UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

UNITED STATES OF AMERICA, THE STATE OF CALIFORNIA, THE STATE OF COLORADO, THE STATE OF CONNECTICUT, THE STATE OF DELAWARE, THE STATE OF FLORIDA, THE STATE OF GEORGIA, THE STATE OF HAWAII, THE STATE OF ILLINOIS, THE STATE OF INDIANA, THE STATE OF LOUISIANA, THE STATE OF MARYLAND, THE COMMONWEALTH OF MASSACHUSETTS, THE STATE OF MICHIGAN, THE STATE OF MINNESOTA, THE STATE OF MONTANA, THE STATE OF NEVADA, THE STATE OF NEW HAMPSHIRE, THE STATE OF NEW JERSEY, THE STATE OF NEW MEXICO, THE STATE OF NEW YORK, THE STATE OF NORTH CAROLINA, THE STATE OF OKLAHOMA, THE STATE OF RHODE ISLAND, THE STATE OF TENNESSEE, THE STATE OF TEXAS, THE COMMONWEALTH OF VIRGINIA, THE STATE OF WISCONSIN, AND THE DISTRICT OF COLUMBIA, *ex rel*. MARC SILVER Plaintiffs, v. OMNICARE, INC., PHARMERICA CORPORATION, CHEM RX CORPORATION, NCS HEALTHCARE, INC., AND NEIGHBORCARE, INC. Defendants.	**RELATOR'S THIRD AMENDED COMPLAINT PURSUANT TO THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. §§3729 *ET SEQ.* AND PENDENT STATE FALSE CLAIMS ACTS** **CIVIL ACTION NO. 1:11-cv-01326-NLH-JS** **JURY TRIAL DEMANDED**

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PLAINTIFF'S SECOND AMENDED COMPLAINT

Plaintiff Marc Silver, on behalf of the United States, the State of California, the State of Colorado, the State of Connecticut, the State of Delaware, the State of Florida, the State of Georgia, the State of Hawaii, the State of Illinois, the State of Indiana, the State of Louisiana, the State of Maryland, the Commonwealth of Massachusetts, the State of Michigan, the State of Minnesota, the State of Montana, the State of Nevada, the State of New Jersey, the State of New Mexico, the State of New Hampshire, the State of New York, the State of North Carolina, the State of Oklahoma, the State of Rhode Island, the State of Tennessee, the State of Texas, the Commonwealth of Virginia, the State of Wisconsin and the District of Columbia (collectively "the States" or "the Plaintiff States"), brings this action for violations of the federal False Claims Act, 31 U.S.C. §§3729 *et seq.* ("False Claims Act" or "FCA"), as well as for violations of the following state false claims acts: The California False Claims Act, Cal. Gov't Code §§12650 *et seq.*; The Colorado Medicaid False Claims Act, 25.5-4-304-25.5-4-310; The Connecticut False Claims Act, Conn. Gen. Stat. § 17b-301b; The District of Columbia False Claims Act, D.C. Code Ann. §§2-308.03 *et seq.*; The Delaware False Claims and Reporting Act, Del. Code Ann. tit. 6, §§1201 *et seq.*; The Florida False Claims Act, Fla. Stat. §§ 68.081 *et seq.*; The Georgia False Medicaid Claims Act, Ga. Code Ann. §§49-4-168 *et seq.*; The Hawaii False Claims Act, Haw. Rev. Stat. §§661-21 *et seq.*; The Illinois Whistleblower Reward and Protection Act, 740 Ill. Comp. Stat. Ann. §§175/1 *et seq.*; The Indiana False Claims and Whistleblower Protection Act, Indiana Code §5-11-5.5; The Louisiana Medical Assistance Programs Integrity Law, La. R.S. 46:437.1 *et seq.*; The Maryland False Health Claims Act of 2010, Md. Code Ann. § 2-602 *et seq.*; The Massachusetts False Claims Act, Mass. Ann. Laws. Ch. 12, §§5A *et seq.*; The Michigan Medicaid False Claims Act, MCLS §§400.601 *et seq.*; The Minnesota False Claims Act, Minn. Stat. § 15C.01 *et seq.*; The Montana False Claims Act, Mont. Code Anno. §§17-8-

401 *et seq.*; The Nevada False Claims Act, Nev. Rev. Stat. §§ 357.010 *et seq.*; The New Hampshire False Claims Act, RSA tit. XII, Ch. 167: 61-b; The New Jersey False Claims Act, N.J. Stat. §2A:32C-1 *et seq.*; The New Mexico Fraud Against Taxpayers Act, N.M. Stat. Ann. §27-2F-4 *et seq.*; The New York False Claims Act, NY CLS St. Fin. §§187 *et seq.*; The North Carolina False Claims Act, 2009-554 N.C. Sess. Laws §§1-605 *et seq.*; The Oklahoma Medicaid False Claims Act, Okla. Stat. tit. 63, §§5053 *et seq.*; The Rhode Island False Claims Act, R.I. Gen. Laws §§9-1.1-1 *et seq.*; The Tennessee Medicaid False Claims Act, Tenn. Code Ann. §§ 71-5-171 *et seq.*; The Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code §§36.001 *et seq.*; The Virginia Fraud Against Taxpayers Act, Va. Code §§8.01-216.1 *et seq.* and the Wisconsin False Claims for Medical Assistance Act, Wis. Stats. §§20.931 (hereinafter referred to collectively as the "State False Claims Acts" or "State FCA's"), to recover all damages, civil penalties and all other recoveries provided for under the Federal False Claims Act and the State False Claims Acts.

I. SUMMARY OF THE CASE

1. Nursing homes provide nursing care and prescription drugs to their patients. To do so, nursing homes need reliable on-site, in-house pharmacy services. Each of the defendants in this matter provided or provide such on-site, in-house "institutional pharmacy" services pursuant to contracts with nursing homes.

2. The nursing home pharmacy model is a "single source" approach due to the administrative and practical complexities involved in providing pharmaceuticals to nursing home patients. That is, nursing homes typically select a single institutional pharmacy to provide prescription drugs to all of that nursing home's residents, regardless of each patient's type of insurance (*e.g.*, Medicaid, Medicare Part A, Medicare Part D, or private insurance).

3. In the latter part of 1998, Medicare changed its payment methodology with respect to Medicare Part A patients in nursing homes. Instead of nursing homes "passing through" the cost of prescription drugs to Medicare, Medicare began paying a fixed sum to nursing homes for the care of nursing home patients, including the cost of prescription drugs. Due to the change, nursing home owners were abruptly placed at financial risk for the costs of prescription drugs provided to these Medicare Part A patients.

4. In response to this change in the incentive structure, the defendants rather suddenly found themselves in a highly competitive environment. In response, they created an illegal kickback scheme which involved a practice known as "swapping." Specifically, the defendants offered commercially unreasonable, below fair-market-value prices[1] for prescription drugs to nursing homes for the nursing homes' Part A patients, *in exchange for* the opportunity to provide the same drugs, at a substantially higher, market-driven cost, to the nursing home's Medicaid and Medicare Part D patients. The nursing homes agreed.

5. The defendants provided these commercially unreasonable prices to nursing homes for their Medicare Part A patients in a variety of forms, including but not limited to the use of: 1) steeply discounted per diem prices, 2) steeply discounted Average Wholesale Prices ("AWP"), and 3) free drugs. Although the form of the discount was not always the same, the goal was always to induce nursing homes with steep discounts in order to obtain the higher-paying business from other government payors. Stated differently, to compensate for the profit they were losing when they charged nursing homes below fair-market-value prices for drugs (for the nursing homes' Medicare Part A patients), the defendants relied on the higher paying business paid for by Medicaid and Medicare Part D.

[1] The terms "commercially unreasonable" and "below fair-market-value" are used interchangeably throughout this Complaint.

6. The scheme was made possible due to two realities of the nursing home industry. First, the defendants knew, as practical matter, it was not feasible for a nursing home to have more than one institutional pharmacy because of, *inter alia*, the complex administrative burdens inherent in nursing home pharmaceutical services. Second, due to the payor demographics in nursing homes, the defendants could afford a "loss leader." Specifically, in the average nursing home, only a small percentage of the patients are covered under Medicare Part A. The vast majority of patients are covered by Medicaid, private insurers, and, as of January 1, 2006, Medicare Part D.[2] Consequently, the defendants could afford to offer below fair-market-value prices when the nursing home was the customer, because they recovered that lost profit through the market-based prices being paid by Medicaid and Medicare Part D. Thus, the defendants used the taxpayer-funded Medicaid and Medicare Part D programs to subsidize steep discounts – otherwise known as kickbacks – to privately owned nursing homes.

7. This swapping/kickback arrangement has been specifically addressed in a host of government program guidances and advisory opinions. These authorities uniformly hold that swapping implicates the Anti-Kickback Statute ("AKS"), and is not protected by the "discount safe harbor."[3]

8. In addition to violating the AKS, swapping violates the drug pricing rules of the California State Medicaid Program, known as Medi-Cal, by charging Medi-Cal higher prices for prescription drugs than other comparable payers.

9. By using the Medicaid and Medicare Part D Programs to subsidize kickbacks to nursing home owners, the defendants profited handsomely at the expense of the Government Plaintiffs. For example, defendant Omnicare's government reimbursements rose consistently

[2] For example, 70% of nursing home residents are covered by Medicaid. Kaiser Family Foundation, "Top 5 Things to Know About Medicaid" February 2011, at pg. 2.
[3] For further, see Section V(C), below.

from 1998 to 2012 ($615 million to $3 billion). The percentage of its sales that came from government payors also rose precipitously (41% to 57%). The table below represents Omnicare's total sales and its approximate payor mix (as a percentage of annual sales):

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Omnicare Total Sales	$1.5B	$1.9B	$2.0B	$2.2B	$2.6B	$3.5B	$4.1B	$5.3B	$6.5B	$6.0B	$6.1B	$6.2B	$6.0B	$6.2B	$6.2B
% of Sales From Medicare	3%	3%	3%	3%	2%	2%	2%	1%	42%	43%	42%	44%	45%	47%	50%
% of Sales from Medicaid	38%	40%	43%	44%	46%	47%	48%	46%	12%	11%	10%	9%	9%	9%	7%
Total Amount of Sales from Medicare	$45M	$57M	$60M	$66M	$52M	$70M	$82M	$53M	$2.7B	$2.6B	$2.6B	$2.7B	$2.7B	$2.9B	$2.9B
Total Amount of Sales from Medicaid	$570M	$760M	$860M	$968M	$1.2B	$1.6B	$2.0B	$2.4B	$780M	$660 M	$610M	$558M	$540 M	$558 M	$434M

10. As illustrated above, Omnicare experienced a significant shift in the way in which it received government money beginning in 2006. More specifically, prior to 2006 Omnicare obtained approximately 45% of its annual sales directly from State Medicaid programs and approximately 2% of its sales directly from Medicare; after 2006, there was a significant change in the federal-state fiscal relationship, explained in detail below, and Omnicare received approximately 10% of its annual sales directly from state Medicaid programs and approximately 45% of its annual sales directly from Medicare. Although the way in which Omnicare was reimbursed changed, the patient population in nursing homes remained the same, as did Omnicare's scheme.

11. Similar to Omnicare, by using the Medicaid and Medicare Part D Programs to subsidize kickbacks to nursing home owners, defendant Pharmerica's government reimbursements rose consistently from 2006 through 2012 ($308.4 million to $1.2 billion). The percentage of its sales that came from government payors also rose precipitously (47.2% to 56.7%). The table below represents Pharmerica's total sales and its approximate payor mix (as a

percentage of annual sales) from 2005 through 2012 (sales information prior to 2005 are unavailable because Pharmerica became a public company in 2007):

	2005	2006	2007	2008	2009	2010	2011	2012
Pharerica Total Sales	522.2M	652.6M	1,217.8M	1,947.3M	1,841.2M	1,847.3M	2,081.1M	1832.6M
% of Sales From Medicare Part D	---	38.6%	45.2%	45.5%	46.3%	46.5%	48%	47.6%
% of Sales from Medicaid	45.4%	8.6%	8.9%	9.3%	9.0%	9.2%	10.4%	9.1%
Total Amount of Sales From Medicare Part D	---	252M	550.2M	885.8M	852.6M	859.5M	998.1M	873M
Total Amount of Sales from Medicaid	237.1M	56.4M	108.8M	181.1M	122.4M	169.6M	217.2M	165.9M

12. The shift in the way defendants were reimbursed occurred because the new prescription drug benefit under Medicare Part D became effective on January 1, 2006. With Part D, as with Medicaid, the defendants continued to receive fair-market-value reimbursements from government payers. The defendants used that profit to subsidize their commercially unreasonable discounts to nursing homes for Part A patients. These continued after the implementation of Part D, i.e., through 2010 and beyond.

13. The amount of money flowing from the government to the Pharmacy Defendants is enormous. For example, defendant Omnicare's government revenue was $3 *billion* in 2012 alone and defendant Pharmerica's was $1.2 *billion* in 2012 alone. Every dollar of government money that was subject to the kickback scheme is recoverable through this lawsuit.[4]

[4] *See* 42 U.S.C. § 1320(a)-7b(g)(clarifying the AKS to expressly state that a violation of the AKS constitutes a "false or fraudulent" claim under the FCA). Prior to this clarification, courts have held that any government payments made for services tainted by illegal referrals are recoverable as damages under the FCA. *See, e.g., United States v. Rogan*, 459 F.Supp.2d 692, 726-727 (N.D. Ill. 2006), *affirmed* 517 F.3d 449 (7th Cir. 2008).

II. THE PARTIES

14. Defendant Omnicare, Inc. ("Omnicare") is a Delaware corporation authorized to do business in the Commonwealth of Kentucky with a corporate office at 1600 River Center II, 100 E. River Center Blvd., Covington, Kentucky. Omnicare owns and operates the nation's largest chain of pharmacies servicing nursing homes and other long term care providers. Omnicare's principal business is to fill prescriptions and to deliver drugs to patients in nursing homes throughout the country. Omnicare enters into contracts with nursing homes to meet the pharmaceutical needs of the residents/patients. Omnicare provides these services to approximately 1.4 million long-term-care residents in 47 states, the District of Columbia and Canada. Omnicare is a publicly traded company listed on the New York Stock Exchange.

15. At all times relevant to the complaint, Defendant NCS Healthcare Incorporated ("NCS"), was a Delaware corporation headquartered at 3201 Enterprise Parkway Beachwood, Ohio 44122. NCS was a leading independent provider of pharmacy services to long-term care institutions including skilled nursing facilities, assisted living facilities and other institutional healthcare facilities. Omnicare acquired NCS on or about January 7, 2003. Omnicare is responsible for the acts and liabilities of NCS as a successor corporation. To the extent that the acts of NCS at issue herein were performed or otherwise attributable to Omnicare, or any subsidiary or affiliate to it, then judgment should be entered against Omnicare where appropriate.

16. At all times relevant to the complaint, Defendant CHEM Rx Corporation ("Chem Rx") was incorporated in the State of Delaware and headquartered at 750 Park Place, Long Beach, New York, 11561. Chem Rx was an institutional pharmacy services company whose core business was providing pharmacy products and services to residents and patients in skilled nursing facilities, assisted living facilities, hospitals, and other long-term alternative care

settings. In September 2010, PharMerica Corporation purchased Chem Rx. PharMerica is responsible for the acts and liabilities of ChemRx as a successor corporation. To the extent that the acts of ChemRx at issue herein were performed or otherwise attributable to PharMerica, or any subsidiary or affiliate to it, then judgment should be entered against PharMerica where appropriate.

17. Defendant PharMerica Corporation ("PharMerica") is incorporated in the State of Delaware and is headquartered at 1901 Campus Place, Louisville, Kentucky. PharMerica operates institutional pharmacies that provide pharmacy services to nursing centers and other healthcare providers.

18. At all times relevant to the complaint, Defendant NeighborCare, Inc. ("NeighborCare") was incorporated in the state of Pennsylvania and was headquartered at 601 East Pratt Street, 3rd Floor, Baltimore, Maryland. NeighborCare was a provider of institutional pharmacy services in the United States. Omnicare acquired NeighborCare in 2005. Omnicare is responsible for the acts and liabilities of NeighborCare as a successor corporation. To the extent that the acts of NeighborCare at issue herein were performed or otherwise attributable to Omnicare, or any subsidiary or affiliate to it, then judgment should be entered against Omnicare where appropriate.

19. Defendants Omnicare, NCS, Chem Rx, PharMerica, and NeighborCare will be collectively referred to as the "Pharmacy Defendants."

20. The United States is a plaintiff to this action. The United States brings this action on behalf of the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS"), which administers the Medicare and Medicaid Programs.

21. The States of California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New Mexico, New Hampshire, New York, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, Virginia, Wisconsin, and the District of Columbia are plaintiffs for whom recovery is sought for damages to their respective state Medicaid programs.

22. The United States and the States are collectively referred to as the "Government Plaintiffs."

23. Plaintiff Marc Silver ("Relator"), is a citizen of the United States and a resident of New Jersey. Mr. Silver has more than 20 years of experience in operating and developing healthcare facilities including nursing homes, assisted living facilities, dialysis units, chronic kidney disease clinics, pharmacies, and clinical blood laboratories. From 1986 through 2007, Relator owned and operated a nursing home with 246 beds known as the Silver Care Center ("Silver Care"). Moreover, from 2001 through May 2007, Relator owned and operated an institutional pharmacy known as Silver Pharmacy. Along with other professional affiliations, Relator has served on the Board of Directors for the American Healthcare Association, where he represented New Jersey in creating public policy and enacting legislation to benefit the long-term-care industry and its patients on a national platform. Additionally, he is the former Chairman of the Executive Committee of the Healthcare Association of New Jersey (formerly the New Jersey Association of Healthcare Facilities). In summary, over the past 25 years, Relator has been involved with various entities and committees, both through industry and government, which debated and set policy for the long-term-care industry in New Jersey and nationwide.

