No. _____

In the Supreme Court of the United States

BOYD & ASSOCIATES,
PETITIONER
V.
BRYAN K. WHITE, M.D., ET AL.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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[A1]

United States Court of Appeals
for the Fifth Circuit

No. 19-11309

Christopher Sean Capshaw,

Plaintiff,

versus

Bryan K. White, M.D., *Individually*,

Defendant,

United States of America, *ex rel.*, Kevin Bryan; Franklin Brock Wendt,

Plaintiffs—Appellants,

Boyd & Associates; Marchand & Rossi, L.L.P., *now known as* Marchand Law, L.L.P.,

Appellants,

versus

Bryan K. White, M.D., *Individually*; Be Gentle Home Health, Incorporated, *doing business as* Phoenix Home Health Care; Suresh Kumar, R.N., *Individually*; Goodwin Home Health Services, Incorporated; Vinayaka Associates, L.L.C., *doing business as* A&S Home Health Care; Goodwin Hospice, L.L.C.; North Texas Best Home

Healthcare, Incorporated; Excel Plus Home Health, Incorporated; Phoenix Hospice, Incorporated; One Point Home Health Services, L.L.C., formerly known as One Point Home Health, L.L.C.; Home Health Plus, Incorporated; International Tutoring Services, L.L.C., formerly known as International Tutoring Services, Incorporated, doing business as Hospice Plus; Curo Health Services, L.L.C., formerly known as Curo Health Services, Incorporated; Hospice Plus, L.P.,

Defendants—Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 3:12-CV-4457
USDC No. 3:13-CV-3392
Filed July 30, 2021

Before Jolly, Stewart, and Oldham, Circuit Judges.
Per Curiam:*

Qui tam relator Christopher Capshaw sued Bryan White, Suresh Kumar, and other defendants under the False Claims Act ("FCA"), 31 U.S.C. § 3729

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* Pursuant to 5th Circuit Rule 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5th Circuit Rule 47.5.4.

et seq. In addition to violations of the FCA, Capshaw alleged violations of the Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, and a federal statute known as the Stark Law, 42 U.S.C. § 1395nn. Specifically, he alleged that White and Kumar "knowingly set up a system of kickbacks and illegal referrals" between American Physician House Calls ("APH") and health care companies that White and Kumar owned. This enabled White and Kumar to "substantially bill" and "receive payment from" Medicare— but only after falsely certifying they had complied with all applicable laws.

Nine months later, Appellants Kevin Bryan and Franklin Wendt filed a similar action against the same and similar defendants. They too alleged violations of the FCA, the Anti-Kickback Statute, and the Stark Law. They too alleged that White and Kumar "directed and committed . . . illegal kickbacks in order to increase [their] . . . number of patients." And they too alleged that APH was "an important source of patient referrals." But Bryan and Wendt's complaint was not completely identical to Capshaw's. In addition to seeking relief under the FCA, they relied on "analogous Texas statutes" like the Texas Medicaid Fraud Prevention Act ("TMFPA"). And in addition to describing a kickback scheme involving APH, they alleged that White and Kumar offered kickbacks to nursing homes, assisted living facilities, and hospitals too.

The district court dismissed Bryan and Wendt's claims under the FCA's first-to-file bar, which prohibits relators from bringing "a related action based on the facts underlying" a pending FCA

qui tam action. 31 U.S.C. § 3730(b)(5). The court determined that Bryan and Wendt's "add[itional] factual details" and "analog[ous]" TMFPA claims were not sufficient to render their action "unrelated" to Capshaw's. So the first-to- file bar applied. The district court subsequently denied Bryan and Wendt's motion for reconsideration.

Despite the district court's dismissal, Bryan and Wendt entered a settlement agreement that released the defendants from their FCA and TMFPA claims and reserved the right "to assert their claims for reasonable expenses, attorney's fees, and costs." Bryan and Wendt later filed three motions for attorney's fees. The district court denied all of them because the first-to-file bar meant Bryan and Wendt were not proper parties to the qui tam action. Bryan and Wendt filed a motion for reconsideration, which the district court also denied. This appeal followed.

We affirm "for essentially the reasons stated by the district court." *Razvi v. Guarantee Life Ins.,* 254 F.3d 1080 (5th Cir. 2001) (per curiam) (unpublished). The district court thoroughly examined the issues in five separate decisions and faithfully applied the statutory text and our precedent in doing so. We see no reason to disturb or expound upon its rulings.

AFFIRMED.

[A5]

Filed 02/12/20

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. 3:12-CV-4457-N

UNITED STATES OF AMERICA, et al.,
ex rel. CHRISTOPHER SEAN
CAPSHAW,

Plaintiffs, §

v.

BRYAN K. WHITE, M.D., et al., §

Defendants.

MEMORANDUM OPINION AND ORDER

This Order addresses the motion for attorney's fees [453] and motion to amend [455] filed by Relators Kevin Bryan and Brock Wendt (collectively, "dismissed relators") and their counsel, Boyd and Associates ("B&A"). For the reasons below, the Court denies the motion for fees. The Court moots the motion to amend per the parties' notice of withdrawal of that motion [461].

[A6]

I. ORIGIN OF THE DISPUTE

This fees dispute arises from a consolidated qui tam action based on an alleged scheme of illegal kickbacks between the named Defendants that was brought by Relator Christopher Capshaw "Capshaw") and the dismissed relators. January 23, 2017, Order 2–6 [256]. In 2015, the Department of Justice began negotiating a settlement agreement with Defendants International Tutoring Services, LLC, Goodwin Hospice, LLC, Phoenix Hospice, LP, Hospice Plus, LP, and Curo Health Services, LLC (collectively, "Settlement Defendants"). July 10, 2017, Order 1 [394]. Prior to final execution of the settlement, this Court dismissed Bryan and Wendt. January 23, 2017, Order 2 [256]. The dismissed relators subsequently moved for attorneys' fees and to enforce settlement [314], and B&A moved for attorney's fees [296]. The movants argued that they were entitled to mandatory statutory attorneys' fees under section 3730(d) of the False Claims Act ("FCA") or, alternatively, that the Settlement Defendants agreed to pay reasonable attorneys' fees and that the Court should enforce an alleged oral settlement agreement. July 10, 2017, Order 1–2 [394]. The Court found that neither section 3730(d) nor the oral contract theory supported an award of attorneys' fees. *Id.* At 5, 10. Subsequently, the Court declined the dismissed relators' motion to reconsider [411] its decision on the motion for attorneys' fees. December 11, 2018, Order 1 [433].

On October 2, 2019, the Court granted the United States and Capshaw's unopposed motion to

dismiss all remaining claims. October 2, 2019, Order [452]. The following day, the dismissed relators and B&A filed this motion for statutory attorneys' fees under the Texas Medicaid Fraud Prevention Act ("TMFPA") [453]. They also moved to amend [455] the Court's Order of dismissal to include a statement reserving jurisdiction to decide awards of attorneys' fees but later filed a notice of withdrawal of that motion [466]. The Court addresses these motions in turn.

II. LEGAL STANDARDS

A. Jurisdiction to Decide Motions for Attorneys' Fees

"It is well established that a federal court may consider collateral issues after an action is no longer pending." *Cooter & Gell v. Hartmarx*, 496 U.S. 384, 395 (1990). The Supreme Court has specifically held that "motions for costs or attorney's fees are independent proceeding[s] supplemental to the original proceeding and not a request for a modification of the original decree." *Id.* (internal quotation omitted). A district court retains jurisdiction to decide motions for attorneys' fees and costs even when dismissal is voluntary. *Yesh Music v. Lakewood Church*, 727 F.3d 356, 363 (5th Cir. 2013)("[V]oluntary dismissals do not deprive courts of the jurisdiction to award attorneys' fees.") (internal citation omitted).

B. Statutory Attorneys' Fees

The Texas Medicaid Fraud Prevention Act provides that a person bringing an action under that chapter is "entitled to receive from the defendant an amount for reasonable expenses, reasonable attorney's fees, and costs that the court finds to have been necessarily incurred" if the defendant is found liable or the claim is settled. TEX. HUM. RES. CODE § 36.110(c). The federal False Claims Act has a similar statutory attorneys' fees provision. In the Fifth Circuit, "[o]nly those parties that are properly a part of the qui tam action are statutorily entitled to the award of attorneys' fees and expenses." *Fed. Recovery Servs., Inc. v. United States*, 72 F.3d 447, 450 (5th Cir. 1995). Where relators are not proper parties to a qui tam action due to one of the federal False Claims Act's jurisdictional bars, their attorneys "are not statutorily entitled to attorneys' fees and expenses." *Id.* at 453.

While there is a circuit split on the issue, Fifth Circuit precedent treats the FCA's first-to-file rule as a "jurisdictional bar." *Compare U.S. ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 373 (5th Cir. 2009); *U.S. ex rel. Ven-A-Care of the Fla. Keys, Inc. v. Baxter Healthcare Corp.*, 772 F.3d 932, 936 (1st Cir. 2014) ("The 'first-to-file' rule is, at least in this Circuit, jurisdictional."), *with U.S. ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 121 (D.C. Cir. 2015) (holding that the first-to-file bar is not jurisdictional and "bears only on whether a *qui tam* plaintiff has properly stated a claim"). The FCA first-to-file rule bars "related action[s]" alleging the same

material elements of fraud alleged in a prior-filed FCA action. 31 U.S.C. 3730(b)(5); *Branch Consultants*, 560 F.3d at 378.

III. THE COURT MOOTS THE MOTION TO AMEND

Although B&A's motion to amend was filed after its motion for attorneys' fees under TMFPA, the Court addresses it first because it raises the question whether this Court has jurisdiction to decide motions for attorneys' fees following the voluntary dismissal of all remaining claims in this case. District courts have jurisdiction to decide issues collateral to a case — such as awards of attorneys' fees — after rendering final judgment, even when dismissal is voluntary. *Cooter & Gell*, 496 U.S. at 395; *Yesh Music*, 508 F.3d at 231. It is thus unnecessary for this Court to amend its order of dismissal to expressly reserve jurisdiction to decide motions for attorneys' fees and costs. Further, the movants filed a notice withdrawing their motion to amend. The Court accordingly moots the motion to amend [455].

IV. THE COURT DENIES THE MOTION FOR FEES

This Court previously found that all the dismissed relators' claims, including their TMFPA claims, were barred by the FCA's first-to-file rule. January 23, 2017, Order 9–11 [256]. Section 3730(b)(5) expressly states that when "a person

brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. 3730(b)(5); *see also Branch Consultants*, 560 F.3d at 378 (explaining that when a "later-filed complaint alleges the same material or essential elements of fraud described in a pending *qui tam* action, §3730(b)(5)'s jurisdictional bar applies"). Here, the dismissed relators filed their complaint in August 2013, nearly a year after Capshaw filed his complaint. Relators' Joint Mtn. Consolidate 2 [16]. The Court found that the dismissed relators' complaint was based on the same material elements of fraud described in Capshaw's first-filed complaint. January 23, 2017, Order 8–9 [256]. Although the dismissed relators' complaint contained new allegations not included in Capshaw's complaint, the Court found that these facts would have been discovered by investigation into Capshaw's allegations. *Id.* at 9; *see United States v. Planned Parenthood of Houston*, 570 F. App'x 386, 389 (5th Cir. 2014) ("The focus is on whether an investigation into the first claim would uncover the same fraudulent activity alleged in the second claim.").

The Court further determined that the fact that the dismissed relators also brought TMFPA claims — and that they were the first relators to raise claims under TMFPA —did not alter the outcome because the TMFPA claims were based on the same material elements of fraud alleged in Capshaw's first-filed action. January 23, 2017, Order 10 [256]. Section 3730(b)(5) operates to bar duplicative qui tam actions that are based on the

same core fraud at issue in first-filed actions. *See Planned Parenthood of Houston*, 570 F. App'x at 389 (observing that the FCA's jurisdictional limits, "including its first-to-file bar," seek to discourage "parasitic lawsuits that merely feed off previous disclosures of fraud") (internal citation omitted). Nothing in the FCA first-to-file bar limits its language to later-filed FCA actions alleging FCA claims. Rather, the FCA language is global in scope and bars "a *related action*" — not just other FCA actions — premised on the same core facts underlying a pending FCA action.[1] § 3730(b)(5) (emphasis added); *see Planned Parenthood of Houston*, 570 F. App'x at 389 ("The first-to-file bar is a relatively broad bar to later-filed actions."); *Branch*, 560 F.3d at 377 ("[A] broader bar furthers the purpose of the FCA's *qui tam* provisions.") (internal citation omitted).

TMFPA is a state law analog to the FCA and is aimed at preventing the same type of acts. Permitting a later-filed action alleging the same core facts as a prior-filed FCA action to continue merely because it involves state law claims would create a run-around the FCA's first-to-file bar and frustrate "the accomplishment and execution of the full purposes and objectives of Congress" evidenced by the FCA's text.[2] *See City of El Cenizo, Tex. v. Texas*, 890 F.3d 164, 178 (5th Cir. 2018) (observing that conflict preemption occurs when a state law prevents the accomplishment of federal law purposes); *see also Planned Parenthood*, 570 F. App'x at 389 (observing that one purpose of the FCA is to "encourage suits from whistleblowers with genuinely valuable

information" while preventing duplicative actions) (internal quotation omitted). The Court thus declined to impose an atextual limit on the FCA and dismissed Relators Bryan and Wendt.

Subsequently, the Court denied the dismissed relators and B&A's motions for statutory attorneys' fees under the FCA [296] [314]. July 10, 2017, Order 1 [394]. Once this Court determined that the dismissed relators were not proper parties and that it lacked subject matter jurisdiction over their claims, it could not award statutory attorney's fees for efforts expended litigating those claims. July 10, 2017, Order 3–5 [394]; *see Fed. Recovery Servs., Inc. v. United States*, 72 U.S. 447, 450, 453 (5th Cir. 1995).

This motion seeks statutory attorneys' fees under the TMFPA. In the briefing for this motion, the dismissed relators, B&A, and the State of Texas argue that the FCA's first-to-file rule does not bar TMFPA claims raised for the first time, even if based on the same core facts as a prior-filed qui tam action, and that this Court consequently has jurisdiction over the TMFPA claims and may award attorneys' fees under TMFPA. The dismissed relators and B&A also reiterated their oral contract theory for attorneys' fees.

As discussed, these arguments have already been presented by the dismissed relators and B&A and rejected in the Court's prior Order. January 23, 2017, Order 6–10 [256]. The parties have cited no new authority decided since the Court's January 2017 Order, and the Court sees no reason to reconsider its judgment. While the TMFPA first-to-file rule is not implicated here, the FCA's first-to-file bar does apply. Consequently, the Fifth Circuit

opinions interpreting the effect of the FCA's first-to-file bar — holding that attorneys' fees are not available when an FCA jurisdictional bar, like the first-to-file rule, precludes a party fr om bringing an action — should apply here and bar any statutory attorneys' fees. *See Branch Consultants*, 560 F.3d at 373; *Fed. Recovery Servs., Inc.*, 72 F.3d at 450–53. Because the FCA first-to-file rule bars both subsequent FCA and TMFPA claims based on the same core facts alleged in a prior FCA action, the Court lacks jurisdiction over all the dismissed relators' claims. Accordingly, the Court has no authority to award TMFPA statutory fees and denies the dismissed relators' and B&A's motion for attorney's fees [453].

CONCLUSION

Because the movants have withdrawn their motion to amend this Court's order dismissing the case, the Court moots the motion to amend. The Court also denies the motion to award statutory attorneys' fees under TMFPA because it lacks jurisdiction over movants and their claims.

Signed February 12, 2020.

_____

David C. Godbey
United States District Judge

Footnotes

1 TMFPA also has a first-to-file rule. TEX. HUM. RES. CODE § 36.106. Like the FCA rule, the TMPFA rule prohibits "related" actions sharing the same core facts as a priorfiled action "brought under this subchapter"—in other words, a previously filed TMFPA case. *Id.* Because Capshaw's prior-filed complaint did not bring TMFPA claims and because the dismissed relators were the first to bring TMPFA claims related to this fraud, the TMFPA first-to-file rule does not apply to the dismissed relators. That is immaterial to the outcome here, however, because the FCA first-to-file rule does apply. A state law cannot shield the parties from an applicable, more restrictive federal law.

2 The dismissed relators observe that the FCA grants district courts "jurisdiction over any action brought under the laws of any State for the recovery of funds paid by a State or local government if the action arises from the same transaction or occurrence as an action brought under section 3730." 31 U.S.C. 3732(b). While this is true, section 3730(b)(5), which declares without limitation that any "related actions" sharing the same core fraud as a *prior-filed* FCA action are barred, should be read to modify the grant of jurisdiction to cover only state law claims brought in conjunction with an FCA action.

[A15]

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. 3:12-CV-04457-N
Filed October 2, 2019

UNITED STATES OF AMERICA, *et al.,*
ex rel. CHRISTOPHER SEAN CAPSHAW,

Plaintiffs,

v.

BRYAN K. WHITE, M.D., *et. al.*,

Defendants.

ORDER

Before the Court is the United States of America and Relator Christopher Sean Capshaw's Joint Unopposed Motion to Dismiss the remaining claims in this action with prejudice pursuant to Rule 41(a)(2) of the Federal Rules of Civil Procedure and the *qui tam* provisions of the False Claims Act, 31 U.S.C. §§ 3729. In the Motion, the United States moves to dismiss its Complaint in Partial Intervention [311] with prejudice, while Relator Capshaw moves to dismiss the claims he has asserted on behalf of himself and on behalf of the United States and the State of Texas in his Second Amended Joint Complaint [278], with prejudice. The

Defendants have not filed any counterclaims or cross-claims in the action, and do not oppose the Joint Motion. Further, the United States and Texas have consented to Relator Capshaw's dismissal of their claims in this action with prejudice. Accordingly, having considered the Motion, the Court finds that the Motion should be and hereby is GRANTED.

