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16 Attorneys for Claimant Jeffrey Mazik

17 UNITED STATES DISTRICT COURT
18 NORTHERN DISTRICT OF CALIFORNIA
19 SAN FRANCISCO DIVISION

20 UNITED STATES OF AMERICA ex
21 rel. RONDA OSINEK,
22 Plaintiff,
23 v.
24 KAISER PERMANENTE, et al.,
25 Defendants

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

**NOTICE OF RELATED ACTION
AND CLAIM OF RELATOR
JEFFREY MAZIK TO SHARE OF
SETTLEMENT PROCEEDS UNDER
31 U.S.C. § 3730(c)(5)**

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(Caption continued on next page)

1 UNITED STATES OF AMERICA ex)
 2 rel. NASER AREFI, AJITH KUMAR,)
 and PRIME HEALTHCARE)
 SERVICES,)
 3)
 Plaintiff,)
 4)
 v.)
 5 KAISER PERMANENTE, et al.,)
 6)
 Defendants)
 7 _____)

Case No. 3:16-cv-01558-EMC
**NOTICE OF RELATED ACTION
 AND CLAIM OF RELATOR
 JEFFREY MAZIK TO SHARE OF
 SETTLEMENT PROCEEDS UNDER
 31 U.S.C. § 3730(c)(5)**

8 UNITED STATES OF AMERICA ex)
 9 rel. MARCIA STEIN AND RODOLFO)
 BONE,)
 10)
 Plaintiff,)
 11)
 v.)
 12 KAISER PERMANENTE, et al.,)
 13)
 Defendants)
 14 _____)

Case No. 3:16-cv-05337-EMC
**NOTICE OF RELATED ACTION
 AND CLAIM OF RELATOR
 JEFFREY MAZIK TO SHARE OF
 SETTLEMENT PROCEEDS UNDER
 31 U.S.C. § 3730(c)(5)**

15 UNITED STATES OF AMERICA and)
 16 STATE OF CALIFORNIA ex rel.)
 GLORYANNE BRYANT and)
 VICTORIA M. HERNANDEZ,)
 17)
 Plaintiff,)
 18)
 v.)
 19 KAISER PERMANENTE, et al.,)
 20)
 Defendants)
 21 _____)

Case No. 3:18-cv-01347-EMC
**NOTICE OF RELATED ACTION
 AND CLAIM OF RELATOR
 JEFFREY MAZIK TO SHARE OF
 SETTLEMENT PROCEEDS UNDER
 31 U.S.C. § 3730(c)(5)**

22 UNITED STATES OF AMERICA and)
 23 STATE OF CALIFORNIA ex rel.)
 MICHAEL BICOCCA,)
 24)
 Plaintiff,)
 25)
 v.)
 26 KAISER PERMANENTE, et al.,)
 27)
 Defendants)
 28 _____)

Case No. 3:21-cv-03124-EMC
**NOTICE OF RELATED ACTION
 AND CLAIM OF RELATOR
 JEFFREY MAZIK TO SHARE OF
 SETTLEMENT PROCEEDS UNDER
 31 U.S.C. § 3730(c)(5)**

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

2 Plaintiff,

3 v.

4 KAISER PERMANENTE, et al.,

5 Defendants
6

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

**NOTICE OF RELATED ACTION
AND CLAIM OF RELATOR
JEFFREY MAZIK TO SHARE OF
SETTLEMENT PROCEEDS UNDER
31 U.S.C. § 3730(c)(5)**

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

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

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

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

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

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

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

1 August 29, 2022, arguing that this Court’s ruling on the first-to-file rule
2 provided a “blueprint” for resolution of Defendants’ motion to dismiss.

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

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

21 9. Because Mazik retained federal False Claims Act claims involving the risk
22 adjustment fraud, Defendants then sought to transfer Mazik’s action to the
23 Northern District of California so that it could be consolidated with this
24 action. Defendants filed the motion on April 8, 2024. The United States
25 opposed the motion to transfer, filing a statement of interest on April 22,
26 2024. On June 14, 2024, the district court denied the motion to transfer. The
27 court thoroughly reviewed the various factors weighing in favor of, and
28 against, transfer, including points of judicial economy and efficiency. The

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

- 14 10. On January 14, 2026, the government announced a settlement of the
15 consolidated action, including resolution of the claims by relators Osinek
16 and Taylor. As a result of the settlement, the government will recover \$556
17 million, and in return, the Defendants will be released of all “covered
18 conduct” claims, defined by the claims asserted in the government’s
19 complaint in intervention.
- 20 11. Relator Mazik anticipates that, as a result of the settlement and release in
21 the consolidated action, Defendants will contend that the doctrines of *res*
22 *judicata* and collateral estoppel will act to extinguish Mazik’s federal False
23 Claims Act claims. Despite the fact that Mazik’s complaint raises factual
24 elements that were not expressly addressed in the Osinek and Taylor
25 complaints, Mazik anticipates that the settlement may well act to preclude
26 Mazik from further pursuing his *qui tam* claims under the federal False
27 Claims Act. Even if relators Osinek and Taylor did not plead elements
28 about defendants fraudulent manipulation of the fraud-detection software on

