-to-file bar should not apply because her complaint, unlike any earlier complaint, detailed a scheme to enroll "phantom students" without their consent and collect financial aid on their behalf. *Id.* at *3. Though the relator's allegations

on this point were "more detailed" than earlier *qui tam* complaints, this district court held that the first-to-file bar required dismissal of her complaint because an earlier complaint had referenced the defendant's collection of student aid for "improperly enrolled students," and thus the "phantom student" allegation was just a factual variation of the same scheme. *See id.*

Nor will geographic or temporal differences between complaints suffice to overcome the bar. *Batiste*, 659 F.3d at 1209. In *Batiste*, the first relator alleged a company-wide fraud but claimed it stopped at his particular office. *Id.* A subsequent relator alleged an ongoing fraud at a different regional office of the company. *Id.* Such differences were "immaterial," the D.C. Circuit held, because if DOJ had investigated the alleged fraud in the first-filed complaint "on a nationwide basis," it would have discovered continuing fraud at the second relator's office. *Id.*

Relators likewise cannot avoid § 3730(b)(5) by naming "different members of the same corporate family," *In re Nat. Gas Royalties Qui Tam Litig.*, 566 F.3d 959, 962 (10th Cir. 2009), especially where the first-filed complaint alleges a "corporate-wide problem" that would give DOJ grounds to investigate all corporate entities, *United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214, 218 (D.C. Cir. 2003). In *Hampton*, the first-filed *qui tam* complaint named a single company, while the second-filed *qui tam* complaint named the same company and regional subsidiaries and employees not named or mentioned in the first action. *Id.* Despite these differences in corporate defendants, the second-filed complaint could not avoid dismissal under the first-to-file bar because the first complaint alleged a "corporate-wide problem" and provided only "examples" and "samplings" of how the fraud occurred. *Id.* Given the first-filed complaint's "broad allegations," the second complaint's focus on specific subsidiaries and naming of employees "were merely variations" on the same alleged fraud in the original *qui tam* action. *Id.*

Finally, relators cannot avoid the first-to-file bar through amendment. *United States ex rel. Carter v. Halliburton Co.*, 144 F. Supp. 3d 869, 880 (E.D. Va. 2015) ("[A]n amendment will not cure the first-to-file bar."). The bar is jurisdictional and requires courts to compare original complaints. *See Lujan*, 243 F.3d at 1186. While a relator can amend to show jurisdiction existed at the time of filing, it may not amend to create jurisdiction. *Morongo Band of Mission Indians v.*

Cal. State Bd. of Equalization, 858 F.2d 1376, 1380 (9th Cir. 1988) ("In determining federal court jurisdiction, we look to the original, rather than to the amended, complaint. Subject matter jurisdiction must exist as of the time the action is commenced."); *see also* Moore et al., *Moore's Federal Practice* § 15.14[3], at 15–34 (3d ed. 1999) (similar). Accordingly, here, the Court must determine whether the first-to-file bar requires dismissal of each Later-Filed Complaint by examining the factual allegations as they were alleged "at the time that action was brought." *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004).

B. The First-to-File Bar Requires Dismissal of All or Portions of the Later-Filed Complaints

The first-filed *Osinek* complaint requires dismissal of all or portions of the five subsequent *qui tam* actions. Osinek alleges a broad, enterprise-wide scheme by "Kaiser Permanente" to defraud the Medicare Advantage program by "upcoding" diagnoses of Medicare Advantage members from at least 2007 to the present. Dkt. No. 1 ¶¶ 2, 6, 24. Her complaint describes techniques that Kaiser allegedly used to perpetrate this scheme—including data-mining and refresh initiatives to eliminate "missed opportunities" to increase reimbursement, pressuring healthcare providers to diagnose risk-adjusting medical conditions, amending medical records through addenda without adequate support, using boilerplate phrases in medical records to feign compliance with allegedly applicable CMS guidelines, and setting policies that allegedly contravened CMS requirements. *Id.* ¶¶ 24–40.

Each of the Later-Filed Complaints repeats allegations about the essential facts of the upcoding scheme first alleged in *Osinek*. That alone triggers the first-to-file bar, as any reasonable DOJ investigation would attempt to identify the various business practices and techniques that produced such "upcoding." But the Later-Filed Complaints even detail many of the exact same practices and techniques that *Osinek* first alleged. The time periods alleged in the Later-Filed Complaints also overlap with the time period at issue in *Osinek*. And while the Later-Filed Complaints name regional and national Kaiser-affiliated entities not named in *Osinek*, those geographic differences are immaterial given *Osinek*'s enterprise-wide allegations about "Kaiser Permanente" as a whole. *See Hampton*, 318 F.3d at 218; *Batiste*, 659 F.3d at 1206–07.

Because *Osinek* and the Later-Filed Complaints allege the same factual scheme to defraud the Medicare Advantage program through the submission of knowingly false risk-adjustment data to CMS, the allegations in the Later-Filed Complaints provide the United States with notice of no new fraud allegations and therefore do not satisfy the purposes of the FCA's *qui tam* provisions. *See Batiste*, 659 F.3d at 1209.

1. *Taylor*

The first-to-file bar requires dismissal of Taylor's complaint in full. The underlying fraudulent scheme alleged by both Osinek and Taylor is the same: Defendants engaged in a systematic effort to "upcode" the diagnoses of Medicare Advantage members. *Taylor* Dkt. No. 1 ¶¶ 5, 61. And many of the factual details about how Kaiser allegedly perpetrated the scheme are the same. Both describe alleged "data mining" algorithms used to identify medical conditions in medical records for upcoding. *Compare* Dkt. No. 1 ¶ 25 *with Taylor* Dkt. No. 1 ¶ 197. Both describe "pressure" supposedly exerted on healthcare providers to diagnose medical conditions that would increase Kaiser's reimbursements under the HCC payment model. *Compare* Dkt. No. 1 ¶¶ 33, 35–36, 40 *with Taylor* Dkt. No. 1 ¶ 134. And both identify many of the same illustrative medical conditions to show how these upcoding schemes allegedly worked: cancer, malnutrition, renal conditions, and respiratory conditions. *Compare* Dkt. No. 1 ¶¶ 25, 27, 37 *with Taylor* Dkt. No. 1 ¶¶ 131, 135, 139, 151. By reading *Osinek*, DOJ had all of the information needed to discover and investigate the allegations in *Taylor*.

Taylor cannot overcome the first-to-file bar by pointing to immaterial factual differences between his complaint and the prior complaint filed by Osinek. For example, that Taylor alleges the fraudulent conduct commenced in 2004, while Osinek alleges it began in 2007, does not save his complaint from dismissal. A mere expansion of an otherwise overlapping date range by the subsequent relator does not overcome the first-to-file bar. *See Batiste*, 659 F.3d at 1209. This rule makes sense: Any reasonable investigation by DOJ into the upcoding practices alleged in *Osinek* would have examined earlier time periods to determine when those alleged practices actually commenced.

Taylor also cannot avoid dismissal simply because he points to examples of the alleged

scheme that occurred in Kaiser's Colorado region whereas Osinek cites examples from Northern California. Courts routinely find that differences in geographic focus are not enough to circumvent the first-to-file bar, particularly where, as here, the first-filed complaint suggests a nationwide fraud. *See, e.g.*, *Hampton*, 318 F.3d at 218; *Batiste*, 659 F.3d at 1206–07. Osinek names a single alleged national defendant—"Kaiser Permanente." Dkt. No. 1. And while she makes clear that the alleged fraud originated with the broader Kaiser Permanente collective, she alleges that Kaiser Permanente encouraged other Kaiser regions to engage in similar upcoding techniques, resulting in an enterprise-wide fraud. *See, e.g.*, *id.* ¶¶ 23, 37. She also cites examples of the alleged scheme from outside the Northern California region, including specific examples from Southern California. *Id.* ¶ 37. In other words, the United States would have discovered the practices alleged in *Taylor* by reasonably investigating the *Osinek* allegations on a nationwide basis. And the United States attempted to do just that—issuing subpoenas in 2013, after the filing of *Osinek*, to Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group that applied to "all . . . subsidiaries, regions, . . . [and] affiliates" of the subpoenaed entities. RJN, Exs. A–D at 2; *see id.*, Ex. E at 1 (clarifying that the 2013 subpoena encompassed the Colorado region).

Nor can Taylor avoid dismissal by pointing to allegations in his Second Amended Complaint that do not appear in his original complaint. Allegations that are not in Taylor's original complaint cannot be used to cure the jurisdictional deficiencies from the time of filing. *See supra* at 17–18. Regardless, the added allegations are still just factual variations of Osinek's broader allegation that Kaiser requires healthcare providers to "review and addend records" to capture diagnoses that will generate additional revenue. *See, e.g.*, Dkt. No. 1 ¶ 33. Specifically, Taylor alleges that in Colorado, Kaiser conducted a retrospective review of medical records to independently identify which diagnosis codes the records supported, a process known as "chart review." Dkt. No. 118 ¶ 120. Taylor contends that this practice resulted in the submission of false diagnosis codes to the Medicare Advantage program and overpayments from CMS. *Id.* ¶ 127. But these allegations describe nothing more than a low-tech version of Osinek's data-mining allegations. While Taylor may add detail about the broader practice, additional detail

alone does not circumvent the first-to-file bar. *See Marion*, 2015 WL 4512843, at *3.

2. *Arefi*

The Court also should dismiss the *Arefi* complaint under the first-to-file bar. Because the *Arefi* Relators have dismissed all claims with prejudice to the extent the United States did not intervene, *Arefi* Dkt. Nos. 67 & 68, the remaining allegations in the complaint concern only an alleged "Medicare Advantage diagnosis upcoding scheme" focused on improper addenda, *Arefi* Dkt. No. 1 ¶¶ 2, 45–47, 78. But § 3730(b)(5) bars these claims because *Osinek* already alleged an upcoding scheme based, in part, on improper addenda. *See* Dkt. No. 1 ¶¶ 20, 29–31.

3. *Stein*

The first-to-file bar requires dismissal of *Stein* in its entirety. The *Stein* Relators allege "a fraudulent scheme to up-code and falsely diagnose" Medicare Advantage members—the same fraudulent scheme first alleged in *Osinek*. *See Stein* Dkt. No. 1 ¶ 50; *see also id.* ¶ 70. In discussing the alleged upcoding scheme, the *Stein* Relators assert three causes of action focused on two specific medical conditions—sepsis and malnutrition—and Kaiser's "refresh" practices. *See generally id.* *Osinek*, too, focuses on an alleged initiative to "refresh" risk-adjusting diagnoses from prior years. *See* Dkt. No. 1 ¶¶ 34, 37. And *Osinek*'s broad focus on upcoding put DOJ on notice of the same alleged scheme at issue in *Stein*, which permitted DOJ to investigate allegations about refresh practices and upcoding involving sepsis and malnutrition.