IT IS THEREFORE ORDERED that the remaining claims asserted in this action by Relator Capshaw (for himself, and on behalf of the United States and Texas) and by the United States should be and hereby are dismissed with prejudice.

SIGNED this 2nd day of October, 2019.

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DAVID C. GODBEY
UNITED STATES DISTRICT JUDGE

[A17]

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. 3:12-CV-4457-N
Filed July 10, 2017

UNITED STATES OF AMERICA *ex rel.*,
CHRISTOPHER SEAN CAPSHAW, *et al.*,

Plaintiffs,

v.

BRYAN K WHITE, *et al.*,

Defendants.

ORDER

This Order addresses Kevin Bryan and Franklin Brock Wendt's (collectively, "dismissed relators") counsel, Marchand & Rossi, LLP's ("M&R") motion for attorneys' fees and motion to enforce settlement [314] and Boyd & Associates' ("B&A") motion for attorneys' fees [296]. The Court denies the motions.

I. ORIGINS OF THE DISPUTE

This case is a consolidated qui tam action that arises out of an alleged scheme of illegal kickbacks between the named Defendants brought by relators Christopher Capshaw and the dismissed relators. The Court presumes familiarity of the underlying facts of this lawsuit as set forth in the Court's January 23, 2017 Order. As part of this ongoing qui tam action, the Department of Justice ("DOJ") negotiated a settlement with Defendants International Tutoring Services, LLC, Goodwin Hospice, LLC, Phoenix Hospice, LP, Hospice Plus, LP, and Curo Health Services, LLC (collectively, the "Settlement Defendants") in summer 2015. The DOJ informed the relators of the settlement and then moved to partially intervene for the purpose of settlement against the Settlement Defendants. *See* Order, October 6, 2016 [235]. The relators' attorneys then began negotiations for determination of attorneys' fees to be included in the final settlement. Prior to the final execution of the settlement, the Court dismissed relators Bryan and Wendt under the first-to-file rule. *See* Order, January 23, 2017. While the Settlement Defendants agreed to pay remaining relator, Christopher Capshaw's attorneys $400,000, the Settlement Defendants and B&A and M&R, respectively, did not reach such an agreement on reasonable attorneys' fees. Instead, the final settlement agreement, executed in March, reserved the rights of the dismissed relators "to assert their claims for reasonable expenses, attorney's fees, and costs under 31 U.S.C. § 3730(d), or upon any other

legal grounds or theory." *See* App. to M&R Mot. for Att'ys' Fees Ex. J (hereafter "Settlement Agreement") 134, ¶ 3 [314-1]. As part of the settlement, the relators received $2,420,852.00. *Id.* at ¶ 2.

B&A now moves under Federal Rule of Civil Procedure 54(d) for statutory attorneys' fees in the amount of $1,122,905.68. *See* Mot. for Approval and Award of Statutory Attorneys' Fees (hereafter "B&A Mot. for Attorneys' Fees") 3 [296]. B&A first contends they are entitled to mandatory statutory attorneys' fees under section 3730(d) of the False Claims Act("FCA"). In the alternative, B&A contends the Settlement Defendants agreed to pay reasonable attorneys' fees, and the Court should enforce an alleged oral settlement agreement or a settlement agreement in principle. *See* B&A Mot. for Attorneys' Fees 8.

M&R likewise moves for statutory attorneys' fees under section 3730(d) of the FCA in the amount of $561,423.11. *See* Mot. for Approval and Award of Reasonable Expenses, Attorney's Fees, and Costs and Mot. to Enforce Settlement (hereafter "M&R's Mot. For Attorneys' Fees") [314]. M&R also moves to enforce the settlement agreement. *Id.* at 12. M&R likewise claims that per an alleged implied contract, the Settlement Defendants are bound by agreement to pay M&R's reasonable attorneys' fees, as determined by the Court.

II. THE COURT DENIES THE MOTIONS

A. Neither B&A nor M&R are Statutorily Entitled to Attorneys' Fees

The False Claims Act ("FCA") provides that parties are entitled to "an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs" in addition to any share of the proceeds of the litigation or settlement. 31 U.S.C. § 3730(d)(1). In the Fifth Circuit, "[o]nly those parties that are properly a part of the qui tam action are statutorily entitled to the award of attorneys' fees and expenses." *Fed. Recovery Servs., Inc. v. United States*, 72 F.3d 447, 450 (5th Cir. 1995). Thus where relators are not proper parties to the qui tam action under one of the FCA's jurisdictional bars, their attorneys "are not statutorily entitled to attorneys' fees and expenses." *Id.* at 453. For instance, in *Federal Recovery Services,* the Fifth Circuit held that the attorneys of relators barred by the public disclosure jurisdictional bar set forth in section 3730(e)(4)(A) of the FCA, were not statutorily entitled to attorneys' fees and expenses. *Id.* at 450, 454. Thus, B&A and M&R's statutory right to attorneys' fees "depends in the first instance upon their client's status as a party in the case." *Id.* at 450.

The Fifth Circuit treats the first-to-file rule as a "jurisdictional bar." *See, e.g. U.S. ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 373 (5th Cir. 2009). Cases from district courts within the Fifth Circuit likewise confirm that the first-to-file

rule is "jurisdictional in nature," and routinely dealt with under a motion to dismiss under Rule 12(b)(1). *U.S. ex rel. Denenea v. Allstate Ins. Co.*, 2011 WL 231780, at *2 (E.D. La. 2011); *see also United States v. Planned Parenthood of Houston*, 570 F. App'x 386, 390 (5th Cir. 2014) (reviewing district court's dismissal of later filed qui tam complaint under motion to dismiss for lack of jurisdiction). B&A and M&R contend that unlike the public disclosure bar at issue in *Federal Recovery Services,* the first-to-file rule does not implicate the Court's subject matter jurisdiction. Under this argument, the first-to-file rule implicates only a relator's statutory standing and therefore Brock and Wendt, despite being dismissed relators, are still entitled to statutory attorneys' fees. B&A and M&R rely primarily on a recent Supreme Court case, *Kellogg Brown & Root Servs., Inc. v. U.S., ex rel. Carter*, 135 S. Ct. 1970 (2015). In *Carter,* the Supreme Court addressed the relevant statute of limitations before the first-to-file rule. *See* 135 S. Ct. at 1978. According to B&A and M&R, the Supreme Court would not have addressed a limitations issue before a jurisdictional issue and thus the first-to-file rule is not a jurisdictional bar.

There is a clear circuit split as to whether the first-to-file rule is jurisdictional. *Compare U.S. ex rel. Ven-A-Care of the Florida Keys, Inc. v. Baxter Healthcare Corp.*, 772 F.3d 932, 936 (1st Cir. 2014) ("The 'first-to-file' rule is, at least in this Circuit, jurisdictional."), *with U.S. ex rel. Heath v. AT & T, Inc.*, 791 F.3d 112, 119 (D.C. Cir. 2015) (holding the first-to-file bar is not jurisdictional and "the first-to-file rule bears only on whether a *qui tam* plaintiff has

properly stated a claim"); *see also U.S. ex rel. Carter v. Halliburton Co.*, 144 F. Supp. 3d 869, 881 n.6 (E.D. Va. 2015) (collecting cases). At present, both the D.C. Circuit and the Second Circuit have held that the first-to-rile rule is not jurisdictional, in part relying on the Supreme Court's recent decision in *Carter*. *See United States ex rel. Hayes v. Allstate Ins. Co.*, 853 F.3d 80, 85 (2d Cir. 2017). However absent controlling law that the first-to-file rule is not jurisdictional, this Court is bound by Fifth Circuit precedent. At least one court within the Fifth Circuit that has addressed this issue post *Carter* continued to treat the first-to-file bar as jurisdictional under the precedent established in *Branch Consultants*. *See United States ex rel. Doe v. Lincare Holdings, Inc.*, 2017 WL 752288, at *3 (S.D. Miss. 2017) (holding putative relator's complaint was "jurisdictionally barred" and dismissing the complaint under Rule 12(b)(1)). Moreover courts in other circuits that likewise treat the first-to-file rule as jurisdictional have continued to do so post *Carter*. *See United States ex rel. Cunningham v. Millennium Labs., Inc.*, 202 F. Supp. 3d 198, 204 (D. Mass. 2016); *see also Halliburton*, 144 F. Supp. 3d at 881 n.6 (refusing to deviate from clearly established precedent that the first-to-file rule is jurisdictional "absent contrary controlling law on the issue"). Accordingly, the Court holds the first-to-file rule remains a jurisdictional bar and under the clear precedent established in *Federal Recovery Services,* Bryan and Wendt were not proper parties to the qui tam action and thus are not statutorily entitled to attorneys' fees or expenses. *See* 72 F.3d at 450.

B. There Is No Valid Implied Contract To Pay Movants' Attorneys' Fees

Thus the Court is left to address the attorneys' claims that the Court should enforce an alleged implied contract to pay attorneys' fees. The movants contend that the Settlement Defendants agreed to pay the relators' reasonable and necessary attorneys' fees, costs and expenses (collectively "fees"), to be determined by negotiation or if necessary by petition to the Court. *See* B&A Reply 1 [367]. The movants argue that the communications between them and the Settlement Defendants' counsel indicate the Settlement Defendants agreed to pay the fees and that based on the Settlement Defendants' conduct it was reasonable for the relators to believe the Settlement Defendants had agreed to pay reasonable fees.

"'[A] district court has inherent power to recognize, encourage, and when necessary enforce settlement agreements reached by the parties.'" *Shepherd v. Wells Fargo Bank*, 2016 WL 4435267, at *2 (W.D. Tex. 2016) (quoting *Bell v. Schexnayder*, 36 F.3d 447, 449 (5th Cir. 1994)). "[S]ettlement agreements, when fairly arrived at and properly entered into, are generally viewed as binding, final and as conclusive of the rights of the parties as is a judgment entered by the court." *Rodriguez v. VIA Metro. Transit Sys.*, 802 F.2d 126, 128 (5th Cir. 1986) (*citing Thomas v. Louisiana*, 534 F.2d 613, 615 (5th Cir. 1976)). "Questions regarding the enforceability or validity of such agreements are determined by

federal law—at least where the substantive rights and liabilities of the parties derive from federal law." *Mid-S. Towing Co. v. Har-Win, Inc.*, 733 F.2d 386, 389 (5th Cir. 1984). "Whether there is an agreement is governed by the federal common law of contracts, which uses the core principles of the common law of contracts that are in force in most states." *Smith v. United States*, 328 F.3d 760, 767 n.8 (5th Cir. 2003) (internal quotations omitted). Because "'federal contract law is largely indistinguishable from general contract principles under state common law,' the court may rely on federal cases, state contract law cases, and other treatises to the extent it finds them persuasive." *Goodman v. Smart Modular Techs., Inc.*, 2016 WL 4435436, *2 (S.D. Tex. 2016) (quoting *In re Deepwater Horizon*, 786 F.3d 344, 354–55 (5th Cir. 2015)).

As a threshold matter, the parties do not challenge the validity of the settlement agreement itself, and the Court is satisfied that the settlement agreement is an enforceable contract. *See In re Capo Energy, Inc.*, 669 F.3d 274, 279–80 (5th Cir. 2012) (noting that in order to form an enforceable contract, there must be "(1) an offer; (2) an acceptance in strict compliance with the terms of the offer; (3) a meeting of the minds; (4) each party's consent to the terms; and (5) execution and delivery of the contract with intent that it be mutual and binding"). Nor is there any ambiguity as to the terms of the settlement agreement. "The primary goal of contract construction "is to ascertain and give effect to the parties' intent as expressed by the words they chose to effectuate their agreement." *In re Deepwater*

Horizon, 470 S.W.3d 452, 464 (Tex. 2015). "[E]very contract should be interpreted as a whole and in accordance with the plain meaning of its terms" such that "no provision is rendered meaningless." *Great Am. Ins. Co. v. Primo*, 2017 WL 749870, at *2 (Tex. 2017). "Unambiguous language must be enforced as it is written." *Goodman*, 2016 WL 4435436, at *2 (citing *Don's Bldg. Supply v. One Beacon Ins.*, 267 S.W.3d 20, 23 (Tex. 2008)). "'Only where a contract is first determined to be ambiguous may the courts consider the parties' interpretation and admit extraneous evidence to determine the true meaning of the instrument.'" *Id.* (quoting *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., v. CBI Indus., Inc.*, 907 S.W.2d 517, 520 (Tex. 1995)).

Here, there is no ambiguity as to the terms of the settlement agreement. The agreement clearly states that the Settling Defendants agreed to pay Capshaw $400,000.00 for reasonable expenses and attorneys' fees and that nothing in the agreement "shall be construed in any way to release, waive, or otherwise affect the rights of Dismissed Relators Kevin Bryan and Brock Wendt to assert their claims for reasonable expenses, attorney's fees, and costs pursuant to 31 U.S.C. § 3730(d), or upon any other legal grounds or theory." *See* Settlement Agreement 134, ¶ 3. The agreement also states "[d]ismissed relators Kevin Bryan and Brock Wendt reserve their right to claim their reasonable expenses, attorneys' fees, and costs under 31 U.S.C. § 3730(d), and Settling Defendants reserve their right to contest any such claims." *Id.* 136, ¶ 8. The Court has already determined that the dismissed relators are not

statutorily entitled to attorneys' fees under section 3730(d). Thus the Court is left to determine whether under any other legal ground or theory, the dismissed relators are entitled to fees.

The only other legal theory that the movants assert is that the Settlement Defendants agreed to pay attorneys' fees under an implied contract theory. B&A and M&R argue that the emails between the relators' counsel and the Settlement Defendants' counsel created an implied contract that the Court should enforce in principle. It is true that courts have been willing to enforce settlement agreements where not all terms are finalized or included in a written settlement agreement. Nor does the presence of an executed written settlement agreement foreclose the possibility that an agreement on attorneys' fees was reached prior to execution of the final settlement agreement. *See generally Neurovision Med. Prod., Inc. v. Medtronic Pub. Ltd. Co.*, 2017 WL 1247139 (E.D. Tex. 2017) (finding email exchange created an enforceable agreement prior to final written settlement, where plaintiff stated "we accept your offer" and email summarized terms, including payment amount). However, here there is no evidence that there was a valid implied contract as to the payment of the movants' fees.

The essential elements of a breach of implied contract action are "the existence of a valid implied contract, performance or tendered performance by the plaintiff, breach of the implied contract by the defendants, and damages resulting from the breach." *Fisher v. Blue Cross & Blue Shield of Texas, Inc.*, 2015 WL 5603711, at *10 (N.D. Tex. 2015) (citing

Sports Supply Grp., Inc. v. Col. Gas Co., 335 F.3d 453, 465 (5th Cir. 2003)). In order to have a valid implied contract, there must be "(1) an offer; (2) an acceptance in strict compliance with the terms of the offer; (3) a meeting of the minds; (4) each party's consent to the terms; and (5) execution and delivery of the contract with intent that it be mutual and binding." *See In re Capo*, 669 F.3d at 279–80. Here, the email exchanges do not show any evidence of a valid implied contract. Particularly, there is no meaningful discussion as to the amount of fees, other than two proffered amounts by the movants and two denials by the Settlement Defendants. *See In re Deepwater Horizon*, 786 F.3d at 357 ("A putative contract is unenforceable if it lacks material or essential terms."). Moreover, there is also no evidence that there was mutual assent. Movants attempt to rely on the conduct of the Settlement Defendants to show assent. But the conduct of the Settlement Defendants indicates a willingness to settle on an amount of attorneys' fees to be included in the final settlement in order to avoid costly continued litigation, not an agreement to pay reasonable attorneys' fees. Instead, there is, in fact, evidence that the movants understood that the Settlement Defendants rejected the movants' offers. *See* App. in Support of Settlement Defs.' Resp. Ex. A, 3 [343]. Accordingly, there is no implied contract for the Court to enforce.

CONCLUSION

Based on the foregoing reasons, the Court denies the motions.

Signed July 10, 2017.

David C. Godbey
United States District Judge

[A29]

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. 3:12-CV-4457-N
Filed June 13, 2017

UNITED STATES OF AMERICA *ex rel.*,
CHRISTOPHER SEAN CAPSHAW, *et al.*,

Plaintiffs,

v.

BRYAN K WHITE, *et al.*,

Defendants.

ORDER

This Order addresses Kevin Bryan and Franklin Brock Wendt's (collectively, "dismissed relators") motion for reconsideration [285]. The Court denies the motion.

Federal Rule of Civil Procedure 54(b) empowers the Court to reconsider any order issued before judgment is entered. Fed. R. Civ. P. 54(b) ("any order . . . that adjudicates fewer than all the claims . . . of fewer than all the parties . . . may be revised at any time before the entry of a

judgment[.]"); *Saqui v. Pride Cent. Am., LLC*, 595 F.3d 206, 210–11 (5th Cir. 2010) ("when a district court rules on an interlocutory order, it is 'free to reconsider and reverse its decision for any reason it deems sufficient, even in the absence of new evidence or an intervening change in or clarification of the substantive law.'") (quoting *Lavespere v. Niagara Mach. & Tool Works, Inc.*, 910 F.2d 167, 185 (5th Cir. 1994) (*abrogated on other grounds by Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075 n.14 (5th Cir. 1994) (en banc))).