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

- 15 12. Under the alternate remedy provision of the False Claims Act, 31 U.S.C. §
16 3730(c)(5), when the government does not intervene in a relator’s action or
17 claim, the relator “shall have the same rights in such proceeding as such
18 person would have had if the action had continued under this section.” “The
19 reach of this subsection is quite broad, for it encompasses ‘any alternate
20 remedy available to the [g]overnment’ through which the government has
21 elected ‘to pursue its [FCA] claim.’ In such circumstances, the inquiry is
22 ‘whether there exists any overlap between Relator’s allegations and the
23 conduct discussed in the settlement agreement.’ Where a settlement
24 agreement ‘extinguished all of Relators’ pending federal False Claims Act
25 pricing claims and thus effectively settled that aspect of their action,’
26 denying the relators a share ‘would be inconsistent with Congress’
27 legislative intent to encourage private citizens to file qui tam suits.’”

28 *United States ex rel. Birchall v. Spinefrontier, Inc.*, 2024 U.S. Dist. LEXIS

1 204367, at *15-16 (D. Mass. Nov. 4, 2024) (citing and quoting *United*
2 *States ex rel. Sun v. Baxter Healthcare Corp.*, 892 F. Supp. 2d 341, 344 (D.
3 Mass. 2012), *United States ex rel. Barajas v. United States*, 258 F.3d 1004,
4 1010 (9th Cir. 2001), and *United States ex rel. Bledsoe v. Cmty. Health Sys.*,
5 342 F.3d 634, 651 (6th Cir. 2003).

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

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

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Respectfully submitted,

Dated: January 15, 2026

Law Office of Jeremy L. Friedman
Mendenhall Law Group

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

Attorney for relator Jeffrey Mazik

EXHIBIT A

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UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA

JEFFREY MAZIK,
Plaintiff-Relator,
v.
KAISER PERMANENTE, INC., et al.
Defendants.

No. 19-cv-00559-DAD-KJN
ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS’ MOTION TO DISMISS RELATOR’S FIRST AMENDED COMPLAINT
(Doc. No. 78)

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

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

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

3 **BACKGROUND**

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

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

20 Medicare beneficiaries may opt to receive benefits through private health plans instead of
21 the traditional fee-for-service Medicare program. (*Id.* at ¶ 18.) Under that option, known as
22 Medicare Advantage, the federal government pays Medicare Advantage organizations such as
23 defendants a “capitated” (i.e., per enrollee) amount for the purpose of providing medical benefits.
24 (*Id.*) The capitated rates vary depending on the health status of the enrollees; less healthy
25 enrollees require more medical care, which necessitates higher capitation reimbursement
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27 ² On October 26, 2022, this case was reassigned to the undersigned. (Doc. No. 93.) The
28 undersigned has endeavored to work through a backlog of inherited submitted motions in civil
cases as quickly as possible since returning to the Sacramento courthouse in late August of 2022.

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

13 Medicare regulations impose certain requirements on Medicare Advantage organizations
14 such as defendants in an effort to curb the potential for organizations to submit unsupported
15 diagnosis codes, which would lead to improperly high capitation rates and inflated revenues to
16 providers. (*Id.* at ¶¶ 24, 26.) For instance, Medicare Advantage organizations must adopt and
17 implement “an effective compliance program, which must include measures that prevent, detect,
18 and correct non-compliance with CMS’ program requirements as well as measures that prevent,
19 detect, and correct fraud, waste, and abuse.” (*Id.* at ¶ 28) (quoting 42 C.F.R. § 422.503(b)(4)(vi)).
20 Medicare Advantage organizations must also certify the accuracy, completeness, and truthfulness
21 of the data provided to CMS as a condition of receiving payment. (*Id.* at ¶ 29) (citing 42 C.F.R.
22 § 422.504). Similarly, the organization must submit an annual attestation signed by its Chief
23 Executive Officer or Chief Financial Officer certifying that the risk adjustment data submitted to
24 CMS is “accurate, complete, and truthful,” acknowledging that risk adjustment data “directly
25 affects the calculation of CMS payments,” and recognizing that “misrepresentations to CMS
26 about the accuracy of such information may result in Federal civil action and/or criminal
27 prosecution.” (*Id.*) CMS also imposes strict requirements on Medicare Advantage organizations’
28 contractual relationships with entities that provide medical services to the organization’s

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

6 Relator, a resident of California, is the former “Senior Practice Leader for Kaiser’s
7 National Compliance Office” and has over 25 years of experience in fraud control, auditing, and
8 compliance. (*Id.* at ¶ 10.) He was “employed by Kaiser” from 2008 to 2017, joining as an
9 “Information Technology Audit Specialist” in May 2008 and transitioning to the role of “Senior
10 Practice Leader in the Fraud Control Program” in March 2012. (*Id.* at ¶ 11.) Relator’s duties
11 included working with regional compliance leadership to implement compliance and fraud
12 control initiatives, using data analytics to improve compliance and fraud-mitigation initiatives,
13 investigating potential fraud, and developing corrective action plans to address fraud risks. (*Id.* at
14 ¶ 12.)