While the *Stein* Relators' allegations focus on sepsis and malnutrition coding initiatives, these allegations do not describe unique fraud schemes. *See Stein* Dkt. No. 1 ¶¶ 50–79. As noted *supra* at 16-17, the Northern District of California concluded in *Marion* that a relator's "more detailed" explanation of a fraud alleged by a prior relator did not allow her to avoid dismissal under the first-to-file bar. *See Marion*, 2015 WL 4512843, at *3. Similarly, in *Batiste*, the D.C. Circuit affirmed dismissal of a relator's complaint under the first-to-file bar because the two complaints alleged variations on the same fraudulent loan scheme. 659 F.3d at 1206–07. The first-filed complaint "focused on the fabrication of oral forbearance requests," while the later-filed complaint "focused on the offering of forbearances to unqualified borrowers." *Id.* While the competing complaints alleged different methods to perpetrate a similar fraud, the differences

were immaterial to the analysis under § 3730(b)(5) because "the allegations of the first complaint [gave] the government grounds to investigate all that is in the second." *Id.*

So too here, *Osinek*'s broad allegations gave DOJ enough factual basis to investigate the condition-specific fraud alleged in *Stein*. The *Stein* Relators purport to explain how Kaiser used incorrect diagnostic standards for both sepsis and malnutrition that improperly increased the rates at which those conditions were reported to CMS. *See Stein* Dkt. No. 1 ¶¶ 50–79. While Osinek does not focus on malnutrition or sepsis, she generally alleges that Kaiser submitted diagnosis codes for complex medical conditions without proper support and that healthcare providers took "HCCs and the Medicare payment system" into account when recording diagnoses, which resulted in upcoding. Dkt. No. 1 ¶¶ 26, 31. *Stein*'s focus on the alleged use of incorrect diagnostic standards for sepsis and malnutrition does no more than repackage *Osinek*'s broader allegations about diagnosing medical conditions without proper support under applicable CMS guidance.[9] The allegations in *Osinek* therefore were sufficient to put DOJ on notice of the alleged fraud, and § 3730(b)(5) requires dismissal of *Stein*. Indeed, the United States' 2013 subpoenas requested documents that encompassed Kaiser's internal diagnostic standards for all medical conditions, demonstrating that *Osinek* gave DOJ the information it needed to investigate Kaiser's diagnosis standards for sepsis and malnutrition. RJN, Ex. A at 14 (requesting documents about "policies, procedures, guidelines, or professional standards (whether internal or external)" related to "diagnoses or diagnosis codes"), 16 (requesting documents about "systems" used to determine "diagnoses or diagnosis codes").

4. *Bryant* (Counts 1–4)

The *Bryant* complaint likewise should be dismissed except for Counts 5 through 8 of the operative complaint, in which Relators allege illegal retaliation that is not subject to the first-to-

[9] In their operative amended complaint, the *Stein* Relators add allegations that Kaiser instructed coders to improperly assign the diagnosis code for "aortic atherosclerosis" any time that condition appeared in a medical record. Dkt. No. 116 ¶¶ 85, 89. Again, the Court should not consider these allegations because they were not included in the original complaint. *See supra* at 17–18. Regardless, they are merely examples of the same upcoding scheme that Osinek already had alleged, and thus do not change the analysis under § 3730(b)(5).

file bar. Like *Osinek*, *Bryant* describes in the *qui tam* complaint "HCC maximization techniques" that allegedly resulted in "systematic over-documenting, over-coding and ***upcoding*** of certain high value HCCs." *Bryant* Dkt. 1 ¶ 54 (emphasis added). The *Bryant* Relators explain that "Kaiser's . . . 'data mining' team . . . used 'algorithms' in the [Northern California] region to identify and capture possible missed [diagnosis codes] . . . referred to as 'missed opportunities.'" *Id.* ¶ 193. This "missed opportunity" allegation mirrors almost exactly the allegations in *Osinek* about "a system to capture 'missed opportunities,' which are brought to the attention of [healthcare providers] to ensure that all possible Medicare [Advantage] billing opportunities are captured." Dkt. No. 1 ¶ 24. Also mirroring *Osinek*, the *Bryant* Relators cite the specific "upcoding" of malnutrition, respiratory conditions, obesity, and renal conditions. *Compare id.* ¶¶ 25, 27, 37 *with Bryant* Dkt. No. 1 ¶¶ 89, 111, 130, 137, 144–45.

And though *Bryant* cites additional medical conditions not discussed in *Osinek*—such as upcoding of aortic atherosclerosis and vent dependence—these examples are not enough to change the § 3730(b)(5) analysis because the business practices and motives alleged to target these conditions are the same in both complaints. *Compare Bryant* Dkt. No. 1 ¶ 87 (alleging that Kaiser issued "directives" to healthcare providers that "contravene" guidance on vent-dependence coding issued by the American Hospital Association's Coding Clinic) *with* Dkt. No. 1 ¶ 29 (alleging that Kaiser Permanente "tells" healthcare providers to make diagnoses in a way that is not appropriate under "CMS guidelines" and "best practices"). *Bryant*'s allegations are just factual variations on *Osinek*'s allegation that Kaiser Permanente "used a variety of algorithms to identify [certain medical] conditions for data mining, which leads to upcoding." *Compare* Dkt. No. 1 ¶ 25 *with Bryant* Dkt. No. 1 ¶ 59 (alleging that Kaiser "implemented an HCC initiative . . . to review and capture [aortic atherosclerosis] diagnoses in all clinic, emergency, outpatient surgery, and inpatient encounters, even when incidental to the encounter").

The *Bryant* complaint also identifies a number of purported ways that "Kaiser emphasizes financial results over compliance and accuracy," citing to a clinical documentation integrity program and meetings of a "Regional Reporting Group." *Bryant* Dkt. No. 1 ¶¶ 178–79, 187–88. The *Osinek* complaint likewise describes a focus on "HCCs and the Medicare payment system

when coding and recording [member] encounters" and efforts to share successful coding initiatives across regions, even though she does not name the Regional Reporting Group or the clinical documentation integrity program specifically. Dkt. No. 1 ¶¶ 26, 37. Accordingly, for purposes of § 3730(b)(5), *Bryant*'s allegations do not meaningfully differentiate the alleged fraud scheme from the scheme alleged in *Osinek*.

5. *Bicocca* (Counts 1 & 2)

Finally, the Court also should dismiss *Bicocca*'s FCA claims under the first-to-file bar. The thrust of the *Bicocca* complaint is that Kaiser "pressured" specialist providers, such as pain-management physicians, to diagnose medical conditions that the specialists "may not have the expertise to address." *Bicocca* Dkt. No. 1 ¶ 105. Bicocca alleges that Kaiser "directs its [healthcare providers] to check off all chronic [medical] conditions that could conceivably apply to a [member] and place a certifying statement in the [member's] record." *Id.* ¶ 94. He also alleges that healthcare providers could receive "a reduction in bonus" if they failed to meet certain coding "threshold[s]." *Id.* ¶ 128–29. Osinek likewise alleges that Kaiser pressured healthcare providers to add diagnoses to members' charts and that healthcare providers "often give in and use the diagnoses that management asks for rather than using their own, original judgment in coding diagnoses." Dkt. No. 1 ¶ 33. And she also focuses on physician incentives, asserting that Kaiser "tracks and rewards [healthcare providers] based on the percentage of chronic conditions they are able to capture and refresh." *Id.* ¶ 37.

Bicocca focuses on upcoding pressure directed at specialists, who he alleges "do not have the expertise to fully advise their patients on the various ailments" that the specialists had to address. *Bicocca* Dkt. No. 1 ¶¶ 110–19. While Osinek does not explicitly mention specialists, Bicocca's allegations do not differ materially from Osinek's broader allegations that Kaiser pressured ***all healthcare providers*** to refresh "99%" of chronic medical conditions, Dkt. No. 1 ¶ 39, which encompass the subset of specialists at issue in *Bicocca*.

In addition, Bicocca's allegations that Kaiser's efforts to diagnose chronic medical conditions without meeting the requirements of a CMS chronic care program are simply a subset of Osinek's allegations that Kaiser violated CMS diagnosis coding and documentation guidelines.

For example, Bicocca alleges that a "trainer stated that if a [member] states in response to a question that he or she is taking medication for a certain condition, this would satisfy the [chronic care program] requirements" for adding a chronic medical condition to the medical record, but this statement "is in direct contradiction to the foregoing guidelines." *Bicocca* Dkt. No. 1 ¶ 126. Osinek similarly alleges that "Kaiser tells [providers] to go back to see what a member's previous test results showed to make diagnoses, which is not an appropriate data source for coding a diagnosis under CMS guidelines." Dkt. No. 1 ¶ 29. In sum, both complaints allege that Kaiser instructed healthcare providers to add diagnoses to members' medical records using methods that allegedly violated CMS guidelines.

IV. CONCLUSION

Allowing the upcoding allegations in the Later-Filed Complaints to proceed would subvert the purpose of the first-to-file bar not once, but five times over. With the contentions in the *Osinek* complaint, DOJ had sufficient information to investigate the upcoding allegations in the five Later-Filed Complaints. The Court should therefore grant Defendants' Motion and dismiss the *Taylor*, *Arefi*, and *Stein* complaints in their entirety, as well as Counts 1 through 4 of the operative *Bryant* complaint and Counts 1 and 2 of the operative *Bicocca* complaint.

Dated: January 18, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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APPENDIX A

Alleged Fraud: "Upcoding" Medicare Advantage Member Diagnoses					
***Osinek* (2013)**	***Taylor* (2014)**	***Arefi* (2015)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
"Kaiser defrauded the United States through a sophisticated scheme to ***upcode diagnoses*** to ensure Medicare [Advantage] payments for reimbursable, high-value [medical] conditions." ¶ 2.[1]	Defendants engaged in a scheme to "***upcode***" diagnoses of Medicare Advantage members. ¶¶ 5, 61, 74, 81, 101.	Defendants engaged in a "***Medicare Advantage diagnosis upcoding scheme***," by "reporting false . . . diagnoses to CMS for Medicare Advantage plan enrollees . . . ." ¶¶ 42, 78.	Defendants engaged in "a fraudulent scheme to ***up-code and falsely diagnose***" Medicare Advantage members. ¶¶ 50, 70.	"***Defendants 'upcode' risk adjustment claims*** by manipulating the documentation and submitting claims and codes to the Medicare Advantage program for diagnoses that the [member] does not have . . . or by claiming that a member was treated for a more serious [medical] condition than the member actually has . . . ." ¶ 11.	Defendants required healthcare providers to "certify that they have managed their patients' chronic [medical] conditions, even though they have not managed the chronic [medical] condition" in order to "***receive additional, undeserved capitation amounts***" from the Medicare Advantage program. ¶¶ 2–3.