24. Relator has standing to bring this action pursuant to 31 U.S.C. §3730(b)(1) and analogous provisions in the State False Claims Acts. Relator brings this action on behalf of the

United States for violations of the Federal False Claims Act and on behalf of each Plaintiff State named herein for violations of its respective State False Claims Act.

25. Relator's complaint is not based on any other prior public disclosures of the allegations or transactions discussed herein in a criminal, civil, or administrative hearing, lawsuit or investigation or in a Government Accounting Office or Auditor General's report, hearing, audit, or investigation, or from the news media.

III. JURISDICTION AND VENUE

26. Jurisdiction is founded upon the Federal False Claims Act, 31 U.S.C. § 3729 et *seq.*, specifically 31 U.S.C. § 3732(a) and (b), and also 28 U.S.C. §§ 1331, 1345.

27. Venue in the District of New Jersey is appropriate under 31 U.S.C. § 3732(a) and sufficient contacts exist for jurisdiction in that the Pharmacy Defendants transact or transacted business in the District of New Jersey.

IV. THE MEDICARE AND MEDICAID PROGRAMS

A. Medicare Part A

28. Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, established the Medicare program. The United States, through HHS, and its sub-agency, CMS, administers the Medicare Program. Part A of the Medicare program ("Part A") covers inpatient services furnished to Medicare beneficiaries by participating providers, including hospitals and nursing homes. 42 U.S.C.S. § 1395d(a).

29. Nursing homes, a/k/a "skilled nursing facilities" or "SNFs," are reimbursed under Part A. A nursing home is a "institution (or distinct part of an institution) which is primarily engaged in providing to residents (A) skilled nursing care and related services for residents who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons." 42 U.S.C. § 1395i-3(a)(1). A nursing home may be freestanding, or it

may be part of a hospital. *See* 42 U.S.C. § 1395yy(a) (discussing reimbursements for both hospital-based and freestanding SNFs).

30. In order to participate in Medicare Part A, a nursing home must execute Form CMS-855A, the Medicare Enrollment Application for institutional providers. As part of completing the CMS-855A, a certification must be executed, which reads in pertinent part:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.

31. Under Medicare Part A, a nursing home provides "post-hospital extended care services for up to 100 days during any spell of illness." 42 U.S.C. § 1395d(a)(2). Pursuant to 42 U.S.C. § 1395x(h), "extended care services" include "such drugs [and] biologicals, . . . furnished for use in the skilled nursing facility, as are ordinarily furnished by such facility for the care and treatment of inpatients." This includes prescription drugs.

32. Prior to July 1, 1998, Medicare Part A reimbursed nursing homes for prescription drugs on an "actual cost" basis, *i.e.*, the institutional pharmacy billed the nursing home for each prescription provided to each patient, and the nursing home later recouped those costs from Medicare through a cost-reporting process that permitted the nursing homes to "true up" to their actual costs. In other words, nursing homes "passed through" all prescription drug costs for Part A patients to the federal government.

33. Consequently, when making a choice regarding which institutional pharmacy to use, nursing homes did not focus on cost. Instead, they chose the pharmacy based on the needs of their patients, and the quality of services provided by the pharmacy. Relevant factors

included, *inter alia*, the breadth of the pharmacy's drug formulary (vis-à-vis the prescription drug needs of the residents), whether the pharmacy offered patient-centric services (*e.g.*, maintaining individual patient drug profiles, maintaining a battery of emergency prescriptions, providing daily delivery services, providing consultant services to assist doctors and nurses, attending the nursing home's quality assurance and infectious disease committee meetings, and providing in-service training to nursing home employees) and certain logistical issues, *e.g.*, how far away was the pharmacy in the event that additional emergency prescriptions were needed.

34. Effective July 1, 1998, Congress changed the reimbursement methodology for nursing home services covered under Part A prospective payment system ("PPS"). Under PPS, the government reimbursed nursing homes for Part A patients based on a flat, per day rate ("bundled rate"). 42 U.S.C. § 1395yy(e). Thus, after July 1, 1998, Medicare Part A began paying nursing homes a flat rate to provide medical care *and* prescription drugs to residents.

35. Under this system, which remains in effect today, nursing homes no longer are reimbursed on an actual cost basis, and thus they can no longer pass-through prescription drug costs to Medicare. Instead, nursing homes pay the institutional pharmacies directly for the cost of the drugs – dollar-for-dollar – but are reimbursed a flat rate by Medicare Part A regardless of the amount the nursing homes actually spend on drugs for its Part A patients. Accordingly, under the PPS/bundled system, nursing homes are financially at risk for the drugs provided to Part A patients. Thus, nursing homes are incentivized to bargain for the lowest available prescription drug prices from the Pharmacy Defendants.

B. <u>The Medicaid Program</u>

36. Medicaid was created on July 30, 1965, through Title XIX of the Social Security Act. Medicaid is a cooperative federal-state program through which the federal government

provides financial assistance to states so that they may furnish medical care to needy individuals. 42 U.S.C.S. § 1396 *et seq.*

37. The law requires state Medicaid plans to execute written agreements between the Medicaid agency and each provider furnishing services under the plan ("provider agreements"). 42 C.F.R. § 431.107(b),

38. Nursing homes and institutional pharmacies, such as the Pharmacy Defendants, are "providers" who are required to sign provider agreements with each state Medicaid program with which the provider wishes to conduct business. Although there are variations in the agreements among the states, the agreements typically require the provider to agree that it will comply with all Medicaid requirements, as well as other federal and state laws, including any applicable Anti-Kickback provisions. In a number of states, the Medicaid claim form itself contains a certification by the provider that the provider has complied with all aspects of the Medicaid program, including compliance with Anti-Kickback laws.

39. Among other things, the Medicaid programs of all states reimburse for prescription drugs. Many states award contracts to private companies to evaluate and to process claims for payment on behalf of Medicaid recipients. Typically, after processing the claims, these private contractors submit claims to the state Medicaid programs, which in turn obtain federal funds from the United States.

40. Through this process, the Pharmacy Defendants supplied prescription drugs to nursing home patients and presented, or caused to be presented, reimbursement claims to state Medicaid programs, their contractors, and the federal government.

C. <u>The California Medicaid Program: "Medi-Cal"</u>

41. The California Department of Health Care Services ("DHCS") (formerly the California Department of Health Services or "DHS") enacts regulations for California State's

Medicaid program, Medi-Cal. As participating Medi-Cal providers, Defendants were and are subject to DHSC regulations that require them to provide services to Medi-Cal patients at their most favorable rates. California Code of Regulations, title 22, section 51501, subdivision (a), requires as follows:

> no provider shall charge for any service or any article more than would have been charged for the ***same service*** or article to ***other purchasers of comparable services or articles under comparable circumstances.*** (Emphasis added.)

42. Defendants' Medi-Cal Provider Agreements also made clear their duty, consistent with the program's public purposes, to charge their lowest fees to DHCS and refrain from conduct that would harm the Medi-Cal program or its beneficiaries. Among other commitments, Defendants agreed to do all of the following:

> **Compliance with Laws and Regulations**. Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHS pursuant to these chapters. . . .
>
> **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.
>
> . . .
>
> **Provider Fraud and Abuse.** Provider agrees that it shall not engage in fraud or abuse.
>
> . . .
>
> **Prohibition of Rebate, Refund or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission, preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission, preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not take any other action or receive any other benefit prohibited by state or federal law.

43. In other words, Defendants agreed to bill Medi-Cal at their lowest rates, not to give or take kickbacks, and to conduct their business relationship with DHCS with a view to the program's public purpose and the welfare of California's medically indigent citizens.

44. To seek reimbursement for a prescription drug, a pharmacy participating in Medi-Cal submits a claim to the contractor that administers the Medi-Cal program. In seeking reimbursement the pharmacy must state its charge for the particular drug.

45. Using state funds, Medi-Cal pays a drug claim if the beneficiary is eligible, the provider is authorized to bill Medi-Cal, the drug is covered by Medi-Cal, and no information known to the Medi-Cal program indicates the claim is otherwise improper or in violation of billing rules. On a regular basis, Medi-Cal seeks reimbursement from the federal government for the federal share of the Medi-Cal expenditures. The claims that have been submitted to Medi-Cal are used to support the pharmacy's reimbursement request. In this way, if a pharmacy submits a fraudulent claim to Medi-Cal, it has caused a false claim to be submitted to both California and the federal government.

D. Medicare Part D

46. The Medicare Part D program ("Part D") began on January 1, 2006.[5] Under Part D, institutional pharmacies submit claims to private insurance carriers ("Part D plans" or "Part D sponsors"). Part D plans enter into subcontracts with pharmacies to provide drugs to the Medicare Part D beneficiaries enrolled in their plans. These include subcontracts with long-term care pharmacies such as the Pharmacy Defendants. These subcontracts are closely negotiated between Part D plans and institutional pharmacies, including the Pharmacy Defendants in the

[5] Part D was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066. Part D provided prescription drug insurance coverage to qualified Medicare beneficiaries beginning on January 1, 2006. 42 U.S.C. § 1395w-101(a)(1). Beneficiaries who are also eligible for Medicaid (the "dual-eligibles") are automatically enrolled in a Part D plan. Accordingly, primary Medicaid coverage for prescription drugs for dual-eligible persons ended on January 1, 2006.

instant case. Both the private insurers and the federal government share the financial risk presented by prescription drugs that are provided to beneficiaries.

47. The implementation of Medicare Part D marked a change in the federal-state fiscal relationship. Under Medicare Part D, the federal Medicare program finances a significant portion of the program using state dollars. The mechanism through which the states help pay for Medicare Part D is commonly referred to as the "clawback" (the statutory term is "phased-down State contribution"). *See* 42 CFR 423.910, published in 780 Fed. Reg. 4584. These "clawback" payments constitute the largest single source of state funds flowing to the federal government from fiscal year 2006 onward.

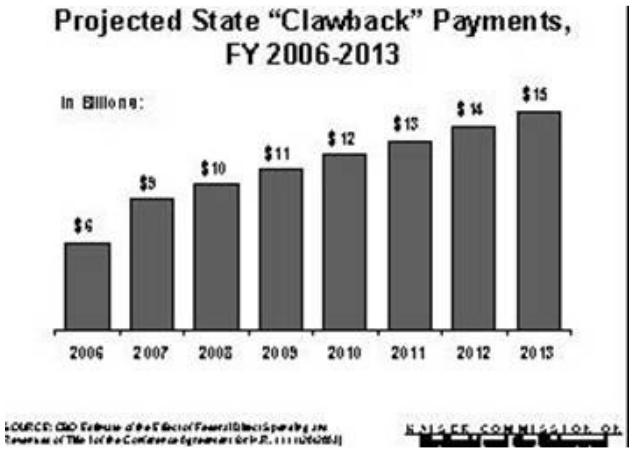
48. Under Medicare Part D, the federal government pays for outpatient drug coverage for elderly and disabled individuals who are eligible for both Medicare and Medicaid (or "dual eligibles"), and the states reimburse the federal government, through the clawback, for the states' portion of the liability. As of January 1, 2006, state Medicaid programs no longer receive federal matching funds for the provision of Medicare-covered outpatient prescription drugs for the dual eligible population. Instead, each state owes a "clawback" payment to the Medicare program that is intended to reflect a percentage of the expenditures that the state would have made had it continued to pay for outpatient prescription drugs for dual eligibles through Medicaid. By statute, this percentage "phases down" from 90% of the estimated state cost in fiscal year 2006 to 75% in fiscal year 2015 and thereafter. A diagram of the phase-down percentage exists below:

Phase-Down Percentage (PD%)	
CY 2006	90%
CY 2007	88 1/3%
CY 2008	86 2/3%
CY 2009	85%
CY 2010	83 1/3%
CY 2011	81 2/3%
CY 2012	80%
CY 2013	78 1/3%
CY 2014	76 2/3%
CY 2015 and thereafter	75%

49. Stated differently, prior to Medicare Part D, state Medicaid programs paid Defendants directly, and the states were then reimbursed by the federal government for the federal government's portion of the obligation. With the advent of Medicare Part D, the tables turned, i.e., the federal government paid Defendants, and the states were then required to reimburse the federal government for the states' portion of the obligation.

50. The amount of each State's clawback payment is determined under a formula established by the Medicare Modernization Act (MMA) and detailed by CMS in regulation. 42 CFR 423.910, published in 780 Fed. Reg. 4584 (January 28, 2005). Each State's payment is the product of a per capita expenditure, the number of dual eligibles in the month, and a phase-down percentage. The per capita expenditure for each State for 2006, reduced by the phase-down percentage for 2006 (90%), is the amount that CMS announced on October 14. These amounts were calculated by CMS using each state's 2003 Medicaid administrative data as submitted through the Medicaid Statistical Information System (MSIS), supplemented with data provided by each state on their capitated dual eligible enrollment, and information from the Medicaid Drug Rebate Program. CMS has worked with states to verify these data and refine their calculations.

51. The amount of money that states are paying under the clawback if substantial. According to the Kaiser Commission, the projected state clawback payments from fiscal year 2006 forward appear below.



State Financing of Medicare Drug Coverage on June 2004 (*available at*: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-clawback-state-financing-of-medicare-drug-coverage.pdf).

V. THE APPLICABLE LAW

A. The Federal False Claims Act

52. The Federal False Claims Act provides, in pertinent part, that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; [or] (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid ...
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person....
>
> * * *
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of

> the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

53. Pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996, 28 U.S.C. § 2461and 64 Fed. Reg. 47099, 47103 (1999), the False Claims Act civil penalties were adjusted to $5,500 to $11,000 for violations occurring on or after September 29, 1999.

B. The Federal Anti-Kickback Statute

54. The federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), ("AKS") arose out of congressional concern that remuneration provided to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or harmful to a vulnerable patient population. To protect the integrity of the Medicare and Medicaid programs from these harms, Congress enacted a prohibition against the payment of kickbacks in any form. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

55. The AKS prohibits any person or entity from offering, making, soliciting, or accepting remuneration, in cash or in kind, directly or indirectly, to induce or reward any person for purchasing, ordering, or recommending or arranging for the purchasing or ordering of federally-funded medical goods or services:

> whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

> (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> (B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both. 42 U.S .C. § 1320a-7b(b). Violation of the statute also can subject the perpetrator to exclusion from participation in federal health care programs and, effective August 6, 1997, civil monetary penalties of $50,000 per violation and three times the amount of remuneration paid.

42 U.S.C.§1320a-7(b)(7) and 42 U.S.C. §1320a-7a(a)(7). Violation of the statute also can subject the perpetrator to exclusion from participation in federal health care programs and, effective August 6, 1997, civil monetary penalties of $50,000 per violation and three times the amount of remuneration paid. 42 U.S.C. §1320a-7(b)(7) and 42 U.S.C. §1320a-7a(a)(7).

56. The Anti-kickback Statute and the corresponding regulations establish a number of ‘‘safe harbors’’ for common business arrangements. The safe harbors protect arrangements from creating liability under the statute. An arrangement must fit squarely in a safe harbor to be protected. Safe harbor protection requires strict compliance with all applicable conditions set out in the relevant regulation. Once the plaintiff proves that the Anti-Kickback Statue applies, the burden shifts to the defendant to prove that its conduct fits within one of the exceptions.

57. The “discount” safe harbor is discussed at 42 C.F.R. §1001.952(h)(5) as follows:

> [T]he term discount means a reduction in the amount a buyer (who buys either directly or through a wholesaler or a group purchasing organization) is charged for an item or service based on an arms-length transaction. The term discount does not include --
>
> (ii) *Supplying one good or service without charge or at a reduced charge to induce the purchase of a different good or service*, unless the goods and services are reimbursed by the same Federal health care program using the same methodology and the reduced charge is fully disclosed to the Federal health care program and accurately reflected where appropriate, and as appropriate, to the reimbursement methodology;

> (iii) *A reduction in price applicable to one payer but not to Medicare, Medicaid or other Federal health care programs.*

42 C.F.R. §1001.952(h)(5)(emphasis added).

C. Applicable Government Program Guidance and Advisory Opinions

58. Swapping has been directly addressed in various statutes, regulations, program guidance, and advisory opinions for more than 20 years. The authorities, without exception, hold that swapping violates the AKS.

59. On July 29, 1991, in the preamble to the "discount" safe harbor, the OIG illustrated the problems with "swapping" and discussed the reasons why swapping is not protected by the discount safe harbor:

> [W]e are aware of cases where laboratories offer a discount to physicians . . . but do not offer the same discount to the Medicare program. In some of these cases, the discount offered to the physician is explicitly conditioned on the physician's referral of all of his or her laboratory business. Such a "discount" does not benefit Medicare, and is therefore inconsistent with the statutory intent for discounts . . . .

56 Fed. Reg. 35977.

60. Four years later, in December, 1994, the OIG warned in a Special Fraud Alert of the risks of such practices:

> The Medicare program pays for laboratory tests provided to patients with end stage renal disease (ESRD) in two different ways. Some laboratory testing is considered routine and payment is included in the composite rate paid by Medicare to the ESRD facility which in turn pays the laboratory. Some laboratory testing required by the patient is not included in the composite rate, and these additional tests are billed by the laboratory directly to Medicare and paid at the usual laboratory fee schedule price.
>
> The OIG is aware of cases where a laboratory offers to perform the tests encompassed by the composite rate at a price below fair market value of the tests performed. In order to offset the low charges on the composite rate tests, the ESRD facility agrees to refer all or most of its non-composite rate tests to the laboratory. This arrangement appears to be an offer of something of value (composite rate tests below fair market value)

> in return for the ordering of additional tests which are billed directly to the Medicare program.
>
> If offered or accepted in return for referral of additional business, the lab's pricing scheme is illegal remuneration under the anti-kickback statute. The statutory exception and "safe harbor" for "discounts" does not apply to immunize parties to this type of transaction, since discounts on the composite rate tests are offered to induce referral of other tests. See 42 C.F.R. §1001.952(h)(3)(ii).