"Although the precise standard for evaluating a motion to reconsider under Rule 54(b) is unclear, whether to grant such a motion rests within the discretion of the court." *Dos Santos v. Bell Helicopter Textron, Inc. Dist.*, 651 F. Supp. 2d 550, 553 (N.D. Tex. 2009) (noting cases in which district courts considered for purposes of a Rule 54(b) motion "whether the movant [was] attempting to rehash its previously made arguments or [was] attempting to raise an argument for the first time without justification"). While the Rule 54(b) standard appears to be less exacting than the standards set forth in Rule 59(e) and Rule 60(b), "considerations similar to those under Rules 59 and 60 inform the Court's analysis." *Id.* The Court may "reconsider and reverse its decision *for any reason it deems sufficient*." *Lavespere*, 910 F.2d at 185 (emphasis added).

The dismissed relators contend the Court erroneously dismissed their claims under the first-to-file rule. *See* Order, January 23, 2017 [256]. The dismissed relators have not advanced any new argument in their motion to reconsider to alter the

Court's judgment in this regard. Accordingly, the Court denies the motion. Because the Court denies the motion, Defendants' Goodwin Home Healthcare Services, Inc., North Texas Best Home Healthcare, Inc., Vinayaka Associates, LLC and One Point Health's motion to strike dismissed plaintiffs' motion for reconsideration [305] and Defendant Suresh Kumar's motion to strike relators' motion to reconsider [307] are moot.

Signed June 13, 2017.

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David C. Godbey
United States District Judge

[A32]

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No. 3:12-CV-4457-N
Filed January 23, 2017

CHRISTOPHER SEAN CAPSHAW, *et al.*,

Plaintiffs,

v.

BRYAN K WHITE, *et al.*,

Defendants.

ORDER

This Order addresses Defendant Curo Health Services, LLC, f/k/a Curo Health Services, Inc. ("Curo") and Defendants Hospice Plus, L.P., Goodwin Hospice, LLC, and International Tutoring Services, LLC's (collectively, the "Hospice Providers") motion to strike the first amended joint complaint [143], Defendant Goodwin Home Healthcare Services, Inc.'s ("Goodwin") motion to dismiss [146], Defendant North Texas Best Home Healthcare Inc.'s ("North Texas Best") motion to dismiss [148], Defendant

Curo's motion to dismiss [150], Defendant Suresh Kumar's motion to dismiss [153], Defendant Vinayaka Associates, LLC d/b/a A&S Home Health Care's ("A&S") motion to dismiss [155], Defendant BE Gentle HomeHealth Inc. d/b/a Phoenix Home Healthcare's ("BE Gentle") motion to dismiss [157], the Hospice Providers' motion to dismiss [160], Defendant Bryan K. White's motion to dismiss [161], Defendant One Point Health Services LLC's ("One Point") motion to dismiss [166], the Defendant Phoenix Hospice, Inc.'s ("Phoenix Hospice") motion to dismiss [168], the United States of America's motion to intervene partially for good cause against Defendants Kumar and White [234], and Kumar's motion for leave to file sur reply to the government's motion to partially intervene [243]. The Court grants the motions in part and denies in part.

Because relators Kevin Bryan, Franklin Brock Wendt, and Sheila Whatley are barred by the first-to-file rule, the Court dismisses their claims under Rule 12(b)(1). Because the first amended joint complaint (FAJC) does not plead the conspiracy allegations against the remaining Defendants with sufficient particularity, the Court dismisses the conspiracy claims without prejudice. Because the FAJC does not plead the allegations against Defendant Kumar and White with sufficient particularity under Rule 9(b), the Court dismisses the claims against them without prejudice. Because the Court dismisses Bryan, Wendt, and Whatley, and because the Court does not find the Defendants are prejudiced by the filing of the FAJC, the Court denies Curo and the Hospice Providers' joint motion to strike the FAJC. Because the United States is unopposed to Kumar's motion for leave to file

surreply to the government's motion to partially intervene, the Court grants the motion. The clerk shall file exhibit B as Defendant Kumar's surreply. *See* Mot. for Leave to File Sur Reply 243 Ex. B [243-2]. Because the claims against White and Kumar are dismissed, the Court denies the United States' motion to intervene partially [234] as moot.

I. ORIGINS OF THE DISPUTE

This case arises out of an alleged scheme of illegal kickbacks between the named Defendants. First, the Sham Loan, Equity, and Rent Scheme involved alleged kickbacks paid by White, Kumar, Curo and the Curo/White/Kumar Part A Companies[1] 1(collectively, "The Sham Loan, Equity, and Rent Scheme Defendants") to Dr. Yale Sage, Kirk Short, and Sheila Whatley, employees of American Physician Housecalls ("APH") in the form of

> (1) free equity interest for Sage and Short in at least one White/Kumar-owned company [BE Gentle], (2) sham loans in the amount of approximately $2,500,000.00 from White to APH

1 The Curo/White/Kumar Part A Companies include BE Gentle, North Texas Best, A&S, Goodwin, the Hospice Providers, Phoenix Hospice, Home Health Plus, Inc., and Excel Plus Home Health, Inc. FAJC ¶ 79. Defendant One Point is no longer included in any allegations regarding the Sham Loan, Equity, and Rent Scheme as the Court granted a partial dismissal as to the Relators' claim that One Point participated in the Sham Loan, Equity, and Rent Scheme. *See* Order, Nov. 28, 2016 [244].

> (primarily owned by Sage), which were never intended to be repaid, and in fact were never repaid, (3) free leased space for APH for which rent was not paid on a monthly basis, and was never intended to be paid at fair market value, and (4) and [sic] cash.

FAJC ¶ 81 [87]. APH allegedly referred patients to the Sham Loan, Equity, and Rent Scheme Defendants because of these illegal kickbacks. *Id.* The FAJC sets forth representative examples of the allegedly kickback-induced illegal referrals. FAJC ¶¶ 99–132.

Second, the FAJC alleges a separate fraudulent scheme, the "Payola Scheme," in which the Payola Scheme Defendants2 bought patient referrals with gifts and payments. *Id.* ¶ 153. The Payola Scheme Defendants allegedly provided remuneration in exchange for patient referrals. *Id.* The purpose of the alleged Payola Scheme was "to defraud Medicare and Medicaid through an illegal kickback-for-referral scheme" in order to "maximize the payments they could receive from Medicare and/or Medicaid." *Id.* ¶ 149. In pursuit of this

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2 The Payola Defendants include White, Kumar, Curo, BE Gentle, North Texas Best, A&S, Goodwin, the Hospice Providers, Phoenix Hospice, Home Health Plus, Inc., Excel Plus Home Health, Inc., and One Point Health Services. FAJC ¶ 148. The FAJC originally also included Kumar's wife, Remani B. Kumar a/k/a Remani Amma, and Kumar's son, Sabari Kumar as Defendants in the Payola Scheme, but the Court granted their motions to dismiss. *See* Order, Nov. 28, 2016 [244].

purpose, the Payola Defendants allegedly cycled patients through the various Defendants' hospices "in order to 'game' Medicare's annual cap on payments for hospice patients, while still billing Medicare for home health services rendered to those patients while they were still 'on deck' [awaiting a new eligibility period] for further hospice care . . ." *Id.* ¶ 164.

Capshaw's original complaint, which he filed individually in 2012, alleged the Sham Loan, Equity, and Rent Scheme in violation of the FCA. *See* Original Compl. ¶ 34 [2]. Relators Bryan and Wendt filed their complaint in 2013 alleging the Payola scheme in violation of the FCA. *See generally* Bryan Complaint [2] *in U.S. ex rel. Bryan, et al. v. Hospice Plus LP, et. al*, Civil Action No. 13-CV-3392-N (N.D. Tex. filed Aug. 23, 2013). Capshaw, Bryan, and Wendt filed a motion to consolidate the cases, which the Court granted. *See* Order, May 15, 2014 [17]. Capshaw, Bryan, and Wendt then filed an amended complaint. *See* Am. Compl. [18]. Capshaw, Bryan, and Wendt filed their first amended joint complaint in 2015, adding Whatley, formerly a defendant, as a relator. *See generally* FAJC [87].

Capshaw, Bryan, Wendt, and Whatley's (collectively, the "Relators") FAJC brings seven claims against the Defendants. First, the Relators claim the Sham Loan, Equity, and Rent Scheme Defendants violated 31 U.S.C. § 3729(a)(1)(A) by participating in the Sham Loan, Equity, and Rent Scheme, which violated the Anti-Kickback Statute ("AKS"), 42 U.S.C. § 1320a-7a, and the Stark Law, 42 U.S.C. § 1395nn(a)(1), causing false and/or

fraudulent claims to be submitted to the United States government. *Id.* ¶ 338. Second, the Relators claim the Payola Defendants violated 31 U.S.C. § 3729(a)(1)(A) by participating in the Payola Scheme, which violated AKS and the Stark Law, causing false and/or fraudulent claims to be submitted to the United States government. *Id.* ¶ 343. Third, the Relators allege the Sham Loan, Equity, and Rent Scheme Defendants violated 31 U.S.C. § 3729(a)(1)(B) by participating in the Sham Loan, Equity, and Rent Scheme, which falsely stated or certified statements and reports used to comply with Medicare and Medicaid regulations which were material to a false or fraudulent claim. *Id.* ¶ 348. Fourth, the Relators claim the Payola Defendants violated 31 U.S.C. § 3729(a)(1)(B) by participating in the Payola Scheme, which falsely stated or certified statements and reports used to comply with Medicare and Medicaid regulations which were material to a false or fraudulent claim. *Id.* at 348. Fifth, the Relators claim the Sham Loan, Equity, and Rent Scheme Defendants violated 31 U.S.C. § 3729(a)(1)(C) by conspiring to participate in the Sham Loan, Equity, and Rent Scheme. *Id.* ¶ 358. Sixth, the Relators claim the Payola Defendants violated 31 U.S.C. § 3729(a)(1)(C) by conspiring to participate in the Payola Scheme. *Id.* ¶ 363. Seventh, the Relators claim the Sham Loan, Equity, and Rent Scheme Defendants violated the Texas Medicaid Fraud Prevention Law ("TMFPL") section 36.002. *Id.* ¶ 368.; *see also* TEX. HUM. RES. CODE § 36.001. Finally, the Relators claim the Payola Defendants violated TMFPL section 36.002. *Id.* ¶ 375.

The United States intervened on October 4, 2016 against Goodwin Hospice, LLC, International Tutoring Services LLC, Phoenix Hospice, and Curo. *See* Unopposed Mot. To Intervene [233]. The United States now moves to intervene against Defendants Kumar and White. *See* Mot. to Intervene Partially [234]. Kumar and White oppose the intervention. The Relators consent to the intervention. Because the Court dismisses the claims against White and Kumar, the government's motion to intervene is moot.

Defendants Goodwin, North Texas Best, Curo, Kumar, A&S, BE Gentle, the Hospice Providers, White, One Point Health Services, and Phoenix Hospice now move to dismiss correlators Whatley, Bryan, and Wendt under the first-to-file rule, and move to dismiss the FAJC's claims under Rule 12(b)(6). The Court grants the motions to dismiss under the first to-file rule and grants the motion to dismiss under 12(b)(6) in part and denies in part.

II. THE COURT DISMISSES WHATLEY, BRYAN, AND WENDT AS CO-RELATORS

A. First-To-File

Under the False Claims Act ("FCA") "no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). When a "later-filed complaint alleges the same material or essential elements of fraud described in a pending

qui tam action, § 3730(b)(5)'s jurisdictional bar applies." *U.S. ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009). The first-to-file jurisdictional bar is broad and operates to bar successive relators. *Id.* "The focus is on whether an investigation into the first claim would uncover the same fraudulent activity alleged in the second claim." *United States v. Planned Parenthood of Houston*, 570 F. App'x 386, 389 (5th Cir. 2014). Thus, where "the later-filed complaint alleges the same material or essential elements of fraud described in a pending *qui tam* action, § 3730(b)(5)'s jurisdictional bar applies." *Branch*, 560 F.3d at 378. Likewise, "[t]he TMFPA's first-to-file bar operates the same way as the FCA's first-to-file bar." *Planned Parenthood*, 570 F. App'x at 389 n.3.

A relator cannot avoid the first-to-file jurisdictional bar "by simply adding factual details or geographic locations to the essential or material elements of a fraud claim against the same defendant described in a prior compliant." *Branch*, 560 F.3d at 378. This is because "a relator who merely adds details to a previously exposed fraud does not help 'reduce fraud or return funds to the federal fisc,' because 'once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds.'" *Id.* (quoting *U.S. ex rel. LaCorte v. SmithKline Beecham Clinical Labs., Inc.*, 149 F.3d 227, 234 (3d Cir. 1998)). For example, in *Planned Parenthood*, the Fifth Circuit held the first-to-file jurisdictional bar applied to a successive relator that alleged "fraud was committed by altering patient records and billing Medicaid

programs for services other than those rendered," even though one relator alleged the services were never performed whereas the other relator alleged the services were improperly coded. 570 F. App'x at 390. Likewise, in *Branch*, the Fifth Circuit held that even new allegations of different geographic locations for the alleged fraud is insufficient "because an investigation into the fraudulent scheme alleged in the first complaint would result in finding identical fraudulent behavior, even across geographic locations." *Id.* at 390, n.4 (citing *Branch*, 560 F.3d at 374).

Nor can a relator avoid the first-to-file rule by either voluntarily intervening or being consolidated into a previously filed *qui tam* action. First, a putative relator cannot circumvent the first-to-file jurisdictional bar by amendment. *See U.S. ex rel. Denenea v. Allstate Ins. Co.*, 2011 WL 231780, at *3 (E.D. La. 2011) (noting that "a relator could not 'circumvent the first-to-file doctrine by seeking entrance to the action via amended complaint[.]'") (quoting *U.S. ex rel. Fry v. Guidant Corp.*, 2006 WL 1102397, at *6 (M.D. Tenn. 2006)). Second, a relator cannot escape the first-to-file bar by consolidating a *qui tam* case with a previously filed *qui tam* action. Allowing a relator to circumvent the first-to-file jurisdictional bar by consolidating a previously file action would undermine the FCA's goal of reducing duplicative *qui tam* litigation. *See Denenea*, 2011 WL 231780, at *3 ("a relator cannot avoid the first-to-file bar by consolidating his claim with an earlier action."); *see also Fed. Recovery Servs., Inc. v. United States*, 72 F.3d 447, 453 (5th Cir. 1995) (holding that

relator could not avoid public disclosure bar by amending complaint to name an additional relator). Thus, if the second case does not pass the "essential facts" or "essential elements" standard applied to section 3730(b)(5), then it is barred under the first-to-file jurisdictional bar. The relators do not cite to, nor is the Court aware of, a case holding otherwise or explaining why the policy underlying the first-to-file would not also militate against allowing new relators to file similar cases and then having them consolidated with pending *qui tam* actions.

Here the co-relators' new additions to Capshaw's original complaint allege the same material or essential elements of fraud described in Capshaw's original complaint. While the FAJC adds allegations into the specifics of the alleged schemes, it does not add details that would not be discovered by a government investigation into Capshaw's claim. Nor do the new allegations result in new fraudulent schemes or causes of action. Thus, Bryan, Wendt, and Whatley's additional allegations are exactly the kind of parasitic cases the first-to-file jurisdictional bar is designed to prevent.

B. Bryan and Wendt Are Barred by The First-To-File Jurisdictional Bar

Bryan and Wendt are barred by the first-to-file jurisdictional bar as they filed their lawsuit after Capshaw, despite later being consolidated into this action. Capshaw's original complaint alleged a scheme of referrals and kickbacks between the defendants which violated the AKS and Stark.

Compl. ¶¶ 31–32. Capshaw specifically alleged that the kickbacks included equity interests, loans which were never meant to be repaid, and leased space in return for patient referrals. *Id.* ¶¶ 34, 70–71. The Bryan Complaint alleged a similar scheme of kickbacks and fraudulent claims. *See generally* Compl. ("Bryan Complaint") [2] *in U.S. ex rel. Bryan, et al. v. Hospice Plus LP, et. al*, Civil Action No. 13-CV-3392-N (N.D. Tex. filed Aug. 23, 2013); *see also* Joint Mot. to Consolidate ¶ 11 [16]. The Bryan Complaint alleged that the Defendants provided remuneration in the form of cash and gifts, in violation of AKS. *See* Bryan Complaint ¶¶ 9, 13. Both complaints then allege that the Defendants falsely certified compliance with AKS via Medicare payment forms, in violation of the FCA. *See* Compl. ¶¶ 60–62, 67–69, 80–81; Bryan Complaint ¶¶ 98–101, 113. While Bryan's complaint alleged remuneration in a different form, Bryan's complaint alleges that the Defendants provided kickbacks, in violation of AKS, in exchange for referrals. *Id.* ¶ 14. Thus the Bryan complaint alleges the same essential facts and claims of fraud as the Capshaw complaint.

Additionally, a government investigation into Capshaw's allegation of kickbacks in exchange for patient referrals among the Defendants would uncover the same fraudulent activity alleged in the Bryan Complaint. Capshaw's alleged fraudulent scheme put the government on notice to conduct an investigation into the Defendants, including the relationship between White and Kumar owned companies and APH. Moreover, Capshaw's original complaint included Whatley as a defendant, thereby

putting the government on notice of her involvement in the allegedly fraudulent scheme. Much of Bryan's allegations include allegedly illegal remuneration paid to Whatley. *See* Bryan Compl. ¶¶ 42–43, 56. It follows then, that a government investigation would likely have discovered the details alleged in the Bryan complaint after an investigation into Capshaw's complaint.