[1] Paragraph citations correspond to the relevant original complaint. All emphases are added.

Alleged "Upcoding" Technique 1: Use of Data Mining/Algorithms to Identify Diagnoseable Medical Conditions			
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**	***Bryant* (2018)**
"Kaiser effectuated its scheme through ***data mining*** . . . ." ¶ 2. Kaiser used "***algorithms*** to identify . . . [medical] conditions for data mining . . . ." ¶¶ 24–25. Kaiser used "a system to capture '***missed opportunities***,' . . . to ensure that all possible Medicare billing opportunities are captured . . . ." ¶ 24. "Kaiser focuses its ***data mining*** on high value [medical] conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue." ¶ 25.	Kaiser "uses an ***algorithm*** to search [medical records] to find words that, individually or in combination, indicate that a [member] has certain diagnoses." ¶ 191. "[A] PowerPoint presented at the Fall 2010 RRG Meeting outlined the results of the 'NLP HCC ***Data Mining*** Pilot." ¶ 197.	Kaiser "performed a ***computer search*** to ***data-mine*** the [data] submissions from the last . . . year to identify the [Medicare Advantage members] with a history of hit-list HCC diagnoses, and used those results to determine which [members'] medical records did not have such hit-list HCC diagnoses submitted . . . ." ¶ 84; *see also* ¶ 100.	"Kaiser's internal data establishes that its ***efforts to mine*** for [aortic atherosclerosis] succeeded in capturing and submitting an enormous increase of [aortic atherosclerosis] codes to Medicare . . . ." ¶ 79. Kaiser has a "'***data mining***' team . . . [which] used '***algorithms***' . . . to identify and capture possible missed HCCs to create 'add files,' referred to as '***missed opportunities***' . . . ." ¶ 193. Kaiser used a ***computer tool*** that "identifies wording and/or full sentences within the electronic health record which contains signs, symptoms, diagnoses and procedures for which a code may possibly be assigned once confirmed and validated by the coding professional." ¶ 198.

Alleged "Upcoding" Technique 2: Refreshing Previously Diagnosed Medical Conditions		
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**
By relying on "what Kaiser terms '***refreshing***' . . . Kaiser was able to increase its billings for high value hierarchical condition categories or HCCs." ¶ 24. "Kaiser tracks and rewards [healthcare providers] based on the percentage of chronic [medical] conditions they are able to capture and ***refresh***." ¶ 37. "Kaiser ties funding allocations to a facility's ***refresh*** . . . rates . . . ." ¶ 39.	Kaiser uses a "program designed to '***refresh***' chronic diagnosis that are submitted one year but not the next." ¶ 186.	Kaiser "submitted or caused to be submitted false and fraudulent [data]resulting from [Kaiser Foundation Health Plan]'s practice of '***refreshing***' missing HCC diagnosis codes." ¶ 80. Kaiser "implemented an improper program designed to identify 'missing' HCC diagnosis codes and have the [healthcare providers] '***refresh***' the missing HCC diagnoses." ¶ 83. "The progress and success of the ***refresh program*** was internally well documented, and tracked the [Medicare Advantage members'] medical records, the HCC diagnoses to be '***refreshed***,' the [healthcare providers] who '***refreshed***' the HCC diagnoses, the HCC diagnosis codes submitted to CMS as [data] as a result of the ***refresh process***, and the increased risk adjustment scores resulting from the ***refresh process***." ¶ 83.

Alleged "Upcoding" Technique 3: Improper Addenda Practices				
***Osinek* (2013)**	***Taylor* (2014)**	***Arefi* (2015)**	***Stein* (2016)**	***Bryant* (2018)**
"Kaiser's Medicare [Advantage member] medical records include ***addenda*** with supporting statements or documentation that were ***not addressed at the time of an encounter***." ¶ 28. Kaiser "prompted" healthcare providers "to ***addend*** diabetes diagnoses to include hyperlipidemia . . . ." ¶ 30.	Kaiser relied on a "radiology report or other test result, rather than a diagnosis documented by an appropriate [healthcare] provider in a face-to-face visit" to support additions to the medical record. ¶ 138. "Kaiser routinely submitted claims where the only documentation to support the diagnosis was a radiologic or lab test, or other ***non-face-to face service***." ¶ 160.	Kaiser submitted diagnosis codes based on "***after-the-fact*** medical record reviews" and "retrospective mining of clinical data." ¶ 2. Kaiser used "queries to induce treating [healthcare providers] to ***add such false and after-the-fact ICD-9-CM diagnoses*** to . . . [members'] charts . . . ." ¶ 8. "Kaiser Defendants . . . [sent] leading and coercive 'physician queries' to improperly induce the treating [provider] to ***change the electronic record*** of the . . . [member's] most recent face-to face encounter by ***adding or substituting the HCC diagnosis*** . . . ." ¶ 47.	Kaiser "***amend[ed]*** the medical record without valid face-to-face encounters . . . ." ¶ 80. "The ***addenda*** refreshing HCC diagnoses were [] invalid . . . ." ¶ 90.	"Coding professionals are permitted . . . to ***query [healthcare] providers for clarification and additional documentation***," but Kaiser used "improper query templates" which "introduce clinical indicators for specific HCC diagnoses to the providers, who in turn routinely follow the suggestion to ***add a reimbursable diagnosis where none existed and should not have been added***." ¶¶ 155, 159, 161.

Alleged "Upcoding" Technique 4: Boilerplate Phrases Used to Indicate Compliance with Alleged Diagnosis Coding Guidelines		
***Osinek* (2013)**	***Bryant* (2018)**	***Bicocca* (2020)**
Kaiser instructs healthcare providers to use "***cloned or boilerplate language*** to make the [member's] record appear to comply with CMS instructions." ¶ 28. "Kaiser also provides ***boilerplate phrases*** . . . [that] can be ***automatically inserted*** through a combination of key strokes . . . ." ¶ 32.	Kaiser "developed a '***SMARTPHRASE***' to ***automatically populate*** the medical record" when diagnosing aortic atherosclerosis. ¶ 62; *see also* 68–69. Kaiser used "'***SMARTPHRASE***' acknowledgments of dietician diagnoses of PCM with a co-signature of dietary notes" when diagnosing malnutrition. ¶ 137.	Kaiser "***provide[d] the language for the certifying statements***" and "directed" healthcare providers to write specific language "in their charts." ¶¶ 97–98. Kaiser instructed healthcare providers to use a ***".FOL" smartphrase*** to support diagnosis coding of chronic medical conditions in medical records. ¶¶ 137–45.

Alleged "Upcoding" Technique 5: Pressure on Healthcare Providers to Diagnose Risk-Adjusting Medical Conditions				
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
"Kaiser ***pressures*** its [healthcare providers] to addend diagnoses and capture the high value HCCs . . . ." ¶ 33. "Kaiser instituted an ***escalation process*** for [providers] who do not agree with the data mining prompts." ¶ 33. Healthcare providers "have ***personal report cards*** based on how they perform in certain areas, which are tied to their ***compensation***." ¶ 34. "Kaiser has mandatory meetings called '***coding parties***,' where [providers] are gathered in a single room . . . and asked to review past progress notes for addenda related to revised medical diagnoses." ¶ 35.	Kaiser "***pressured*** [healthcare providers] to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis . . . ." ¶ 134.	Kaiser "tracked . . . the [healthcare providers] who 'refreshed' the HCC diagnoses." ¶ 83. "Kaiser's coders then ***met with the [providers] to ensure that the hit-list HCC diagnoses were refreshed***." ¶ 84.	"Kaiser's various regions . . . ***compete*** with each other on which region manages to capture the highest number of HCCs and improved risk scores." ¶ 190. Kaiser used "***leading***" queries that "***improperly suggested***" the appropriate diagnosis. ¶¶ 124, 134, 137–38, 141–42, 155–59, 161–64, 182–83, 186.	"Defendants ***intentionally instruct*** [healthcare providers] to certify that they have managed [members'] chronic [medical] conditions . . . ." ¶ 2. "Defendants . . . ***effectively discourage*** [providers] from complying with CMS regulations . . . ." ¶ 6. "Defendants . . . implied that [providers] would be ***disciplined*** or otherwise ***adversely acted upon*** if they did not [address chronic medical conditions]. Examples of this were a ***reduction of bonus***." ¶ 129. "[T]he administrative chiefs of every department received

Alleged "Upcoding" Technique 5: Pressure on Healthcare Providers to Diagnose Risk-Adjusting Medical Conditions				
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
Kaiser "***pressures***" healthcare providers to diagnose Medicare Advantage members "through incentive Programs" such as monetary rewards. ¶ 36. "***[C]ompetitive pressure*** is not only exerted between regions, but within the region" to have the highest risk scores. ¶¶ 37, 38.				emails detailing which doctors were not checking at least 90% of the listed chronic [medical] conditions with every [member]. In meetings between department chiefs, the group would discuss which departments were most successful in meeting this criterion." ¶¶ 132–33.

Alleged "Upcoding" Technique 6: Guidance & Policies			
***Osinek* (2013)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
"Kaiser ***told its [healthcare providers] to diagnose*** chronic kidney disease instead of" lower-value medical conditions. ¶ 26. "[W]hen CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser ***tells its [providers] to change coding practices*** to reflect new reimbursable codes." ¶ 27. "Kaiser ***tells [providers] to go back to see what a member's previous test results showed to make diagnoses***, which is not an appropriate data source for coding a diagnosis under CMS guidelines . . . ." ¶ 29. "Kaiser ***tells its [providers] to change diagnoses to upcode*** to higher value and more complicated forms of diseases." ¶ 30.	Kaiser relied on an "***improper Sepsis diagnostic standard*** that overstated the frequency of Sepsis diagnoses . . . ." ¶ 50. Kaiser relied on "***coding instructions and query restrictions*** [that] violate ICD-9 Guidelines and AHIMA ethical coding guidelines." ¶ 54. Kaiser relied on a malnutrition ***documentation standard that "fails"*** to meet CMS requirements. ¶ 71.	Kaiser relied on ***inaccurate diagnostic standards*** for certain medical conditions. ¶¶ 59–60, 67, 69–72, 75, 86–88, 96, 99–101, 111–13, 117–121, 123, 130, 137, 146. "Kaiser consistently publishes and ***enforces internal company policies and procedures that contravene coding and diagnostic principles*** that are widely accepted and enforced within the broader coding community." ¶ 151. "Many of Kaiser's ***proprietary policies*** regarding diagnosing and coding are intentionally ***constructed to be less restrictive than the norm*** in furtherance of the company's emphasis on profit over compliance." ¶ 152.	Kaiser trained healthcare providers to select diagnosis codes based on ***inaccurate diagnostic standards***. ¶¶ 6, 88–96, 103–118, 124–127, 143–152.