OIG Special Fraud Alert (December 19, 1994).

61. Five years later, in 1999, the OIG commented more on such arrangements as follows:

> [s]uch price reductions create a risk that a supplier may be offering remuneration in the form of discounts on business for which the purchaser pays the supplier, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program to the supplier. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payer's discounted rates.[6] . . . Accordingly, the discount safe harbor specifically excludes "a reduction in price applicable to one payor **but not to Medicare or a State health program.**" See 42 CFR §1001.952(h)(3)(iii).

OIG Advisory Opinion 99-2 (March 4, 1999), at pg. 5 (emphasis added).

62. The arrangement in question in OIG Advisory Opinion 99-2 involved ambulance companies providing nursing homes with steep discounts for transporting Medicare Part A patients, in exchange for the opportunity to provide ambulance services to nursing home patients covered by Medicare Part B and other federal programs under which the nursing home was not responsible for transportation costs. After concluding that the discount safe harbor was not applicable, the OIG provided the following analysis regarding the kickback implications of such an arrangement:

[6] "This is particularly problematic when the contracting payer is a PPS SNF, because Medicare Part B payments essentially may subsidize Part A PPS payments that the government has determined are appropriate and adequate to cover the SNF's costs" (footnote and quote in original).

> The circumstances surrounding the arrangement suggest that a nexus may exist between the discount to the SNFs for PPS-covered transports and referrals of other Federal health care program business.[7] First, the SNFs are in a position to direct a significant amount of business to [the ambulance company] that is not covered under the PPS payment. Second, both parties have obvious motives for agreeing to trade discounts on PPS business for referrals of non-PPS business: the SNFs to minimize risk of losses under the PPS system and [the ambulance company] to secure business in a highly competitive market. Third, [the ambulance company's] request for an advisory opinion comes amidst a considerable number of informal inquiries and anecdotal reports regarding discounts to SNFs that this Office has received since enactment of SNF PPS [on July 1, 1998]. These inquiries and reports suggest that suppliers of a wide range of SNF services are giving SNFs discounts for PPS-business that are linked, directly or indirectly, to referrals of Part B business.

OIG Advisory Opinion 99-2 (March 4, 1999), at pgs. 5-6 [bracketing added].

63. OIG Advisory Opinion 99-2 goes on to provide additional insight regarding other, similar improper business arrangements:

> In evaluating whether an improper nexus exists between a discount and referrals of Federal business in a particular arrangement, we look for indicia that the discount is not commercially reasonable in the absence of other, non-discounted business. In this regard, discounts on SNF PPS business that are particularly suspect include, but are not limited to:
>
> - discounted prices that are below the supplier's cost, and
> - discounted prices that are lower than the prices that the supplier offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of Part A business generated by the PPS SNF, but (ii) does not have any potentially available Part B or other Federal health care program business.
>
> This is an illustrative, not exhaustive, list of suspect discounts; other arrangements may be equally suspect. Each of the above pricing arrangements independently gives rise to an inference that the supplier and the SNF may be "swapping" discounts on Part A business in exchange for profitable non-discounted Part B business, from which the supplier can recoup losses incurred on the discounted business . . . . In connection with items or services provided to PPS SNFs, the presence of **either** of these discount arrangements is particularly suspect under the anti-kickback

[7] "We note that the Agreement contains statements to the effect that remuneration provided under the Agreement is not intended to induce referrals of other business. We find these statements self-serving and not persuasive" (footnote and quote in original).

> statute. Other indicators of suspect discounts include (i) discounts on PPS-covered business that are coupled with exclusive supplier agreements and (ii) discounts on Medicare PPS or other capitated or prospective program business made in conjunction with explicit or implicit agreements to refer other facility business to the supplier, including Part B or other Federal health care program business.

OIG Advisory Opinion 99-2 (March 4, 1999), at pg. 6 (emphasis in original).

64. In March 2000, the OIG issued a formal Program Guidance which discussed risk areas for nursing homes under the Anti-Kickback Statute. Citing OIG Advisory Opinion 99-2, swapping was specifically identified as a problem, and was defined as follows:

> "Swapping" occurs when a supplier gives a nursing facility discounts on Medicare Part A items and services in return for the referrals of Medicare Part B business. With swapping, there is a risk that suppliers may offer a SNF an excessively low price for items or services reimbursed under PPS in return for the ability to service and bill nursing facility residents with Part B coverage. *See* OIG Advisory Opinion 99-2 (February 1999).

OIG Program Guidance for Nursing Facilities. 65 Fed. Reg. 14289 (March 16, 2000)(Ftn. 75).

65. Although the Anti-kickback Statute, particularly when combined with the authorities cited immediately above, prohibits the conduct at issue in this complaint, that conclusion was effectively codified on September 30, 2008, when the OIG issued an additional Program Guidance regarding "swapping" in the Medicare Part A nursing home context:

> Nursing facilities often obtain discounts from suppliers and providers on items and services that the nursing facilities purchase for their own account. In negotiating arrangements with suppliers and providers, a nursing facility should be careful that there is no link or connection, explicit or implicit, between discounts offered or solicited for business that the nursing facility pays for and the nursing facility's referral of business billable by the supplier or provider directly to Medicare or another Federal health care program. ***For example, nursing facilities should not engage in ''swapping'' arrangements by accepting a low price from a supplier or provider on an item or service covered by the nursing facility's Part A per diem payment in exchange for the nursing facility referring to the supplier or provider other Federal health care program business, such as Part B business excluded from consolidated billing, that the supplier or provider can bill directly to a Federal health care program. Such***

> ***''swapping'' arrangements implicate the anti-kickback statute and are not protected by the discount safe harbor.***
>
> As we have previously explained in other guidance, the size of a discount is not determinative of an anti-kickback statute violation. Rather, the appropriate question to ask is ***whether the discount is tied or linked, directly or indirectly, to referrals of other Federal health care program business.*** When evaluating whether an improper connection exists between a discount offered to a nursing facility and referrals of Federal health care program business billed by a supplier or provider, suspect arrangements include below-cost arrangements or arrangements at prices lower than the prices offered by the supplier or provider to other customers with similar volumes of business, but without Federal health care program referrals. Other suspect practices include, but are not limited to, discounts that are coupled with exclusive provider agreements and discounts or other pricing schemes made in conjunction with explicit or implicit agreements to refer other facility business. ***In sum, if any direct or indirect link exists between a price offered by a supplier or provider to a nursing facility for items or services that the nursing facility pays for out-of-pocket and referrals of Federal business for which the supplier or provider can bill a Federal health care program, the anti-kickback statute is implicated.***

OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56832 (emphasis added).

D. Violations of the Anti-Kickback Statute Form the Basis of FCA Liability

66. Congress has long viewed the elimination of kickbacks as central to any efforts to combat Medicare fraud and abuse. *See United States v. Greber*, 760 F.2d 68, 70-71 (3d. Cir. 1985). Because kickback schemes negatively affect the integrity of federal health care programs, the United States has a strong interest in ensuring the continued viability of False Claims Act actions to deter and redress health care fraud predicated upon kickbacks. *United States ex rel. Charles Wilkins and Daryl Willis v. United Health Group, Inc. et al.,* (3d Cir. Oct. 2010)(No. 10-2747) (Brief for the United States as Amicus Curie Supporting Appellant)("Amicus Brief").

67. To protect against the erosion of patient care and patient safety, courts uniformly agree that compliance with the AKS is a material condition of payment under the Medicare program. *See United States ex rel. Schmidt v. Zimmer, Inc.,* 386 F.3d 235, 243 (3d Cir. 2004);

United States ex rel. Conner v. Salina Regional Health Ctr., 543 F.3d 1211, 1223 n.8 (10th Cir. 2008); *United States ex rel. McNutt v. Haleyville Medical Supplies,* 423 F.3d 1256, 1259-1260 (11th Cir. 2005); and *United States v. Rogan,* 459 F. Supp. 2d 692, 717 (N.D. Ill. 2006), *aff'd*, 517 F.3d 449 (7th Cir. 2008).

68. These and other courts have held that a person or entity who violates the AKS and submits a claim or causes another to do so has violated the False Claims Act regardless of what form the claim or statement takes. Many of these courts have reasoned that the claims are false, and thus violate the FCA, because there is a false certification – either express or implied – as to compliance with the AKS each time a claim is submitted.[8]

69. Moreover, the AKS was recently amended to expressly state what these courts had already held, namely, that a violation of the AKS constitutes a "false or fraudulent" claim under the FCA. 42 U.S.C. § 1320(a)-7b(g).

70. Finally, in February, 2012, a federal court for the first time directly addressed whether swapping in the nursing home context can form the basis for liability under the FCA. *See United States ex rel. McDonough v. Symphony Diagnostic Services, Inc. et al.*, 2011 U.S. Dist. LEXIS 153583 (S.D. Ohio 2012). In denying the defendant's motion to dismiss, the *McDonough* court held that the defendant's "agreements with [nursing homes] to provide free or heavily discounted, below market x-ray services under Medicare Part A in exchange for exclusive referrals for the [nursing homes'] Medicare Part B services states a claim for relief from violations of the Anti-Kickback statute and the FCA." *Id*. at 23-24. The same dynamic is

[8] *See, e.g., United States v. Rogan*, 517 F.3d 449, 452 (7th Cir. 2008); *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp*., 125 F.3d 899, 902 (5th Cir.1997); *United States ex rel. Schmidt v. Zimmer, Inc*., 386 F.3d 235, 245 (3d Cir. 2004); *Mason v. Medline Industries, Inc.,* 2010 WL 653542, at *5-9 (N.D. Ill. Feb. 18, 2010); *United States v. ex rel. Jamison v. McKesson Corp*., 2009 WL 3176168 (N.D. Miss. September 29, 2009); *In re Pharmaceutical Indus. Average Wholesale Price Litig*., 491 F. Supp. 2d 12, 17-18 (D. Mass. 2007); *United States ex rel. Bidani v. Lewis*, 264 F. Supp. 2d 612, 615-16; *United States ex rel. Franklin v. Parke-Davis*, 2003 WL 20048255 (D. Mass. August 22, 2003); *United States ex rel. Pogue v. Diabetes Treatment Centers of America*, 238 F. Supp. 2d 258, 264 (D.D.C. 2002); and *United States ex rel. Bartlett v. Tyrone Hospital, Inc*., 234 F.R.D. 113, 121 (W.D. Pa. 2001).

present in the instant case: the Pharmacy Defendants are providing heavily discounted, below market drug prices under Medicare Part A in exchange for referrals of the nursing homes' Medicaid and Part D business.

71. Through the schemes alleged in this complaint, nursing homes are choosing institutional pharmacies based upon the biggest inducement they can get, instead of basing their choices on the quality of the goods and services provided by the pharmacies. This distorted decision-making is the reason that the Anti-Kickback Statute prohibits swapping.

VI. THE KICKBACK SCHEME

A. The Form of the Kickback

72. The kickbacks alleged herein involve inducements to nursing homes in exchange for the revenue provided by other government payors. However, the form of the inducement is not always the same. Relator alleges that the kickbacks were provided in various forms, including but not limited to the following: 1) steeply discounted per diem prices for drugs, 2) steeply discounted AWP prices for drugs, and 3) free drugs.

73. Per Diem Pricing – Relator owned Silver Care nursing home from 1986 to 2007. Relator can testify that the advent of the PPS/bundled rate payment system for Medicare Part A patients caused nursing home owners grave concern because they realized they would now be financially at risk for the cost of prescription drugs for Part A patients.

74. This concern rather abruptly placed heavy competitive pressure on the Pharmacy Defendants to lower costs to nursing home owners for Part A patients. The Pharmacy Defendants were suddenly competing with each other for customers: nursing home owners.

75. The Pharmacy Defendants responded with an illegal solution, in the form of kickbacks. As noted above, Part A patients make up a small percentage of the typical nursing home population; the vast majority of patients are covered by Medicaid and/or Part D. In

negotiations with nursing homes, institutional pharmacies began agreeing to provide prescription drugs to Medicare Part A residents at flat, highly discounted per day rates ("per diem rates"), in exchange for the full-price, market-driven rates paid by Medicaid (and, as of January 1, 2006, Medicare Part D). Thus, institutional pharmacies provided steep discounts for a small minority of patients, while charging full market price for the vast majority of the patient population.

76. AWP Pricing – in addition to providing below fair-market-value prices *via* per diems, many institutional pharmacies, including Defendant Omnicare, began providing discounts via AWP pricing schedules. The following example illustrates this form of the inducement.

77. Genesis Healthcare is a large nursing home chain which operates more than 200 nursing homes. Up until 2005, Genesis had its own nursing home pharmacy, namely, Defendant Neighborcare.

78. In 2005, Defendant Omnicare purchased Defendant Neighborcare. After the sale, Omnicare began providing institutional pharmacy services to nursing homes owned by Genesis.

79. In November 2008, Relator was working on a prescription drug cost-control project with executive-level representatives of Genesis. At that time, Omnicare was continuing to provide institutional pharmacy services for Genesis-owned facilities. A Genesis executive informed Relator that the discounts it was receiving from Omnicare were not based on per diem rates, but rather, the discounts were based on AWP.

80. In subsequent interactions with Genesis, Relator was informed that the discount provided by Omnicare via the AWP-based system was far below the prices being charged to Medicaid and Medicare Part D. Thus, regardless of the fact that the discount had now taken another form, the effect was the same. Nursing homes received commercially unreasonable, below fair-market-value discounts with respect to the small minority of patients insured by Medicare Part A. In exchange, the Pharmacy Defendants received the full-price revenue

provided by the nursing homes' other residents, the vast majority of whom were insured by Medicaid and Medicare Part D.

81. Free Drugs – Relator alleges that certain pricing agreements between institutional pharmacies and nursing home owners included "carve out" provisions. These clauses provided nursing homes with steep discounts on prescription drugs, *except for* a select group of particularly expensive products (*e.g.*, Lovenox, Procrit, Epogen, etc.). Such products were "carved out" from the discounted pricing agreements and were to be paid for separately by the nursing home. However, Relator alleges that such carve out provisions were commonly "waived" by institutional pharmacies, *i.e.*, the nursing homes were not billed for, and thus did not have to pay for, the allegedly carved-out drugs. When this occurred, the nursing home received free drugs from its pharmacy provider, thus "sweetening" the already significant inducement provided by the per diem rates or the heavily discounted AWP prices.

B. The Value and Increasing Depth of the Kickback

82. Relator has maintained detailed records of his pharmacy costs during the time he owned Silver Care. Those records include a monthly census – *i.e.*, the average number of patients in the nursing home on a given day, by payor class – and monthly financial statements which reflect the actual amount of money Silver Care paid for prescription drugs provided to Medicare Part A patients.

83. Relator's pre-PPS pharmacy provider was Cherry Hill Pharmacy. At that time (early 1998) institutional pharmacies – such as the Pharmacy Defendants and Cherry Hill Pharmacy – did not provide discounted per diem rates for Medicare Part A patients. Rather, invoices to nursing homes were fee-for-service, *i.e.*, the dollar sum of all of the actual prescriptions filled for Medicare Part A patients. Based on this fee-for-service system, for the 16

month period from January 1998 through April 1999, the total amount paid by Silver Care to Cherry Hill Pharmacy for prescription drugs provided to Medicare Part A patients was **$621,419.**

84. With respect to Silver Care, the per diem/kickback rate went into effect on May 1, 1999. For the 16 month period that followed, the amount paid by Silver Care for prescription drugs provided to Medicare Part A patient drugs was **$378,806.** Thus, under the per diem rate, a/k/a the "kickback rate," Silver Care received discounts during this period totaling approximately **$242,613** from its pharmacy providers (which included Defendant NCS).

85. Relator's costs can also be broken down into daily components, *i.e.*, precise discount amounts, per patient, per day. That comparison is also remarkable. For the 16 month period from January 1998 through April 1999, the average daily drug bill for each Medicare Part A patient was $42.82. For the 16 month period from May 1999 through August 31 2000 – meaning the first 16 months that Silver Care received the steeply discounted prices – the average daily drug costs to Silver Care for each Medicare Part A patient was $24.94. Stated differently, under the per diem, Silver Care received kickbacks of **$17.88 per patient, per day**.

86. All of that said, the most telling data involves two "snapshots." The first is the amount Silver Care paid for drugs in April 1999, just before the switch to the kickback rate: **$50,598**. The second is the amount Silver Care paid for drugs in May 1999, the first month of the kickback rate: **$27,973**. Literally overnight, Silver Care's costs dropped like a stone.