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

27 ³ Relator’s allegations in his FAC are ambiguous as to whether state-run Medicaid programs
28 impose similar compliance regulations.

1 In late 2015, relator was tasked with comparing the functionalities offered by two claims
2 analytics vendors, McKesson and Verisk, with which defendants routinely contracted. (*Id.* at
3 ¶¶ 55, 56.) McKesson offers auditing software called ClaimsXten that detects fraudulent billing
4 practices using “a robust set of rules.” (*Id.* at ¶ 57.) However, defendants chose to deactivate 25
5 of the 54 rules used by ClaimsXten—“the principal software program that they were supposedly
6 relying on [to] detect such billing fraud.” (*Id.*) When a group of employees including relator
7 used a Verisk program to double-check data from “the Georgia region” produced by ClaimsXten,
8 the group found \$5.3 million in overpayments stemming from defendants’ decision to deactivate
9 nearly half the rules in ClaimsXten. (*Id.* at ¶ 59.) Defendants neither reactivated the disabled
10 rules nor rectified the \$5.3 million in overpayments. (*Id.* at ¶¶ 60, 61.) Relator presented the
11 group’s findings on the Georgia region to several Kaiser executives named in the FAC, but none
12 of those executives took any action. (*Id.* at ¶¶ 61, 62.)

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

19 On June 30, 2016, relator participated in a call with Marita Janiga, “Executive Director of
20 Investigations in Kaiser’s National Compliance, Ethics & Integrity Office,” and the U.S.
21 Department of Health and Human Services’ Office of the Inspector General (“OIG”). (*Id.* at
22 ¶¶ 54, 76.) The purpose of the call was to discuss issues surrounding claims accuracy and claims
23 recovered through fraud reduction efforts. (*Id.* at ¶ 76.) Janiga made several false statements
24 during the call related to compliance issues, such as claiming that “Kaiser and its regional offices
25 were ‘fully integrated,’ so there was no need for the OIG to inquire into its claims processes.”
26 (*Id.* at ¶ 79.) Worried that relator would speak up to correct her or to discuss his overpayment

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

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

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

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

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

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

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

4 Based on the above allegations, relator asserts the following eleven claims in his FAC⁶:

- 5 (1) violation of the federal False Claims Act (“federal FCA”), 31 U.S.C § 3279(a)(1);
6 (2) violation of the California FCA, California Government Code §§ 12650, *et seq.*; (3) violation
7 of the Colorado Medicaid FCA, Colorado Revised Statutes §§ 25.5-4-303.5, *et seq.*; (4) violation
8 of the Georgia Taxpayer Protection Against False Claims Act (“TPAFCA”), Georgia Code §§ 23-
9 3-120, *et seq.*; (5) violation of the Hawai‘i FCA, Hawai‘i Revised Statutes §§ 661-21, *et seq.*;
10 (6) violation of the Virginia Fraud Against Taxpayers Act, Virginia Code §§ 8.01-216.1, *et seq.*;
11 (7) violation of the Washington Medicaid Fraud FCA, Washington Revised Code §§ 74.66.005, *et*
12 *seq.*; (8) unlawful retaliation in violation of the federal FCA, 31 U.S.C. § 3730(h); (9) unlawful
13 retaliation in violation of the California FCA, California Government Code § 12653;
14 (10) unlawful retaliation in violation of California Labor Code § 1102.5(b); and (11) retaliatory
15 common law termination in violation of public policy.

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

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

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

1 complaint necessarily relies on them, and matters of public record. *Lee v. City of Los Angeles*,
2 250 F.3d 668, 688–89 (9th Cir. 2001).