Alleged "Upcoding" Technique 6: Guidance & Policies			
***Osinek* (2013)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
Healthcare "providers were ***told to capture diagnoses*** of Peripheral Vascular Disease [] and Diabetic Peripheral Vascular Disease [] using Carotid Artery Stenosis as evidence." ¶ 31.			

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **[PROPOSED] ORDER GRANTING MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **[PROPOSED] ORDER GRANTING MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **[PROPOSED] ORDER GRANTING MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

[PROPOSED] ORDER GRANTING MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

[PROPOSED] ORDER

With good cause shown, Defendants' Motion to Dismiss Pursuant to False Claims Act's First-to-File Bar is GRANTED. The False Claims Act's first-to-file bar, 31 U.S.C. § 3730(b)(5), requires dismissal of the *Taylor*, *Arefi*, and *Stein* complaints in their entirety, Counts 1 through 4 of the operative *Bryant* complaint, and Counts 1 and 2 of the operative *Bicocca* complaint. The Court dismisses those complaints and causes of action with prejudice.

IT IS SO ORDERED.

DATED:

_____
HONORABLE EDWARD M. CHEN
UNITED STATES DISTRICT JUDGE

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
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I. INTRODUCTION

Pursuant to Federal Rule of Evidence 201, Defendants[1] hereby request that the Court take judicial notice of the date and contents of four subpoenas issued by the Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS-OIG"), an agency of the U.S. government, to Kaiser Foundation Health Plan, The Permanente Medical Group, Southern California Permanente Medical Group, and Kaiser Foundation Hospitals on December 4, 2013. HHS-OIG issued these subpoenas after Relator Ronda Osinek filed a *qui tam* complaint against "Kaiser Permanente" in this matter on August 22, 2013. *See* Dkt. No. 1. The four subpoenas are attached to the accompanying Declaration of David Deaton ("Deaton Declaration").

Defendants also request that the Court take judicial notice of the contents of a letter from the U.S. Department of Justice ("DOJ") to David Deaton, counsel for Defendants, about the production of documents from the Colorado region pursuant to a subpoena issued on December 4, 2013. This letter is also attached to the Deaton Declaration.

Finally, Defendants request that the Court take judicial notice of the fact that the California Secretary of State website does not list "Kaiser Permanente" as a registered business entity. A printout of a webpage from the California Secretary of State website is attached as an exhibit to the Deaton Declaration. This request for judicial notice is made in support of Defendants' Motion to Dismiss Pursuant to the False Claims Act's First-to-File Bar.

II. ARGUMENT

The Court may take judicial notice of matters "not subject to reasonable dispute" in that they "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). Courts may "consider . . . matters of judicial notice . . .

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[1] "Defendants" are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and Permanente Federation, LLC.

without converting the motion to dismiss into a motion for summary judgment." *United States v. Ritchie*, 342 F.3d 903, 908 (9th Cir. 2003).

A. HHS-OIG Subpoenas and DOJ Letter

The date and contents of the four HHS-OIG subpoenas and the DOJ letter listed below are subject to judicial notice. Government records are the proper subject of judicial notice when the facts being noticed therein are not "subject to reasonable dispute." *See Disabled Rights Action Comm. v. Las Vegas Events, Inc.*, 375 F.3d 861, 866 n.1 (9th Cir. 2004). Courts routinely take judicial notice of government-issued "letters," "memos," and "bulletins." *City & Cty. of San Francisco v. Sessions*, 372 F. Supp. 3d 928, 937 n.1 (N.D. Cal. 2019). Government letters and similar documents need not be publicly available to be judicially noticeable. *See, e.g.*, *Lee v. Delta Air Lines Inc.*, 2021 WL 4527955, at *2 (C.D. Cal. Aug. 23, 2021) (taking judicial notice of a California Department of Fair Employment and Housing Determination letter "because it [is] a record of an administrative governmental body, and the accuracy of the source of the document cannot be reasonably questioned"). For example, the Ninth Circuit has taken judicial notice of a licensing agreement between a state entity and a private party. *See Disabled Rights Action Comm.*, 375 F.3d at 866 n.1.

Defendants request that the Court take judicial notice of the following government documents:

1. **Exhibit A** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Kaiser Foundation Health Plan, and advising that the subpoena applies to "all . . . subsidiaries, regions, . . . [and] affiliates" of Kaiser Foundation Health Plan. Ex. A at 5. This subpoena includes two attachments: Attachment A and Attachment B, though Defendants request judicial notice of the contents of Attachment A only. Attachment A includes twelve pages of definitions and instructions followed by thirteen specifications, many of which have subparts, calling for the production of documents. *Id.* at 4–20. These specifications request "all documents" about a variety of topics, including "goals or objectives . . . related . . . to . . . diagnoses or diagnosis codes or HCCs," "training or education . . . [regarding] diagnoses or diagnosis codes or HCCs," "audits," and "systems . . . used to determine, document, assign,

review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees." *Id.* at 16–20. Attachment B includes protected health information of Medicare Advantage members, and Defendants do not request judicial notice of its contents; it is not included in the Exhibit.

2. **Exhibit B** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to The Permanente Medical Group. Like the subpoena issued to Kaiser Foundation Health Plan, it includes two attachments requesting the same categories of records that were requested from Kaiser Foundation Health Plan. As with the request for judicial notice of Exhibit A, Defendants only request judicial notice of Attachment A.

3. **Exhibit C** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Southern California Permanente Medical Group. Like the subpoena issued to Kaiser Foundation Health Plan, it includes two attachments requesting the same categories of records that were requested from Kaiser Foundation Health Plan. As with the request for judicial notice of Exhibit A, Defendants only request judicial notice of Attachment A.

4. **Exhibit D** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Kaiser Foundation Hospitals. Like the subpoena issued to Kaiser Foundation Health Plan, it includes two attachments requesting the same categories of records that were requested from Kaiser Foundation Health Plan. As with the request for judicial notice of Exhibit A, Defendants only request judicial notice of Attachment A.

5. **Exhibit E** is a letter dated June 7, 2017 sent from Senior Trial Counsel Arthur Di Dio, Assistant U.S. Attorney Erica Hitchings, and Assistant U.S. Attorney Edwin Winstead of DOJ to David Deaton of O'Melveny & Myers LLP. This letter communicated to Mr. Deaton "a prioritization of document requests for the Colorado Region" pursuant to the December 4, 2013 HHS-OIG subpoenas. Ex. E at 1.

These exhibits are all properly subject to judicial notice. First, all of the exhibits are documents issued by an agency of the United States, making them government records. Second, Defendants submit these records to show only (1) that the subpoenas were issued to Kaiser Foundation Health Plan, The Permanente Medical Group, Southern California Permanente

Medical Group, and Kaiser Foundation Hospitals on December 4, 2013; (2) that a letter was sent to counsel for Defendants prioritizing the production of documents related to the Colorado region pursuant to that subpoena; and (3) the contents of the requests within the subpoenas—all of which are not "subject to reasonable dispute." *See Disabled Rights Action Comm.*, 375 F.3d at 866 n.1.

B. California Secretary of State Website

"Kaiser Permanente" is not listed as a registered business entity on the California Secretary of State website. The absence of a record showing that Kaiser Permanente is a registered entity in the State of California is also information subject to judicial notice.[2] "[I]nformation made publicly available on a website maintained by a government entity is judicially noticeable." *Platte River Ins. Co. v. P & E Automation, Inc.*, 2013 WL 12123688, at *2 (C.D. Cal. June 19, 2013) (judicially noticing documents available on the California Secretary of State's website). Therefore, courts in the Ninth Circuit routinely take judicial notice of the contents of the California Secretary of State's website. *See, e.g.*, *Phan v. Costco Wholesale Corp.*, 2019 WL 6050903, at *1 n.2 (N.D. Cal. Nov. 15, 2019) (judicially noticing information from the California Secretary of State website); *Green v. First Tenn. Bank Nat'l Ass'n*, 2021 WL 4846952, at *2 (N.D. Cal. Oct. 18, 2021) (same); *Breckenridge Prop. Fund 2016, LLC v. Gonzalez*, 2017 WL 3381155, at *2 n.2 (N.D. Cal. Aug. 7, 2017) (same); *L'Garde, Inc. v. Raytheon Space & Airborne Sys.*, 805 F. Supp. 2d 932, 938 (C.D. Cal. 2011) ("The Court finds that the accuracy of the results of records searches from the Secretary of State for the State of California corporate search website can be determined by readily accessible resources whose accuracy cannot reasonably be questioned.").

Exhibit F shows the results of a search for "Kaiser Permanente" on the California Secretary of State website.[3] The Court should take judicial notice of the fact that the California Secretary of State website does not show any registered business entity listed as "Kaiser

[2] Because the *Osinek* complaint identifies "Kaiser Permanente" as being "headquartered in Oakland California," only search results from the California Secretary of State website are included in this request for judicial notice. *See* Dkt. No. 1 ¶ 6.

[3] These search results are also accessible at https://businesssearch.sos.ca.gov/CBS/SearchResults?filing=&SearchType=CORP&SearchCriteria=kaiser+permanente&SearchSubType=Keyword.

Permanente."

III. CONCLUSION

The Court should grant Defendants' request and take judicial notice of (1) the December 4, 2013 subpoenas issued by HHS-OIG to Kaiser Foundation Health Plan, The Permanente Medical Group, Southern California Permanente Medical Group, and Kaiser Foundation Hospitals; (2) the June 7, 2017 letter sent to counsel for Defendants; and (3) the absence of "Kaiser Permanente" on the California Secretary of State website, as requested herein.

Dated: January 18, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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DAVID DEATON
DAVID J. LEVISS
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Attorneys for Defendants

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC.,

Plaintiff,

v.

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

Defendants.

Case No. 3:16-cv-01558-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE,

Plaintiff,

v.

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

Defendants.

Case No. 3:16-cv-05337-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:18-cv-01347-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

I, David Deaton, hereby declare and state as follows:

1. I am an active member in good standing of the State Bar of California. I am a partner of O'Melveny & Myers LLP, counsel of record for Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and Permanente Federation, LLC (collectively, "Defendants") in the above-captioned cases. I submit this declaration in support of Defendants' Motion to Dismiss Pursuant to the False Claims Act's First-to-File Bar. This declaration is based upon my personal knowledge and, if called as a witness, I could and would testify to the matters set forth below.

2. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of the Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS-OIG") to Kaiser Foundation Health Plan is attached hereto as **Exhibit A**.

3. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to The Permanente Medical Group is attached hereto as **Exhibit B**.

4. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Southern California Permanente Medical Group is attached hereto as **Exhibit C**.

5. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Kaiser Foundation Hospitals is attached hereto as **Exhibit D**.

6. A true and correct copy of a letter dated June 7, 2017 sent from U.S. Department of

Justice Senior Trial Counsel Arthur Di Dio, Assistant U.S. Attorney Erica Hitchings, and Assistant U.S. Attorney Edwin Winstead to me is attached hereto as **Exhibit E**.

7. A true and correct copy of the results for a search of "Kaiser Permanente" on the website of the California Secretary of State performed at my direction by an attorney at my firm on December 29, 2021 is attached hereto as **Exhibit F**. These search results are also accessible at https://businesssearch.sos.ca.gov/CBS/SearchResults?filing=&SearchType=CORP&SearchCriteria=kaiser+permanente&SearchSubType=Keyword. The results of this search show no registered entity with that name.

8. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

EXECUTED this 18th day of January, 2022.

/s/ David Deaton
David Deaton

EXHIBIT A

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

Custodian of Records
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, CA 94612

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negroni
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15428

To: *Custodian of Records*
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, CA 94612

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "KAISER FOUNDATION HEALTH PLAN, INC. " refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

INSTRUCTIONS

1. All documents provided in response to this subpoena are to include all versions of responsive documents with marginalia and post-it notes and other similar documents attached thereto, as well as all preliminary drafts or revisions, any attachments or enclosures, and any copies or duplicates that are not identical to the original because of additions, deletions, alterations or notations.

2. This subpoena requires the production of all responsive documents that are under your possession, custody or control. To the extent that documents responsive to this subpoena once were, but no longer are, in your possession, custody, or control, this subpoena requires production of all existing indices, lists, or documents in your possession, custody, or control which reflect the transfer or destruction of, or references to, such documents. If no documents exist that are responsive to a specification, a written statement to that effect shall be provided at the time of production.

3. To the extent that documents responsive to this subpoena are publicly available, it shall be sufficient to provide a list of such documents provided that such documents will be made promptly available to the Office of Inspector General (OIG) upon request.

4. Where a subpoena specification includes the limiting language "FOR MEDICARE ADVANTAGE ENROLLEES" a document is responsive to the specification if it either concerns Medicare Advantage enrollees specifically or concerns a broader category of patients or enrollees that includes Medicare Advantage enrollees.

5. **Collection of Electronically Stored Information (ESI)**
The following instructions shall apply to the production of Electronically Stored Information (ESI) and digitized (scanned) images. Careful consideration should be given to the methodology, implementation and documentation of ESI collection to ensure that all responsive data and metadata are preserved in the collection process.

a. **Specification Modifications**
Any modifications or deviations from the Production Specifications may be done only with the express permission of the OIG.

b. **Production Format of ESI and Imaged Hard Copy**
Responsive ESI and imaged hard copy shall be produced in the format outlined below. All ESI, except as outlined below in sections i-q, shall be rendered to type TIFF image format, and accompanied by a Concordance® Image Cross Reference file. All applicable metadata (see section c below) shall be extracted and provided in Concordance® load file format.

i. **Image File Format:** All images, paper documents scanned to images, or rendered ESI, shall be produced as 300 dpi single-page TIFF files, CCITT Group IV (2D Compression). Documents should be uniquely and sequentially Bates numbered with an endorsement burned into each image.

A. All TIFF file names shall include the unique Bates number burned into the image.

B. Each Bates number shall be a standard length, include leading zeros in the number, and be unique for each produced page.

C. All TIFF image files shall be stored with the ".tif" extension.

D. Images should be able to be OCR'd using standard COTS products, such as LexisNexis LAW PreDiscovery™.

E. All pages of a document or all pages of a collection of documents that comprise a folder or other logical grouping, including a box, should be delivered on a single piece of media.

F. No image folder shall contain more than 1000 images.

ii. **Concordance® Image Cross Reference file:** Images should be accompanied by a Concordance® Image Cross Reference file that associates each Bates number with its corresponding single-page TIFF image file. The Cross Reference file should also contain the image file path for each Bates numbered page.

A. Image Cross Reference Sample Format:

```
ABC00000001,OLS,D:\DatabaseName\Images\001\
ABC00000001.TIF,Y,,,
ABC00000002,OLS,D:\DatabaseName\Images\001\
ABC00000002.TIF,,,,
ABC00000003,OLS,D:\DatabaseName\Images\001\
ABC00000003.TIF,,,,
ABC00000004,OLS,D:\DatabaseName\Images\001\
ABC00000004.TIF,Y,,,
```

iii. **Concordance® Load File**: Images should also be accompanied by a "text load file" containing delimited text that will populate fields in a searchable, flat database environment. The file should contain the required fields listed in section c below.

A. ASCII text delimited load files are defined using the following delimiters:

Field Separator	*^ or Code 094*
Text Qualifier	*| or Code 124*
Substitute Carriage Return or New Line () or Code 013	

B. The extracted/OCR text should always be the final delimited field in the text load file.

C. The text file should also contain hyperlinks to applicable native files, such as Microsoft Excel or Word files.

D. There should be one line for every record in a collection.

E. The load file must contain a field map/key listing the metadata fields in the order they appear within the data file. For example, if the data file consists of a First Page of a Record (Beginning Bates), Last Page of a Record (End Bates), Document Range (a.k.a. Family Range), Document Date, File Name, and a Title, then the structure may appear as follows:
|BEGBATES|^|ENDBATES|^|FAMILYRNG|^|DOCDATE|^|FILENAME|^|TITLE|

F. Example of a minimal text load file:
BEGBATES	^	ENDBATES	^	OCR
ABC00000001	^	ABC000000003	^	OCR TEXT
ABC00000004	^	ABC000000022	^	OCR TEXT
ABC00000023	^	ABC000000150	^	OCR TEXT
ABC00000151	^	ABC000000200	^	OCR TEXT

c. **Required Metadata/Database Fields**

i. An "X" denotes that the indicated field should be present in the load file produced.

ii. "Other ESI" includes non-email or hard copy documents, including but not limited to data discussed in sections f-h, and l-o below.

Field name	Field Description	Field Type	Field Value	Hard Copy	E-Mail	Other ESI
COMPANY	Company/Organization submitting data	Full Text	Unlimited	X	X	X
BOX#	Submission/volume/box number	Note Text	10	X	X	X
CUSTODIAN	Custodian(s)/Source(s) - format: Last, First or ABC Dept	Multi-Entry	Unlimited	X	X	X
AUTHOR	Creator of the document	Note Text	160			X
BEGDOC#	Start Bates (including prefix) - No spaces	Note Text	60	X	X	X
ENDDOC#	End Bates (including prefix) - No spaces	Note Text	60	X	X	X

Field name	Field Description	Field Type	Field Value	Hard Copy	E-Mail	Other ESI
DOCID	Unique document bates # or populate with the same value as Start Bates (DOCID = BEGDOC#)	Note Text	60	X	X	X
PGCOUNT	Page Count	Integer	10	X	X	X
PARENTID	Parent's DOCID or Parent's Start Bates (for EVERY document including all Child documents)	Note Text	60	X	X	X
ATTACHIDs	Child document list; Child DOCID or Child Start Bates	Multi-Entry	60	X	X	X
ATTACHLIST	List of Attachment bates numbers	Multi Entry	Unlimited		X	X
BEGATTACH	Start Bates number of first attachment	Note Text	60	X	X	X
ENDATTACH	End Bates number of last attachment	Note Text	60	X	X	X
PROPERTIES	Privilege notations, Redacted, Document Withheld Based On Privilege	Multi-Entry	Unlimited	X	X	X
RECORD TYPE	File, E-mail, Attachment, or Hardcopy	Note Text	60	X	X	X
FROM	Author - format: Last name, First name	Note Text	160		X	X
TO	Recipient- format: Last name, First name	Multi-Entry	Unlimited		X	X
CC	Carbon Copy Recipients - format: Last name, First name	Multi-Entry	Unlimited		X	X
BCC	Blind Carbon Copy Recipients - format: Last name, First name	Multi-Entry	Unlimited		X	X
SUBJECT	Subject/Document Title	Note Text	Unlimited		X	X
DOCDATE	Document Date/Date Sent - Format MM/DD/YYYYY	Date Keyed	MM/DD/YYYY			X
BODY	E-mail body, Other Electronic Document Extracted text, or OCR	Full Text	Unlimited	X	X	X
TIMESENT	Time e-mail was sent	Time	10		X	
DATECRTD	Date Created	Date	MM/DD/YYYY		X	X
DATESVD	Date Saved	Date	MM/DD/YYYY		X	X

Field name	Field Description	Field Type	Field Value	Hard Copy	E-Mail	Other ESi
DATEMOD	Date Last Modified	Date Keyed	MM/DD/YYYY		X	X
DATERCVD	Date Accessed/Received	Date	MM/DD/YYYY	X	X	X
FILESIZE	File Size	Note Text	10			X
FILENAME	File name - name of file as it appeared in its original location	Full Text	Unlimited			X
APPLICATION	Application used to create native file (e.g. Excel, Outlook, Word)	Note Text	160		X	X
FILEPATH	Data's original source full folder path	Full Text	Unlimited		X	X
NATIVELINK	Current file path location to the native file	Full Text	Unlimited		X	X
FOLDERID	E-mail folder path (e.g. Inbox\Active) or Hard Copy container information (e.g. Folder or binder name)	Full Text	Unlimited	X	X	
PARAGRAPH	Subpoena/request paragraph number to which the document is responsive	Multi-Entry	Unlimited	X	X	X
HASH	Hash value (used for deduplication or other processing)	Note Text	Unlimited		X	X
MESSAGEHEADER	Email header. Can contain IP address	Full Text	Unlimited		X	
ATTACHMCOUNT	Number of attachments to an email	Note Text	10		X	
FILETYPE	Identifies the application that created the file	Note Text	160		X	X
COMMENTS	Identifies whether the document has comments associated with it	Note Text	10		X	X

d. **De-duplication, Near-duplicate Identification, Email Conversation Threading and Other Culling Procedures**

De-duplication of exact copies within a custodian's data may be done, but all "filepaths" must be provided for each duplicate document. Any other procedure which attempts to cull, filter, group, separate or de-duplicate, etc. (i.e., reduce the volume of material) shall not be done without the express approval of the OIG. All objective coding (e.g., near

dupe ID or e-mail thread ID) shall be discussed and produced to the OIG as additional metadata fields.

e. **Hidden Text**

All hidden text (e.g. track changes, hidden columns, mark-ups, notes) shall be expanded and rendered in the image file. For files that cannot be expanded the native files shall be produced with the image file.