Nor does the fact that the Bryan Complaint alleged the TMFPA claims for the first time alter the Court's conclusion. The TMFPA false claims provisions encompass the same fraudulent scheme as Capshaw's original FCA claims. *See United States ex rel. De Souza v. AstraZeneca PLC*, 72 F. Supp. 3d 561, 568 (D. Del. 2014). The additional defendants that Bryan and Wendt added to Capshaw's complaint do not change the result because an FCA action against a corporation works to bar subsequent actions alleging the same essential fraudulent scheme against its subsidiaries and affiliates. *See Branch Consultants*, 560 F.3d at 379 (citing *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1280 n.4 (10th Cir. 2004)). For the forgoing reasons, co-relators Bryan and Wendt are barred by the first-to-file jurisdictional bar.

C. Whatley Is Likewise Barred by The First-To-File Jurisdictional Bar

Whatley, a former defendant in Capshaw's original complaint, is likewise barred by the first-to-file jurisdictional bar despite being added via

amendment because she fails the "essential facts" or "essential elements" test. *See Denenea*, 2011 WL 231780, at *3. The Relators attempt to circumvent this result by arguing the addition of Whatley via amendment does not qualify as an "intervention" within the meaning of section 3730(b)(5). To support this argument, the Relators point to a recent unpublished opinion out of the Eastern District of Texas that adopted a narrow definition of intervention used by the Tenth Circuit in such cases. *See United States v. Homeward Residential, Inc.*, 2015 WL 3776478, at *4 (E.D. Tex. 2015). In *Homeward*, the court relied on a Tenth Circuit case holding that the plain legal meaning of the term "intervene" within section 3730(b)(5) "'implies intervention of the types set forth in Rule 24(b)(2), and the addition of parties does not constitute intervention.'" *Id.* (quoting *U.S. ex rel. Precision Co. v. Koch Indus., Inc.*, 31 F.3d 1015, 1017 (10th Cir. 1994)). Thus under *Precision*, a voluntarily added second relator would not be barred because it is not "an intervention" within the meaning of Rule 24. 31 F.3d. at 1017–18. The Court need not decide whether to adopt this reasoning, because the court in *Homeward* rejected the first-to-file jurisdictional bar because the relator "made new allegations within the amended complaint." *Homeward* at *4. In fact, the *Homeward* court based its decision to reject the reasoning of several other courts, which held the first-to-file jurisdictional bar applied to adding relators via amendment, on the fact that those relators did not assert new allegations or claims. *Id.* That is not the case here. As discussed below, here,

the new relators do not add additional allegations that satisfy the "essential facts" or "material elements" standard. Nor do the new allegations result in new causes of action against the Defendants. Accordingly, *Homeward* does not apply in this case.[3]

Because Whatley's allegations only add detail to the previously alleged fraud allegations, her claims are barred by the first-to-file rule. The FAJC alleges that Whatley, who began as a defendant in Capshaw's original complaint, provided over 107 gigabytes of detailed information. *See* FAJC ¶ 16. The amended complaint in this *qui tam* action alleged two fraudulent schemes, the Sham Loan, Equity, and Rent Scheme and the Payola Scheme. *See* Am. Compl. [18]. And while Whatley's allegations add details to the Payola Scheme, they allege the same essential elements and facts of the allegedly fraudulent Payola Scheme. For example, Whatley's additional allegations add specific instances and locations for the Payola Scheme, but she still alleges the same material elements of fraud, specifically the pattern of using gifts and payments to induce patient referrals. *See* FAJC ¶ 293. Whatley does allege specific instances of allegedly illegal kickbacks. *See* FAJC ¶¶ 277–283. But both the amended complaint and Capshaw's original complaint already alleged such a scheme of kickbacks and referrals. *See* Compl. ¶ 34. Thus

[3] The Court need not decide whether it agrees with *Homeward's* adoption of the Tenth Circuit's narrow definition of the term "intervene."

Whatley's allegations only add detail to the previously alleged Payola scheme. Moreover, Capshaw alleged in the Sham Loan, Equity, and Rent Scheme that the Defendants violated the FCA by offering equity interests in companies, loans that were never intended to be repaid, and leased space in exchange for patient referrals. Compl. ¶34 [2]. Whatley's additional allegations to this alleged scheme are minimal. *See* FAJC ¶ 81.

Whatley's additional allegations, in both fraudulent schemes, only add detail to Capshaw's fraud allegations. It is also of note that the FAJC does not allege any new causes of action as a result of the additional information provided by Whatley. Accordingly, Whatley is barred by the first-to-file rule and dismissed as a co-relator in this action.

III. THE COURT GRANTS IN PART AND DENIES IN PART THE MOTIONS TO DISMISS UNDER RULE 12(B)(6)

Because the FAJC does not plead the conspiracy allegations, claims five and six, against the remaining Defendants with sufficient particularity, the Court dismisses the conspiracy claims without prejudice. Because the FAJC does not plead allegations against Defendant Kumar and White with sufficient particularity under Rule 9(b), the Court dismisses the claims against them without prejudice. The Court denies the remainder of the motions to dismiss.

A. The Rule 12(b)(6) Standard

When considering a Rule 12(b)(6) motion to dismiss, a court must determine whether the plaintiff has asserted a legally sufficient claim for relief. *Blackburn v. City of Marshall*, 42 F.3d 925, 931 (5th Cir. 1995). A viable complaint must include "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). To meet this "facial plausibility" standard, a plaintiff must "plead[] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A court generally accepts well-pleaded facts as true and construes the complaint in the light most favorable to the plaintiff. *Gines v. D.R. Horton, Inc.*, 699 F.3d 812, 816 (5th Cir. 2012). But a court does not accept as true "conclusory allegations, unwarranted factual inferences, or legal conclusions." *Ferrer v. Chevron Corp.*, 484 F.3d 776, 780 (5th Cir. 2007). A plaintiff must provide "more than labels and conclusions, and a formulaic recitation of the elements of a cause of action will not do." *Twombly*, 550 U.S. at 555. "Factual allegations must be enough to raise a right to relief above the speculative level on the assumption that all the allegations in the complaint are true (even if doubtful in fact)." *Id.* (internal citations omitted).

In ruling on a Rule 12(b)(6) motion, a court generally limits its review to the face of the pleadings, accepting as true all well-pleaded facts and viewing them in the light most favorable to the

plaintiff. *See Spivey v. Robertson*, 197 F.3d 772, 774 (5th Cir. 1999). However, a court may also consider documents outside of the pleadings if they fall within certain limited categories. First, "[a] court is permitted . . . to rely on 'documents incorporated into the complaint by reference, and matters of which a court may take judicial notice.'" *Dorsey v. Portfolio Equities, Inc.*, 540 F.3d 333, 338 (5th Cir. 2008) (quoting *Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007)). Second, "[a] written document that is attached to a complaint as an exhibit is considered part of the complaint and may be considered in a 12(b)(6) dismissal proceeding." *Ferrer*, 484 F.3d at 780. Third, a "court may consider documents attached to a motion to dismiss that 'are referred to in the plaintiff's complaint and are central to the plaintiff's claim.'" *Sullivan v. Leor Energy, LLC*, 600 F.3d 542, 546 (5th Cir. 2010) (quoting *Scanlan v. Tex. A & M Univ.*, 343 F.3d 533, 536 (5th Cir. 2003)). Finally, "[i]n deciding a 12(b)(6) motion to dismiss, a court may permissibly refer to matters of public record." *Cinel v. Connick*, 15 F.3d 1338, 1343 n.6 (5th Cir. 1994) (citation omitted); *see also, e.g.*, *Funk v. Stryker Corp.*, 631 F.3d 777, 783 (5th Cir. 2011) (stating, in upholding district court's dismissal pursuant to Rule 12(b)(6), that "the district court took appropriate judicial notice of publicly-available documents and transcripts produced by the [Food and Drug Administration], which were matters of public record directly relevant to the issue at hand").

B. The Rule 9(b) Standard

"[C]laims brought under the FCA must comply with the particularity requirements of Rule 9(b) for claims of fraud." *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 735 F.3d 202, 204 (5th Cir. 2013) (citations omitted). Rule 9(b) states: "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally." FED. R. CIV. P. 9(b). Under Rule 9(b), a plaintiff must include the "'time, place and contents of the false representations, as well as the identity of the person making the misrepresentation and what [that person] obtained thereby.'" *U.S. ex rel. Hebert v. Dizney*, 295 F. App'x 717, 721 (5th Cir. 2008) (citing *United States ex rel. Russell v. Epic Healthcare Mgmt. Group*, 193 F.3d 304, 308 (5th Cir. 1999)). The Fifth Circuit has interpreted Rule 9(b) to require "at a minimum, that a plaintiff set forth the who, what, when, where, and how of the alleged fraud." *Steury*, 735 F.3d at 204 (citing *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 625 F.3d 262, 266 (5th Cir. 2010)).

A complaint alleging a violation of the FCA that does not allege the details of an actually submitted false claim, "may nevertheless survive by alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). Thus, while a relator may not be required to prove details as to each false

claim, the "standard nonetheless requires the relator to provide other reliable indications of fraud and to plead a level of detail that demonstrates that an alleged scheme likely resulted in bills submitted for government payment." *U.S. ex rel. Nunnally v. W. Calcasieu Cameron Hosp.*, 519 F. App'x 890, 893 (5th Cir. 2013).

C. The False Claims Act

A person who "(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval," or "(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim," or "(C) conspires to commit a violation of [A or B]," violates the FCA and is subject to civil liability. 31 U.S.C. §3729(a)(1)(A)–(C). Claims under section 3729(a)(1)(A) are commonly referred to as "presentment claims." *U.S. ex rel. Colquitt v. Abbott Labs.*, 864 F. Supp. 2d 499, 511 (N.D. Tex. 2012). Claims under section 3729(a)(1)(B) are commonly referred to as "false statement claims." *Id.* Under the FCA, knowing and knowingly are defined to "mean that a person, with respect to information—(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. §3729(b)(1). To properly plead a violation of the FCA, a FCA complaint must allege "[(1)] a false statement or fraudulent course of conduct; (2) made or carried out with the requisite scienter; (3) that was material;

and (4) that caused the government to pay out money or to forfeit moneys due (i.e., that involved a claim)." *U.S. ex rel. Longhi v. United States*, 575 F.3d 458, 467 (5th Cir. 2009); *see also United States ex rel. Karvelas v. Melrose–Wakefield Hosp.*, 360 F.3d 220, 225 (1st Cir. 2004) ("[T]he [FCA] attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the claim for payment.") (quotations omitted); *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301, 1311 (11th Cir. 2002) ("The submission of a claim is . . . the *sine qua non* of a False Claims Act violation.").

FCA liability for false-statement claims may be imposed "'when the contract under which payment is made was procured by fraud.'" *Longhi*, 575 F.3d at 467–68 (citing *United States ex rel. Willard v. Humana Health Plan of Texas, Inc.*, 336 F.3d 375, 384 (5th Cir. 2003)). This is considered fraudulent inducement. *Id.* Thus even where "'subsequent claims for payment made under the contract were not literally false, [because] they derived from the original fraudulent misrepresentation, they, too, became actionable false claims.'" *Id.* (citing *United States ex rel. Laird v. Lockheed Martin Eng'g & Science Servs. Co.*, 491 F.3d 254, 259 (5th Cir. 2007)). Because "the government has conditioned payment of a claim upon a claimant's certification of compliance with, for example, a statute or regulation, a claimant submits a false or fraudulent claim when he or she falsely certifies compliance with that statute or regulation." *U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 902 (5th Cir. 1997).

The AKS and Stark Law are common "predicate violations" for imposing FCA liability. The AKS is a criminal statute which prohibits "the knowing or willful offering to pay, or soliciting, any remuneration to induce the referral of an individual for items or services that may be paid for by a federal health care program." *Nunnally,* 519 F. App'x at 893. "A violation of the AKS can serve as the basis for a FCA claim when the Government has conditioned payment of a claim upon the claimant's certification of compliance with the statute, and the claimant falsely certifies compliance." *Id*. "Stark bars entities from submitting claims to federal health care programs if the services forming the basis of the claims were furnished pursuant to referrals from physicians with which the entities had a financial relationship." *U.S. ex rel. Parikh v. Citizens Med. Ctr.*, 977 F. Supp. 2d 654, 663 (S.D. Tex. 2013); *see also* 42 U.S.C. § 1395nn(a)(1). The elements of a predicate AKS or Stark violation "must also be pleaded with particularity under Rule 9(b), because they are brought as a FCA claim." *Nunnally*, 519 F. App'x at 894; *see also Parikh*, 977 F. Supp. 2d at 666.

D. The Court Dismisses the Conspiracy Claims Against All Defendants

Because the FAJC does not allege a conspiracy existed with sufficient particularity to satisfy Rule 9(b) or 12(b)(6), the Court dismisses the civil conspiracy claims against all defendants. "[T]o prove a False Claims Act conspiracy, a relator must show '(1) the existence of an unlawful agreement between

defendants to get a false or fraudulent claim allowed or paid by [the Government] and (2) at least one act performed in furtherance of that agreement.'" *Grubbs*, 565 F.3d at 193 (alteration in original) (citing *United States ex rel. Farmer v. City of Houston*, 523 F.3d 333, 343 (5th Cir. 2008)). Under Rule 9(b), "a plaintiff alleging a conspiracy to commit fraud must 'plead with particularity the conspiracy as well as the overt acts . . . taken in furtherance of the conspiracy.'" *Grubbs*, 565 F.3d at 193 (citing *FC Inv. Group LC v. IFX Markets, Ltd.*, 529 F.3d 1087, 1097 (D.C. Cir. 2008)).

In order to sufficiently plead a conspiracy, the relator must plead sufficient facts to establish there was an agreement to defraud the government. For example, in *Grubbs*, the relator alleged "specific language" attributed to two individual doctors that indicated "or at least from which a reasonable jury could infer, that they were in agreement between themselves and some members of the nursing staff to improperly record unprovided services for the purpose of getting fraudulent claims paid by the Government." *Id.* at 193–94. The language, coupled with the "temporal circumstances of the meeting" suggested a conspiratorial design. *Id.* at 194. The Fifth Circuit held that inferring that the two doctors were in agreement was not conclusory or speculative. *Id.* Importantly, the court held that

to conclude that the remaining defendants, both individual doctors and the hospital, were also in agreement was a stretch. *Id.* "Even taking the allegations as true—that various doctors over a period of years each submitted certain false claims—

does not, by itself, do more than point to a possibility of an agreement among them." *Id.* Thus, even evidence of a period of submitting false claims, while sufficient to state a claim under Rule 9(b) for violations of section 3729(a)(1) and 3729(a)(2), is not enough to state a claim for conspiracy under section 3729(a)(3). Likewise, in *Dekort v. Integrated Coast Guard Systems*, the court held that allegations that three defendants independently violated the FCA and had "agreed to or acquiesced in violations by the other Defendant(s), on other occasions," were insufficient to plead conspiracy. 705 F. Supp. 2d 519, 548 (N.D. Tex. 2010).

Here, the FAJC's allegations in support of the conspiracy claim are not pled with sufficient particularity to establish there was an agreement. For instance, the FAJC alleges that the Defendants "had the requisite knowledge and agreed to . . . maintain the cycle of self-interested and kickback-induced patient referrals . . . in order to bill and receive substantial Medicare and Medicaid payments from the government." FAJC ¶ 83. The FAJC also alleges the Payola Defendants "had the requisite knowledge and agreed to and/or ratified" the Payola conspiracy. FAJC ¶ 149. But the FAJC does not contain any factual allegations that suggest the existence of an unlawful agreement for either scheme. Specifically, the FAJC does not allege any facts that indicate any of the Defendants entered into an agreement to defraud the government. Unlike *Grubbs*, where the relator alleged certain doctor defendants verbally entered into an agreement at a meeting, the FAJC contains no allegations that any

of the Defendants agreed to conspire together in either the Payola or Sham Loan, Equity and Rent Scheme. At best, the FAJC alleges a period of submitting false claims by individual actors or acquiescence to an unlawful scheme – neither of which is sufficient to plead an unlawful agreement existed.

Accordingly the FAJC fails to plead a conspiracy. Because the FAJC does not sufficiently allege that there was an agreement to conspire, the Court dismisses claims five and six against all remaining Defendants.

E. The Court Grants Kumar and White's Motions to Dismiss

Because the FAJC does not allege with sufficient particularity that either White or Kumar committed a predicate violation of the FCA – either a violation of the AKS or Stark – and therefore filed a false claim or caused a false claim to be filed, they cannot be held liable in their individual capacities. Nor does the FAJC allege with sufficient particularity facts necessary to pierce the corporate veil. Accordingly, the claims against White and Kumar are dismissed.

First, the FAJC does not allege that either Kumar or White submitted a false claim as a direct violation of the FCA. "[T]he submission of a false claim is the *sine qua non* of a False Claims Act violation." *U.S. ex rel. Gonzalez v. Fresenius Med. Care N. Am.*, 748 F. Supp. 2d 95, 116 (W.D. Tex.

2010) (citing *Hopper v. Solvay Pharm., Inc.*, 588 F.3d 1318, 1328 (11th Cir. 2009)). The FAJC does not allege Kumar or White, individually, made any false claims or statements to the government. Specifically, the FAJC fails to allege a single specific patient for which Kumar or White submitted a false claim.