87. The chart below illustrates the dramatic impact of the kickbacks:

SILVER CARE CENTER									
MEDICARE PART A COSTS									
JANUARY 1, 1998 TO AUGUST 31, 2000									
TOTAL DRUG COSTS				Part A Patient Days			Per Patient, Per Day Costs		
	1998	1999	2000	1998	1999	2000	1998	1999	2000
JAN	$21,966	$48,687	$23,130	743	902	1,040	$29.56	$53.98	$22.24
FEB	$29,152	$40,710	$25,023	894	946	1,074	$32.61	$43.03	$23.30
MAR	$28,700	$42,806	$24,869	1,035	901	1,241	$27.73	$47.51	$20.04
APR	$31,974	$50,598	$21,037	891	955	992	$35.89	$52.98	$21.21
MAY	$32,681	$27,763	$31,857	1,014	944	1,067	$32.23	$29.41	$29.86
JUN	$42,719	$20,725	$26,599	978	891	1,010	$43.68	$23.26	$26.34
JUL	$46,017	$21,317	$33,932	983	777	1,205	$46.81	$27.44	$28.16
AUG	$48,966	$21,003	$34,817	935	735	1,030	$52.37	$28.58	$33.80
SEP	$43,433	$20,056	$32,103	751	779	1,092	$57.83	$25.75	$29.40
OCT	$45,126	$12,868	$26,843	835	682	989	$54.04	$18.87	$27.14
NOV	$33,100	$15,014	$28,035	886	773	1,088	$37.36	$19.42	$25.77
DEC	$34,784	$18,796	$30,299	864	946	1,101	$40.26	$19.87	$27.52
Totals	$438,618	$340,343	$338,544	10,809	10,231	12,929	$40.86	$32.51	$26.23

16 Mo. "Fee-for-Service" Costs*	$621,419	Part A Pt. Days	14,513	Fee-for-Service Costs	**$42.82**
16 Mo. "Per Diem" Costs*	$378,806	Part A Pt. Days	15,186	Per Diem Costs	**$24.94**
Kickback over 16 Month Period	$242,613			Kickback Per Pt., Per Day	$17.88

*"Fee-for Service" Costs are the actual payments for each prescription for each patient

*"Per Diem" Costs are the flat-rate, per patient, per day payments from Silver Care to the Pharmacy Defendants

88. This chart is simply an exemplar of the deep discounts provided by the Pharmacy Defendants to their nursing home customers. Relator alleges that the Pharmacy Defendants continued to engage in illegal swapping on a national basis through 2011, and beyond.

C. The Pharmacy Defendants Kickback Scheme is Long-Term, and National in Scope

89. The kickback scheme executed by the Pharmacy Defendants has been extremely successful. The Pharmacy Defendants and nursing homes across the country have engaged in it since the inception of the per diem system, *i.e.,* for the past 12-13 years.

90. For example, in early 1999, at a New Jersey Post-Acute Network ("NJPAN") meeting in New Jersey, Relator discussed the Medicare Part A per diem arrangements with the attendees present. Relator states that representatives of Omnicare were touting to nursing home

owners that the difference in billing and reimbursement practices with respect to Medicare and Medicaid patients could be used to lower the nursing homes' drug costs. Specifically, Omnicare offered to substantially lower its charges for Medicare Part A patients, thus saving money for the nursing homes, as long as it could leverage its position by continuing to provide or commence providing pharmacy services to the nursing homes' Medicaid and other patients.

91. Additionally, Relator can testify that in early 1999, he received such proposals from several institutional pharmacies, including Defendants Omnicare, Neighborcare, and NCS. Several meetings to discuss these proposals were held at Silver Care Center. Additionally, informal discussions were undertaken at events of the Health Care Association of New Jersey. Each of the above-named Defendants offered a differential payment system between the Medicare Part A patients and the Medicaid and private-pay patients. Each proposal involved the offer of a steeply discounted per diem rate for Medicare Part A patients' drug costs – on average, approximately $25 dollars per patient, per day – in exchange for the right to service Silver Care's other patients, whose insurers – primarily Medicaid – would be charged significantly higher prices for the same drugs.

92. Relator ultimately chose Defendant NCS to be Silver Care's pharmacy provider. The contract with NCS provided for a per diem rate of approximately $25 per Medicare Part A patient, per day.

93. It should be noted that the contract with NCS, like all of the other proposals and contracts between nursing homes and the Pharmacy Defendants the Relator witnessed, contained a provision which stated that the discounted per diem was a "beginning" rate which was subject to periodic review (quarterly, semi-annually, or annually) based on changes in market prices and patient acuities. Despite the fact that the contracts specified that the initial per diem rate was designed to be "trued up" to reflect actual costs and profit margins at specific periods, Relator

can testify that such periodic market-based adjustments *did not occur*, such that prices remained highly discounted for Part A patients' drug prescriptions over the life of the various contracts.

94. With regard to Relator's knowledge of the practices at other nursing homes in both New Jersey and other states throughout the country, Relator has detailed information based on his role in the nursing home industry from 1998 through 2010, and conversations he had with knowledgeable personnel who worked in nursing homes and/or institutional pharmacies.

95. For example, during this period of time, Relator was very actively involved in the American Health Care Association ("AHCA"), and the Health Care Association of New Jersey ("HCANJ"). The AHCA is the largest nursing home provider organization in the United States and represents providers in nearly every state. The HCANJ is its New Jersey affiliate. Moreover, Relator at various times served as both a Regional Representative and on the AHCA's Board of Directors. With respect to the HCANJ, at various times Relator served as the New Jersey Representative to the AHCA, and served on multiple management and executive committees.

96. In those roles, Relator attended dozens of national, regional, and local conferences attended by nursing home owners from all over the country. Relator can testify that managing the cost of prescription drugs for Medicare Part A patients was a significant and sensitive topic in the industry, and at these meetings/conferences. Indeed, from 1998 through 2010, Relator spoke with scores of nursing home owners across the country. The primary topic of these discussions was the "bottom line," *i.e.*, the Medicare Part A discount arrangements and actual per diem rates being provided by the Pharmacy Defendants in order to capture full price government business.

97. An example of the scheme detailed above is provided by the relationship between Omnicare and Saunders House, a nursing home located in Wynnwood, PA. In November 2006,

with respect to the nursing home's Part A patients, Omnicare induced the nursing home with a per diem price of **$14 per patient, per day**, in exchange for the nursing homes' fair-market-value Medicaid and Part D business.

98. Actual Omnicare invoices demonstrate this fraud. For example, on November 25, 2006, with respect to Medicare Part A patient #6331, Omnicare billed the nursing home $434 for the preceding month. The bill – Omnicare Reference # M5100593 – described the charges as "14.00 Per Diem," for a period of 31 days, and an "Amount Due" of $434 (31 days x $14/day = $434). Numerous other invoices reflect the same $14 per diem rate for numerous other Part A patients.

99. Contrariwise, Omnicare billed Medicaid and/or Part D on a full-price, fee-for-service basis, including patients #'s 4828, 5703, 5195, 5543, 5526, 4199, 4680, 5212, 4919, 5565, 5844, 5610, 6013, 3829, 5767, 3480, 5034, 4293, 4600, 6196, 3904, 4189, 5641, 4457, 5922, 5140, 5520, 3839, 3890, 5285, 4505, 4088, 5409, 4807, 5482, 5986, 5412, 5030, 5524, 5704, 5072, 1938, 5601, 6014, 5052, 5292, 5012, 5457, 5251, 4808, 5266, 6018, 4974, 4890, 4305, 5214, 5589, 5775, 3280, 5108, 4797, and 2592. The "pull through" profit generated by the prescriptions paid for by Medicaid and Part D more than made up for the commercially unreasonable discounts provided to Saunders House for its Part A patients. Additional examples of similar conduct follow.

100. In July 2010, Relator met with a management-level employee of DePaul Health Care, a nursing home chain operating nursing homes in Pennsylvania and New Jersey. This individual stated that the current contract with Defendant Omnicare continued to provide deeply discounted per diem rates for Part A patients in order to capture Medicaid and Medicare Part D program business at full market price.

101. In October of 2010, Relator was a vendor at the Health Care Association of New Jersey ("HCANJ") convention in Atlantic City, New Jersey. Relator confirmed with no less than five nursing home owners that they continued to have "swapping" arrangements with their respective institutional pharmacies whereby they received the steep discounts in order to capture the more lucrative government business.

102. Southgate Health Care Center is a nursing home located in Carneys Point, NJ. Relator can state that in February 2011, a Southgate employee who had knowledge of the nursing home's pharmacy contract with Defendant Chem Rx stated that Chem Rx was offering the nursing home a per diem rate of $22 per Part A patient, per day (exclusive of certain carve outs, including intravenous medications), while simultaneously servicing the nursing home's full market price Medicaid and Part D patients. As detailed at length above, such deep discounts have only one purpose: to induce the nursing home to select the offeror of the discounts – in this case, Chem Rx – to serve the all of the facility's patients, including Medicare Part D and Medicaid patients.

D. Additional Evidence Related To Defendant Omnicare's Kickbacks

1. Interview of Donald Gale

103. On January 19, 2010, Donald Gale filed a complaint on behalf of the United States against Omnicare pursuant to the False Claims Act, captioned *United States of America ex rel. Donald Gale v. Omnicare, Inc.*, 1:10-cv-0127, in the Northern District of Ohio (hereinafter referred to as the "*Gale* Case"). A copy of the Complaint is attached hereto at Exhibit 1, and is hereby incorporated by reference as if fully set forth herein. On April 23, 2013, Mr. Gale was interviewed with respect to the allegations in this Complaint. During the interview, Mr. Gale stated the following.

104. He was employed by Omnicare from 1994 through March 2008. During this time, he served in a number of positions, including Consulting Pharmacist, Director, Director of Operations, Vice-President of Operations, and General Manager of Omnicare's Wadsworth, Ohio pharmacy.

105. Mr. Gale's promotion to General Manager occurred in March 2008. He remained in this position until he resigned in late February 2010. In the course of his duties, Gale routinely reviewed and approved pricing worksheets and quotes in contracts offered by Omnicare to nursing homes for drugs; thus, Gale frequently discussed Omnicare's per diem pricing with other Omnicare employees, including multiple Regional Vice Presidents and other Omnicare employees who were aware of the per diem prices being offered by Omnicare.

106. One such employee was Michael Mautz. At the time Mr. Gale worked for Omnicare, Mr. Mautz was Omnicare's "pricing gatekeeper," *i.e.*, he was the person responsible for adjusting Omnicare's drug prices on a nationwide basis. Mr. Gale stated that he had dozens of conversations regarding drug pricing with Mr. Mautz, both during their regularly scheduled monthly calls, and at other times during his employment with Omnicare.

107. Mr. Mautz commonly interacted with Omnicare's Regional Vice Presidents and General Managers regarding pricing changes. Mr. Mautz reported that, in order to maintain contracts with individual nursing facilities, Regional Vice Presidents and other senior Omnicare employees commonly applied pressure to keep prices *below cost* in order to maintain the nursing homes' business. In addition to this "everyday below-cost pricing," Mr. Mautz stated that he was often asked to "forgive" particular charges, such as high-cost intravenous drug charges incurred by nursing homes shortly before the nursing home's contract with Omnicare was up for re-negotiation. Mr. Mautz told Mr. Gale that in these instances, he was asked to "wipe the slate

clean" – i.e., give expensive free drugs to the nursing home – so as not to spoil the upcoming contract discussions and potentially lose the nursing home as a client.

108. On a broader level, Omnicare's gatekeepers, Mr. Mautz was directly involved in setting the per diem prices offered to nursing homes for their Part A patients. During numerous conversations with Mr. Gale, Mr. Mautz specifically stated that the per diem prices for drugs and supplies were below Omnicare's own costs. Mr. Mautz stated that this practice was nationwide, and told Mr. Gale that "there are many customers getting even lower prices than Menorah Park and Montefiore" (two of Mr. Gale's nursing home customers who received below-cost per diem prices).

109. Mr. Gale noted that the relationship between the government and Omnicare was a frequent topic of discussion, particularly after the November 9, 2006, Corporate Integrity Agreement ("CIA") was executed by Omnicare (subsequently amended on October 26, 2007). Mr. Gale stated that after the CIA was executed, Omnicare's leadership no longer viewed the per diems primarily as a "financial" concern (*i.e.*, Omnicare was providing drugs below cost). Rather, the per diems began to be viewed as a "compliance" concern (*i.e.,* the per diems violated the anti-kickback statute).

110. The result was a half-hearted effort to raise the per diems to a commercially reasonable value. To that end, two of Mr. Gale's customers – the aforementioned nursing homes in Menorah Park and Montefiore – were specifically targeted for price increases to their per diems. Mr. Gale was present in meetings with both facilities with respect to the proposed price increases. Bert Brady, National Sales Manager, and Ross Schrader, Regional Manager, were also present. Both Menorah Park and Montefiore rejected Omnicare's proposal to raise their per diem prices. In order to maintain the facilities' business, Omnicare backed off and continued to service the facilities at the kickback-tainted prices.

111. The fact that per diem prices were below Omnicare's own costs for the drugs and supplies was confirmed by Mr. Gale's personal experience. For example, with respect to a specific facility with which he personally negotiated the pricing contract, Omnicare offered the nursing facility a per patient price of $19/day, despite the fact that the usual and customary cost to provide drugs to that facility's patients was approximately $65/day.

112. Mr. Gale also stated that certain nursing homes with whom he negotiated were "running up the bill" by ordering, for Part A patients, drugs that the patients did not need. The facilities did this to stockpile free drugs – as recipients of a per diem price, they could order unlimited drugs for their Part A patients yet still only pay the flat, below-cost fee. These facilities would then supply the drugs received for free to other patients, including residents covered by Medicaid and Medicare Part D.

113. For example, Mr. Gale stated that, with respect to the Menorah Park Center for Senior Living located at 27100 Cedar Road, Beachwood, Ohio ("Menorah Park"), the Executive Director had a standing order prescribing, for all Part A patients, Tylenol, certain laxatives, and various creams/ointments. These medications were provided by Omnicare as part of the Part A per diem, but were stocked in the pharmacy and were later provided to non-Part A patients. In this way, Omnicare provided free goods as an additional inducement to keep the nursing homes' business.

114. Anthony Solaro was the Omnicare Regional Vice President of the Western Region, which included California and the Great Plains. Mr. Solaro began working for Omnicare in 1994, when Omnicare purchased a pharmacy (Lo-Med Prescription Services) which Solaro owned and operated. Mr. Gale recalls a specific conversation he had with Mr. Solaro regarding per diems paid in California. Mr. Solaro, who had already expressed to Mr. Gale his concern regarding the legality of the below-market per diem prices being offered elsewhere in

his region on multiple occasions, stated that the per diem prices offered to nursing homes in California were so low that they were "off the charts."

115. Other Omnicare Regional Vice Presidents also questioned the legality of the per diem rates. During Mr. Gale's employment, Ross Schrader was Omnicare's Regional Vice President for the Midwestern Region, which included Ohio, Michigan, and parts of Indiana. Mr. Schrader told Mr. Gale that the below cost per diems being offered by Omnicare in these states "can't be legal." Further, Mr. Schrader stated that the discounted per diems Omnicare was offering to nursing homes were the topic of frequent conversations at meetings of Omnicare's Regional Vice Presidents. At these meetings, Mr. Schrader learned that "in several regions, the situation was worse than ours," meaning that some other regions were offering larger kickbacks than his own Midwest region. With respect to Omnicare's prices to nursing homes in California, Mr. Schrader told Mr. Gale that "California is out of control." Finally, at one of these meetings, Schrader openly told the assembled executives that the per diems arrangements were illegal.

116. Finally, these statements were specifically and directly corroborated by Mr. Mautz, who stated that in the 2008-2009 time period, Omnicare offered nursing homes in California per diems that were below $10/day.

2. Evidence Cited in the *Gale* Litigation

117. In his lawsuit against Omnicare, Mr. Gale filed a motion for summary judgment.[9] The public record in that case reveals evidence which supports the allegations made herein.

118. For example, Mr. Mautz's statements that Omnicare's per diem prices were below Omnicare's own costs for drugs and supplies was corroborated by Omnicare employee Robert Dries. Mr. Dries, testifying in the *Gale* case as the corporation pursuant to Rule 30(b)(6), Fed. R. Civ. P., stated that Omnicare calculated gross margins on its per diem contracts based upon

[9] Curiously, Omnicare did not move for summary judgment against Gale.

the cost of purchasing the drugs it sold to its customers, subtracted from the revenue generated by those drugs. *See* Exhibit 2 (Dries Tr. 88:18-89:8.8).[1] Mr. Dries further stated that if a gross margin on a per diem was negative, that figure demonstrated a loss to Omnicare for that line of business during the relevant period. *Id*. (Dries. Tr. 240:4-240:20).

119. Further, Regional Vice President Schrader's testimony at his deposition in the *Gale* Case corroborates his earlier statements to Mr. Gale. Omnicare had financial analysts perform analysis on per diem arrangements on a quarterly and monthly basis. *See* Exhibit 3 [Dries Tr. 57:10-15; 113:22-114:1; 259:8-18]. These analyses showed negative gross margins (i.e., Omnicare was offering commercially unreasonable discounts in order to induce nursing homes to choose, or remain with, Omnicare). Mr. Schrader testified that he received such reports on a regular basis, and that he considered the implications of the AKS when recommending approvals of per diem pricing during the review process. *See* Exhibit 4 (Schrader Tr. 183:12-18; 146:15-147:8).

120. Moreover, Schrader testified that he knew that the federal AKS required that Omnicare not price the prescription drugs it sold to its per diem facilities below their cost. *See* Exhibit 5 (Schrader Tr. 146:15-147:8; 148:5-148:10). Indeed, in April of 2009, he sent an email to Deb Kissner, Director of Customer Renewal, noting that "Pricing below our cost is a different matter and would be call [sic] an Inducement meaning giving things away from one side to gain business from another side." *See* Exhibit 6.

121. In addition to the Regional Vice Presidents, the per diems were also discussed among Omnicare executive management. Mr. Dries testified that the inception of the PPS reimbursement system was a significant event, and thus, Omnicare's Chief Operating Officer, Chief Financial Officer and Chief Executive Officer, among other management, would have been engaged in discussions regarding whether to provide per diem Part A arrangements to

nursing homes. *See* Exhibit 7 (Dries Tr. 90:7-92:25). Messrs. Dries and Schrader both stated Omnicare had a required review process whereby per diem pricing requests would have been captured on a pricing worksheet that was submitted into the corporate office. *See* Exhibit 8 (Dries. Tr. 79:6-17) and Exhibit 9 (Schrader Tr. 50:4-51:15). Moreover, beginning around 2005, all per diem requests were required to be submitted to a Corporate Pricing Committee. *See* Exhibit 10 (Dries Tr. 42:3-17; 48:8-19; 80:20-24). Mr. Dries emphasized that the Pricing Committee would be responsible for approving pricing that was offered "below a benchmark," and any other "unusual pricing terms." *Id*. (Dries Tr. 42:3-42:17; 48:8-48:19).