f. **Embedded Files**

All non-graphic embedded objects (Word documents, Excel spreadsheets, .wav files, etc.) that are found within a file shall be extracted and produced. For purposes of production the embedded files shall be treated as attachments to the original file, with the parent/child relationship preserved.

g. **Image-Only Files**

All image-only files (non-searchable .pdfs, multi-page TIFFs, Snipping Tool [and other] screenshots, etc., as well as all other images that contain text) shall be produced with associated OCR text and metadata fields identified in section c above for "Other ESI."

h. **Hard Copy Records**

i. All hard copy material shall reflect accurate document unitization including all attachments and container information (to be reflected in the ParentID, AttachID, beg attach, end attach and group ID). Unitization in this context refers to identifying and marking the boundaries of documents within the collection, where a document is defined as the smallest physical fastened unit within a bundle (e.g., staples, paperclips, rubber bands, folders, or tabs in a binder). The first document in the collection represents the parent document and all other documents will represent the children.

ii. All documents shall be produced in black and white TIFF format unless the image requires color. An image "requires color" when color in the document adds emphasis to information in the document, or is itself information that would not be readily apparent on the face of a black and white image. Images identified as requiring color shall be produced as color 300 dpi single-page JPEG files.

iii. All objective coding (e.g., document date or document author) shall be discussed and produced to the OIG as additional metadata fields.

i. **Production of Email Repositories**

Email repositories, also known as email databases (e.g., Outlook .PST, Lotus .NSF, etc.), can contain a variety of items, including: messages, calendars, contacts, tasks etc. For purposes of production, responsive items shall provide the "Email" metadata fields outlined in section c above, including but not limited to all parent items (mail, calendar, contacts, tasks, notes, etc.) and child files (attachments of files to email or other items) with the parent/child relationship preserved. Email databases from operating systems

other than Microsoft Exchange shall be produced after consultation and only with the express approval of the OIG.

j. **Production of Items Originally Generated in E-Mail Repositories but Found and Collected Outside of Email Repositories, i.e., "Stand-alone" Items**
If parent email or other parent items (e.g., calendar, contacts, tasks, notes, etc.) are found and collected outside of email repositories (e.g., items having extensions like .MSG, .HTM, .MHT, etc.), then all such produced items shall provide the "Email" metadata fields outlined in section c above, including but not limited to any attachments, maintaining the family (parent/child) relationship.

k. **Production of Instant Messenger (IM), Voicemail Data, etc.**
The responding party shall identify, collect, and produce any and all data which is responsive to the requests which may be stored in cell phone/PDA/Blackberry/smart phone data, voicemail messaging data, instant messaging, text messaging, conference call data and related/similar technologies. However, such data, logs, metadata or other files related thereto, as well as other less common but similar data types, shall be produced after consultation and only with the express approval of the OIG.

l. **Productions of Structured Data**
Prior to any production of responsive data from a structured database (e.g., Oracle, SQL, MySQL, QuickBooks, etc.), the producing party shall provide the database dictionary and a list of all reports that can be generated from the structured database. The list of reports shall be provided in native Excel (.xls) format.

m. **Productions of Structured Data from Proprietary Applications**
Prior to any production of structured data from proprietary applications (e.g., proprietary timekeeping, accounting, etc.) the producing party shall provide the database dictionary and a list of all reports that can be generated from the structured database. The list of reports shall be produced in native Excel (.xls) format.

n. **Production of Photographs with Native File or Digitized ESI**
Photographs shall be produced as single-page .JPG files with a resolution equivalent to the original image as it was captured/created. All .JPG files shall have extracted metadata fields provided in a Concordance® load file format as defined in the field specifications for "Other ESI" as outlined in section c above.

o. **Images from which Text Cannot be OCR Converted**
An exception report shall be provided when limitations of paper digitization software/hardware or attribute conversion do not allow for OCR text conversion of certain images. The report shall include the electronic bates, document id or Bates number(s) corresponding to each such image.

p. **Production of Native Files (When Applicable Pursuant to These Specifications)**
All native file productions shall have extracted metadata fields provided in a

Concordance® load file format as defined in the field specifications for "Other ESI" as outlined in section c above.

i. **Common files to be produced in Native Format.** All spreadsheet and presentation files shall be produced in the unprocessed "as kept in the ordinary course of business" state (i.e., in native format). The file produced should maintain the integrity of all source, custodian, application, embedded and related file system metadata. No alteration shall be made to file names or extensions for responsive native electronic files.

ii. **Uncommon Files to be produced in Native Format.** ESI shall be produced in a manner which is functionally useable. The following are examples:

A. AutoCAD data, e.g., .DWG, .DXF, shall be processed/converted and produced as single-page .JPG image files and accompanied by a Concordance® Image formatted load as described above. The native files shall be placed in a separate folder on the production media and linked by a hyperlink within the text load file.

B. GIS data shall be produced in its native format and be accompanied by a viewer such that the mapping or other data can be reviewed in a manner that does not detract from its ability to be reasonably understood.

C. Audio and video recordings shall be produced in native format and be accompanied by a viewer if such recordings do not play in a generic application (e.g., Windows Media Player).

iii. **Electronic Bates (DocID) Convention.** Eletronic Bates (DocID) shall not exceed 30 characters in length and shall include leading zeros in the numeric portion; the Electronic Bates (DocId) shall be a unique name/number common to each document. If the OIG agrees to a rolling production, the naming/numbering convention shall remain consistent throughout the entire production. There shall be no spaces between the prefix and numeric value. If suffixes are required, please use "dot notation". Below is a sample of dot notation:

PREFIX0000001	PREFIX0000003
PREFIX0000001.001	PREFIX0000003.001
PREFIX0000001.002	PREFIX0000003.002

q. **Format of ESI from Non-PC or Windows-based Systems**

The format of ESI from non-PC or Windows-based Systems (e.g., Apple, IBM mainframes and UNIX machines) shall be the subject of discussion and shall only be produced with the express approval of the OIG.

r. **Media Formats for Storage and Delivery of Production Data**

Electronic documents and data shall be delivered on any of the following media:

i. CD-ROMs and/or DVD-R (+/-) formatted to ISO/IEC 13346 and Universal Disk Format 1.02 specifications.

ii. External hard drives, USB 2.0 (or better) or eSATA, formatted to NTFS format specifications.

iii. Storage media used to deliver ESI shall be appropriate to the size of the data in the production.

iv. Media should be labeled with the case name, production date, bates range, and producing party.

s. **Virus Protection and Security for Delivery of Production Data**
Production data shall be free of computer viruses. Any files found to include a virus shall be quarantined by the producing party and noted in a log to be provided to the OIG. Password protected or encrypted files or media shall be provided with corresponding passwords and specific decryption instructions. No encryption software shall be used without the approval of the OIG.

t. **Compliance and Adherence to Generally Accepted Technical Standards**
Production shall be in conformance with standards and practices established by the National Institute of Standards and Technology ("NIST" at www.nist.gov), U.S. National Archives & Records Administration ("NARA" at www.archives.gov), American Records Management Association ("ARMA International" at www.arma.org), American National Standards Institute ("ANSI" at www.ansi.org), International Organization for Standardization ("ISO" at www.iso.org), and/or other U.S. Government or professional organizations.

u. **Transmittal Letter to Accompany Deliverables**
All deliverables shall be accompanied by a transmittal letter including all of the following information at a minimum: production date, case name and number, request paragraph responding to, identity of producing party, production volume name, electronic Bates number (document id or control numbering), Bates number ranges referenced, custodian names, and total number of records.

v. **Read Me Text File**
All deliverables shall include a read me text file at the root directory containing: total number of records, total number of images/pages or files, mapping of fields to plainly identify field names, types, lengths and formats. The file shall also indicate the field name to which images will be linked for viewing, date and time format, and confirmation that the number of files in load files matches the number of files produced.

w. **Exception Log**

An Exception Log shall be included documenting any production anomalies utilizing by the electronic Bates number (document id or control numbering) assigned during the collection, processing and production phases.

6. **Privilege Logs**

Productions that include claims of privilege or confidentiality, (resulting in documents, or portions of documents, being withheld), shall be accompanied by a Privilege Log that identifies the document(s) by Bates range and the basis for each claim or privilege. The Privilege Log shall be electronically produced in native Excel (.xls) or Access (.mdb) and for any document withheld on the ground of any claimed privilege shall include:

a. The type of document being withheld (e.g., letter, memorandum, handwritten notes, marginalia, etc.);

b. The name and title of the author (and if different, the preparer and signatory);

c. The name(s) and title(s) of the individual(s) to whom the document was addressed;

d. The name(s) and title(s) of the individuals to whom the document or a copy of the document was sent or to whom the document or a copy, or any part thereof, was shown;

e. The date of the document;

f. The number of pages;

g. A brief description of the subject matter;

h. A statement of the specific basis on which privilege is claimed; and

i. The paragraph or subparagraph under the heading **"SPECIFICATIONS"** to which it is responsive.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more Kaiser Foundation Health Plan, Inc. facilities or other groups with one or more other Kaiser Foundation Health Plan, Inc. facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at Kaiser Foundation Health Plan, Inc. facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all Kaiser Foundation Health Plan, Inc. components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all Kaiser Foundation Health Plan, Inc. components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at Kaiser Foundation Health Plan, Inc. facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at Kaiser Foundation Health Plan, Inc. related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or

projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between Kaiser Foundation Health Plan, Inc. and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

Custodian of Records
The Permanente Medical Group
1950 Franklin Street, 18th floor
Oakland, CA 94612

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negrom
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15429

To: *Custodian of Records*
The Permanente Medical Group
1950 Franklin Street, 18th floor
Oakland, CA 94612

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

RETURN OF SERVICE

I, being a person over 18 years of age, hereby certify that a copy of this subpoena was duly served on the person named herein by means of -

1. *personal delivery to an individual, to wit:*

_____
(Name)

_____
(Title)

_____
(Address)

2. *personal delivery to an address, to wit:*

_____
(Description of premises)

_____
(Address)

_____
(Address)

3. *registered or certified mailing to:*

_____
(Name)

_____
(Address)

_____
(Address)

at _____ *( ) a.m.*
( ) p.m. on _____

_____
(Signature)

_____
(Title)

UNITED STATES OF AMERICA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Upon contumacy or refusal to obey, this subpoena shall be enforceable by order of the appropriate United States District Court.