3 **B. Heightened Pleading Standard Under Rule 9(b)**

4 “When an entire complaint, or an entire claim within a complaint, is grounded in fraud
5 and its allegations fail to satisfy the heightened pleading requirements of Rule 9(b), a district
6 court may dismiss the complaint or claim.” *Vess v. Ciba-Geigy Corp. USA*, 317 F.3d 1097, 1107
7 (9th Cir. 2003). Under Rule 9(b), the “circumstances constituting the alleged fraud [must] be
8 specific enough to give defendants notice of the particular misconduct . . . so that they can defend
9 against the charge and not just deny that they have done anything wrong.” *Kearns v. Ford Motor*
10 *Co.*, 567 F.3d 1120, 1124 (9th Cir. 2009) (internal quotation marks omitted) (quoting *Bly-Magee*
11 *v. California*, 236 F.3d 1014, 1019 (9th Cir. 2001)). To satisfy the particularity standard of
12 Rule 9(b), “a pleading must identify the who, what, when, where, and how of the misconduct
13 charged, as well as what is false or misleading about the purportedly fraudulent statement, and
14 why it is false.” *Moore v. Mars Petcare US, Inc.*, 966 F.3d 1007, 1019 (9th Cir. 2020)
15 (quotations omitted) (quoting *Davidson v. Kimberley-Clark Corp.*, 889 F.3d 956, 964 (9th Cir.
16 2018)). However, “[m]alice, intent, knowledge, and other conditions of a person’s mind may be
17 alleged generally.” *Irving Firemen’s Relief & Ret. Fund v. Uber Techs., Inc.*, 998 F.3d 397, 404
18 (9th Cir. 2021) (quoting Fed. R. Civ. P. 9(b)); *see also Klaehn v. Cali Bamboo LLC*, No. 21-
19 55738, 2022 WL 1830685, at *2 (9th Cir. 2022)⁷ (“Under Fed. R. Civ. P. 9(b), a plaintiff must
20 plead circumstances from which a court can plausibly infer the defendant’s knowledge.”).

21 **ANALYSIS**

22 **A. Federal FCA Claim**

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

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

1 money or property to the Government,” or “conspires to commit” any of the previously listed
2 violations.

3 1. First-to-File Bar

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

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

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

1 the Taylor Complaint with relator’s allegations in his FAC.⁹

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

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

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

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

11 In his opposition, relator acknowledges that:

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

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

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

1 Complaint and relator’s FAC both broadly allege schemes wherein defendants knowingly
2 requested CMS reimbursements premised on erroneous diagnosis codes. Consequently, the
3 government was “already . . . equipped to investigate” the broader scheme alleged by relator here.
4 *Batiste*, 659 F.3d at 1209. Relator’s allegations as to this general scheme “have no additional
5 benefit for the government,” which was already on notice of the alleged fraud from the Taylor
6 Complaint. *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1189 (9th Cir.
7 2001). Accordingly, relator’s federal FCA claim is barred insofar as it alleges a general
8 fraudulent scheme wherein defendants knowingly requested CMS reimbursements premised on
9 erroneous diagnosis codes. *See Osinek I*, 601 F. Supp. 3d at 567 (“Based on *Osinek*, the
10 government had grounds to investigate all that is in the Taylor Complaint which points to the
11 same basic problem. . . . [A]t bottom, Dr. Taylor’s broader claim is that high-value conditions
12 were diagnosed without following the practices required by Medicare regulations. This is
13 fundamentally the same charge that Ms. Osinek makes.”).

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

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

5 Accordingly, relator’s federal FCA claim will be dismissed without leave to amend,
6 except to the extent it is premised on defendants’ alleged tampering with compliance software.
7 *See Osinek I*, 601 F. Supp. 3d at 569 (holding that “[t]he *Taylor* case is not dismissed in its
8 entirety but only in part” because “*Taylor* differs materially from *Osinek* in three ways”); *id.* at
9 574 (“*Taylor* is dismissed except to the extent that it pleads (1) a nationwide or corporate-wide
10 fraud; (2) a fraud based on improper coding by external providers; and (3) a fraud based on True
11 Positive results from the NLP program.”); *see also United States ex rel. Jahr v. Tetra Tech EC,*
12 *Inc.*, 2022 WL 2317268, at *6 (N.D. Cal. June 28, 2022) (holding that certain “allegations [were]
13 dismissed under the first-to-file bar” where the prior complaint “would plausibly have provided
14 the government with notice of the material facts of similar claims,” but also concluding that other
15 allegations appearing in the earlier filed complaint “are much too general to preclude [the
16 relator’s] allegations about soil sampling”).

17 2. Falsity

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

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

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

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

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

8 3. Materiality

9 “Under the [federal] False Claims Act, the term ‘material’ means having a natural
10 tendency to influence, or be capable of influencing, the payment or receipt of money or property.”
11 *United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1018 (9th Cir. 2018). “[T]here is not
12 a bright-line test for determining whether the [federal] FCA’s materiality requirement has been
13 met.” *United States ex rel. Godecke v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1212 (9th Cir.
14 2019). “No single fact or occurrence determines materiality”; indeed, even “the Government’s
15 decision to expressly identify a provision as a condition of payment is relevant, but not
16 automatically dispositive.” *United States ex rel. Winter v. Gardens Reg’l Hosp. & Med. Ctr.*,
17 *Inc.*, 953 F.3d 1108, 1121 (9th Cir. 2020) (internal quotation marks omitted).