Nor does the FAJC allege White or Kumar caused a false claim to be submitted. The FAJC fails to allege fraudulent inducement by White or Kumar, or how White or Kumar "caused the submission of false claims," as to either individual. *U.S. ex rel. Colquitt*, 864 F. Supp. 2d at 536 (noting that "the Defendants, as the source of the remuneration given to the providers, caused the submission of those false claims (presentment liability) and/or caused the providers to make the false certifications that rendered the claims false (false-statement liability)"). Specifically, the FAJC fails to allege that Kumar or White violated the AKS or the Stark Act, individually, thereby fraudulently inducing a claim to be submitted to the government. While the FAJC alleges numerous referrals made by the Curo, White, Kumar Companies as part of the Payola Scheme, allegedly in violation of the AKS, none of the factual allegations even insinuate that Kumar or White provided the remuneration that was allegedly provided in return for outside referrals. *See* FAJC ¶¶ 211–215, 242–255. The FAJC alleges the Curo, White, Kumar Companies provided the remuneration, not Kumar or White individually. *Id.* Individually, the FAJC alleges Kumar and White gave their employees extra remuneration, which is expressly allowed by the AKS. *Id.* ¶¶ 298–303, 310;

see also 42 U.S.C. § 1320(b)(3)(B). Nor does the FAJC delineate between the allegedly impermissible remuneration and employee remuneration. Moreover, the FAJC claims Kumar used gifts and money to secure referrals, but it is entirely devoid of any factual allegations that Kumar participated, individually, in the Sham Loan, Equity, and Rent Scheme and thereby caused a false claim to be submitted. As for White, the FAJC alleges he gave free equity to Sage and Short, sham loans, and free leased space to APH, however the FAJC does not explain how providing this alleged remuneration would influence other physicians to refer patients. Instead, the FAJC makes general allegations about White and Kumar's individual involvement in the scheme, rather than including particular allegations sufficient to support the inference that White or Kumar submitted false claims or unlawfully induced referrals in violation of the FCA.

Likewise, claims seven and eight, which allege White and Kumar violated the TMFPA, are not pled with sufficient particularity. TMFPA claims, because of their similarity to FCA provisions, are evaluated "under the FCA's well-defined legal requirements." *U.S. ex rel. Williams v. McKesson Corp.*, 2014 WL 3353247, at *4 (N.D. Tex. 2014). Accordingly the TMFPA claims against White and Kumar in their individual capacity are likewise dismissed.

The FAJC's argument that the corporate veil should be pierced to allow Kumar and White to be individually liable is equally unavailing. "The corporate veil may be pierced to hold an alter ego liable for the commitments of its instrumentality

only if (1) the owner exercised complete control over the corporation with respect to the transaction at issue and (2) such control was used to commit a fraud or wrong that injured the party seeking to pierce the veil." *Bridas S.A.P.I.C. v. Gov't of Turkmenistan*, 345 F.3d 347, 359 (5th Cir. 2003).

The corporate veil may also be pierced "[w]hen a defendant causes a corporation to be used to perpetrate a fraud on the plaintiff for defendant's own benefit . . ." *BAC Home Loans Servicing, LP v. Texas Realty Holdings, LLC*, 901 F. Supp. 2d 884, 910 (S.D. Tex. 2012) (citing *Sid Richardson Carbon & Gasoline Co. v. Interenergy Res., Ltd.*, 99 F.3d 746, 752 (5th Cir. 1996)).

Because the Court already determined the FAJC did not allege with sufficient particularity a fraud claim against the individual defendants, the argument that either White or Kumar used his corporations as a sham to perpetrate a fraud is also insufficiently pled at this stage to impose personal liability. *See Shandong Yinguang Chem. Indus. Joint Stock Co. v. Potter*, 607 F.3d 1029, 1035 (5th Cir. 2010) ("[Plaintiff] alleges that [defendant] used [corporation] as a sham to perpetrate a fraud, which entitles it to pierce the corporate veil and impose personal liability. This claim requires proof that [defendant] committed an actual fraud against it."); *see also Ryan, LLC v. Inspired Dev., LLC*, 2013 WL 12137012, at *10 (N.D. Tex. 2013) ("Because [plaintiff] has failed to state a claim for actual fraud, it cannot pierce the liability shield of the LLC and hold [defendant] individually liable for breach of [contract.]").

As stated in Part II(D), the FAJC does not state a claim for the conspiracy claims in Capshaw's fifth and sixth causes of action.4 Thus, the Court grants Kumar and White's motions to dismiss in their entirety.

F. The Court Denies the Remainder of the Defendants' Motion to Dismiss

The Court denies the remainder of the Defendants' motions to dismiss. The FAJC sufficiently alleges a fraudulent scheme whereby kickbacks were used to induce patient referrals, a violation of AKS. The FAJC also alleges the remaining Defendants certified compliance when presenting bills for payment to Medicare.

A relator need not allege every detail in a FCA claim raising the presentment provision. Generally, the "time, place, and contents of the false representations, as well as the identity of the person making the misrepresentation and what that person obtained thereby" must be alleged to satisfy the particularity requirements of Rule 9(b). *United States ex rel. Russell v. Epic Healthcare Mgmt. Grp.*,

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4 The Court also notes that the FAJC's conspiracy claims against White and Kumar necessary fail on independent grounds. A "[r]elator cannot plead a conspiracy to commit an FCA violation without successfully alleging an FCA violation." *U.S. ex rel. Westbrook v. Navistar, Inc.*, 2012 WL 10649207, at *9 (N.D. Tex., 2012) (citing *United States ex rel. Coppock v. Northrup Grumman Corp.*, 2003 WL 21730668, at *14 n.17 (N.D. Tex. 2003) ("[S]econdary liability for conspiracy under § 3729(a)(3) cannot exist without a viable underlying claim.").

193 F.3d 304, 308 (5th Cir. 1999) (alteration in original). Because Rule 9(b) is context specific, the courts also allow relators to "allege particular details of a scheme to submit false claims along with reliable indicia that lead to a strong inference that claims were actually submitted." *U.S. ex rel. Davis v. Lockheed Martin Corp*., 2010 WL 4607411, at *7 (N.D. Tex. 2010). In such cases, "courts have allowed the plaintiff to plead the fraudulent scheme with particularity and provide representative examples of specific fraudulent acts conducted pursuant to that scheme." *U.S. ex rel. Bennett v. Medtronic, Inc*., 747 F. Supp. 2d 745, 768 (S.D. Tex. 2010) (quotations omitted). Thus where the scheme is alleged with sufficiently particular details, along with reliable indicia that claims were submitted, the complaint survives a motion to dismiss. *Grubbs*, 565 F.3d at 190; *see also Parikh*, 977 F. Supp. 2d at 671 ("*Grubbs* makes clear that it is the scheme, rather than individual instances of fraudulent claims, that an FCA relator must plead with particularity.").

Taking the pleadings of the FAJC as true, the FAJC alleges sufficient facts of a fraudulent scheme. The FAJC alleges referrals were given in exchange for "free equity interest for Sage and Short in at least one White/Kumar-owned company [BE Gentle], (2) sham loans in the amount of approximately $2,500,000.00 from White to APH (primarily owned by Sage) . . . (3) free leased space for APH for which rent was not paid on a monthly basis . . . (4) and cash." FAJC ¶ 81; *see also* FAJC ¶¶ 285, 311–12. The FAJC also gives specific examples of referrals from APH to the Defendants. *See* FAJC ¶¶ 98–132. These

specific allegations include dates and the context of the referrals. *Id.*

The FAJC also alleges reliable indicia that the Defendants submitted false claims to the government in violation of the FCA. Specifically, the FAJC describes in detail the forms used by the Defendants to submit claims to the government for payment, including the Electronic Data Interchange enrollment form, Medicare program enrollment application, and annual cost reports. FAJC ¶¶ 50, 55, 139–40, 142, 220, 321–24. The FAJC's allegations regarding these forms specifically calls out the certification of compliance with the AKS and Stark law contained therein. *Id.* The FAJC also sets forth allegations regarding how the reports were entered into the billing system as part of the fraudulent scheme. FAJC ¶¶ 163, 220. Thus the FAJC alleges "a description of the billing system that the records were likely entered into—[giving] defendants adequate notice of the claims." *Grubbs*, 565 F.3d at 191.

The FAJC alleges representative examples of the fraudulent scheme with reliable indicia that claims were submitted to the government. Accordingly, claims one, two, three, four, seven, and eight survive the motion to dismiss.

CONCLUSION

Because their claims are barred by the first-to-file rule, the Court dismisses Kevin Bryan, Franklin Brock Wendt, and Sheila Whatley as relators. The

Court also dismisses the claims against Defendants Bryan K. White and Suresh Kumar in their individual capacities without prejudice. The Court dismisses the conspiracy claims, claims five and six, as to all remaining Defendants, and denies the remaining Rule 12(b)(6) motions. Capshaw has thirty days to replead his complaint to address the noted deficiencies. Because the claims against White and Kumar are dismissed, the Court denies the United States' motion to intervene against White and Kumar [234] as moot.

Signed January 23, 2017.

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David C. Godbey
United States District Judge

[A63]

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT
NO. 19-11309

Filed August 26, 2021

Christopher Sean Capshaw,
Plaintiff,

versus

Bryan K. White, M.D., Individually,
Defendant,

United States of America, ex rel, Kevin Bryan; Franklin Brock Wendt,
Plaintiffs—Appellants,

Boyd & Associates; Marchand & Rossi, L.L.P., *now known as* Marchand Law, L.L.P.,
Appellants,

versus

Bryan K. White, M.D., Individually; Be Gentle Home Health, Incorporated, *doing business as* Phoenix Home Health Care; Suresh Kumar, R.N., individually; Goodwin Home Health Services, Incorporated; Vinayaka Associates, L.L.C., *doing business as* A&S Home Health Care; Goodwin Hospice, L.L.C.; North Texas Best Home Healthcare,

Incorporated; Excel Plus Home Health, Incorporated; Phoenix Hospice, Incorporated; One Point Home Health Services, L.L.C., *formerly known as* One Point Home Health, L.L.C.; Home Health Plus, Incorporated; International Tutoring Services, L.L.C., *formerly known as* International Tutoring Services, Incorporated, *doing business as* Hospice Plus; Curo Health Services, L.L.C., *formerly known as* Curo Health Services, Incorporated; Hospice Plus, L.P.,

Defendants—Appellees,

Appeal from the United States District Court for the Northern District of Texas
USDC No. 3:12-CV-4457
USDC No. 3:13-CV-3392

ON PETITION FOR REHEARING EN BANC

Before Jolly, Stewart, and Oldham, *Circuit Judges*.

PER CURIAM:

Treating the petition for rehearing en banc as a petition for panel rehearing (5th Cir. R. 35 I.O.P.), the petition for panel rehearing is DENIED. Because no member of the panel or judge in regular active service having requested that the court be polled on rehearing en banc (Fed. R. App. P. 35 and 5th Cir. R. 35), the petition for rehearing en banc is DENIED.

FILED September 3, 2021

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

United States Court of Appeals
Fifth Circuit
FILED July 30, 2021
Lyle W. Cayce
Clerk

No. 19-11309

Christopher Sean Capshaw,
Plaintiff,

versus

Bryan K. White, M.D., Individually,
Defendant,

United States of America, ex rel, Kevin Bryan; Franklin Brock Wendt,
Plaintiffs—Appellants,

Boyd & Associates; Marchand & Rossi, L.L.P., *now known as* Marchand Law, L.L.P.,
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versus

Bryan K. White, M.D., Individually; Be Gentle Home Health, Incorporated, *doing business as* Phoenix

Home Health Care; Suresh Kumar, R.N., Individually; Goodwin Home Health Services, Incorporated; Vinayaka Associates, L.L.C., *doing business as* A&S Home Health Care; Goodwin Hospice, L.L.C.; North Texas Best Home Healthcare, Incorporated; Excel Plus Home Health, Incorporated; Phoenix Hospice, Incorporated; One Point Home Health Services, L.L.C., *formerly known as* One Point Home Health, L.L.C.; Home Health Plus, Incorporated; International Tutoring Services, L.L.C., *formerly known as* International Tutoring Services, Incorporated, *doing business as* Hospice Plus; Curo Health Services, L.L.C., *formerly known as* Curo Health Services, Incorporated; Hospice Plus, L.P.,

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Appeal from the United States District Court
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USDC No. 3:12-CV-4457
USDC No. 3:13-CV-3392

Before Jolly, Stewart, and Oldham, *Circuit Judges*.

J U D G M E N T

This cause was considered on the record on appeal and was argued by counsel.

IT IS ORDERED and ADJUDGED that the judgment of the District Court is AFFIRMED.

IT IS FURTHER ORDERED that appellants pay to appellees the costs on appeal to be taxed by the Clerk of this Court.

STATUTES INVOLVED

1. 28 U.S.C. § 1367:

§ 1367. Supplemental jurisdiction

(a) Except as provided in subsections (b) and (c) or as expressly provided otherwise by Federal statute, in any civil action of which the district courts have original jurisdiction, the district courts shall have supplemental jurisdiction over all other claims that are so related to claims in the action within such original jurisdiction that they form part of the same case or controversy under Article III of the United States Constitution. Such supplemental jurisdiction shall include claims that involve the joinder or intervention of additional parties.

(b) In any civil action of which the district courts have original jurisdiction founded solely on section 1332 of this title [28 USCS § 1332], the district courts shall not have supplemental jurisdiction under subsection (a) over claims by plaintiffs against persons made parties under Rule 14, 19, 20, or 24 of the Federal Rules of Civil Procedure, or over claims by persons proposed to be joined as plaintiffs under Rule 19 of such rules, or seeking to intervene as plaintiffs under Rule 24 of such rules, when exercising supplemental jurisdiction over such claims would be inconsistent with the jurisdictional requirements of section 1332 [28 USCS § 1332].

(c) The district courts may decline to exercise supplemental jurisdiction over a claim under subsection (a) if—

(1) the claim raises a novel or complex issue of State law,

(2) the claim substantially predominates over the claim or claims over which the district court has original jurisdiction,

(3) the district court has dismissed all claims over which it has original jurisdiction, or

(4) in exceptional circumstances, there are other compelling reasons for declining jurisdiction.

(d) The period of limitations for any claim asserted under subsection (a), and for any other claim in the same action that is voluntarily dismissed at the same time as or after the dismissal of the claim under subsection (a), shall be tolled while the claim is pending and for a period of 30 days after it is dismissed unless State law provides for a longer tolling period.

(e) As used in this section, the term "State" includes the District of Columbia, the Commonwealth of Puerto Rico, and any territory or possession of the United States.

2. 31 U.S.C. § 3729:

§ 3729. False claims

(a) Liability for certain acts.

(1) In general. Subject to paragraph (2), any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages. If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions. A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions. For purposes of this section—

(1) the terms "knowing" and "knowingly"—

(A) mean that a person, with respect to information—

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(c) Exemption from disclosure. Any information furnished pursuant to subsection (a)(2) shall be exempt from disclosure under section 552 of title 5.

(d) Exclusion. This section does not apply to claims, records, or statements made under the Internal Revenue Code of 1986 [26 USCS §§ 1 et seq.].

3. 31 U.S.C. § 3730:

§ 3730. Civil actions for false claims

(a) Responsibilities of the Attorney General. The Attorney General diligently shall investigate a violation under section 3729 [31 USCS § 3729]. If the Attorney General finds that a person has violated or is violating section 3729 [31 USCS § 3729], the Attorney General may bring a civil action under this section against the person.

(b) Actions by private persons.

(1) A person may bring a civil action for a violation of section 3729 [31 USCS § 3729] for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) [Rule 4(i)] of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The Government may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 20 days after the complaint is unsealed and served upon the defendant pursuant to Rule 4 of the Federal Rules of Civil Procedure.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the Government shall—

(A) proceed with the action, in which case the action shall be conducted by the Government; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to qui tam actions.

(1) If the Government proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to

continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)

(A) The Government may dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the Government of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion.

(B) The Government may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the Government that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the Government's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as—

(i) limiting the number of witnesses the person may call;

(ii) limiting the length of the testimony of such witnesses;

(iii) limiting the person's cross-examination of witnesses; or

(iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the person in the litigation.

(3) If the Government elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the Government so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the Government's expense). When a person proceeds with the action, the court, without limiting the status and rights of the person initiating the action, may nevertheless permit the Government to intervene at a later date upon a showing of good cause.

(4) Whether or not the Government proceeds with the action, upon a showing by the Government that certain actions of discovery by the person initiating the action would interfere with the Government's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more

than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the Government has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(5) Notwithstanding subsection (b), the Government may elect to pursue its claim through any alternate remedy available to the Government, including any administrative proceeding to determine a civil money penalty. If any such alternate remedy is pursued in another proceeding, the person initiating the action shall have the same rights in such proceeding as such person would have had if the action had continued under this section. Any finding of fact or conclusion of law made in such other proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of the preceding sentence, a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the United States, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(d) Award to qui tam plaintiff.

(1) If the Government proceeds with an action brought by a person under subsection (b), such

person shall, subject to the second sentence of this paragraph, receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government [General] Accounting Office report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of this paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(2) If the Government does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an

amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the Government proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of section 3729 [31 USCS § 3729] upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of section 3729 [31 USCS § 3729], that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the United States to continue the action, represented by the Department of Justice.

(4) If the Government does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorneys' fees and expenses if the defendant prevails in the action and the court finds that the claim of the person bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain actions barred.

(1) No court shall have jurisdiction over an action brought by a former or present member of the armed forces under subsection (b) of this section against a member of the armed forces arising out of such person's service in the armed forces.