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "THE PERMANENTE MEDICAL GROUP" refers to the person or entity with its primary offices located at 1950 Franklin Street, 18th floor, Oakland, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more The Permanente Medical Group facilities or other groups with one or more other The Permanente Medical Group facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at The Permanente Medical Group facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all The Permanente Medical Group components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all The Permanente Medical Group components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis

codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at The Permanente Medical Group facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at The Permanente Medical Group related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between The Permanente Medical Group and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

Custodian of Records
Southern California Permanente Medical Group
Walnut Center
393 East Walnut Street
Pasadena, CA 91188

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigation
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negroni
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15430

To: *Custodian of Records*
Southern California Permanente Medical Group
Walnut Center
393 East Walnut Street
Pasadena, CA 91188

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

RETURN OF SERVICE

I, being a person over 18 years of age, hereby certify that a copy of this subpoena was duly served on the person named herein by means of -

1. *personal delivery to an individual, to wit:*

_____
(Name)

_____
(Title)

_____
(Address)

2. *personal delivery to an address, to wit:*

_____
(Description of premises)

_____
(Address)

_____
(Address)

3. *registered or certified mailing to:*

_____
(Name)

_____
(Address)

_____
(Address)

at _____( ) *a.m.* ( ) *p.m. on* _____

_____
(Signature)

_____
(Title)

UNITED STATES OF AMERICA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Upon contumacy or refusal to obey, this subpoena shall be enforceable by order of the appropriate United States District Court.

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP " refers to the person or entity with its primary offices located at Walnut Center, 393 East Walnut Street, Pasadena, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more Southern California Permanente Medical Group facilities or other groups with one or more other Southern California Permanente Medical Group facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at Southern California Permanente Medical Group facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all Southern California Permanente Medical Group components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all Southern California Permanente Medical Group components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis

codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at Southern California Permanente Medical Group facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at Southern California Permanente Medical Group) related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between Southern California Permanente Medical Group and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

DEC / 5 2013

LEGAL DEPARTMENT

Custodian of Records
Kaiser Foundation Hospitals
One Kaiser Plaza
Oakland, CA 94612

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negroni
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15427

To: *Custodian of Records*
Kaiser Foundation Hospitals
One Kaiser Plaza
Oakland, CA 94612

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "KAISER FOUNDATION HOSPITALS" refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more Kaiser Foundation Hospitals facilities or other groups with one or more other Kaiser Foundation Hospitals facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at Kaiser Foundation Hospitals facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all Kaiser Foundation Hospitals components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all Kaiser Foundation Hospitals components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis

codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at Kaiser Foundation Hospitals facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at Kaiser Foundation Hospitals related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between Kaiser Foundation Hospitals and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT E

U.S. Department of Justice

Robert C. Troyer
Acting United States Attorney
District of Colorado

Edwin G. Winstead
Assistant United States Attorney
Civil Health Care Fraud Coordinator

1801 California Street, Ste 1600 *(303) 454-0100*
Denver, Colorado 80202 *(303) 454-0404 Fax*

Via E-Mail

June 7, 2017

David Deaton, Esq.
O'Melveny & Myers, LLP.
610 Newport Center Drive, 17th Floor
Newport Beach, CA 92660

RE: Request for Kaiser Colorado Region Documents

Dear David:

Pursuant to my telephone call with you on June 2nd, and consistent with an earlier call on February 10, 2017, we would like to prioritize your production under the Department of Health and Human Services, Office of Inspector General subpoena issued December 4, 2013. Requests 1-24 are specific to Kaiser's Colorado Region, including its interactions with Kaiser's national office. Requests 24 through 28 are not so limited; for these requests, Kaiser should produce relevant documents from all regions.

Please note that this letter is a prioritization of document requests for the Colorado Region and does not indicate a limitation of the production requests as specified in the December 4, 2013 subpoena. Moreover, this request is consistent with, and is not intended to disrupt, the production priorities contained in Erica Hitchings' e-mail of February 5, 2016 describing the "next wave of document productions" and any production projects already under way. This letter prioritizes the production of documents for the Colorado Region and provides detailed requests to assist you in expediting the production. To allow us to better track your production for these Colorado Region requests we ask that you add a "CO" to the bates identifier for documents produced in response to this letter.

To assist you in understanding the requests, we first provide definitions of some of the key terms used in the requests:

Defined Terms

"Accuracy" means whether diagnoses and/or HCCs submitted for Risk Adjustment by Kaiser to CMS were valid and supported by documentation in the medical record. This term is usually associated with determining if Kaiser's claims were inappropriately up-coded or over-coded.

"Addendum" is an addition to a patient medical record at some time after the date of a face-to-face encounter with a patient.

"Chart Review" means an audit or other review of a patient's medical records intended to find diagnosis codes not previously submitted as part of a Risk Adjustment Claim and/or review the accuracy of diagnoses previously submitted as part of a Risk Adjustment Claim.

"Chronic Refreshable Diagnosis" means a diagnosis that generally does not resolve, meaning once a patient has that diagnosis he or she typically has it for life. Examples include, *inter alia*, (1) Chronic Kidney Disease (HCC 131); (2) Peripheral Vascular Disease (HCC 105); (3) Congestive Heart Failure (HCC 80); (4) Diabetes with Renal or Peripheral Circulatory Manifestation (HCC 15); and (5) Diabetes with Neurologic or Other Specified Manifestation (HCC 16).

"Coders/Auditors" means any person within one of the groups with Kaiser Colorado responsible for coding and risk adjustment issues including: (1) the "Risk Adjustment" or "RA" group or "Medicare Risk Business Services" or "MRBS coders responsible for coding all hospital discharge charts and one-off revenue enhancement projects; (2) the "Resolute Coders" involved generally with fee-for-service claims; (3) the "Coding Educators" responsible for auditing the Kaiser physicians; and (4) the "Coding Quality Assurance" or "QA" department responsible for auditing all other coders.

"Diagnosis Validation Audits" are Reviews that determine the Accuracy of HCCs submitted for Risk Adjustment.

"Missed Opportunity" means any diagnosis that could have been submitted to CMS for Risk Adjustment but was not.

"NLP Process" means application of computer-assisted coding software to a patient's medical records to find diagnosis codes not previously submitted as part of a Risk Adjustment Claim.

"Pre-Submission Diagnosis Review" means a review or audit of whether diagnosis codes submitted to Kaiser by hospitals, physicians, or other providers Validate before those diagnosis codes are submitted to CMS in connection with a Risk Adjustment Claim. The term Pre-Submission Diagnosis Review includes, but is not limited to: (1) the selection of all claims with a given diagnosis code for review by coders before the diagnosis is released for submission to CMS; (2) the use of a Best Practice Alert ("BPA") or other warning in the electronic medical record to warn a provider if he or she enters a diagnosis code that appears inconsistent with other information in the

medical record (*e.g.*, a diagnosis of acute stroke during an office visit); or (3) the use of logic in the claims processing system to prevent certain diagnosis codes from being submitted if they are inconsistent with other information in the medical record (*e.g.*, the submission of a diagnosis code for Sick Sinus Syndrome when the patient has a pacemaker that is functioning normally).

"Refreshable Delete Review" (also known as a "Stop Prompt") means a Review of diagnosis codes that were the basis for a Risk Adjustment Claim in one year, but were not coded or were otherwise inactivated in the patient's medical record in the following year.

"Region" means the geographic area, physician group, and Kaiser subsidiaries affiliated with each Medicare Advantage health plan offered by Kaiser Permanente and/or its affiliates in Colorado.

"Review" means an audit or other process whereby a coder, physician or other similar person determines whether one or more Risk Adjustment Claims and/or the diagnosis code that provides the basis for the Risk Adjustment Claims are Validated.

"Reviewed" means that a coder, physician, or other similar person determines whether a Risk Adjustment Claim and/or the diagnosis code that provides the basis for the Risk Adjustment Claim is Validated.

"Risk Adjustment Claim" refers to a diagnosis code: (a) that falls into an HCC that qualifies for a per-member-per-month risk Adjustment payment under the Medicare Advantage program; (b) that was submitted by or on behalf of Kaiser to the United States; and (c) for a Kaiser member. This term only includes claims that resulted in a per-member-per-month payment to Kaiser. This term includes claims that were submitted by or on behalf of Kaiser to CMS, resulted in a payment from CMS to Kaiser, but were later deleted by Kaiser. If more than one diagnosis codes that fall within the same HCC were submitted to CMS for a given patient in a given year, either from the same provider or from multiple providers, this counts as only one Risk Adjustment Claim.

"True Positive Diagnosis" means a diagnosis in a patient's medical record that has been identified through an NLP Process as not previously submitted as part of a Risk Adjustment Claim and found appropriate for submission to CMS as part of a Risk Adjustment Claim by two non-Kaiser coders.

"Validate[d]" means that a diagnosis code that was the basis for a Risk Adjustment Claim is supported by medical record documentation and otherwise complies with CMS rules governing the submission of Risk Adjustment Claims.

Documents Requested

1. Produce all documents[1] relating to all Reviews conducted by or on behalf of Kaiser, including, but not limited to, annual "probe" audits, Risk Adjustment Data Validation ("RADV")

[1] Please refer to the original HHS-IG December 4, 2013 subpoena for the definition of documents and other terms used in this letter.

audits, pre-RADV audits, audits of claims submitted by external providers (*i.e.*, providers who are not directly employed by or affiliated with Kaiser) (*e.g.*, 2011 Exempla audit performed by Treska Francis, Southern Colorado Forms Review), audits conducted by external vendors such as, *inter alia*, Peak Health Solutions, and/or audits targeted at Risk Adjustment Claims submitted for specific diseases or diagnoses (*e.g.*, 2014 audit of acute stroke diagnoses submitted for 2013 dates of service). For this request it is not necessary to produce the underlying medical records that were the subject of the Reviews.

2. For each of the three types of Pre-Submission Diagnosis Reviews specifically enumerated in the definition of Pre-Submission Diagnosis Review, produce all documents concerning the design, implementation, modification, and/or termination of the computer program and any reports or analysis regarding the operation and results of the computer program.

3. Produce all documents related to policies and procedures used to Validate any True Positive Diagnosis Code after the Colorado Region receives the diagnosis from the NLP Process but before the diagnosis codes are submitted to CMS in connection with a Risk Adjustment Claim.

4. Produce copies of the minutes taken at, agendas prepared for, and all written materials presented in connection with Kaiser Colorado's Medicare Advantage working groups, including, but not limited to, the Medicare Steering Committee, the Medicare Initiatives Group, the Coding Sponsors group, and the Medicare Risk Initiatives group.

5. All directions, policies, procedures, guidelines and guidance provided to Kaiser Colorado Coder/Auditors concerning:

a. Chronic Refreshable Diagnoses;
b. NLP;
c. contact with physicians;
d. EMR Prompts to physicians;
e. high risk HCC's;
f. "Epic Electronic Refresh"; and,
g. coder authorization based on information in a medical record to add diagnoses.

6. Produce all e-mails from physicians to Coder/Auditors in response to prompts or communications concerning diagnosis coding or the Refreshable Delete Review initiative.

7. Produce all general information (not individual patient specific), guidance, training, policies, and educational audits provided by Kaiser Coder/Auditors to physicians concerning coding issues.