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

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

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

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1 4. Lumping

2 Defendants next argue that relator’s allegations in the FAC impermissibly lump
3 defendants together in violation of Rule 9(b). (Doc. No. 78 at 21); *see also Swartz v. KPMG LLP*,
4 476 F.3d 756, 764–65 (9th Cir. 2007) (“Rule 9(b) does not allow a complaint to merely lump
5 multiple defendants together but require[s] plaintiffs to differentiate their allegations when suing
6 more than one defendant . . . and inform each defendant separately of the allegations surrounding
7 [their] alleged participation in the fraud.”). Defendants argue that relator has failed to allege what
8 role each defendant played in the alleged scheme and that it is not “plausible” that all defendants
9 engaged in precisely the same conduct. (Doc. No. 78 at 21–22); *see also Swoben*, 848 F.3d at
10 1184 (noting that while lumping is prohibited, “[t]here is no flaw in a pleading, however, where
11 collective allegations are used to describe the actions of multiple defendants who are alleged to
12 have engaged in precisely the same conduct”). In his opposition to the pending motion, relator
13 argues that “the Ninth Circuit has rejected nearly identical arguments in at least two other FCA
14 actions against other Medicare Advantage organizations.” (Doc. No. 85 at 18) (citing *Swoben*,
15 848 F.3d at 1184; *Silingo*, 904 F.3d at 677).

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

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

1 with the auditing software: All defendants “work in cooperation with each other,” “act in
2 concert,” and, crucially, “mak[e] centralized decisions with respect to CMS compliance, claim
3 making, [and] responsibility for tracking and reporting information that goes into claims for
4 Medicare reimbursements”¹² (Doc. No. 48 at ¶¶ 15, 16.) In doing so, relator has sufficiently
5 alleged that each defendant decided, or acquiesced in the decision, to tamper with defendants’
6 auditing software and disable some of its key features. *See Silingo*, 904 F.3d at 677 (“[A]
7 complaint need not distinguish between defendants that had the exact same role in a fraud.”);
8 *United States ex rel. Osinek v. Kaiser Permanente*, No. 13-cv-03891-EMC, 2023 WL 4054279, at
9 *10 (N.D. Cal. June 15, 2023) (“*Osinek VT*”) (finding the relator had not improperly lumped the
10 defendants together in part because “[t]he FAC provides sufficient details” as to “the general
11 roles played by the health plans and the physician medical groups with respect to risk adjustment”
12 and because the relator’s “allegations that Kaiser’s risk adjustment operations were integrated
13 and/or involved collaboration” substantiated the relator’s allegations that “the various Kaiser
14 entities have allegedly engaged in the same basic conduct”).

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

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

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

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

4 5. Conspiracy

5 “General civil conspiracy principles apply to conspiracy claims under the False Claims
6 Act.” *United States ex rel. Calisesi v. Hot Chalk, Inc.*, No. 13-cv-01150-PHX-NVW, 2015 WL
7 1966463, at *13 (D. Ariz May 1, 2015). “Thus, ‘to prove a False Claims Act conspiracy, a relator
8 must show (1) the existence of an unlawful agreement between defendants to get a false or
9 fraudulent claim allowed or paid by [the Government] and (2) at least one act performed in
10 furtherance of that agreement.’” *Osinek VI*, 2023 WL 4054279, at *8 (quoting *United States ex*
11 *rel. Grubbs v. Ravikumar Kanneganti*, 565 F.3d 180, 193 (5th Cir. 2009)).

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

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

20 **B. State FCA Claims**

21 1. Georgia TPAFCA

22 Defendants argue that relator’s Georgia TPAFCA claim must be dismissed because it is
23 premised on fraud purportedly perpetrated against a state-administered Medicaid program and
24 must therefore be brought instead under the Georgia False Medicaid Claims Act. (Doc. No. 78 at
25 21 n.11.) Relator does not respond to this argument in his opposition brief.

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

1 knowingly presents or causes to be presented to the Georgia Medicaid program a false or
2 fraudulent claim for payment or approval . . . shall be liable to the State of Georgia for a civil
3 penalty consistent with the civil penalties provision of the federal False Claims Act . . .”).
4 Relator alleges that defendants submitted false claims to “Medicaid programs with the various
5 states.” (Doc. No. 48 at ¶ 2.) Consequently, relator must bring this claim under the Georgia
6 False Medicaid Claims Act.

7 Accordingly, relator’s Georgia TPAFCA claim will be dismissed without leave to amend.
8 *See United States ex rel. Miller v. Reckitt Benckiser Grp. PLC*, __ F. Supp. 3d __, 2023 WL
9 6849436, at *19 (W.D. Va. 2023) (dismissing the relator’s claim “as it pertains to the Georgia
10 Taxpayer Protection False Claims Act but allow[ing] Miller to proceed under the Georgia False
11 Medicaid Claims Act”).