122. Similar to the Regional Vice Presidents, Omnicare senior management had knowledge that the per diems implicated the Anti-Kickback Statute. For example, Omnicare circulated to members of its senior management the HHS-OIG Supplemental Compliance Program Guidance for Nursing Facilities, 73 Fed. Reg. 56832 (2008). Omnicare had highlighted sections in the guidance which specifically explained how swapping can constitute a kickback. *See* Exhibit 11. Moreover, Omnicare brought information regarding pricing below costs to its meetings with customers. *See* Exhibit 12.

3. Omnicare's Kickbacks to Montefiore Nursing Home

123. The Montefiore Home ("Montefiore") is a 240-bed nursing home located in Beachwood, Ohio. Originally, Defendant Neighborcare contracted with Montefiore to provide institutional pharmacy services to the facility. In Montefiore's and Neighborcare's 2003 contract, Neighborcare offered Montefiore a per diem of $22.50 with exclusions for vaccines and chemotherapy. *See* Exhibit 13.

124. As of the date of its purchase by Omnicare in 2005, Neighborcare was offering 383 facilities per diem rates. *See* Exhibit 14. The average per diem rate offered was $14.47, the

average per diem rate shortfall was $7.99 (meaning Neighborcare lost $7.99 on each per diem). Annually, Neighborcare lost approximately $19 million on per diems. *Id*.

125. In November 2005, after defendant Omnicare purchased Neighborcare, Montefiore and Omnicare entered into a new contract for a three year term with automatic one-year extensions whereby Omnicare offered Montefiore a per diem rate of $21.25 with exclusions for certain drugs. The contract stated that the per diem rate was to be reviewed annually, with a new rate being agreed upon between the pharmacy and the nursing home. However, as of January 11, 2010, the rate remained at $21.25, even though the contract had expired and had been rolled over several times on a 30- or 90 day basis. *See* Exhibit 15.

126. The $21.25 per diem Montefiore received from Omnicare was below Omnicare's Usual & Customary ("U&C") rate for the entire life of the contract. Omnicare's U&C was what Omnicare charged a fee-for-service payer, i.e., what Omnicare charged to other payers in the open market, including Medicaid and Part D providers, who paid for products on a drug-by-drug basis (as opposed to a flat per diem).

127. In a March 16, 2009 email from Omnicare financial analyst Mike Mautz, he states "[g]iven [Montefiore's] Per Diem rate of $21.25 and [Omnicare's] U&C/day of $35.97, looks like [Omnicare's] Per Diem revenue would increase by 69% moving to [fee for service] (great for the pharmacy, much higher cost for the facility)." *See* Exhibit 16. Omnicare knew it was offering Montefiore a significant discount which was far below the market price.

128. The $21.25 per diem rate which Omnicare charged Montefiore was consistently below the U&C over the life of the contract. Specifically, Omnicare created a "PPS Risk Share and Adjustment Sheet" specific to Montefiore (hereinafter "PPS Risk Share Sheet"). The PPS Risk Share Sheet contains information on, *inter alia*, the per diems charged to the nursing home and Omnicare's U&C for the same drugs on a monthly basis. These PPS Risk Share Sheets

show that Omnicare was knowingly losing money on the per diem rates it was offering to Montefiore.

129. A relevant portion of Omnicare's PPS Risk Share Sheet, showing Omnicare's U&C and per diems charged to Montefiore in 2006, is pictured below:

PPS Risk Share and Adjustment Sheet
Omnie00070480 Restricted PPS report, 581 Montefiore tab

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
581 Montefiore	Patients Billed	Days Billed	Total PerDiems Paid Rx&IV	Rate	Total Default Rx&IV	Rate		Pharmacy Per Diem Charged	Rate	Legend Usual & Customary	Rate	OTC U/C	Rate	SEPS Exclusions	IV Per Diem Billed
JANUARY 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
FEBRUARY 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
MARCH 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
APRIL 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
MAY 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
JUNE 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
JULY 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
AUGUST 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
SEPTEMBER 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
OCTOBER 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
NOVEMBER 2005			0.00	#DIV/0!	0.00	#DIV/0!			#DIV/0!		#DIV/0!		#DIV/0!		
DECEMBER 2005	100	1,339	29,123.25	21.75	37,590.61	28.07		29,123.25	21.75	34,216.03	25.55	1,820.32	1.36	126.44	0.00
JANUARY 2006	88	1235	26,243.75	21.25	41,950.68	33.97		26,243.75	21.25	36,335.23	29.42	1,430.17	1.16	5,443.26	0.00
FEBRUARY 2006	87	1190	25,287.50	21.25	51,689.50	43.44		25,287.50	21.25	40,809.33	34.29	1,325.01	1.11	8,636.79	0.00
MARCH 2006	98	1361	29,005.25	21.31	44,832.41	32.94		28,921.25	21.25	40,041.71	29.42	1,673.71	1.23	2,463.13	84.00
APRIL 2006	109	1590	33,787.50	21.25	49,972.47	31.43		33,787.50	21.25	47,668.52	29.98	1,632.34	1.03	1,449.77	0.00
MAY 2006	118	1591	33,808.75	21.25	56,031.11	35.22		33,808.75	21.25	48,397.34	30.42	1,952.37	1.23	2,194.49	0.00
JUNE 2006	106	1516	32,215.00	21.25	56,307.03	37.14		32,215.00	21.25	50,685.20	33.43	1,761.67	1.16	796.61	0.00
JULY 2006	93	1399	29,728.75	21.25	55,535.62	39.70		29,728.75	21.25	42,966.39	30.71	826.27	0.59	675.13	0.00
AUGUST 2006	99	1377	29,261.25	21.25	45,837.68	33.29		29,261.25	21.25	42,457.37	30.83	1,417.01	1.03	725.12	0.00
SEPTEMBER 2006	100	1460	31,025.00	21.25	52,118.68	35.70		31,025.00	21.25	47,151.90	32.30	1,223.76	0.84	812.46	0.00
OCTOBER 2006	102	1229	26,116.25	21.25	52,860.74	43.01		26,116.25	21.25	45,042.60	36.65	1,102.96	0.90	(285.50)	0.00
NOVEMBER 2006	100	1,429	30,366.25	21.25	48,740.82	34.11		30,366.25	21.25	45,038.73	31.52	1,302.60	0.91	1,112.79	0.00
DECEMBER 2006	102	1,395	29,643.75	21.25	51,836.44	37.16		29,643.75	21.25	50,078.16	35.90	1,471.13	1.05	3,160.25	0.00
QUARTER TO DATE	**304**	**4,053**	**86,126.25**	21.25	**153,438.00**	**37.86**		**86,126.25**	**21.25**	**140,159.49**	**34.58**	**3,876.69**	**0.96**	**3,987.54**	**0.00**
SIX MONTH TO DATE	596	8,289	176,141.25	21.25	306,929.98	37.03		176,141.25	21.25	272,735.15	32.90	7,343.73	0.89	6,200.25	0.00
2006 YTD TOTALS	1,202	16,772	356,489.00	21.26	607,713.18	36.23		356,405.00	21.25	536,672.48	32.00	17,119.00	1.02	27,184.30	84.00
PPS HISTORICAL															
2005 TOTALS	100	1,339	29,123.25	21.75	37,590.61	28.07		29,123.25	21.75	34,216.03	25.55	1,820.32	1.36	126.44	0.00
2004 TOTALS	0	0	0.00	#DIV/0!	0.00	#DIV/0!		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00
2003 TOTALS	0	0	0.00	#DIV/0!	0.00	#DIV/0!		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00
2002 TOTALS	0	0	0.00	#DIV/0!	0.00	#DIV/0!		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00
2001 TOTALS	0	0	0.00	#DIV/0!	0.00	#DIV/0!		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00
2000 TOTALS	0	0	0.00	#DIV/0!	0.00	#DIV/0!		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00
1999 TOTALS	0	0	0.00	#DIV/0!	0.00	#DIV/0!		0.00	#DIV/0!	0.00	#DIV/0!	0.00	#DIV/0!	0.00	0.00
GRAND TOTAL	1,302	18,111	385,612.25	21.29	645,303.79	35.63		385,528.25	21.29	570,888.51	31.52	18,939.32	1.05	27,310.74	84.00

PPS Analysis 2006															
		Facility 2006	Facility Historical	Omnicare 2006 Avg				**Risk Share Type**	None						
Total Paid with Exclusions		383,673.30	412,922.99					Actual Difference		0.00		1st Qtr Risk Share			0.00
Total Medicare Paid per day		22.88	22.80	23.17	per day			10% Difference		0.00		2nd Qtr Risk Share			0.00
								Net		0.00		3rd Qtr Risk Share			0.00
Saved from Crossover Billing		56,177.69	58,079.07									4th Qtr Risk Share			0.00
Crossover per day		3.35	3.21	3.44	per day			Facility Share		0.00		**Total YTD Risk Share**			0.00
								Pharmacy Share		0.00					
Lost from Unreturned Medications		0.00	0.00												
Unreturned per day		0.00	0.00	0.31	per day			**Rate Adjustment**		**To Review & Agree**		Adjusted Per Diem Rate			**37.86**

130. According to this PPS Risk Share Sheet, in December 2006, Omnicare's year-to-date per diem charged was $356,489, while the U&C cost of those very same drugs was $536,672. Thus, the market-driven U&C daily price amounted to $37.86 – fully 78% higher than

the $21.25 per diem charged to Montefiore. *See* Exhibit 17. In plain words, Omnicare offered Montefiore a cash kickback of $180,183 ($536,672 – $356,489). What's worse is that at the same time Montefiore was being induced with a 78% discount, government payers such as Medicaid and Part D were paying full price at the same pharmacy counter.

131. A year later, in December, 2007, the year to date per diem charged was $402,135, while the U&C was $539,701. Omnicare's internally-calculated per diem – what it would have charged a non-Part A payer – was $32.08 per day. *See* Exhibit 18. Thus, the kickback in 2007 was "only" $137,566.

132. In December, 2008, the year to date per diem charged was $390,596, despite a U&C of $539,006. The internally-calculated per diem $37.68 per day. *See* Exhibit 30.[10] The 2008 kickback thereby rose to $148,410.

133. Thus, Omnicare knew when it acquired Neighborcare that the Montefiore per diem resulted in a -42.8% gross margin; that is, for every dollar Omnicare received from Montefiore, it spent $1.42. *See* Exhibit 19.

134. Omnicare also knew that at the time of Montefiore's last rate change – in October, 2003 – its per diem rate with Montefiore was $25.00. *Id*. This rate—a known 42% loss on the $25 per diem—is obviously irrational, i.e., commercially unreasonable, unless Omnicare was getting something in return.

135. Indeed, Omnicare was getting something in return, and Omnicare knew it – in November 2005, Omnicare entered into a contract with Montefiore which offered the even lower rate of $21.25, for a full three years. *See* Exhibit 20. This rate continued through at least Mr. Gale's departure in February 2010.

[10] As discussed above in Section VI(B), these margins are strikingly similar to the what happened at Relator Silver's drug costs for Part A patients when he switched from a fee for service pharmacy provider to a per diem pharmacy.

136. In 2007, Mr. Mautz performed an analysis showing that Omnicare's revenue from Montefiore per diems for 2006 was substantially less than his calculations for cost of goods sold. Mr. Mautz calculated that the per diem necessary to break even – just on the cost of goods sold – would be, at minimum, $28.26, while the U&C figure for the same drugs for the year was $36.23. *See* Exhibit 21.

137. In an October 2007 PPS analysis, Mr. Mautz showed that for 3021 patient per diem days, actual revenue on the $21.25 per diem was $64,196, while the cost of those drugs was $129,073. Thus, the discount was over 100% from the cost of goods sold. Moreover, had Omnicare charged Montefiore the same prices it charged government payers, Montefiore would have paid $172,897, which is nearly triple the amount it actually paid. *See* Exhibit 22.

138. In August 2008, Mr. Schrader was copied on an email from Mr. Mautz that read "See attached file for Montefiore which lists annual Net Sales at $2.3 million and Gross Margin at $326,000. Their current $21.25 Per Diem is showing negative GM." *See* Exhibit 23. The attached spreadsheet showed that from January to June of 2008, Omnicare's per diem revenue left a gross "profit" of -53.4%. This enormous loss led Mr. Gale to reply, "Is the per diem wrong? How can we have a per diem that is losing us money?" *See* Exhibit 24 and 25.

139. A spreadsheet created in November 2008 and sent via email from Mr. Mautz to Mr. Schrader (and others) shows that for each month from January through October 2008, Montefiore's per diem pricing left a negative gross profit ranging from -36.4% to - 70.1% on net revenue of $332,547. *See* Exhibit 26. In that same 10 month period, Omnicare posted a positive gross margin from the revenue from all other types of pharmacy sales made to Montefiore of $1,604,948, the majority of which was Medicaid and Medicare Part D, yielding positive gross margins ranging from 23.8% to 47.4% on total net revenue of $1,331,574.00. *Id.* Thus, the

scheme worked: lose money on the per diems, but make up those losses – and more – through profits generated by Medicare Part D and Medicaid patients.

140. Mr. Gale, who served for 2008 and 2009 as the General Manager of the facility which serviced the Montefiore contract, stated by declaration that the reason Omnicare agreed to accept deeply-discounted per diem rates from Montefiore was to obtain its other business, including its government healthcare business. *See* Exhibit 27, Gale Dec., ¶10. Mr. Gale stated that Omnicare's per diems were a "loss leader" to secure other business. *Id*., Gale Dec., ¶3. Omnicare's practice was to meet a facility's demand to maintain or gain business, and in fact, met Montefiore's demand to keep its other profitable business. *Id*., Gale Dec. ¶¶4-5, 9-10; *see also* Exhibit 28 (Schrader Testimony 110:11-11-13).

141. It is clear that the discounts Omnicare offered were below Omnicare's own costs (even without factoring in the overhead costs absorbed by all institutional pharmacies, as suggested by the OIG guidance).[11] The numbers analyzed above show that Omnicare knowingly and consistently lost money on its Part A business with Montefiore, but recovered that lost profit through referrals from Montefiore for other business, including government healthcare business.

142. Despite knowing Montefiore's rate was below cost for several years, "no Per Diem rate adjustment has been approved over the last several years." *See* Exhibit 29. Omnicare knew that its conduct implicated the AKS, yet continued to offer substantial cost reductions to Montefiore from 2005 through at least February 2010. The same is true for hundreds of other nursing homes throughout the United States.

[11] "In determining whether a discount is below cost, [the OIG] look[s], for example, at the total of all costs (including labor, overhead, equipment, etc.) divided by the total number of [in that case, laboratory tests]." Adv. Op. 99-13 at n.4.

E. Additional Evidence Related to Pharmerica's Kickback Scheme

143. Andrew S. Lenick ("Lenick") worked for many years at American Baptist Homes of the West ("ABHOW"), a chain of long term care facilities, and was in charge of negotiating the SNF's contracts with institutional pharmacies for the supply of prescription drugs, pharmacy supplies and consulting services. Lenick specifically recalls negotiating contracts between Kindred Pharmacy Services (a long term care institutional pharmacy) and a number of SNF's, including but not limited to Pilgrim Haven (located in Los Altos, CA), The Terraces of Los Gatos (located in Los Gatos, CA), San Joaquin Gardens (located in Fresno, CA) and Piedmont Gardens (located in Oakland, CA). Lenick states that he negotiated per diem rates for these SNFs with Kindred representative Marilyn Groves in late 1999 or early 2000, and that the per diem rates ranged between $8.95/Day and approximately $12/day.

144. The following is a portion of a draft of a typical contract between Kindred and ABHOW; this portion offers the SNF a per diem rate of $8.95 for the SNFs Medicare Part A patients. (*See* full draft attached hereto as Exhibit 31):

SCHEDULE A

2. Per Diem

Health Care Facility shall pay Pharmacy at the rates set forth below for Pharmaceutical Services:

A. Medicare Part A Per Diem Pricing

Health Care Facility shall pay $ 8.95 per day per Medicare Part A patient (which shall include date of admission and date of discharge).

145. In 2001, Lenick became the President of Advanced Healthcare Solutions ("AHS"), an Arizona corporation that provided consulting and billing services for long term care facilities through December 2012. Although he had left ABHOW, Lenick remained responsible for negotiating contracts on behalf of the nursing homes named above.

146. In early 2007, PharMerica Long-Term Care and Kindred Pharmacy Services – competitors in the LTC pharmacy market - were separated from their respective parent companies to form defendant Pharmerica. Lenick will testify that at that time, he was continuing to advise the above-named nursing homes regarding their long-term care contracts. Lenick will testify that defendant Pharmerica honored the contracts at the same prices.[12]

147. Lenick will further testify that although the contracts contained so-called "true-up" clauses such as the one depicted below, these clauses were not utilized by Kindred or defendant Pharmerica when it assumed the contracts, such that the contracts were not trued up.

> The parties agree that the Medicare Part A Per Diem Pricing will be reviewed every three months, and adjusted. Within 90 days after the date of the Agreement, and every 90 days from that date forward (Review Period),

> Pharmacy shall calculate the average pharmaceutical charge for the Medicare Part A and Managed Care patients utilizing the FSS rates for exclusion meds (minus exclusions) actually provided during the Review Period.