8. Produce all documents relating to economic or percentage goals, performance plans, evaluations, quotas, incentive plans and/or goals, given to Coder/Auditors concerning the Medicare

Advantage Plan including, but not limited to goals for Refresh rate, Accuracy, and/or Missed Opportunities.

9. Produce all documents relating to performance plans, evaluations, quotas, incentive plans, and/or goals for Kaiser Physicians or outside providers concerning the Medicare Advantage plans.

10. Produce all documents relating to any response or action taken by the Colorado Region concerning issues and coding errors identified by the National Compliance Office audits or RADV audits including, but not limited to, any additional audits performed as a result of Accuracy issues raised by those audits.

11. Produce all contracts or amendments to contracts between Kaiser and Colorado outside providers including, but not limited to, Swedish Medical Center, Pueblo Clinic, SLC Health (formerly Exempla) Good Samaritan, SLC Health Lutheran Medical Center, SLC Health Good Samaritan Medical Center, Centura St. Thomas More Hospital, Memorial Hospital, SLC Health St. Joseph's Hospital and Life Care Centers of America.

12. Produce all documents from Kaiser physicians or outside providers to Kaiser Colorado Coder/Auditors concerning any coding issues.

13. Produce all documents relating to extrapolation of Review findings and/or using probe audit findings to do additional reviews of patient records.

14. Produce all documents relating to return on investment (ROI) calculations or estimates for Review projects.

15. Produce all documents including lists entitled "Medicare Risk Projects" and or "Audit Projects" and all documents relating to these lists.

Kaiser Colorado Custodians and Files

Please provide all e-mails for the following current and former Kaiser Colorado or Kaiser National employees in addition to all documents in files currently or previously controlled by them as indicated for each individual:

16. Valerie Clark, Kaiser Colorado Director of Claims Quality (previously Kaiser Colorado Manager of Coding Compliance): Please produce all Valerie Clark's e-mail and all other documents related to:

a. Kaiser Colorado external provider coding issues;

b. Kaiser Colorado internal provider diagnosis-specific coding issues; and,

c. Kaiser Colorado's annual probes and corrective action plans (CAPs).

17. Robert DeRush, Medicare Advantage Data Analyst: Please produce all Robert DeRush's e-mail and all other documents related to:

a. internal filters; and,
b. filters for external providers.

18. Treska Francis, Kaiser Colorado Quality Manager for Medicare Advantage (previously Kaiser Colorado Manager of Medicare Risk Coding): Please produce all of Treska Francis' e-mail as well as all documents contained in in her computer or to which her computer was mapped relating to her duties as Quality Manager for Medicare Advantage and/or Manager of Medicare Risk Coding including, but not limited to:

a. Kaiser Colorado external provider coding issues (including a contract with Peak Health Solutions for an audit of external providers);
b. reports generated through the upside-only Chart Review work of MRBS and MedPartners;
c. all materials related to Treska's audit of the Southern Colorado external hospitals;
d. Chart Reviews for the annual probes;
e. Kaiser Colorado internal provider diagnosis-specific coding issues;
f. Chart Reviews for the annual probes; and,
g. MRBS upside-only hospital chart review.

19. Rusalyn Maitlen, former Kaiser Colorado Manager of Medicare Advantage Risk Coding: Please produce all Rusalyn Maitlen's e-mail and all other documents related to:

a. Kaiser Colorado external provider coding issues (including the PEAK audit);
b. Kaiser Colorado internal provider diagnosis-specific coding issues (including Kaiser Colorado's internal filters); and,
c. Kaiser Colorado internal filters including the creation, maintenance, administration, and discontinuation of Kaiser Colorado's internal filters.

20. Elyse McNulty, Kaiser Colorado Coding Director: Please produce all of Elyse McNulty's e-mail as well as all documents contained on all Medicare-related Kaiser Colorado drives to which her computer is or has been mapped. These documents should include, but not be limited to:

a. Kaiser Colorado external provider coding issues (including the PEAK audit and use of MedPartners);
b. Kaiser Colorado internal provider diagnosis-specific coding issues (including Kaiser Colorado's internal filter);
c. natural language processing issues; and,
d. coding of Chronic Refreshable Diagnoses.

21. Dr. James Taylor, former CPMG Medical Director of Revenue Cycle/Claims: Please produce all e-mails to and from Dr. Taylor along with all document related to the following subjects:

a. external provider coding issues;
b. Kaiser Colorado internal provider diagnosis-specific coding issues;
c. natural language processing;
d. coding of Chronic Refreshable Diagnoses; and,
e. "re-sweeping" and submission of Kaiser Colorado's deleted diagnoses.

22. Jeremy Walsleben, Member of National Medicare Finance team (previously Manager of the Kaiser Colorado Medicare Advantage Division): Please produce all Jeremy Walsleben's e-mail and all other documents related to:

a. the deleted diagnoses in Colorado being "re-swept" and submitted to CMS after Hawaii took over Colorado's claims processing;
b. Kaiser Colorado external provider coding issues; and,
c. Kaiser Colorado internal provider diagnosis-specific coding issues (including Kaiser Colorado's internal filter).

23. Dr. Teresa Welsh, CPMG Physician Director of Coding: Please produce all Dr. Welsh's e-mail and all other document related to:

a. physician incentives;
b. external providers diagnosis specific issues, (e.g., stroke issues);
c. natural language processing; and,
d. internal filters.

Requests Not Limited to the Colorado Region

24. Please provide all e-mails for the following Kaiser National employee in addition to all documents in files currently or previously controlled by the employee:

Janet Franklin, Director of Kaiser National Medicare Compliance: Please produce all Janet Franklin's e-mail and all other documents related to:

a. "mismapping" issues in Kaiser's EMR system; and,
b. auditing of Kaiser's EDG file.

25. Produce copies of agendas prepared for, and/or minutes taken at, and all written materials presented in connection with, Kaiser's Regional Reporting Group ("RRG") meetings, including pre-sessions providing Medicare Advantage introductory materials, including, but not limited to Simon Cohn's presentation on the fundamentals of the Risk Adjustment program, since 2004, including the versions of the materials presented at the RRG meetings, and the versions of the materials posted to

Kaiser's internal website. This request reiterates the February 5, 2016 e-mail request of Erica Hitchings.

26. Produce all documents that relate to situations where the display diagnosis shown in Kaiser's national Electronic Medical Record system (HealthConnect) mismapped to an incorrect ICD-9 diagnosis code (*e.g.*, "oral contraceptive" mismapped to the diagnosis code for oral cancer; neurogenic claudication mismapped to vascular claudication).

27. Produce all documents related to correction plans for error rates found in any Reviews including, but not limited to, annual National Compliance Office probe audits and RADV audits.

28. For all Reviews conducted by the National Compliance Office, produce all documents relating to the method and criteria used to construct the audit including, but not limited to:

a. the sample frame sizes for each strata (i.e. Tier) in all probe audits;
b. the details of each sample unit including, but not limited to:
    i. the strata;
    ii. the original HCC;
    iii. the audited HCC;
    iv. the original payment amount;
    v. the adjusted payment amount under the audited HCC;
    vi. the result of the audit (i.e. the category of discrepancies, if any);
    vii. relevant demographic information; and,
    viii. relevant procedure or encounter level information.
c. an explanation of how sample sizes were determined; and,
d. an explanation of the random selection methodology that was used for sample selection.

Please feel free to call if you have any questions concerning this request.

Sincerely,

Arthur Di Dio by EBW
Arthur S. Di Dio
Senior Trial Counsel,
Civil Fraud Section
U.S. Department of Justice

Erica Hitchings by EBW
Erica Blachman Hitchings
Assistant U.S. Attorney
U.S. Attorney's Office
Northern District of California

Edwin G. Winstead
Assistant U.S. Attorney
U.S. Attorney's Office
District of Colorado

Cc: Hope S. Foster, Esq.

EXHIBIT F

Dr. Shirley N. Weber
California Secretary of State

Business Search - Results

The California Business Search is updated daily and reflects work processed through Tuesday, December 28, 2021. Please refer to document **Processing Times** for the received dates of filings currently being processed. The data provided is not a complete or certified record of an entity.

- Select an entity name below to view additional information. Results are listed alphabetically in ascending order by entity name, or you can select a column title to change the sort order.
- To refine the search results, enter a word or a string of words in the "Narrow search results" box. The "Narrow search results" will search on all fields of the initial search results.
- For information on checking or reserving a name, refer to **Name Availability**.
- For information on requesting a more extensive search, refer to **Information Requests**.
- For help with searching an entity name, refer to **Search Tips**.
- For descriptions of the various fields and status types, refer to **Frequently Asked Questions**.

Results of search for Corporation Name keyword "kaiser permanente" returned 9 entity records (out of 9 records found).

Show 10 entities per page

Narrow search results:

Entity Number	Registration Date	Status	Entity Name	Jurisdiction	Agent for Service of Process
C1892763	06/27/1994	SOS/FTB SUSPENDED	KAISER PERMANENTE - ASIAN PACIFIC AMERICAN NETWORK	CALIFORNIA	SANDY WU
C1864563	08/13/1993	DISSOLVED	KAISER PERMANENTE AFRICAN AMERICAN ASSOCIATION	CALIFORNIA	MICHAEL STINE, JR
C3887000	03/22/2016	ACTIVE	KAISER PERMANENTE BERNARD J. TYSON SCHOOL OF MEDICINE, INC.	CALIFORNIA	CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE (C1592199)

Entity Number	Registration Date	Status	Entity Name	Jurisdiction	Agent for Service of Process
C1884872	03/22/1994	ACTIVE	**KAISER PERMANENTE INSURANCE COMPANY**	CALIFORNIA	CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE (C1592199)
C1964001	03/18/1996	ACTIVE	**KAISER PERMANENTE INTERNATIONAL**	CALIFORNIA	CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE (C1592199)
C0280716	12/03/1953	MERGED OUT	**KAISER PERMANENTE PACIFIC CREDIT UNION**	CALIFORNIA	JOSEPH S MELCHIONE
C2062457	12/09/1997	DISSOLVED	**KAISER PERMANENTE VENTURES**	CALIFORNIA	THE PRENTICE-HALL CORPORATION SYSTEM, INC. (C0257078)
C0216180	04/19/1947	DISSOLVED	**KAISER-PERMANENTE ADVISORY SERVICES**	CALIFORNIA	THE PRENTICE-HALL CORPORATION SYSTEM, INC. (C0257078)
C0254653	06/07/1951	DISSOLVED	**KAISER-PERMANENTE HEALTH PLAN**	CALIFORNIA	ARTHUR H BERNSTEIN

Showing 1 to 9 of 9 entities

Previous 1 Next

Modify Search New Search