12 2. All Other States

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

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18 ¹⁴ *See State v. Altus Fin., S.A.*, 36 Cal. 4th 1284, 1299 (2005) (“[T]he CFCA ‘is patterned on
19 similar federal legislation’ and it is appropriate to look to precedent construing the equivalent
20 federal act.”) (quoting *Laraway v. Sutro & Co., Inc.*, 96 Cal. App. 4th 266, 274 (2002)); *United*
21 *States ex rel. Lovato v. Kindred Healthcare, Inc.*, No. 15-cv-02758-CMA-NYW, 2020 WL
22 9160872, at *8 n.5 (D. Colo. Dec. 14, 2020) (finding that the relator’s CMFCA claim “rise[s] and
23 fall[s] on the adequacy of the relator’s [federal] FCA claims”), *adopted by Colorado ex rel.*
24 *Lovato v. Kindred Healthcare, Inc.*, No. 15-cv-02759-CMA, 2021 WL 1085423 (D. Colo.
25 Mar. 22, 2021); *United States ex rel. Lockyer v. Hawaii Pac. Health*, 490 F. Supp. 2d 1062, 1072
26 (D. Haw. 2007) (“Hawaii’s False Claims Act extends liability in situations nearly identical to the
27 federal FCA.”); *United States ex rel. Fortunatè v. Nduime Youth & Fam. Servs., Inc.*, No. 16-cv-
28 00653, 2020 WL 5507217, at *15 (E.D. Va. Sept. 11, 2020) (“[T]he VFATA is based on the
federal civil False Claims Act’ Because the [federal] FCA and the VFATA contain similar
provisions, federal courts in Virginia apply the same standard to VFATA claims.”) (quoting
Lewis v. City of Alexandria, 756 S.E.2d 465, 469 (Va. 2014)); *United States ex rel. Siegel v. Novo*
Nordisk, Inc., No. 15-cv-00114-PRW, 2022 WL 16716299, at *8 (W.D. Okla. Nov. 4, 2022)
 (“For the reasons explained with respect to Plaintiffs’ claims . . . based upon alleged violations of
the [federal] FCA, the Court concludes that Plaintiffs’ claims related to alleged violations of the
[Washington Medicaid Fraud FCA] . . . satisfy Rule 9(b)’s heightened pleading standard for
fraud-based claims.”).

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

10 The court concludes that relator has failed to allege all but one of his state FCA claims
11 with sufficient particularity. With the exception of California and Medi-Cal, discussed below, he
12 does not specifically identify any of the state programs to which he alleges defendants presented
13 false claims. This failure alone renders relator’s allegations insufficient under the heightened
14 standards of Rule 9(b), with the exception of those allegations relating to California. *See United*
15 *States ex rel. Everest Principals, LLC v. Abbott Lab’ys, Inc.*, 622 F. Supp. 3d 920, 935 (S.D. Cal.
16 2022) (dismissing the relator’s state FCA claims because “Relator has not alleged with
17 particularity how any false claims were submitted to each state identified in the FAC”); *cf. United*
18 *States ex rel. Nowak v. Medtronic, Inc.*, 806 F. Supp. 2d 310, 357 (D. Mass. 2011) (dismissing the
19 relator’s state FCA claims because she “fails to identify any specific fraudulent or false claim
20 submitted to any state”). Accordingly, relator’s claims brought under the Colorado, Hawai‘i,
21 Virginia, and Washington false claims statutes will be dismissed. Nonetheless, because these
22 deficiencies can “possibly be cured by the allegation of other facts,” leave to amend will be
23 granted as to these claims. *Cook, Perkiss & Liehe, Inc. v. N. Cal. Collection Servs.*, 911 F.2d 242,
24 247 (9th Cir. 1990).

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

1 after discovery of the false claim.” Cal. Gov. Code § 12651(a). Relator alleges that, “[a]t a
2 minimum,” defendants were the beneficiaries of false claims, subsequently discovered those
3 claims’ falsity, and failed to disclose the falsity of the claims to the state of California.

4 Defendants argue that relator has failed to allege falsity, materiality, or a fraudulent scheme with
5 sufficient particularity. (Doc. No. 78 at 20.)

6 The court finds that relator has sufficiently alleged falsity and knowledge as to his
7 California FCA claim. Relator alleges that he conducted an audit in September 2016 of claims
8 data from August 3, 2010 through July 30, 2016 and that this audit revealed \$181 million in
9 overpayments from Medi-Cal¹⁵ arising from unsupported diagnosis codes.¹⁶ (Doc. No. 48 at
10 ¶ 86.) Relator has thereby alleged the “who, what, when, where, and how” of the fraudulent
11 scheme with sufficient particularity. *Silingo*, 904 F.3d at 677 (quoting *United States ex rel.*
12 *Cafasso v. Gen. Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1055 (9th Cir. 2011)). Moreover, relator
13 alleges that defendants approved these claims for overpayments despite their knowledge of their
14 falsity. (Doc. No. 48 at ¶ 86.) Relator further alleges that the more he “spoke up about Kaiser’s
15 improper processes for handling unsupported diagnostic codes and the resulting overpayments . . .
16 the more he was sidelined” and denied access to defendants’ compliance data. (*Id.* at ¶ 96.)
17 Instead of taking corrective action, relator alleges that defendants “continued to resist, obstruct,
18 and dismiss” his efforts, “especially” after relator began reporting to Sutcliffe in approximately
19 July 2016. (*Id.*) Relator’s allegations are therefore also sufficient to permit the court to draw the
20 reasonable inference of defendants’ knowledge, which need only be alleged generally. *See Fed.*

21 _____
22 ¹⁵ Relator also alleges that the same audit uncovered \$181 million in overpayments from “other
23 Medicaid programs,” but he again does not specify which programs or states were involved.