(2)

(A) No court shall have jurisdiction over an action brought under subsection (b) against a Member of Congress, a member of the judiciary, or a senior executive branch official if the action is based on evidence or information known to the Government when the action was brought.

(B) For purposes of this paragraph, "senior executive branch official" means any officer or employee listed in paragraphs (1) through (8) of section 101(f) of the Ethics in Government Act of 1978 (5 U.S.C. App.).

(3) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the

subject of a civil suit or an administrative civil money penalty proceeding in which the Government is already a party.

(4)

(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed—

(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) [(ii)] who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

(f) Government not liable for certain expenses. The Government is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant. In civil actions brought under this section by the United States, the provisions of section 2412(d) of title 28 shall apply.

(h) Relief from retaliatory actions.

(1) In general. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, agent or associated others in furtherance of an action under this section or other efforts to stop 1 or more violations of this subchapter [31 USCS §§ 3721 et seq.].

(2) Relief. Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the

appropriate district court of the United States for the relief provided in this subsection.

(3) Limitation on bringing civil action. A civil action under this subsection may not be brought more than 3 years after the date when the retaliation occurred.

4. 31 U.S.C. § 3732:

§ 3732. False claims jurisdiction

(a) Actions under section 3730. Any action under section 3730 [31 USCS § 3730] may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by section 3729 [31 USCS § 3729] occurred. A summons as required by the Federal Rules of Civil Procedure shall be issued by the appropriate district court and served at any place within or outside the United States.

(b) Claims under State law. The district courts shall have jurisdiction over any action brought under the laws of any State for the recovery of funds paid by a State or local government if the action arises from the same transaction or occurrence as an action brought under section 3730 [31 USCS § 3730].

(c) Service on State or local authorities. With respect to any State or local government that is named as a co-plaintiff with the United States in an action brought under subsection (b), a seal on the action ordered by the court under section

3730(b) [31 USCS § 3730(b)] shall not preclude the Government or the person bringing the action from serving the complaint, any other pleadings, or the written disclosure of substantially all material evidence and information possessed by the person bringing the action on the law enforcement authorities that are authorized under the law of that State or local government to investigate and prosecute such actions on behalf of such governments, except that such seal applies to the law enforcement authorities so served to the same extent as the seal applies to other parties in the action.

5. 42 U.S.C. § 1396h:

§ 1396h. State false claims act requirements for increased State share of recoveries

(a) In general. Notwithstanding section 1905(b) [42 USCS § 1396d(b)], if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

(b) Requirements. For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has

in effect a law that meets the following requirements:

(1) The law establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code [31 USCS § 3729], with respect to any expenditure described in section 1903(a) [42 USCS § 1396b(a)].

(2) The law contains provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in sections 3730 through 3732 of title 31, United States Code [31 USCS §§ 3730–3732].

(3) The law contains a requirement for filing an action under seal for 60 days with review by the State Attorney General.

(4) The law contains a civil penalty that is not less than the amount of the civil penalty authorized under section 3729 of title 31, United States Code [31 USCS § 3729].

(c) Deemed compliance. A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

(d) No preclusion of broader laws. Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United

States Code [31 USCS § 3729], with respect to programs in addition to the State program under this title [42 USCS §§ 1396 et seq.], or with respect to expenditures in addition to expenditures described in section 1903(a) [42 USCS § 1396b(a)], from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.

6. TEX. HUM. RES. CODE § 36.110:

Sec. 36.110. Award to Private Plaintiff.

(a) If the state proceeds with an action under this subchapter, the person bringing the action is entitled, except as provided by Subsection (b), to receive at least 15 percent but not more than 25 percent of the proceeds of the action, depending on the extent to which the person substantially contributed to the prosecution of the action.

(a-1) If the state does not proceed with an action under this subchapter, the person bringing the action is entitled, except as provided by Subsection (b), to receive at least 25 percent but not more than 30 percent of the proceeds of the action. The entitlement of a person under this subsection is not affected by any subsequent intervention in the action by the state in accordance with Section 36.104(b-1).

(b) If the court finds that the action is based primarily on disclosures of specific information, other than information provided by the person bringing the action, relating to allegations or transactions in a Texas or federal criminal or

civil hearing, in a Texas or federal legislative or administrative report, hearing, audit, or investigation, or from the news media, the court may award the amount the court considers appropriate but not more than 10 percent of the proceeds of the action. The court shall consider the significance of the information and the role of the person bringing the action in advancing the case to litigation.

(c) A payment to a person under this section shall be made from the proceeds of the action. A person receiving a payment under this section is also entitled to receive from the defendant an amount for reasonable expenses, reasonable attorney's fees, and costs that the court finds to have been necessarily incurred. The court's determination of expenses, fees, and costs to be awarded under this subsection shall be made only after the defendant has been found liable in the action or the claim is settled.

(d) In this section, "proceeds of the action" includes proceeds of a settlement of the action.

7. TEX. HUM. RES. CODE § 36.106:

Sec. 36.106. Intervention by Other Parties Prohibited.

A person other than the state may not intervene or bring a related action based on the facts underlying a pending action brought under this subchapter.

8. SENATE REPORT NO. 99-345 AT 16, 25 (99TH CONGRESS, 2ND SESSION, CALENDAR NO. 742, COMMITTEE ON THE JUDICIARY, JULY 28, 1986, TO ACCOMPANY S. 1562. THE FALSE CLAIMS ACT REFORM ACT OF 1985), available at https://www.justice.gov/sites/default/files/jmd/legacy/2013/10/31/senaterept-99-345-1986.pdf (last visited September 7, 2021):

And finally, in response to comments from the National Association of Attorneys General, the subcommittee adopted a provision allowing State and local governments to join State law actions with False Claims Act actions brought in Federal district court if such actions grow out of the same transaction or occurrence.

…

Subsection (b)(5) of section 3730 further clarifies that only the Government may intervene in a qui tam action. While there are few known instances of multiple parties intervening in past qui tam cases, *United States v. Baker-Lockwood Manufacturing Co.,* 138 F.2d 48 (8th Cir. 1943), the Committee wishes to clarify in the statute that private enforcement under the civil False Claims Act is not meant to produce class actions or multiple separate suits based on identical facts and circumstances.

[A90]

United States Court of Appeals
for the Fifth Circuit

No. 19-11309

Christopher Sean Capshaw,

Plaintiff,

versus

Bryan K. White, M.D., *Individually*,

Defendant,

United States of America, *ex rel.*, Kevin Bryan; Franklin Brock Wendt,

Plaintiffs—Appellants,

Boyd & Associates; Marchand & Rossi, L.L.P., *now known as* Marchand Law, L.L.P.,

Appellants,

versus

Bryan K. White, M.D., *Individually*; Be Gentle Home Health, Incorporated, *doing business as* Phoenix Home Health Care; Suresh Kumar, R.N., *Individually*; Goodwin Home Health Services, Incorporated; Vinayaka Associates, L.L.C., *doing business as* A&S Home Health Care; Goodwin Hospice, L.L.C.; North Texas Best Home Healthcare, Incorporated; Excel Plus Home

Health, Incorporated; Phoenix Hospice, Incorporated; One Point Home Health Services, L.L.C., formerly known as One Point Home Health, L.L.C.; Home Health Plus, Incorporated; International Tutoring Services, L.L.C., formerly known as International Tutoring Services, Incorporated, doing business as Hospice Plus; Curo Health Services, L.L.C., formerly known as Curo Health Services, Incorporated; Hospice Plus, L.P.,

Defendants—Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 3:12-CV-4457
USDC No. 3:13-CV-3392
Filed July 30, 2021

Before Jolly, Stewart, and Oldham, Circuit Judges.
Per Curiam:*

Qui tam relator Christopher Capshaw sued Bryan White, Suresh Kumar, and other defendants under the False Claims Act ("FCA"), 31 U.S.C. § 3729

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* Pursuant to 5th Circuit Rule 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5th Circuit Rule 47.5.4.

et seq. In addition to violations of the FCA, Capshaw alleged violations of the Federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, and a federal statute known as the Stark Law, 42 U.S.C. § 1395nn. Specifically, he alleged that White and Kumar "knowingly set up a system of kickbacks and illegal referrals" between American Physician House Calls ("APH") and health care companies that White and Kumar owned. This enabled White and Kumar to "substantially bill" and "receive payment from" Medicare— but only after falsely certifying they had complied with all applicable laws.

Nine months later, Appellants Kevin Bryan and Franklin Wendt filed a similar action against the same and similar defendants. They too alleged violations of the FCA, the Anti-Kickback Statute, and the Stark Law. They too alleged that White and Kumar "directed and committed . . . illegal kickbacks in order to increase [their] . . . number of patients." And they too alleged that APH was "an important source of patient referrals." But Bryan and Wendt's complaint was not completely identical to Capshaw's. In addition to seeking relief under the FCA, they relied on "analogous Texas statutes" like the Texas Medicaid Fraud Prevention Act ("TMFPA"). And in addition to describing a kickback scheme involving APH, they alleged that White and Kumar offered kickbacks to nursing homes, assisted living facilities, and hospitals too.

The district court dismissed Bryan and Wendt's claims under the FCA's first-to-file bar, which prohibits relators from bringing "a related action based on the facts underlying" a pending FCA

qui tam action. 31 U.S.C. § 3730(b)(5). The court determined that Bryan and Wendt's "add[itional] factual details" and "analog[ous]" TMFPA claims were not sufficient to render their action "unrelated" to Capshaw's. So the first-to- file bar applied. The district court subsequently denied Bryan and Wendt's motion for reconsideration.

Despite the district court's dismissal, Bryan and Wendt entered a settlement agreement that released the defendants from their FCA and TMFPA claims and reserved the right "to assert their claims for reasonable expenses, attorney's fees, and costs." Bryan and Wendt later filed three motions for attorney's fees. The district court denied all of them because the first-to-file bar meant Bryan and Wendt were not proper parties to the qui tam action. Bryan and Wendt filed a motion for reconsideration, which the district court also denied. This appeal followed.

We affirm "for essentially the reasons stated by the district court." *Razvi v. Guarantee Life Ins.,* 254 F.3d 1080 (5th Cir. 2001) (per curiam) (unpublished). The district court thoroughly examined the issues in five separate decisions and faithfully applied the statutory text and our precedent in doing so. We see no reason to disturb or expound upon its rulings.

AFFIRMED.

THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

UNDER SEAL

Plaintiffs

FILED UNDER SEAL
DO NOT PUT IN PACER

COMPLAINT

vs.

PURSUANT TO
31 U.S.C.
§§3729-3732,
FEDERAL FALSE
CLAIMS ACT

UNDER SEAL

JURY TRIAL DEMAND

Defendants

COMPLAINT

FILED UNDER SEAL

The United States District Court
For The Northern District of Texas
Dallas Division

UNITED STATES OF AMERICA *Ex rel.* KEVIN BRYAN AND FRANKLIN BROCK WENDT	CIVIL ACTION NO.____
and	FILED UNDER SEAL DO NOT PUT IN PACER
STATE OF TEXAS *Ex rel.* KEVIN BRYAN AND FRANKLIN BROCK WENDT	COMPLAINT PURSUANT TO 31 U.S.C §§ 3729-3732, FEDERAL FALSE CLAIMS ACT
Plaintiffs, vs.	
Hospice Plus, LP; International Tutoring Services, LLC, f/k/a International Tutoring Services, Inc., and d/b/a Hospice Plus; Curo Health Services, LLC f/k/a Curo Health Services, Inc.; Suresh Kumar, R.N., individually;	JURY TRIAL DEMANDED

and Bryan K.
White, M.D.,
individually.

Defendants.

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COMPLAINT PURSUANT TO 31 U.S.C. §§ 3729-3733,
FEDERAL FALSE CLAIMS ACT

The United States of America and the State of Texas, by and through *qui tam* Relators Kevin Bryan ("Bryan") and Franklin Brock Wendt ("Wendt") (collectively herein, "Relators" or "Qui Tam Plaintiffs"), bring this action under 31 U.S.C. §§ 3729-3733 (the "False Claims Act"), the Medicare and Medicaid Patient Protection Act of 1987, 42 U.S.C. § 1320a-7b ("Anti-Kickback Statute") and analogous Texas statutes, to recover all damages, penalties and other remedies established by the False Claims Act and analogous Texas law, and on behalf of the United States, the State of Texas, and Relators would show the following:

PARTIES

1. Relator Kevin Bryan ("Bryan") is an individual citizen of the United States and currently resides in Rockwall, Texas.

2. Relator Franklin Brock Wendt ("Wendt") is an individual citizen of the United States and currently resides in Denison, Texas.

3. Defendant Hospice Plus, L.P. is a Delaware corporation with its principal place of business at 3100 McKinnon, Suite 2100, Dallas, TX 75201. Hospice Plus, LP, may be served by serving its registered agent for service of process, Kathleen Fritz, Vice President, National Registered Agents, Inc., 350 N. St. Paul Street, Suite 2900, Dallas, Texas 75201-4234.

4. Defendant International Tutoring Services, LLC, f/k/a International Tutoring Services, Inc., and d/b/a Hospice Plus is a Delaware limited liability company with its principal place of business at 3100 McKinnon, Suite 2100, Dallas, TX 75201. International Tutoring Services, LLC, may be served by serving its registered agent for service of process, Kathleen Fritz, Vice President, National Registered Agents, Inc., 350 N. St. Paul Street, Suite 2900, Dallas, Texas 75201-4234.

5. Defendant Curo Health Services, LLC f/k/a Curo Health Services, Inc. is a Delaware limited liability company with its principal office address at 491 Williamson Road, Suite 204, Mooresville, NC 28117. Curo Health Services, LLC, may be served by serving its registered agent for service of process, CT Corporation System, 150 Fayetteville Street, Box 1011, Raleigh, North Carolina, 27601.

6. Defendant Suresh Kumar, R.N., ("Kumar") is an individual residing in Dallas County, Texas, who may be served with process at his residence, 2629 Serenity Ct., Carrollton, Texas 75010.

7. Defendant Dr. Bryan K. White, M.D. is an individual residing in Tarrant County, Texas, who may be served with process at his residence, 1307 Sylvan Ct., Arlington, Texas, 76012.

JURISDICTION AND VENUE

8. Jurisdiction and venue are proper in this Court for the following reasons:

a. Jurisdiction for this Court exists pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(1) and 31 U.S.C. § 3732(a), because Relators'

claims seek remedies on behalf of the United States for Defendants' multiple violations of 31 U.S.C. § 3729, some or all of which occurred in the Northern District of Texas, The Court has both general and specific personal jurisdiction over Defendants because each of them transacts substantial business and/or resides within the Northern District of Texas, and because a substantial part of the transactions upon which this action is based occurred in the Northern District of Texas. This Court has supplemental jurisdiction over the State FCA claims pursuant to 31 U.S.C. § 3732(b) and 28 U.S.C. § 1367.

b. Venue exists in the United States District Court for the Northern District of Texas pursuant to 31 U.S.C. § 3730(b)(1), because the Defendants reside in, are qualified to do business in the State of Texas, and/or have transacted substantial business within the State of Texas and in Texas.

INTRODUCTION

9. This is a civil action to recover damages and civil penalties on behalf of the United States of America and the State of Texas arising from false claims for payment submitted to the United States and State of Texas, false statements including false certifications, kickbacks, and other violations of federal and state law. This *Qui Tam* Complaint, as of the summer of 2013, describes what is at least an eight-year-long practice by two north Texas businessmen, their hospice and home health companies, and the subsequent owner of those businesses, of "buying" terminally ill Medicare and Medicaid patients from area nursing homes, assisted living facilities, doctors, and hospitals, with all types of gifts, including cash, gift cards, lunches, dinners, happy hours, tickets to Rangers and Cowboys games, elaborate Christmas gifts, cars, manicures and pedicures, and free power lift chairs for disabled patients, as well as with the services of skilled nursing staff that they offered and provided at no cost to area nursing homes and assisted living facilities in return for the promise and performance of hospice and home health patient referrals.

10. Relator Kevin Bryan (“Bryan”), who worked for Defendant Hospice Plus, LP, ("Hospice Plus") from early 2006 to November of 2012, and for a home health company owned in whole or in part by one of Hospice Plus's owners from May of 2013 to July, 2013, was Hospice Plus's Director of Marketing. Relator Franklin Brock Wendt ("Wendt") worked as a nurse marketer for Hospice Plus from 2009 to July

2013. Relators were each involved in carrying out Hospice Plus's pay-for-patients scheme, and were both eye witnesses to the same efforts by fellow employees and by Hospice Plus's two principals, which were continuous and are ongoing. Relators describe herein how Hospice Plus's two principals, Suresh G. Kumar, R.N., ("Kumar") and Bryan K. White, M.D., ("White"), directed and committed these illegal kickbacks in order to increase Hospice Plus's patient census (its number of patients at any given time). Relators have personal knowledge that more than 75 percent, conservatively, of all patients referred to Hospice Plus since 2006 were from sources that Hospice Plus was bribing and rewarding on an ongoing basis. Relators witnessed that more than 90 percent of these patients were Medicare or Medicaid patients, and approximately 90 percent of those were Medicare. Hospice Plus submitted claims for payment electronically to CMS every month for these patients. All of these claims were false claims under the False Claims Act and the Texas Medicaid Fraud Prevention Act because they were for patients who had been obtained with kickbacks and/or rewards to the referring organization, its managers and/or employees, or the patient.

11. Because of the number of patients involved (on average, approximately 600 Medicare patients per year, though Relators say the actual number is probably higher) and Medicare's reimbursement schedule for hospice patients (on average $200 per patient, per day, 365 days per year), the amount of money the Defendants have obtained

from the Federal government by their fraud is, to date, probably in excess of $350,000,000.00.