148. While running AHS, Lenick was hired by many other SNFs to provide consulting services and advice in their contract negotiations with institutional pharmacies, including defendant PharMerica, for the supply of prescription drugs, pharmacy supplies and pharmacy services. Lenick will testify that Pharmerica continued to provide steeply discounted drugs to numerous SNF's in many states across the country, including but not limited to California.

[12] Indeed, Lenick can state that Pharmerica was particularly aggressive in its pricing when compared with defendant Omnicare. Often, these two companies competed for the same nursing home, each offering a lower per diem rate. Lenick will testify that whenever he was involved in negotiations which included both companies, defendant Pharmerica provided the lowest price.

149. For example, Lenick will testify that from 2008-2010 he was hired by the SNF Vista Del Monte, located at 3775 Modoc Road, Santa Barbara, California, to examine its contract with Kindred. Vista Del Monte was one facility among a chain of approximately twenty (20) long term care facilities named Front Porch Communities and Services ("Front Porch"). The following is a list of long term care facilities affiliated with Front Porch:

- The Alhambra located at 2400 S Freemont Ave., Alhambra, CA;
- Carlsbad by the Sea located at 2855 Carlsbad Blvd., Carlsbad, CA;
- Casa de Manana located at 840 Coast Blvd., La Jolla, CA;
- Claremont Manor located at 605 W Harrison Ave., Claremont, CA;
- Fredericka Manor located at 183 Third Avenue, Chula Vista, CA;
- Kingsley Manor located at 1055 N Kingsley Drive, Los Angeles, CA;
- Sunny View Manor located at 22445 Cupertino Road, Cupertino, CA;
- Villa Gardens located at 842 E Villa St., Pasadena, CA;
- Vista Del Monte located at 3775 Modoc Road, Santa Barbara, CA;
- Walnut Village located at 891 S. Walnut Street, Anaheim, CA;
- Wesley Palms located at 2404 Loring Street, San Diego, CA;
- The Lutheran Health Facility of Alhambra located at 2021 Carlos St., Alhambra, CA;
- Carlsbad by the Sea Care Center located at 2855 Carlsbad Blvd., Carlsbad, CA;
- Fredericka Manor Care Center located at 111 Third Avenue, Chula Vista, CA;
- Kingsley Care Center located at 1055 N Kingsley Drive, Los Angeles, CA;
- Sunny View Care Center located at 22445 Cupertino Road, Cupertino, CA;
- Villa Gardens Health Center located at 842 E Villa St., Pasadena, CA;
- Vista Del Monte Health Care Center located at 3775 Modoc Road, Santa Barbara, CA;
- Walnut Manor Care Center located at1401 W Ball Road, Anaheim, CA; and
- Claremont Care Center located at 621 W Bonita Ave., Claremont, CA.

150. Lenick states that in addition to consulting with the SNF Vista Del Monte, he also served as a consultant to many of these other Front Porch facilities in examining their contracts for the supply of prescription drugs, pharmacy supplies and consulting services, including but not limited to Fredericka Manor Care Center and Sunny View Health Care Center.

151. Lenick will testify that all of the facilities received steeply discounted per diems from defendant Pharmerica. For example, the following is an excerpt of the pricing section of a contract executed between Kindred and Vista Del Monte dated April 1, 2002. (The fully

executed contract between Vista Del Monte and Kindred attached hereto at Exhibit 32). The excerpt clearly establishes a per diem rate of $11/day for Medicare Part A patients.

PHARMACEUTICAL SERVICES AGREEMENT

SCHEDULE A

Vista Del Monte

Health Care Facility shall pay Pharmacy at the rates set forth below for Pharmaceutical Services:

A. Medicare Part A Per Diem Pricing

Health Care Facility shall pay $11.00 per day per Medicare Part A patient (which shall include date of admission and date of discharge).

The per diem rate includes:

- Routine oral prescription medications
- Topical, Ophthalmic and otic medications.

The per diem rate excludes:

- IV products and supplies
- OTC products

Health Care Facility shall pay to Pharmacy the Average Wholesale Price plus ten percent (10%) for OTC products. Average Wholesale Price shall be defined as the average wholesale price per Bergen-Brunswig Corporation (or its successor) as of the date of the billing.

If a Medicare Part A resident is (i) no longer Medicare Part A eligible, (ii) discharged for any reason, or (iii) discontinues medications or supplies for any reason, Health Care Facility shall return the unused medications or supplies to Pharmacy (if not otherwise prohibited by law or regulation) within ten (10) days of such change.

The parties agree that the Medicare Part A Per Diem Pricing will be reviewed every three months, and adjusted. Within 90 days after the date of the Agreement, and every 90 days from that date forward ("Review Period"), Pharmacy shall calculate the average pharmaceutical charge for the Medicare Part A and Managed Care patients utilizing the rate of AWP – 5% + $3.95 ("Review Rate") for the medications and supplies (minus exclusions) actually provided during the Review Period. Any variance between the per diem rate and the Review Rate will be charged or credited to the facility.

152. As noted previously, the merger which formed defendant Pharmerica occurred in 2007. Lenick can state through his work with the above-named facilities that defendant Pharmerica assumed and subsequently honored the contracts between Kindred and its nursing home customers, including the contractual terms – and prices – discussed immediately above.

Moreover, Lenick can state that defendant Pharmerica did not enforce the so-called true up clauses.

153. Such prices are commercially unreasonable, are below fair market value, and constitute kickbacks under the AKS. Since compliance with the AKS is a condition of payment under the FCA, PharMerica's bills to government payers constitute false claims. As specifically discussed below in paragraphs 179 and 184, Relator owned an institutional pharmacy, and kept detailed records of both his acquisition costs (the cost of drugs), and his operational costs (salaries for pharmacists, technicians, delivery costs, etc.). In 2006, his acquisition costs averaged $29.41 per patient, per day, and his operational costs averaged $10.88 per patient, per day. Thus, *just to break even*, he needed to get paid $40.29 per patient, per day. Thus viewed, it is virtually certain that PharMerica offered prices to nursing homes which fell far below its own acquisition costs, and even further below its own total costs. The reason is simple – PharMerica recaptured those losses, and handsomely profited, by billing Medicaid and Medicare Part D at substantially higher prices.

154. In addition, these prices violate the California-specific laws cited in this Complaint (both *supra* and *infra*). By way of simple example, PharMerica cannot dispute that such per diems fall below the prices it charged California Medicaid (cited below at paragraph 191). Under California law, institutional pharmacies cannot offer deep discounts to certain customers without also offering those same deep discounts to Medicaid. Here, there is no dispute as to what happened: PharMerica offered the discounts to nursing home owners, but did not offer the discounts to California Medicaid.

VII. LEGAL ANALYSIS

A. The Law as Applied to Institutional Pharmacies

155. As discussed in detail above, Congress (through the AKS and the Code of Federal Regulations) and the OIG (through Fraud Alerts, Preamble Comments, Advisory Opinions, and Formal Program Guidances) have repeatedly stressed that "swapping" arrangements implicate the AKS, and further, are not protected by the discount safe harbor.

156. Perhaps the best summary of the problem associated with swapping arrangements comes from the OIG Advisory Opinion issued on March 4, 1999:

> [s]uch price reductions create a risk that a supplier [the institutional pharmacy] may be offering remuneration in the form of discounts on [Part A] business for which the purchaser [the nursing home] pays the supplier, in exchange for the opportunity to service and bill for higher paying Federal health care program business reimbursed directly by the program [Medicaid and Medicare Part D] to the supplier. In such circumstances, neither Medicare nor Medicaid benefits from the discount; to the contrary, Medicare and Medicaid may, in effect, subsidize the other payer's discounted rates. . . . This is particularly problematic when the contracting payer is a PPS SNF, because [Medicaid and Medicare Part D] payments essentially may subsidize Part A PPS payments that the government has determined are appropriate and adequate to cover the SNF's costs.

OIG Advisory Opinion 99-2, at page 5, and ftn.10 [bracketing added]. The same situation is present here: the federal government has determined the amount of money – in the form of a flat, daily rate – which is "appropriate and adequate" to cover the nursing homes' costs for providing care to Medicare Part A patients. Thus, when a nursing home accepts a Medicare Part A patient into its facility, the nursing home agrees to accept the flat rate as full payment. The Pharmacy Defendants should not be providing nursing homes with additional remuneration for Part A patients through subsidies paid for by Medicaid and Medicare Part D.

157. The arrangement in question in OIG Advisory Opinion 99-2 involved ambulance companies providing nursing homes with a steep discount for transporting Medicare Part A

patients, in exchange for the opportunity to provide ambulance services to nursing home patients covered by Medicare Part B and other federal programs under which the nursing home was not responsible for transportation costs. After concluding that the discount safe harbor was not applicable, the OIG provided the following analysis regarding the kickback implications of such an arrangement:

> The circumstances surrounding the arrangement suggest that a nexus may exist between the discount to the SNFs for PPS-covered transports and referrals of other Federal health care program business.[13] First, the SNFs are in a position to direct a significant amount of business to [the ambulance company] that is not covered under the PPS payment. Second, both parties have obvious motives for agreeing to trade discounts on PPS business for referrals of non-PPS business: the SNFs to minimize risk of losses under the PPS system and [the ambulance company] to secure business in a highly competitive market. Third, [the ambulance company's] request for an advisory opinion comes amidst a considerable number of informal inquiries and anecdotal reports regarding discounts to SNFs that this Office has received since enactment of SNF PPS [on July 1, 1998]. These inquiries and reports suggest that suppliers of a wide range of SNF services are giving SNFs discounts for PPS-business that are linked, directly or indirectly, to referrals of Part B business.

Id. at page 5-6 (citation includes language in footnote)[bracketing added].

158. This language is directly applicable to this case. First, nursing homes "are in a position to direct a significant amount of business" to the Pharmacy Defendants that is not covered under the bundled/PPS payment. Specifically, the vast majority of nursing home patients is not covered under the bundled/PPS payment, and instead is covered by full price payors, including Medicaid and Medicare Part D.

159. Second, both the nursing homes and the Pharmacy Defendants "have obvious motives for agreeing to trade discounts on PPS business for referrals of non-PPS business: the [nursing homes] to minimize risk of losses under the PPS system," and the Pharmacy Defendants

[13] "We note that the Agreement contains statements to the effect that remuneration provided under the Agreement is not intended to induce referrals of other business. We find these statements self-serving and not persuasive."

"to secure business in a highly competitive market." *Id.* [bracketing added]. This latter factor is particularly cogent here, where, as discussed above, the impetus for the kickbacks was the competitive market itself.

160. Third, it is not a coincidence that the swapping scheme at issue in the instant case – conceived in or about 1998 and executed beginning that year or early 1999 – coincided simultaneously with the OIG's observation in the March 4, 1999, advisory opinion cited above that it was receiving "inquiries and reports suggest[ing] that suppliers of a wide range of SNF services are giving SNFs discounts for PPS-business that are linked, directly or indirectly, to referrals of [other federal program] business." Stated differently, the change to the bundled/PPS payment methodology caused swapping concerns with respect to various nursing home vendors, not just the institutional pharmacies at issue here.

161. Advisory Opinion 99-2 goes on to provide additional insight regarding which business arrangements are improper, stating:

> In evaluating whether an improper nexus exists between a discount and referrals of Federal business in a particular arrangement, we look for indicia that the discount is not commercially reasonable in the absence of other, non-discounted business. In this regard, discounts on SNF PPS business that are particularly suspect include, but are not limited to:
>
> - discounted prices that are below the supplier's cost, and
> - discounted prices that are lower than the prices that the supplier offers to a buyer that (i) generates a volume of business for the supplier that is the same or greater than the volume of Part A business generated by the PPS SNF, but (ii) does not have any potentially available Part B or other Federal health care program business.
>
> This is an illustrative, not exhaustive, list of suspect discounts; other arrangements may be equally suspect. Each of the above pricing arrangements independently gives rise to an inference that the supplier and the SNF may be "swapping" discounts on Part A business in exchange for profitable non-discounted [other Federal program business], from which the supplier can recoup losses incurred on the discounted business . . . .

162. Here, the discounted prices offered by the Pharmacy Defendants are "lower than the prices that the [institutional pharmacy] offers to a [nursing home] that (i) generates a volume of business for the [institutional pharmacy] that is the same or greater than the volume of Part A business generated by the [nursing home], but (ii) does not have any potentially available Part B or other Federal health care program business." *Id.* [bracketing added]. For example, the prices paid by huge commercial insurers with deep bargaining power substantially exceed the prices paid by nursing home owners, many of whom have virtually no bargaining power except for their capability to refer full price Medicaid and Part D business to the Pharmacy Defendants. [14]

163. In summary, institutional pharmacies, motivated by greed and willing to break the law, reacted to the 1998 program changes by actively, opportunistically, and illegally competing for revenue by offering kickbacks to the entities that were in a position to steer market share in their direction.

B. The Discounts Provided by the Pharmacy Defendants to Nursing Homes are "Directionally Inconsistent," Below Fair-Market-Value, and Commercially Unreasonable

164. As discussed above, the number of drugs prescribed to an average nursing home patient has been consistently rising each year. Moreover, the cost of prescription drugs has been rising each year at a rate substantially higher than inflation. Notwithstanding these powerful trends, the discounts provided by the Pharmacy Defendants are going in the opposite direction, *i.e.*, the prices offered to nursing homes for drugs provided to their Medicare Part A patients are

[14] Finally, it should be noted that OIG Advisory Opinion 99-2 provided the following additional guidance with respect to swapping arrangements:

> The risk of improper "swapping" is compounded by the likelihood that SNFs will refer non-PPS business to their contracted PPS provider . . . as a matter of practical convenience . . . .

Such practical convenience factors are present here, in that it is highly impractical for nursing homes to have more than one in-house pharmacy. Thus, the supplier – here, the Pharmacy Defendants – knew to a practical certainty that if they could induce the nursing home by using the subsidized price, they would in return receive the vast majority of the nursing home's pharmaceutical business at full price.

going down. Relator alleges this "directional inconsistency" is due to the competition between the Pharmacy Defendants for the referrals provided by nursing home owners. Relator can establish directional inconsistency from both a macro and micro perspective.

165. The literature establishes what just about any person in America already knows: the usage of prescription drugs and the cost of prescription drugs are rising at an alarming rate. The nursing home industry is no exception. Evidence from national surveys of institutional pharmacists shows that the utilization of drugs in nursing homes is increasing over time. For example:

- In 1994, the average nursing home patient was taking 5.4 daily medications, and was ordered 3.4 "as needed" ("prn") medications.
- By 1997, the average nursing home patient was taking 5.9 daily medications, and was ordered 3.6 prn medications.
- By 2000, the average nursing home patient was taking 6.7 daily medications, was ordered 2.6 prn medications, and was actually administered 3.75 prn doses of medication per day.[15]
- By 2003, the average nursing home patient was taking 8.1 daily medications, and was ordered 3.2 prn medications.[16]

166. Relator can directly corroborate this trend in three ways. First, as noted above, Relator owned and operated Silver Care from 1986 through 2007. Starting in 2001 and through 2007, Relator also owned and operated Silver Pharmacy, an institutional pharmacy serving his own nursing home and other long term care facilities. As a nursing home owner and as the owner of an institutional pharmacy, Relator prepared reports analyzing the usage of prescription drugs within Silver Care and other long term care facilities. Relator can testify that, without

[15]D. Tobias and M. Sey, "General and Psychotherapeutic Medication Use in 328 Nursing Facilities: A Year 2000 National Survey," Consultant Pharmacist, 16, no. 1 (2001): 52.
[16] It should also be noted that from 2000 through 2003, the number of nursing home residents on 9 or more medications rose more than 50%.

exception, the usage and cost of prescription drugs on a per patient basis rose continually, increasing each year.

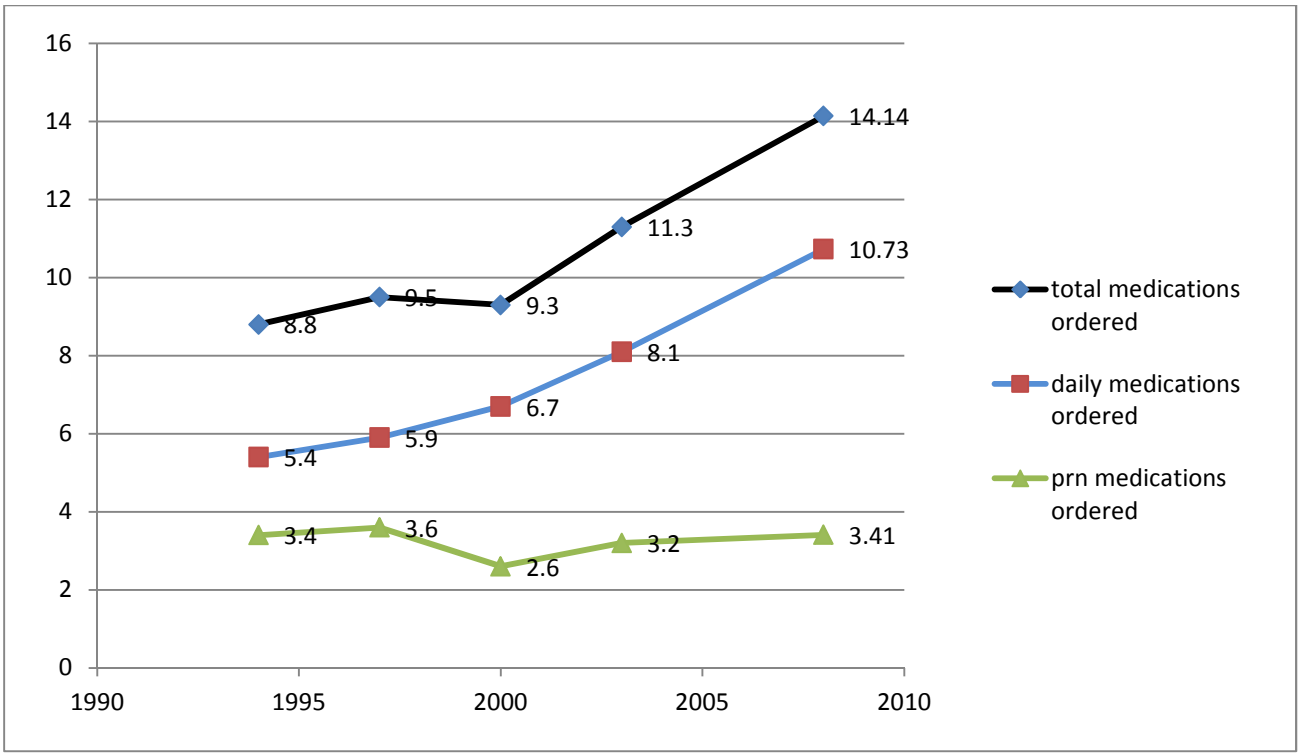
167. Second, from 1986 through 2010, Relator was deeply involved in regional and national affairs within the nursing home community both on a policy level and on an operational level. Relator can testify that he reviewed countless industry publications, presentations, and reports regarding the usage and cost of prescription drugs in nursing homes. Without exception, the usage and cost of drugs within the industry rose continuously, year after year.