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

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

6 The court finds that relator has also adequately alleged materiality. Defendants argue that
7 relator has failed to allege that any of the state programs used risk-adjustment models based on
8 diagnosis code data, making it unclear how the codes could affect any purported overpayments.
9 (Doc. No. 78 at 20–21.) But in the court’s view, relator expressly alleges exactly this
10 information: “Although the above-described risk adjustment model is primarily used in
11 conjunction with Medicare Advantage (Medicare Part C) plans, there are several other
12 government-funded capitation rate plans that rely upon substantially the same model . . . such as
13 Medi-Cal in California” (Doc. No. 48 at ¶ 33.) Given this allegation and the enormous size
14 of the alleged overpayments, the court finds that relator has alleged materiality. *See Osinek IV*,
15 640 F. Supp. 3d at 910 (“[T]he magnitude of the noncompliance weighs in favor of materiality, as
16 the government has asserted that Kaiser has ‘reap[ed] thousands of dollars for each inaccurate
17 diagnosis code and hundreds of millions of dollars for its scheme.’”); *cf. Silingo*, 904 F.3d at 673
18 (“The importance of accurate data certifications and effective compliance programs is obvious: if
19 enrollee diagnoses are overstated, then the capitation payments . . . will be improperly inflated.”).
20 Defendants’ motion to dismiss relator’s California FCA claim will therefore be denied.

21 **C. Retaliation Claims**

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

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

28 //

1 *Centinela Hosp. Med. Ctr.*, 521 F.3d 1097, 1104 (9th Cir. 2008).¹⁷ Retaliation claims under the
2 California Labor Code and common law have similar elements. *See* Cal. Lab. Code § 1102.5(b)
3 (“An employer . . . shall not retaliate against an employee for disclosing information . . . to a
4 person with authority over the employee . . . if the employee has reasonable cause to believe that
5 the information discloses a violation of . . . or noncompliance with” a state or federal statute or
6 regulation); *McVeigh v. Recology S.F.*, 213 Cal. App. 4th 443, 472 (2013) (collecting cases
7 describing how a California common law retaliation claim is analogous to one brought under the
8 California FCA). “Protected conduct” under the federal FCA requires “an objectively reasonable,
9 good faith belief that [the defendant] was possibly committing fraud against the government.”
10 *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 908 (9th Cir. 2017); *see also*
11 *McVeigh*, 213 Cal. App. 4th at 456, 469, 472 (noting that a relator must have “reasonably based
12 suspicions” of false claims or illegal activity under the California FCA, California Labor Code
13 § 1102.5(b), and California common law).

14 1. Against PMG Defendants

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

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

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

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

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

5 It is plausible from relator’s allegations recounted above that he was the employee of
6 defendants KFHP and KF Hospitals, two nationwide entities. *See O’Neill*, 2018 WL 684765, at
7 *11 (finding it plausible that the relator was an employee of the defendants because she “goes on
8 to allege specific facts about the nature of her employment”). However, the court cannot draw
9 the reasonable inference from relator’s descriptions of his job functions, which all revolved
10 around nationwide compliance programs, that he was employed by the PMG defendants, each a
11 regional collection of physicians. Accordingly, relator’s retaliation claims against the PMG
12 defendants will be dismissed. Because this deficiency can “possibly be cured by the allegation of
13 other facts,” leave to amend will also be granted as to those claims. *Cook*, 911 F.2d at 247.

14 2. Against Defendants KFHP and KF Hospitals

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

22 The court finds that relator has adequately alleged that he was engaged in protected
23 activity.¹⁸ “An employee engages in a protected activity by investigating matters which are
24 calculated or reasonably could lead to a viable [False Claims Act] action.” *Campie*, 862 F.3d at
25 907 (internal quotation marks omitted). Relator’s investigation actually led to a viable FCA
26 action, and his allegations certainly support the reasonable inference that he had “an objectively