12. Hospice Plus's principals, Suresh G. Kumar, R.N., and Bryan K. White, M.D., have, since the early 2000's, created and operated many hospice and home health companies in north Texas, including Hospice Plus North East, Phoenix Hospice, Phoenix Hospice Care, Goodwin Hospice, Choice Hospice, Choice Plus Hospice, Home Health Plus, Phoenix Home Healthcare, Goodwin Home Health, Excel Plus Home Health, North Texas Best Home Healthcare, A&S Home Health Care, One Point Home Health, and One Point Health Services. All of these companies, some of which were housed together for years, have been procuring patient referrals using gifts, bribes, and rewards. Suresh Kumar's family members, including his wife, Remani Kumar, his son, Sabari Kumar, his cousin (or nephew), Sathyajith Nair, and also his accountant, Hari Pillai, have been principals in some of these companies. Dr. White's sister, Kelli White, has been Director of Sales and Vice President of Finance and Risk Management of Hospice Plus. Kumar and White methodically grew Hospice Plus's census using bribes, kickbacks and rewards, and then sold Hospice Plus, and its various affiliates, to Curo Health Services, LLC, ("Curo") of North Carolina, in 2011 or 2012. Curo Health Services' principals were actively involved in the evaluation of Hospice Plus and have actively overseen its operations in Texas along with Kumar and White since its acquisition.

13. The purpose of this action is to bring into the public light violations of the Anti-Kickback Statute ("AKS"), 42 USC § 1320a-7(b), and of the False

Claims Act ("FCA"), 31 USC § 3729 *et seq.*, resulting from the fraudulent conduct of Hospice Plus, Kumar, White, and Curo, which have been ongoing continuously since at least as early as 2005, and to recover damages for the United States and Texas from the perpetrators. The purpose of the AKS is to eliminate the practice of willfully offering, paying, soliciting, making or accepting payment to induce or reward any person or entity for referring, recommending or arranging any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program, which includes any State health program or health program funded in part by the federal government. 42 U.S.C. §§ 1320a-7(b)(b) and 1320a-7(b)(f). A claim that includes items or services resulting from a violation of these anti-kickback sections constitutes a *per se* false or fraudulent claim for purposes of the FCA.

14. The unlawful activities violating, in part, the FCA, included the proactive, purposeful actions of Defendants. Defendants' violations were not minor or inadvertent but systematic conduct arising out of Defendants' greed and disregard for legal consequence or harm to others.

15. False claims against the United States arise when a false certification by a contractor, express or implied, is used to obtain a payment. An express false certification is the fraudulent completion of a certificate of compliance with a statute or regulation that is material to the government's decision to make a payment. As a direct, proximate and foreseeable result of the Defendants' fraudulent course of conduct as set forth above and herein, the

Defendants submitted tens of thousands of false and fraudulent claims and certifications to Medicare, and thousands of false and fraudulent claims to Medicaid, seeking payment for their hospice care patients and home health care patients from at least 2005 through the present day.

THE MEDICARE PROGRAM

16. The Medicare program, established by Title XVIII of the Social Security Act, *42 U.S.C. § 1395 et seq.*, is a government-sponsored health insurance program that pays for covered medical services provided to eligible aged and disabled individuals. The Medicare program is supervised by the Centers for Medicare and Medicaid Services, ("CMS") in the Department of Health and Human Services ("HHS"). CMS in turn contracts with private organizations referred to as "fiscal intermediaries," to act as the HHS Secretary's agents in reviewing and paying claims submitted by health care providers. 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.3, 421.100. Congress requires a medical provider to file a claim for payment on one of the claim forms prescribed by CMS. 42 C.F.R. § 424.32(a)(1).

17. According to the CMS, a hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the conditions of participation for hospices, and has a valid Medicare provider agreement. Although some hospices are part of a hospital, nursing home, or home health agency, hospices must meet specific Federal requirements and be separately certified and approved for Medicare participation. CMS requires an entity that wishes to

participate in the Medicare program to submit a completed 855A claim form "Medicare Federal Health Care Provider/Supplier Applications that will Bill Medicare Fiscal Intermediaries," or Form CMS-855B "Medicare Federal Health Care Provider/Supplier Applications that will Bill Medicare Carriers" to request payment for specific medical services. 42 C.F.R. § 424.32(b). Form 855-A requires the provider to sign a certification that states in relevant 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.

18. If a provider submits false, inaccurate, or incomplete information on its CMS 855B or 855A claim for Medicare payment, or if a provider submits a claim to CMS when it knew or should have known that it was not entitled to receive Medicare payment, it is considered a false statement and/or certification to the Government and is actionable under the FCA. Any claim for payment that includes a request for payment for items or services resulting from a

violation of the Anti-Kickback Statute, 42 USCS § 1320a-7b, constitutes a false or fraudulent claim for purposes of the FCA. 42 USCS § 1320a-7b(g). Intent is not an element of an Anti-Kickback Act violation. 42 USCS § 1320a-7b(h). In addition, in submitting a claim for Medicare reimbursement, the provider certifies that the submitted claim is eligible for Medicare reimbursement and that the provider is in compliance with all Medicare requirements. Herein, due to illegal kickbacks, virtually all claims were not eligible.

THE ANTI-KICKBACK STATUTE

19. The purpose of the Anti-Kickback Act, 42 USCS § 1320a-7b ("AKS") is to eliminate the practice of any person or entity from knowingly and willfully offering, paying, soliciting, making or accepting payment to induce or reward any person or entity for referring, recommending or arranging any good or items for which payment may be made in whole or in part by a federal health care program, which includes any State health program or health program funded in part by the federal government. 42 U.S.C. §§ 1320a-7(b)(b) and 1320a-7(b)(f).

20. A "kickback" means any money, fee, commission, credit, gift, item of value or compensation of any kind which is provided directly or indirectly, for the purpose of obtaining favorable treatment with a contract. Under the AKS, it is illegal to (1) knowingly and willfully (2) offer or pay any remuneration (3) to induce such person to refer an individual to a person for the furnishing or arranging . . . of any item or service for which payment may be made in whole or in part under a Federal health care program. *See* 42

U.S.C. § 1320a-7b(b)(2). In pertinent part, the AKS states:

> (b) Illegal remuneration
>
> (1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind –
>
> > (A) in return for referring 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) in return for purchasing, leasing, ordering, or arranging for or recommending 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.

> (2) 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).

21. In addition to criminal penalties, a violation of the AKS can also subject the perpetrator

to exclusion from participation in federal health care programs (42 U.S.C. §1320a-7(a), civil monetary penalties of up to $50,000 per violation (42 U.S.C. §1320a-7a(a)(7), and three times the amount of remuneration paid, offered, solicited, or received, regardless of whether any part of the remuneration is for a lawful purpose. 42 U.S.C. §1320a-7a(a).

22. In addition to the penalties provided for in this section or section 1128A [42 USCS § 1320a-7a], a claim that includes items or services resulting from a violation of these sections constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code [The False Claims Act, 31 USCS §§ 3721 et seq.]. With respect to violations of section 42 USCS § 1320a-7b(b), a person need not have actual knowledge of this section or specific intent to commit a violation of this section. 42 USCS § 1320a-7b.

23. Similarly, the Stark law generally prohibits a physician from referring Medicare and Medicaid patients for designated health services to an entity in which the physician has a nonexempt financial interest. 42 U.S.C. §§ 1395nn(a)(1) and 1396b(s). The goal of Stark is "to curb overutilization of services by physicians who could profit by referring patients to facilities in which they have a financial interest." *See* Jo-Ellyn Sakowitz Klein, *The Stark Laws: Conquering Physician Conflicts of Interest*, 87 GEO. L.J. 499, 511 (1998). Stark has three prima facie elements: (1) a "financial relationship" between a physician and a medical entity; (2) a referral from such physician to the medical entity for designated health services; and (3) a claim presented or caused to

be presented by such medical entity to an individual, third party payor, or other entity for designated health services furnished pursuant to a referral under subparagraph (A). *See* 42 U.S.C. §1395nn(a)(1).

THE CORPORATE DEFENDANTS

24. Defendant Suresh G. Kumar, R.N., ("Kumar") formed International Tutoring Services, Inc., in 2003. International Tutoring Services, Inc., assumed the name "Hospice Plus" in June of 2004. Defendant Hospice Plus, L.P., was formed in July of 2005 by Defendant Bryan K. White, M.D., ("White"). International Tutoring Services, LLC, was formed in September of 2010, and International Tutoring Services, Inc., was converted to International Tutoring Services, LLC, in September of 2010. Defendant International Tutoring Services, LLC, f/k/a International Tutoring Services, Inc., and d/b/a Hospice Plus is sometimes referred to herein as Defendant "International Tutoring." Defendant Curo Health Services, LLC, sometimes referred to herein as Defendant "Curo", acquired International Tutoring Services, LLC, Hospice Plus, L.P., and many of their affiliated entities, which were owned and/or operated by Defendants White and Kumar in or about 2010 to 2012.

25. At all times relevant hereto, Defendant Hospice Plus was the Alter Ego, as that term is defined by law, of Defendant International Tutoring. In particular, at all times material hereto, Defendant International Tutoring dominated Defendant Hospice Plus to the extent that Defendant Hospice Plus was a mere tool or business conduit of Defendant International Tutoring, such that the ostensible

separate legal existence of said Defendants was a fiction. Further, Defendant Hospice Plus was, at all times relevant hereto, and continues to be, undercapitalized relative to the risks it took in the Texas health care market, such that the corporate veil of Defendant Hospice Plus should be pierced and Defendant International Tutoring should be held liable for the tortious conduct of Defendant Hospice Plus.

26. Pursuant to said doctrine, Defendant International Tutoring is responsible for the acts and/or omissions of the vice principals, employees, servants, agents, ostensible agents, and/or representatives of Defendant Hospice Plus.

27. Further, at all times relevant hereto prior to Defendant Curo's acquisition of Defendants International Tutoring and Hospice Plus, Defendants International Tutoring and Hospice Plus were each the Alter Ego, as that term is defined by law, of Defendants Kumar and White. On information and belief, Defendants White and Kumar controlled International Tutoring and Hospice Plus completely, commingled corporate funds of Defendants International Tutoring and Hospice Plus with their own funds, and hired and utilized employees for Defendants International Tutoring and Hospice Plus interchangeably. Moreover, Defendants Kumar and White undercapitalized Defendants International Tutoring and Hospice Plus relative to the risks those entities took in the Texas health care market, such that the corporate veil of Defendants International Tutoring and Hospice Plus should be pierced and Defendants Kumar and White should be held liable for

the tortious conduct of Defendants International Tutoring and Hospice Plus.

28. Pursuant to said doctrine, Defendants Kumar and White are responsible for the acts and/or omissions of the vice principals, employees, servants, agents, ostensible agents, and/or representatives of Defendants International Tutoring and Hospice Plus.

FACTS – RELATOR KEVIN BRYAN

29. Relator Kevin Bryan ("Bryan") witnessed violations from 2005 to November of 2012 and from May to July of 2013. Bryan was a marketer, an assistant marketing director, and then a marketing director for Defendant Hospice Plus from 2006 to 2012. Relator is a Texas native, who received his degree in Fire Science in 1996 from Kilgore College Fire Academy and subsequently became a certified firefighter/emergency medical technician ("EMT"). After working as an EMT and operating his own emergency medical response business for several years, in about 2002 Bryan went to work for American Hospice as a Community Liaison. American Hospice, which was based in DeSoto, Texas and Fort Worth, Texas provided hospice care to terminally ill patients who had been given a diagnosis with a life expectancy of six months or less if the illness were to run its normal course.

30. In the course of his employment with American Hospice, Bryan met Dr. Bryan White, who at the time was the Medical Director at Lennwood Nursing Home. Dr. White was employed at the time

by Vitas Innovative Hospice Care, and later became a "team physician" for American Hospice. In the course of his employment at American Hospice, Bryan would find nursing homes in need of a doctor and would suggest Dr. White, so that American Hospice would have a relationship with those facilities, which could help with hospice patient referrals. Bryan then met Dr. White's partner, Dr. Gene Bigham, who also became a team physician at American Hospice. Dr. Bigham was also Medical Director with Dr. White at some facilities.

31. In the fall of 2004, approximately seven months before Dr. White resigned from American Hospice, Bryan had lunch with Kirk Short, who was opening American Physician Housecalls, or "APH". APH provided medical and nursing services at patients' homes, primarily to the chronic and terminally ill. Short was looking for a physician that worked in a large number of nursing homes, so Bryan told Short about Dr. White. This was in the fall of 2004, while Dr. White was still with American Hospice. Bryan introduced the two at a lunch. During the lunch Short, White, and Bryan discussed Dr. White's plans for a new hospice company, which he was in the process of forming as Hospice Plus, and also discussed the potential for a large number of homebound patients, as that is a primary source of revenue in the hospice market.

32. A few months after that lunch, but while Dr. White was still with at American Hospice, Bryan and Dr. White met again with Short, and also Yale Sage, another owner of APH, to introduce them to Dr. White's business concept of the hospice business, and

the potential he saw for large profits in that business. In the spring of 2005, Dr. White resigned from American Hospice and opened Hospice Plus. Bryan stayed at American Hospice for another year, and left there in about January or February of 2006.

33. In 2005, during his final year working for American Hospice, Bryan was at Park Manor, a skilled nursing and rehabilitation facility, when Angela Chatham, the Marketing Manager for Hospice Plus at the time, and Dr. White were hosting a luncheon for all of the department heads (roughly 30-40) of Park Manor, including the Administrator, the Director of Nursing ("DON"), and the Charge Nurses.

34. In about February of 2006, after losing a majority of patients to Hospice Plus, Bryan left American Hospice and joined Hospice Plus. Bryan was employed with Hospice Plus from 2006 to 2012. Bryan first met Suresh Kumar ("Kumar") in 2006 for his job interview. Kumar was Dr. White's business partner. When Bryan first started at Hospice Plus, he would go to nursing homes where he marketed for Hospice Plus. Bryan would introduce himself as the new marketing representative for Hospice Plus, and as time went on, Bryan would give staff members a Dillard's or Macy's gift card, or do a lunch for the staff. Bryan turned in these expenses to Kelli White, Dr. White's sister, who was the accounts payable manager at Hospice Plus. The purpose of these efforts was to induce the facilities or responsible personnel to refer patients to Hospice Plus. Bryan also worked closely with Hospice Plus's marketing manager, Angela Chatham.

35. In the hospice and nursing home industry, March is Social Work Month. Social Work

Month is set aside to honor social workers throughout the country for their hard work. At the beginning of March, 2006, Dr. White, Angela Chatham, and Bryan purchased gifts, and Visa gift cards, to distribute throughout the month to personnel at various facilities. They gave gift cards to Mark Knoll, Administrator at Laurenwood Nursing and Rehabilitation, Ann Mann, Director of Nursing at Laurenwood, Gary Bagwell, a social worker at Mesquite Tree Nursing Center, and various doctors at Treemont Nursing Home, to name a few who received such gifts. The three started by distributing gifts to these facilities, where Dr. White was medical director, since those facilities would be a good source of patient referrals to Hospice Plus. At the time, Bryan was a marketing representative with Hospice Plus. At Dr. White's instruction, Hospice Plus's marketing employees also did this during National Nursing Home Administrator's Week (March), Nurse's Week (May), and Certified Nurse's Aide Week (June) of 2006. These gift cards were in amounts ranging from $10 up to $100. Dr. White had the marketers deliver the more expensive cards to the various administrators and directors of nursing, and less expensive cards to the charge nurses and nursing staff of these facilities. The purpose of giving all of these cards and gifts was to induce the recipients and the facilities for which they worked to refer patients, including Medicare and Medicaid patients, to Hospice Plus.

36. In the summer of 2006, Bryan began assisting the marketing manager, Angela Chatham, with hosted lunches at nursing facilities where Dr.

White was the medical director. The first lunch Bryan helped host was for the entire staff at Doctor's Nursing Home in Dallas. At the time, Chatham and Bryan didn't have company issued credit cards, so Dr. White would have Kelli White, his sister, who was the accounts payable manager at Hospice Plus, cut a check and give it to Chatham and/or Bryan to cover the meeting or function expenses, or Dr. White would attend with the marketing employees and pay for it himself. The intent of hosting these lunches for the staffs of the nursing facilities was to induce them to refer patients, including Medicare and Medicaid patients, to Hospice Plus. This was well known at Hospice Plus.

37. Dr. White also had the Hospice Plus marketing employees host free "happy hours" and sponsor parties for referral sources. In the spring and summer of 2007, Dr. White had the marketers host several parties, including a Cinco de Mayo party at Benavides Mexican Restaurant, for the administrators, directors of nursing, and social workers of the nursing homes from whom Hospice Plus was getting patient referrals, including Beth, Director of Nursing at Park Manor, Roy, the Administrator from Red Oak Nursing Home, and Kelly, the Activities Director at Avanté Rehabilitation Center in Irving, to name a few. On another occasion, in about March of 2006, Hospice Plus marketers hosted a big dinner at a Dallas steakhouse for Michael Tobias, who at the time owned several Lexington Independent Living facilities. None of the guests paid anything for their food or drink, since Hospice Plus had paid for it all. Mr. Tobias and Dr. White

subsequently produced a marketing commercial about the quality of care and facilities at the Lexington Independent Living homes. Also, a woman named Susie at Treemont Nursing Home told Bryan that Dr. White took her and some co-workers to Ocean Prime. The purpose of hosting these dinners was to induce the guests to refer patients, including Medicare and Medicaid patients, to Hospice Plus.