168. Third, Relator interacted with many other nursing homes on the issue of the usage and cost of prescription drugs. Through this work, it was not uncommon for Relator to come into possession of detailed information regarding the usage of drugs within particular nursing homes other than Silver Care.

169. For example, as noted above, Relator worked with executives at Genesis Healthcare on a project related to their prescription drug usage/costs. In connection with that work, Genesis provided the Relator with the November 2008 Medication Administration Records ("MARs") for patients at Cranbury Nursing and Rehabilitation ("Cranbury"), a typical nursing home located in Middlesex, NJ. The MARs show that there were at least 142 patients residing at Cranbury in November 2008. A page by page analysis of the MARs reveals that the average patient was taking 10.7 daily medications.[17] Additionally, each patient was ordered an average of 3.4 medications on a prn basis,[18] for a total of 14.1 daily medications ordered.

170. The chart below summarizes the data available in the literature, and the Relator's data from Cranbury. In short, medication usage in nursing homes roughly doubled between 1994 and 2008.

[17] Of these, 8.3 were prescription medications.
[18] Of these, 1.6 were prescription medications.



171. While this chart helps demonstrate that the number of prescriptions per patient trended steeply higher through the late 1990's and 2000's, the average cost of prescription drugs also rose at a rate much faster than the rate of inflation:

> Prescription drug prices as measured by the Consumer Price Index increased 3.4% in 2009, 2.5% in 2008, 1.4% in 2007, and 4.3% in 2006. The average annual growth in prescription drug prices from 2000 to 2009 was 3.6 percent, compared to 4.1% for all medical care and 2.5% for all items. Industry data show that retail prescription prices (which reflect both manufacturer price changes for existing drugs and changes in use to newer, higher-priced drugs) rose from an average price of $38.43 in 1998 to $71.69 in 2008; the average brand name prescription price in 2008 was almost 4 times the average generic price ($137.90 vs. $35.22).

Kaiser Family Foundation, Prescription Drug Trends (2010)(*available at*: http://www.kff.org/rxdrugs/upload/3057-08.pdf).

172. Nor has the rise in prescription drug prices, overall, been offset by the fact that many drugs utilized in nursing homes have "gone generic" in recent years:

> AARP's Public Policy Institute finds that average manufacturer price increases for brand name and specialty prescription drugs widely used by Medicare beneficiaries continued to far outstrip the price increases for other consumer goods and services in the 12 months ending with March 2010. In contrast, average

> manufacturer prices for widely used generic drugs fell during the same time period. These trends resulted in an average annual rate of increase of 5.3 percent for manufacturer drug prices during the 12 months ending with the first quarter of 2010 despite an extremely low rate of general inflation for all consumer goods and services.

AARP Public Policy Institute, Insight on the Issues, "Rx Watchdog Report: Drug Prices Continue to Climb Despite Lack of Growth in General Inflation Rate" (2010)(*available at*: http://assets.aarp.org/rgcenter/ppi/health-care/i43-watchdog.pdf).

173. The findings discussed in this section are corroborated by Relator's experience with Silver Pharmacy. As the owner of an institutional pharmacy, Relator purchased drugs at market rates, sold them to customers, and then analyzed the revenue he received from sales. Without exception, Relator can testify that the prices he paid to purchase drugs rose at a rate higher than inflation, as did the prices he charged to customers when he resold the drugs.

174. Notwithstanding these strong headwinds, the prices charged to nursing homes for their Part A patients have not risen. Rather, the prices have actually fallen, as institutional pharmacies like the Pharmacy Defendants compete for referrals from nursing homes. So, drugs cost more, more drugs are being prescribed to patients, and government payors like Medicaid and Part D are paying these higher prices, yet the prices charged to nursing homes by the Pharmacy Defendants are going in the opposite direction.

175. For example, in the late 1990's and early 2000's, Silver Care – located in Cherry Hill, NJ – was receiving per diem rates of approximately $25 for its Part A patients. Yet, after more than ten years of rising utilization and rising costs, a similarly situated entity – Southgate Nursing Home in Carneys Point, NJ – was receiving per diem rates of $22 from Defendant Chem Rx (a company now owned by Defendant Pharmerica). Similarly, Saunders House in Wynnewood, PA, was receiving per diems of $14 from Omnicare for its Part A patients.

176. This directional inconsistency is compounded by the acuity levels of the average Part A patient vs. the average Medicaid or Part D patient. Specifically, it is widely recognized

that Part A patients are prescribed more medications than the average nursing home patient for a number of reasons, including that they typically have just been discharged from a hospital, post-surgery. Thus, in addition to any already-prescribed daily medications, Part A patients have greater need for pain medications, antibiotics to fight infection from the surgical wound, intravenous fluids, anti-coagulants to prevent blood clots, anesthesia drugs, and so on.

177. That the directionally inconsistent prices provided to nursing homes for Part A patients are commercially unreasonable can be further established by an analysis of the actual cost of drugs to institutional pharmacies.

178. Silver Pharmacy provides a good example. Relator purchased the pharmacy's drugs through AmerisourceBergen, a large national wholesaler. However, Silver Pharmacy did not bargain alone. Rather, Silver Pharmacy joined a group purchasing organization/supply contracting company known as Provista/Novation ("Provista"). Provista leveraged nearly $40 billion dollars in purchasing power in its discount negotiations with AmerisourceBergen.

179. For calendar year 2006 – the same calendar year during which Omnicare was offering per diem prices of $14/day for Part A patients – Relator purchased pharmaceuticals in the amount of $2,457,425 from AmerisourceBergen. Silver Care's total number of "patient days" for 2006 – meaning the sum of the daily census figures for each day in 2006 – was 83,560. Thus, the cost for drugs alone, per patient, per day, was $29.41 (2,457,425/83,560 = $29.41). Based on these costs, Omnicare's per diem pricing was commercially unreasonable, as it was less than half of the actual costs absorbed by a similarly situated purchaser.

180. Indeed, it is highly plausible that Omnicare was losing money at these prices. Given the amount of drugs being taken by each patient, and the rising cost of drugs overall, how can a pharmacy make money by providing drugs to nursing home patients for $14/day? The answer is, it can't. However, the Pharmacy Defendants can and do make money via the "pull

through" business provided by Medicaid and Part D, which amounted to approximately $4 billion to defendant Omnicare in 2011 alone.

181. These are particularly salient observation when one considers that the institutional pharmacies themselves acknowledge that their costs are high: "[i]t has been well documented and broadly understood that prescription costs in long term care are legitimately higher than retail due to the unique elderly population as well as specialized packaging, 24 hour service and multiple daily deliveries."[19] This statement highlights an important issue: in addition to the actual cost of drugs, the Pharmacy Defendants incurred other significant costs in providing drugs to their nursing home customers. "In determining whether a discount is below cost, [the OIG] look[s], for example, at the total of all costs (including labor, overhead, equipment, etc.) divided by the total number of [in that case, laboratory tests]." Adv. Op. 99-13 (November 30, 1999); Letter, Kevin G. McAnaney, Chief, Industry Guidance Branch, September 22, 1999 at n.4 (*available at* http://oig.hhs.gov/fraud/docs/advisoryopinions/1999/ao99_13.htm) (last visited June 13, 2013).

182. Based on the Relator's experience as a nursing home owner and institutional pharmacy owner, Relator can testify that each of the Pharmacy Defendants in this case is responsible for, *inter alia*, the costs incurred within the following service sequence:

- Prescriptions ("Orders") are received from the physician, verified by the pharmacy, and entered into the pharmacy's computer system.

- The Orders are sent to the filling stations (buildings where Orders are physically filled by pharmacy technicians). This typically involves considerable work, including removing the drugs from their containers and repackaging them into, *e.g.*, monthly "blister packs." Thus, this step involves considerable salary, real estate, and supply costs.

[19] Quote from November 2, 2011 statement issued by the Long Term Care Pharmacy Alliance ("LTCPA"). As noted in the statement, "LTCPA membership is comprised of two national chain-based LTC pharmacy providers, Omnicare and PharMerica, in addition to approximately 900 independent LTC pharmacies that together serve 1.8 million Medicare Part D beneficiaries, or ninety percent of all LTC facility residents."

- A pharmacist – whose salary is paid by the pharmacy – must verify that the Order, as filled, is correct.

- 6 and sometimes 7 days a week, the Orders are delivered by the pharmacy to each individual nursing home. This involves road transportation, drivers, dispatchers, gas, etc. Thus, this step also involves considerable costs.

183. Relator, having previously owned an institutional pharmacy, can testify that these costs are substantial. For example, in order to supply his customers, Relator employed multiple full time pharmacists, pharmacy technicians, and others. Silver Pharmacy also incurred typical supply costs, and typical office overhead.

184. Relator kept detailed financial records documenting these operational costs. Averaged out over a period of a year, the costs incurred by Silver Pharmacy amounted to $10.88 per patient, per day.[20] Thus, the total cost to Silver Pharmacy to provide drugs to residents of Silver Care was $40.29, per patient, per day ($29.41 + $10.88 = $40.29). Thus, to turn a profit, Silver Pharmacy needed to bill and receive from its customers an average which exceeded $40.29 per patient, per day. Payment of less than $40.29 per patient, per day would have resulted in a financial loss.

185. In addition to the macro perspective which establishes the directionally inconsistent nature of the prices offered by the Pharmacy Defendants, and the micro perspective provided by Relator's experiences as the owner of a nursing home and institutional pharmacy, there is another plausible methodology to demonstrate that these discounts were kickbacks.

186. Specifically, a reasonable comparison can be made between the "volume of business" that a nursing home generates through its Part A patients, and the volume of business generated by other purchasers – such as commercial insurers – who do "not have any potentially

[20] Moreover, Silver Pharmacy's ancillary costs were likely lower than those of the Pharmacy Defendants. Silver Pharmacy was located on the grounds of Silver Care, and thus Relator did not incur the rather substantial real estate and delivery costs absorbed by the Pharmacy Defendants.

available . . . other Federal health care program business" to refer to the Pharmacy Defendants. OIG Advisory Opinion 99-2 (March 4, 1999), at pg. 6.

187. As noted previously, a percentage of nursing home patients are insured by large private carriers who have considerable bargaining power with the Pharmacy Defendants due to the number of patients they insure. Despite the fact that private insurers represent an equal and in many cases a much larger volume of business than most nursing home owners, Relator can testify based on his own experience in the nursing home pharmacy industry that both before and after the advent of Medicare Part D, private insurers – who are not in a position to refer other Federal health care program business to the Pharmacy Defendants (whereas nursing homes owners are) – paid substantially higher prices than nursing homes.

188. Relator is directly aware of this because Silver Pharmacy billed insurance companies for prescription drugs provided to their insureds from 2001 through May 2007. Whether patients were privately insured with no connection to a government payor, or patients were insured by a private insurer via Medicare Part D, Relator can state that private insurers paid and continue to pay substantially higher prices than nursing home owners, including nursing home owners with virtually no bargaining power.

189. Indeed, Relator is aware of the proprietary pricing schedules for more than a dozen leading health insurance plans that provide prescription drugs to patients in nursing homes on the basis of Average Wholesale Price ("AWP"). These prices are fiercely negotiated between the insurers and their customers.

190. By way of example, the chart below lists proprietary prices negotiated between MHA Long Term Care Network ("MHA") and 12 large private insurers for the fourth quarter of 2010. MHA is a group purchasing organization with considerable buying power, and counts more than 1000 long term care pharmacies as members. As reflected in the chart below, the

average prices negotiated between MHA and the listed private insurers during 2010 were AWP-11.2%, with a dispensing fee average of $5.08.

191. Relator is also familiar with the prices paid by the Medicaid programs of the Plaintiff States. These prices are also heavily negotiated between the states and the institutional pharmacy providers. As reflected in the chart below, the average prices paid by a representative sample of state Medicaid programs during 2010 was AWP-13.3%, with a dispensing fee average of $4.19, whereas the AWP-based discounts provided to nursing home owners for Part A patients were far below this prices.

STATE	PRICE	DISP. FEE	PRIVATE PAYOR	PRICE	DISP. FEE
CA	AWP-17%	$7.25	ARGUS	AWP-12%	$5.00
DC	AWP-10%	$4.50	CAREMARK/CVS	AWP-13%	$4.75
FL	AWP-16.4%	$3.73	CIGNA	AWP - 8.52%	$5.00
GA	AWP-11%	$4.63	RX AMERICA	AWP-13%	$4.75
HI	AWP-10.5%	$4.67	WELLPOINT NEXTRX	AWP - 9.8%	$4.50
MD	AWP-12%	$3.69	INFORMEDRX (SXC)	AWP-13%	$5.00
MN	AWP-12%	$3.65	MEDIMPACT	AWP-12.5%	$5.50
NV	AWP-15%	$4.76	NPS	AWP-8.53%	$5.00
NJ	AWP-17.5%	$3.73	RX OPTIONS, ENVISION RX	AWP-12%	$5.00
NM	AWP-14%	$2.50	RX SOLUTIONS	AWP-14%	$5.00
VA	AWP-10.25%	$3.75	WALGREEN'S	AWP-8.56%	$5.75

WI	AWP-14%	$3.44		WELLCARE	AWP - 9%	$5.75		
TOTAL AVG	**AWP -13.31 %**	**$4.19**		***TOTAL AVG***	**AWP -11.16%**	**$5.08**		

192. As demonstrated throughout this Complaint, market-driven prices – and particularly the prices charged to commercial insurers – are far higher than the kickback-laden prices provided to nursing home owners. Stated differently, the prices provided by the Pharmacy Defendants to nursing home owners are well below fair-market-value. The reason for the discounts is simple – once the nursing home selects a particular institutional pharmacy, all of the full-price Medicaid and Medicare Part D business is directed to the chosen pharmacy, who uses the profits from those sales to subsidize future discounts to the nursing home.

193. In the end, the kickback scheme alleged herein results in decreased levels of patient care with respect to pharmaceuticals, an area of nursing home practice which is critical to patient care and quality of life. Through the scheme, nursing homes are choosing institutional pharmacies based upon the deepest discount on drugs for their Medicare Part A patients, instead of choosing based on what the institutional pharmacies offer to patients such as:

i. A deep and comprehensive prescription drug formulary;

ii. Maintaining drug profiles on each resident to make sure no resident receives a contra-indicated medicine or a medicine to which they are allergic;

iii. Consulting services from the pharmacy staff (including the pharmacist) to the facility staff re: drugs indications, intravenous solution mixing, biologicals, etc.;

iv. Maintaining a supply of "emergency" drugs and emergency kits;

v. Attend meetings of the Facility's committee meetings, e.g., quality assurance, infectious control, etc.;

vi. Conduct in-service education programs relating to pharmaceutical services;

vii. Twice daily delivery of drugs on weekdays (rather than once a day, every other day, or weekly), and once daily on weekends (rather than no delivery on weekends);

viii. "STAT" delivery of medicines, *i.e.*, immediate delivery when requested;

ix. Monthly drug regimen reviews by pharmacist;

x. Computerized physician ordering and processing of scripts;

xi. Periodic reviews of the medication room;

xii. Periodic visits from the pharmacy's nurse consultant; and

xiii. Periodic nursing physician order recaps.

194. These patient-care-related factors are the very reason that Congress and the courts have uniformly held that offering kickbacks which influence the provision of health care services violates the False Claims Act.

VIII. FALSE CLAIMS

195. As noted above, the Pharmacy Defendants executed provider agreements with each of the state Medicaid programs to which they submitted drug reimbursement claims. Compliance with the AKS is a precondition to payment from state Medicaid programs.

196. The Pharmacy Defendants also entered into contracts with Medicare Part D sponsors; the contracts contain language obligating them to comply with all applicable federal laws, regulations, and CMS instructions. 42 C.F.R. § 423.505(i)(4)(iv). Compliance with the federal AKS is a precondition to payment from Medicare Part D and other federal payors.

197. As detailed above, the Pharmacy Defendants entered into untold numbers of the Medicare Part A kickback arrangements with nursing homes. These contracts violate the AKS, and no safe harbor applies. Through these contracts, the Pharmacy Defendants submitted or

caused to be submitted claims for reimbursement to the Medicaid programs of the Plaintiff States, and to various federal government health care programs including Medicare and TRICARE.