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

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

3 The court further concludes that relator has alleged that the employer defendants knew of
4 his engagement in protected activity. Defendants cite the Ninth Circuit’s decision in *Campie*, 862
5 F.3d 890, which suggested that “when an employee is tasked with [monitoring and reporting
6 activities and] such investigations, it takes more than an employer’s knowledge of that activity to
7 show that an employer was on notice of a potential *qui tam* suit.” *Id.* at 908. However, the
8 court’s decision in *Campie* actually supports relator’s retaliation claims here. The Ninth Circuit
9 held in that case that the relator sufficiently alleged that the defendant had knowledge of his
10 engagement in protected activity because he had alleged that he “was told it was ‘none of his
11 concern’ when he discussed contamination and adulteration problems on multiple occasions” and
12 that he had “explicitly complained that [his employer] was violating FDA regulations.” *Id.* Here,
13 relator similarly alleges that his supervisors “took overt steps to prevent [him] from investigating
14 any further himself” and that he “pointed out that, pursuant to applicable regulations, Kaiser was
15 required to review and investigate all identified overpayments within 60 days.” (Doc. No. 48 at
16 ¶¶ 66, 64.) The Ninth Circuit also stressed that the relator in *Campie* had alleged that “he was
17 selectively circumvented and excluded from the regulatory review process in which he was meant
18 to take part” *Campie*, 862 F.3d at 908 (brackets and internal quotation marks omitted).
19 Similarly, relator here alleges that he was denied access to the software and databases necessary
20 for his job in order to “sideline” him, “even though claims data review was the central role
21 assigned to Relator on the compliance team.” (Doc. No. 48 at ¶¶ 99–101.) Lastly, the Ninth
22 Circuit highlighted the relator’s allegation that he had threatened to inform the FDA if his
23 employer continued its fraudulent conduct. *Campie*, 862 F.3d at 908. Here, relator alleges that
24 his employer was so fearful that he would disclose information about fraudulent billing practices
25 during a call with HHS OIG that his employer preemptively told him “[not to] say a word.”
26 (Doc. No. 48 at ¶ 81.) Taken as a whole, relator’s allegations are similar to or even stronger than
27 those found to be sufficient by other district courts to allege a defendant’s knowledge of a
28 relator’s engagement in protected activity. *See United States ex rel. Osinek v. Permanente Med.*

1 *Grp., Inc.*, 2022 WL 16934763, at *9 (N.D. Cal. Nov. 14, 2022) (“*Osinek IP*”) (finding that the
2 relator had adequately alleged the defendant’s knowledge in part because she “was not just
3 reporting a coding problem but trying to remediate it, implicitly raising the point that the coding
4 was not legally permissible”); *United States ex rel. Garrett v. Kootenai Hosp. Dist.*, No. 17-cv-
5 00314-CWD, 2020 WL 3268277, at *10 (D. Idaho June 17, 2020) (finding that the relator had
6 sufficiently alleged the defendant’s knowledge where she had alleged that she made reports “to
7 correct alleged illegal fraudulent practices, not simply to report regulatory compliance issues in
8 the course of her employment” and that her employer had “responded by openly and actively
9 resisting her efforts”).

10 Accordingly, defendants’ motion to dismiss relator’s retaliation claims brought against
11 defendants KFHP and KF Hospitals will be denied.¹⁹

12 CONCLUSION

13 For the reasons explained above,

- 14 1. Defendants’ motion to dismiss relator’s complaint is granted in part and denied in
15 part as follows:
 - 16 a. Relator’s claim for violation of the federal False Claims Act (“FCA”) is
17 dismissed without leave to amend, except to the extent that claim is
18 premised on defendants alleged tampering with compliance software;
 - 19 b. Defendants’ motion to dismiss relator’s claim for violation of the federal
20 FCA, to the extent that claim is premised on defendants alleged tampering
21 with compliance software, is denied;
 - 22 c. Relator’s claim brought pursuant to the Georgia Taxpayer Protection
23 Against False Claims Act is dismissed without leave to amend;

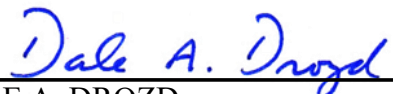
24 /////

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

- 1 d. Relator’s claims brought pursuant to the Colorado Medicaid FCA, Hawai‘i
2 FCA, Virginia Fraud Against Taxpayers Act, and Washington Medicaid
3 Fraud FCA are dismissed, with leave to amend;
- 4 e. Defendants’ motion to dismiss relator’s claim brought pursuant to the
5 California FCA is denied;
- 6 f. Relator’s retaliation claims brought against defendants The Permanente
7 Medical Group, Inc., Southern California Permanente Medical Group, and
8 Colorado Permanente Medical Group, P.C. are dismissed, with leave to
9 amend;
- 10 g. Defendants’ motion to dismiss relator’s retaliation claims brought against
11 defendants Kaiser Foundation Health Plan and Kaiser Foundation
12 Hospitals is denied;
- 13 2. Within twenty-one (21) days from the date of entry of this order, relator shall file
14 either a second amended complaint, or a notice of his intent not to file a second
15 amended complaint and to proceed only on the claims found to be cognizable in
16 this order; and
- 17 3. Pursuant to the court’s order (*see* Doc. No. 100), the parties shall file a joint status
18 report regarding the scheduling of this action within 30 days from the date of entry
19 of this order. The court will thereafter issue a scheduling order.

20 IT IS SO ORDERED.

21 Dated: February 13, 2024

22 
23 DALE A. DROZD
24 UNITED STATES DISTRICT JUDGE
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27
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