198. Each of these claims was accompanied by an express or implied certification that the transaction was not in violation of federal or state statutes, regulations, or program rules. Each of those certifications was false, because each claim for payment was tainted by the kickback arrangement detailed in this Complaint. Given the more than 20 years of statutory and regulatory guidance with respecting to such illegal "swapping" arrangements, the Pharmacy Defendants – all of whom are experienced health care providers with detailed knowledge of the laws applicable to government programs – knew that the claims were tainted by the kickback scheme, and thus were not reimbursable by government programs such as Medicaid or Medicare Part D. Knowingly submitting or causing the submission of claims for prescription drugs which are not reimbursable creates liability under the FCA and the State FCA's.[21] Thus, each of these claims to the Governments from the Pharmacy Defendants constituted a violation of section 3729 of the FCA, and the analogous provisions of the State FCA's.

[21] Knowingly causing the submission of claims that are ineligible for payment under a federal healthcare program constitutes a violation of the FCA. *See U.S. ex. rel. Franklin v. Parke-Davis*, 147 F. Supp. 147, 152-153 (D.Mass. 2001); *See also U.S. ex rel. Nowak v. Medtronic, Inc.,* Case Nos. 1:08-cv-10368 and 09-cv-11625, D. Mass. (United States of America's Statement of Interest, at 6)("[t]o the extent that a healthcare provider seeks reimbursement for a procedure that is ineligible for payment under a federal healthcare program . . . because the program places other conditions on coverage that are not satisfied, the claim is false"), and *U. S. v. Medco Physicians Unlimited*, 2000 U.S. Dist. LEXIS 5843, at *27 (N.D. Ill. Mar. 15, 2000) (granting partial summary judgment for plaintiff on the issue of liability with respect to its claim that Medco submitted false claims for non-reimbursable meals and transportation costs.)

IX. ADDITIONAL FALSE CLAIMS AS TO THE STATE OF CALIFORNIA

199. The California False Claims Act, codified in the California Government Code sections 12650, *et seq.*, states that it is a violation to: (a) Knowingly present or cause to be presented false claims for payment or approval of claims for Medi-Cal reimbursement; and/or, (b) Knowingly make, use, or cause to be made or used false records or statements to get false claims paid or approved by California for Medi-Cal reimbursement.

200. Under Title 22, Section 51501, subdivision (a) of the California Code of Regulations, "no provider shall charge for any service or any article more than would have been charged for the same service or article to other purchasers of comparable services or articles under comparable circumstances" (the "Comparative Pricing Rule").

201. California also has prohibitions with respect to the exchange of remuneration and Medi-Cal program business. Specifically, under the Business and Professions Code, it is prohibited to offer or accept "any rebate, refund, . . . discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers." California Business and Professions Code §650. Similarly, all Medi-Cal providers, including institutional pharmacies, are prohibited from soliciting or receiving "any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in valuable consideration of any kind . . . in return for the referral . . . of any person for the furnishing . . . of any service" paid for by Medi-Cal. California Welfare and Institutions Code §14107.2.

202. During the time period relevant to this complaint, the Pharmacy Defendants had swapping arrangements with nursing homes throughout California. Under these arrangements, discounted per-diem rates were given to the nursing homes at the same time that Medi-Cal was being billed at the non-discounted prices for the same drugs; despite the fact that Medi-Cal and the nursing homes were purchasers of comparable services under comparable circumstances.

Accordingly, each claim submitted by the Pharmacy Defendants to Medi-Cal was in violation of the Comparative Pricing Rule, the Business and Professions Code, and the Welfare and Institutions Code.

203. In submitting claims for payment to Medi-Cal, each Pharmacy Defendant certified that their services complied with California statutes and regulations. Those certifications were false, in that the Pharmacy Defendants were in fact charging far lower fees to other purchasers of comparable services under comparable circumstances, and because the deep discounts were prohibited remuneration in exchange for Medi-Cal business.

204. Consequently, each such claim for payment was a false claim in violation of California's False Claims Act (Gov. Code § 12650 *et seq*.).

COUNT I

FEDERAL FALSE CLAIMS ACT

31 U.S.C. §3729(a)(1)[1986] and 31 U.S.C. §3729(a)(1)(A)[2009]

205. Relator repeats and re-alleges each and every allegation contained in the paragraphs above as though fully set forth herein.

206. Defendants knowingly presented or caused to be presented a false or fraudulent claim for payment or approval in violation of 31 U.S.C. §3729(a)(1)[1986] and 31 U.S.C. §3729(a)(1)(A)[2009].

207. By virtue of the false or fraudulent claims that Defendants presented, the United States has suffered actual damages and is entitled to recover treble damages and a civil penalty for each false claim.

COUNT II

FEDERAL FALSE CLAIMS ACT
31 U.S.C. §§ 3729(a)(2) [1986] and
31 U.S.C. §3729(a)(1)(B)[2009]

208. Relator repeats and re-alleges each and every allegation contained in the paragraphs above as though fully set forth herein.

209. Defendants knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by the Government, in violation of 31 U.S.C. § 3729(a)(2) [1986]. Defendants' false records or statements caused the Plaintiff States to submit false and inflated claims to the United States for the federal portion of Medicaid.

210. Defendants knowingly made, used or caused to be made or used, false records or statements material to false or fraudulent claims to the United States Government. Defendants' false records or statements caused the Plaintiff States to submit false and inflated claims to the United States for the federal portion of Medicaid in violation of 31 U.S.C. §3729(a)(1)(B)[2009].

211. By virtue of the false or fraudulent claims that Defendants caused to be presented, the United States has suffered actual damages and is entitled to recover treble damages and a civil penalty for each false claim.

COUNT III

FEDERAL FALSE CLAIMS ACT
31 U.S.C. §3729(a)(3)[1986] and
31 U.S.C. §3729(a)(1)(C)[2009]

212. Relator repeats and re-alleges each and every allegation contained in the paragraphs above as though fully set forth herein.

213. Through these acts, and further as set forth in Counts I and II, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the United States has suffered actual damages.

COUNT IV

THE CALIFORNIA FALSE CLAIMS ACT (the "Act"), CALIFORNIA GOVERNMENT CODE §§ 12651, et seq.

214. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein, including but not limited to evidence that shows Defendants violated California Business and Professions Code §650, California Welfare and Institutions Code §14107.2, and the California Code of Regulations Title 22 §51501(a).

215. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 12651(a)(1) of the Act. Such claims caused actual damages to the State.

216. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 12651(a)(2) of the Act. Such claims caused actual damages to the State.

217. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT V

CONNECTICUT FALSE CLAIMS ACT FOR PUBLIC ASSISTANCE PROGRAMS (the "Act") CONN. GEN. STAT. § 17b-301 et seq.

218. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

219. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 17b-301b(1) of the Act. Such claims caused actual damages to the State.

220. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 17b-301b(2) of the Act. Such claims caused actual damages to the State.

221. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT VI

THE DELAWARE FALSE CLAIMS AND REPORTING ACT (the "Act"), DEL. CODE ANN. TIT. 6, § 1201 et seq.

222. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

223. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 1201(a)(1) of the Act. Such claims caused actual damages to the State.

224. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 1201(a)(2) of the Act. Such claims caused actual damages to the State.

225. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT VII

THE DISTRICT OF COLUMBIA FALSE CLAIMS ACT (the "Act"), D.C. CODE ANN. §§ 2-308.14 et seq.

226. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

227. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the District of Columbia in violation of Section 308.14(a)(1) of the Act. Such claims caused actual damages to the State.

228. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 308.14(a)(2) of the Act. Such claims caused actual damages to the State.

229. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT VIII

THE FLORIDA FALSE CLAIMS ACT (the "Act"), FLA. STAT. §§ 68.082(2) et seq.

230. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

231. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 68.082(2)(a) of the Act. Such claims caused actual damages to the State.

232. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 68.082(2)(a) of the Act. Such claims caused actual damages to the State.

233. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT IX

GEORGIA FALSE MEDICAID CLAIMS ACT (the "Act")
GA. CODE ANN. §49-4-168.1 et seq.

234. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

235. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 49-4-168.1(a)(1) of the Act. Such claims caused actual damages to the State.

236. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 49-4-168.1(a)(2) of the Act. Such claims caused actual damages to the State.

237. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT X

HAWAII FALSE CLAIMS ACT (the "Act")
HAW. REV. STAT. §661-21 et seq.

238. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

239. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 661-21(a)(1) of the Act. Such claims caused actual damages to the State.

240. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 661-21(a)(2) of the Act. Such claims caused actual damages to the State.

241. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XI

THE ILLINOIS WHISTLEBLOWER REWARD AND PROTECTION ACT (the "Act"), 740 ILL. COMP. STAT. ANN. §§ 175/3 et seq.

242. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

243. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 175/3(a)(1) of the Act. Such claims caused actual damages to the State.

244. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 175/3(a)(2) of the Act. Such claims caused actual damages to the State.

245. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XII

THE INDIANA FALSE CLAIMS AND WHISTLEBLOWER PROTECTION ACT (the "Act"), INDIANA CODE 5-11-5.5-2 et seq.

246. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

247. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 5-11-5.5-2(b)(2), of the Act. Such claims caused actual damages to the State.

248. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 5-11-5.5-2(b)(8), of the Act. Such claims caused actual damages to the State.

249. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XIII

LOUISIANA MEDICAL ASSISTANCE PROGRAMS INTEGRITY LAW (the "Act") LA. REV. STAT. § 46:438.3 et seq.

250. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

251. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 46:438.3(A) of the Act. Such claims caused actual damages to the State.

252. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 46:438.3(B) of the Act. Such claims caused actual damages to the State.

253. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XIV

THE MARYLAND FALSE HEALTH CLAIMS ACT (THE "ACT")
MD. CODE ANN., HEALTH-GEN §§2-602 et seq.

254. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

255. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 2-602(A)(1), of the Act. Such claims caused actual damages to the State.

256. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 2-602(A)(2), of the Act. Such claims caused actual damages to the State.

257. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XV

THE MASSACHUSETTS FALSE CLAIMS ACT (the "Act"),
MASS. ANN. LAWS. CH. 12, §§ 5B et seq.

258. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

259. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 5B(1), of the Act. Such claims caused actual damages to the State.

260. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 5B(2), of the Act. Such claims caused actual damages to the State.

261. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XVI

MICHIGAN MEDICAID FALSE CLAIMS ACT (the "Act"), MCLS §§ 400.607 et seq.

262. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

263. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 400.607(1), of the Act. Such claims caused actual damages to the State.

264. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 400.607(3), of the Act. Such claims caused actual damages to the State.

265. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XVII

MINNESOTA FALSE CLAIMS ACT (the "Act"),
MINN. STAT. §15C.02 et seq.

266. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

267. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 15C.02(a)(1), of the Act. Such claims caused actual damages to the State.

268. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 15C.01(a)(2), of the Act. Such claims caused actual damages to the State.

269. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XVIII

MONTANA FALSE CLAIMS ACT
MONT. CODE ANN. 17-8-403(1) et seq.

270. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

271. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 17-8-403(1)(a), of the Act. Such claims caused actual damages to the State.

272. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 17-8-403(1)(b) of the Act. Such claims caused actual damages to the State.

273. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XIX

THE NEVADA SUBMISSION OF FALSE CLAIMS TO STATE OR LOCAL GOVERNMENT ACT (the "Act"), NEV. REV. STAT. §§ 357.040 et seq.

274. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

275. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 357.040(1)(a), of the Act. Such claims caused actual damages to the State.

276. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 357.040(1)(b), of the Act. Such claims caused actual damages to the State.

277. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XX

NEW HAMPSHIRE FALSE CLAIMS ACT (the "Act") N.H. REV. STAT. ANN. §167:61-b et seq.

278. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

279. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 167:61-b(I)(a), of the Act. Such claims caused actual damages to the State.

280. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 167:61-b(I)(b), of the Act. Such claims caused actual damages to the State.

281. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXI

NEW JERSEY FALSE CLAIMS ACT (the "Act")
N.J. STAT. §2A:32C-3 et seq.

282. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

283. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 2A:32C-3(a), of the Act. Such claims caused actual damages to the State.

284. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 2A:32C-3(b), of the Act. Such claims caused actual damages to the State.

285. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXII

THE NEW MEXICO MEDICAID FALSE CLAIMS ACTN.M. STAT. ANN. § 27-14-4A et seq.

286. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

287. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 27-14-A(1), of the Act. Such claims caused actual damages to the State.

288. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 27-14-4A(2), of the Act. Such claims caused actual damages to the State.

289. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXIII

THE NEW YORK FALSE CLAIMS ACT (the "Act"), NY CLS ST. FIN. § 189 et seq.

290. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

291. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 189(1)(a), of the Act. Such claims caused actual damages to the State.

292. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 189(1)(b), of the Act. Such claims caused actual damages to the State.

293. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXIV

NORTH CAROLINA FALSE CLAIMS ACT (the "Act")
N.C. GEN. STAT. §1-607(A) et seq.

294. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

295. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 1-607(A)(1), of the Act. Such claims caused actual damages to the State.

296. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 1-607(A)(2), of the Act. Such claims caused actual damages to the State.

297. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXV

OKLAHOMA MEDICAID FALSE CLAIMS ACT (the "Act")
OKLA. STAT. TIT. 63, §5053.1B et seq.

298. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

299. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 5053.1B(1), of the Act. Such claims caused actual damages to the State.

300. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 5053.1B(2), of the Act. Such claims caused actual damages to the State.

301. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXVI

RHODE ISLAND FALSE CLAIMS ACT (the "Act")
R.I. GEN. LAWS §9-1.1-3 et seq.

302. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

303. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 9-1.1-3(a)(1), of the Act. Such claims caused actual damages to the State.

304. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 9-1.1-3(a)(2), of the Act. Such claims caused actual damages to the State.

305. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXVII

THE TENNESSEE MEDICAID FALSE CLAIMS ACT (the "Act"), TENN. CODE ANN. §§ 71-5-182(a) et seq.

306. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

307. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 71-5-182(a)(1)(A), of the Act. Such claims caused actual damages to the State.

308. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 71-5-182(a)(1)(B), of the Act. Such claims caused actual damages to the State.

309. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXVIII

TEXAS MEDICAID FRAUD PREVENTION ACT TEX. HUM. RES. CODE ANN. §36.002 ET SEQ.

310. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

311. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 36.002(1), of the Act. Such claims caused actual damages to the State.

312. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 36.002(4), of the Act. Such claims caused actual damages to the State.

313. Through these acts, Defendant knowingly made a claim for a product that has been adulterated, debased, mislabeled or that is otherwise inappropriate in violation of Section 36.002(7). Such claims caused actual damages to the State.

314. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXIX

THE VIRGINIA FRAUD AGAINST TAXPAYERS ACT (the "Act"), VA. CODE §§ 8.01-216.3A ET SEQ.

315. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

316. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 8.01-216.3A(1), of the Act. Such claims caused actual damages to the State.

317. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 8.01-216.3A(2), of the Act. Such claims caused actual damages to the State.

318. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXX

WISCONSIN FALSE CLAIMS FOR MEDICAL ASSISTANCE ACT (the "Act") WIS. STAT. §20.931(2) ET SEQ.

319. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

320. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section 20.931(2)(a), of the Act. Such claims caused actual damages to the State.

321. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section 20.931(2)(b), of the Act. Such claims caused actual damages to the State.

322. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

COUNT XXXI

COLORADO MEDICAID FALSE CLAIMS ACT (the "Act")
Colorado Stat. §§25.5-4-304 - 25.5-4-310

323. Relator re-alleges and incorporates by reference each and every allegation contained in the paragraphs above as though fully set forth herein.

324. Through these acts, the Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment to the State in violation of Section §§25.5-4-304 - 25.5-4-310), of the Act. Such claims caused actual damages to the State.

325. Through these acts, the Defendants knowingly made, used, or caused to be made or used false records or statements material to a false or fraudulent claim to the State, in violation of Section §§25.5-4-304 - 25.5-4-310of the Act. Such claims caused actual damages to the State.

326. Through these acts, and further as set forth in the preceding three paragraphs, Defendants conspired with nursing homes to commit violations of the Act. By virtue of this conspiracy, the State has suffered actual damages.

REQUESTS FOR RELIEF

WHEREFORE, Relator, on behalf of the United States and the Plaintiff States, demands that judgment be entered in their favor and against Defendants for the maximum amount of damages and such other relief as the Court may deem appropriate on each Count. This includes, with respect to the Federal False Claims Act, three times the amount of damages to the Federal Government plus civil penalties of no more than Eleven Thousand Dollars ($11,000.00) and no less than Five Thousand Five Hundred Dollars ($5,500.00) for each false claim, and any other recoveries or relief provided for under the Federal False Claims Act.

This Request also includes, with respect to the state statutes cited above, the maximum damages permitted by those statutes and the maximum fine or penalty permitted by those statutes, and any other recoveries or relief provided for under the State FCA's.

Further, Relator requests that he receive the maximum amount permitted by law of the proceeds of this action or settlement of this action collected by the United States and the Plaintiff States, plus reasonable expenses necessarily incurred, and reasonable attorneys' fees and costs. Relator requests that his award be based upon the total value recovered, both tangible and intangible, including any amounts received from individuals or entities not parties to this action.

DEMAND FOR JURY TRIAL

A jury trial is demanded in this case.

Dated: September 19, 2013

Respectfully submitted,

s/ Lisa J. Rodriguez

Lisa J. Rodriguez
Schnader Harrison Segal & Lewis LLP
Woodland Falls Corporate Park
220 Lake Drive East, Suite 200
Cherry Hill, NJ 08002-1165
(856) 482-5222
ljrodriguez@schnader.com

BERGER & MONTAGUE, P.C.
Sherrie R. Savett (PA Bar No. 17646)
Daniel R. Miller (PA Bar No. 68141)
Shauna B. Itri (NJ Bar No.044372005; PA Bar No. 201611)
1622 Locust Street
Philadelphia, PA 19103
(215) 875-3000
ssavett@bm.net
dmiller@bm.net
sitri@bm.net