38. Bryan kept gift cards in his pockets whenever he went to any nursing home, assisted living facility, or any other location where he might get patient referrals, and handed them out to staff members as a way of inducing them to give Hospice Plus more patients. The purpose of all of these gift cards, gifts, lunches and parties was to induce the facilities to refer patients to Hospice Plus.

39. These efforts worked well, as the facilities to whom Hospice Plus gave these gifts, and for whom it purchased the lunches and provided dinners, increased the number of patients they referred to Hospice Plus. As is true of hospice patients in general, more than 95 percent of these patients were insured by Medicare or Medicaid, with the rest being private pay or uninsured patients. Of the 95 percent who were insured by Medicare or Medicaid, the vast majority of them, probably 90 percent, were Medicare patients.

40. In September or October of 2006, Angela Chatham resigned from Hospice Plus, and Bryan was promoted to Director of Marketing. As Director of Marketing at Hospice Plus, Bryan's job was to increase the number of patients referred to Hospice Plus, find new employees, to continue giving gifts to

referral sources as a method of getting new patients, and to find new ways of getting new patient referrals. Bryan reported directly to Dr. White, who oversaw marketing efforts, including marketing expenses.

41. Every year from 2006 to 2009, Dr. White hosted a Hospice Plus Christmas party, which was usually held in the ballroom at the Renaissance Hotel in Dallas, and the guests included Hospice Plus referral sources. These included Sam George Thoyakulathu in Bonham, Sheila Halcrow from American Physician Housecall "(APH"), and Dr. Tyson Barnes and his wife, Carmen, from Terrell, Texas, as well other doctors. Before Hospice Plus's November, 2006 Christmas party, at Dr. White's instructions, Bryan went to a "big-box" retail store (a Target, Wal-Mart or Sam's Club) in Mesquite, Texas, to purchase a flat-screen television, and delivered it to Lexington Independent Living on Spankybranch Drive in Dallas for Michael Tobias, its owner. Dr. White instructed Bryan to do this so that Lexington would have the television for its own company Christmas party. Bryan delivered the television, introduced himself, and thanked Tobias's staff for the patients they had been sending Hospice Plus. The purpose of this gift was to reward Dr. Tobias and the staff at Lexington Independent Living for the patients, including Medicare and Medicaid patients, they had been referring to Hospice Plus, and to induce them to refer additional patients, including Medicare and Medicaid patients, to Hospice Plus.

42. American Physicians Housecalls ("APH"), which provided medical and nursing services at patients' homes, had a large presence in the Dallas

area, and in 2007 it was an important source of patient referrals for Hospice Plus. Although APH was not a "home health" company or a "hospice" company, it did provide care to home health patients of other companies. APH's doctors and nurses simply made house calls to homebound patients and were therefore an important potential source of patient referrals for Hospice Plus. Sheila Halcrow was Vice President of Operations for APH. Halcrow and Bryan worked together on patient referrals. Because Bryan had many contacts in the health care industry, he helped Halcrow place home health patients who were dissatisfied with their current home health provider, but who were not qualified for hospice, with other home health companies. In return, Halcrow referred patients who qualified for hospice to Hospice Plus. Additionally, Kirk Short, Chief Operating Officer, and Yale Sage, Chief Executive Officer of APH, would allow Dr. White to review the charts of APH patients to find diagnoses that would qualify them for hospice. Halcrow would then contact the patient's family and explain the benefits of hospice, and would send them to either Hospice Plus or Phoenix Hospice, as instructed by Dr. White. In return for those referrals, Bryan was instructed to give Halcrow gifts such as gift cards, lunches, or whatever item of monetary benefit she requested. On information and belief, Kumar paid for Halcrow to have plastic surgery as a "gift."

43. When Bryan started at Hospice Plus, on information and belief Kumar had already opened a company called Home Health Plus; while Dr. Gene Bigham and Dr. White were operating another company, which on information and belief was

Phoenix Hospice. Starting in 2007 and 2008, Halcrow sent patients to both these companies, as she also did to Hospice Plus, which she did either directly or through Bryan, so that all three companies could grow their census. The same marketing schemes of bribes, kickbacks and rewards were used to get patient referrals for all three of these companies.

44. In or about January 2007, Kumar took over the management of the marketing team, and Hospice Plus issued the marketing staff, including Bryan, individual corporate American Express cards in January or February. On Kumar's instructions, given over time, the marketing staff used their company cards to purchase gift cards, alcohol, expensive dinners for doctors, and other gifts to be given to referral sources in exchange for patient referrals to Hospice Plus.

45. Shortly after February 2007, Dr. White hired Scott Burkett from American Hospice to join the Hospice Plus marketing department. Over time, Dr. White hired more marketing employees to support these efforts to obtain more patient referrals. The total actual monthly expenses the Hospice Plus marketing team spent on gifts for patient referrals were commonly thousands of dollars. Upon information and belief, from 2007 to 2009, Burkett's company American Express card charges would range from $8,000 - $12,000, much of which was for the purchase of gifts for his solicitation of patient referrals to Hospice Plus. On information and belief, the marketing team collectively would spend in total anywhere from $100,000 to $200,000 a year, thousands of dollars of which were for gifts for patient

referrals. In 2009 the Christmas "gifts" alone that Hospice Plus gave to its referral sources and potential referral sources cost more than $30,000. Additionally, in 2010 the Christmas "gifts" were more than $18,000. All of the marketing team members were charging at least $1,000 to $2,000 monthly in "gifts" for patient referrals on their company American Express cards. In early 2007, soon after he was hired, Burkett became Assistant Director of Marketing for the Southern Dallas-Fort Worth Region, while Bryan was responsible for the Northern Dallas- Arlington area. Burkett and Bryan each reported directly to Kumar, and also pitched new marketing concepts to Dr. White. Among other "marketing" strategies, Kumar gave the Bradfield House, an assisted living facility in Mesquite, Texas, an electric wheelchair for one of its patients. On information and belief, Kumar used his own personal funds for this purchase. Bryan sponsored lunches and open houses at Bradfield, and gave Ann, their Administrator, gift cards, all using his Hospice Plus company American Express card. Ann was married to a Hospice Plus chaplain.

46. As part of their jobs, every Monday at 10:00 a.m. from 2007 until Bryan left the Dallas office to work outlying areas early in 2010, Burkett and Bryan pitched ideas to Kumar about how to get more patient referrals. Kumar expected Burkett and Bryan to assist with ideas to get patients referred to Hospice Plus.

47. In October of 2007, while Bryan continued as Director of Marketing for Hospice Plus, Kumar had Bryan form KBryan Consulting, Inc., because Bryan had been spending a large amount of

time getting patients for Kumar's new home health companies, including Home Health Plus. KBryan Consulting was paid $100 for each patient Bryan got for Home Health Plus. Bryan obtained these patients mostly from Halcrow at APH. On Kumar's instructions, Bryan created false KBryan consulting time invoices to submit to Home Health Plus so that it would not appear that Home Health Plus was paying Bryan for referrals. These invoices would therefore reflect that Bryan had provided consulting to facilities and doctors including Seven Oaks Nursing Home, St. Paul Hospital, Dr. Abubaker, Dr. Sam George Thoyakulathu, and Dr. Shaw at Red River Regional, Dr. Garrett Price at Medical Center of Plano, Bradfield Assisted Living, UT Southwestern Oncology, Treemont Assisted Living, Dr. Ololade Ries, and many others.

48. On September 11, 2008, Kelli White emailed Bryan an expense report form and a "sample filled out expense report," which she included "to give Bryan an idea of what she was looking for." The sample items of expenses that she, Hospice Plus's billing manager, was "looking for" included $200 for a business lunch with doctors, $340 for a "cookout function" at Park Manor Nursing Home, $600 for pizzas at Cedar Hill Nursing Home, $500 for tickets to Cowboys games for the Administrator of Avanté Rehabilitation Center, and $3,000 for a karaoke party for the southern region nursing homes. The purpose of these types of gifts, which Hospice Plus was "looking for" its marketers to give, was to induce the recipients to refer patients, including Medicare and Medicaid patients, to Hospice Plus.

49. Another of Hospice Plus's schemes to induce patient referrals, which was expressly approved by Kumar or Dr. White, involved offering to provide the services of nurses and/or Certified Nurse's Aides (CNAs) to nursing homes or assisted living facilities. Medicare pays nursing homes (assisted living facilities) a per diem for patients at the nursing home facility who are on hospice. The facility's per diem is for specific services to the patient, which includes a certain amount of nursing care and a certain amount of CNA care, such as emptying bedpans, and helping patients with dressing and feeding. When a patient living in a nursing home is on hospice care, the patient's hospice company, which is a Medicare/Medicaid certified company separate from the nursing home company, is also paid a per diem by Medicare for providing certain items of care, including having a CNA at the facility on three days of the week. On each of those three days, the hospice CNA will typically spend one to two hours to provide the specified care to a given patient. Hospice Plus marketers, including Bryan, would approach a nursing home or an assisted living facility where Hospice Plus had two to four hospice patients, and propose that, as soon as the facility had referred to Hospice Plus a total of six patients housed at the facility, Hospice Plus would place one of its own nurses or CNAs, or both, at that facility <u>full time</u> (eight hours a day, five days a week, and sometimes seven days a week), as long as that facility would get Hospice Plus more than eight patients at that facility quickly. In other words, Hospice Plus would offer to provide a facility the services of additional staff to help

with the facility's work, including providing care to non-Hospice Plus patients, in order to induce patient referrals. Hospice Plus needed a total of eight patients at a facility to justify the cost of placing one full-time CNA there, because the CNAs were contracted with Medicare to provide at least one hour of care for each patient per day. Eight patients would justify one full-time CNA (i.e., 8 patients x 3 days/week/patient X 1-2 hrs. /day = 24 - 48 hours per week = 3 to 6 full days). Hospice Plus, however, offered to put a full time CNA at a facility when it reached only six patients, and sometimes as few as only four patients, as an inducement to receive the majority of referrals from that facility. Hospice Plus made it a condition that the facility get Hospice Plus to at least eight patients at that facility or Hospice Plus would have to pull its CNAs out of that facility. Suddenly pulling a full-time caregiver, and leaving only a part-time person could leave the facility short-staffed, as it takes time to find and hire qualified caregivers. This could potentially put patients' wellbeing at risk. Hospice Plus marketers, including Burkett and Bryan did this from about 2008 to 2010 in all their territories. Hospice Plus did this at Doctors' Nursing Home, Balch Springs Nursing Home, Plaza at Edgemere (now just "Edgemere"), and Mesquite Tree Nursing Home, among others. The purpose of this offer by Hospice Plus of "free" skilled nursing labor was to induce these facilities to refer patients, including Medicare and Medicaid patients, to Hospice Plus. This scheme resulted in additional patient referrals to Hospice Plus.

50. From 2008 to 2010, Burkett and Bryan continued to expand territories, with each of them responsible for finding nurses, physicians, and new marketers to continue using these same techniques for soliciting patient referrals. Hospice Plus gave Visa gift cards to, among others, Gary Bagwell, a social worker, and Dee, the Director of Nursing, at Mesquite Tree Nursing Home, Kelly, the Activities Director at Avanté Rehabilitation Center in Irving, and Trackea Scott, a social worker at Balch Springs Nursing Home. Bryan also gave a bottle of vodka about once a month as a gift to Dee at Mesquite Tree Nursing Home, and once gave a bottle of vodka as a gift to the Director of Nursing at Rowlette Nursing Home and Rehabilitation Center. The purpose of these gifts was to induce the recipients and the facilities for which they worked to refer patients, including Medicare patients, to Hospice Plus.

51. Hospice Plus was most successful in marketing to nursing homes, but it needed help in getting patient referrals from hospitals. So in about 2008, Dr. White had Bryan meet with Traci Tigert, R.N., who, like Burkett, was better at getting referrals from physicians and hospitals. Kumar also sent Bryan to meet with his contacts, who were mostly Indian doctors and others he had worked with in the past, to provide a lunch, deliver paperwork for them, put on a party, or do some other favor for them. Traci would bring her contacts to Kumar, including Dr. Vaqar Dar and Dr. Michael Blackmon, a pulmonologist, who were given positions as "team doctors" with Hospice Plus. Once these doctors had become Hospice Plus team doctors, they would come to Hospice Plus's office to

provide Interdisciplinary Team meetings ("IDT's"). Dr. Mark Fleschler, Dr. Luis Trigo, and Dr. Jeffrey Phillips from Presbyterian Hospital of Dallas were also recruited as team doctors. Although these doctors may have provided care to Hospice Plus patients, Dr. White and Kumar made it clear that they were recruiting these specific doctors so that they would then refer more hospice patients to Hospice Plus. This all occurred from about 2008 to 2010. These Hospice Plus "team doctors" were, on information and belief, paid $3,000 per month. The purpose of these payments, in addition to compensation for whatever medical services the doctors provided, was to induce them to refer patients, including Medicare patients, to Hospice Plus.

52. Jorge Decena was hired by Dr. White in about 2008 to take over Bryan's Dallas area Hospice Plus accounts, and also as its Spanish speaking representative. Bryan trained Decena, who was a witness to demands for gifts that the facilities would place on Hospice Plus in order for Hospice Plus to continue getting patient referrals. On one occasion, Jorge Decena and Bryan attended a lunch at APH with an APH physician, Dr. Silva. Dr. Silva expressed his anger that Dr. White was reviewing all of APH's patients' charts, and said that he believed that it was wrong, and ended the lunch abruptly. Bryan told Dr. White about the incident and White told Bryan not to go to APH anymore. This was in the late summer, or early fall of 2008.

53. In August of 2008, in an effort to meet its census goal for that month, Hospice Plus offered its employees a raffle ticket for each patient referral they

brought to the company, with a grand prize for the raffle being a trip to Cancun. This offer was announced, in part, with a poster that was put up in Hospice Plus's offices. That poster read:

WANTED

Community Referrals

Bring in a referral and receive a ticket for our raffle drawing!!!

Help us achieve our company census goal for the month of August.

REWARD*

Grand Prize: Cancun Trip

Ask a department head for details

* Marketers not included

That raffle drawing was later held at a Hospice Company party, which Kelli White, Hospice Plus's Director of Sales and Vice President of Finance and Risk Management, attended.

54. In late 2008, Hospice Plus began marketing in the Bonham area. There Bryan met Dr. Sam George Thoyakulathu and Dr. Shaw, and gave gifts and lunches to facilities in the area, such as Clyde Cosper Nursing Home. The purpose of these gifts and lunches was to induce the recipients and the facilities for which they worked to refer patients, including Medicare patients, to Hospice Plus.

55. Hospice Plus also began to focus its marketing and solicitation efforts on the Sherman/Denton area, and the area in between, for sources of patient referrals whom Bryan would introduce to Kumar. Kumar in turn would have them interview with Dr. White, who would offer them some

type of position with Hospice Plus, as, for instance a nurse, or a nurse marketer, to help get patients referred from the facilities where they worked.

56. In 2009, Hospice Plus, Home Health Plus, and Phoenix Hospice, whose offices had all been housed at Treemont Nursing Home since their establishment, moved into separate offices. The Hospice Plus office moved to Uptown Dallas, as did APH's offices: Hospice Plus moved to the second floor and APH moved to the fourth floor of the same building. There were also other companies that worked with Hospice Plus and APH on the third floor. At this time Kumar sent Bryan back to APH to talk with Sheila Halcrow about getting patients for Kumar's additional new healthcare companies. As had been the longstanding practice, Bryan would go to Halcrow, she would find patients and assist with having APH refer them to Hospice Plus, then Bryan would deliver cash payments to her, which were as much as $2,000 at a time, as well as concert tickets, and other gifts. Frequently, getting these patient referrals from Halcrow and APH, or from another source, was as simple as Bryan going to Kumar, and telling him what the person or facility wanted in return. Kumar would either get it for Bryan to give to that person or facility or, with Kumar's approval, Bryan would purchase it with his Hospice Plus company American Express card. On one or more occasions, on Kumar's instructions, Bryan gave cash to one of these individuals in return for them referring patients to Hospice Plus.

57. On another occasion, in 2009, Dr. White had Bryan go to Costco and buy Christmas gifts to give

to nursing home clients. Bryan bought multiple pallets of Christmas gift items, such as chocolate, cookie tins, gingerbread houses, wine baskets, cheese and sausage baskets, snowmen figures filled with cookies or other goodies, ticket packages to Stars games, and other items. Bryan had to rent two U-Haul trucks to transport all of these items, and keep them in a storage unit until Hospice Plus personnel could deliver them. Bryan, Burkett, Silas Shelton, Traci Tigert, and others delivered these gifts to nursing homes, assisted living facilities, hospitals and doctors' offices. These included Treemont, Park Manor, Doctors' Nursing Home, Charleton Methodist Hospital, Dr. Fleschler, Dr. Phillips, Dr. Trigo, Villa at Mountain View Nursing Home, Mesquite Tree Nursing Home, Balch Springs Nursing Home, and many others. Hospice Plus gave these gifts to reward the facilities and personnel for the patients, including Medicare and Medicaid patients, they had referred to Hospice Plus, and also to induce them to keep referring such patients to Hospice Plus. These gifts, which were charged to Bryan's company American Express card, totaled approximately $30,000.

58. In the summer of 2009, Bryan met co-Relator, Franklin Brock Wendt ("Wendt") on a fishing trip with a mutual friend. Wendt and Bryan talked about their jobs and discovered that Wendt had many contacts in areas in which Bryan was being pushed by Hospice Plus to develop new business, including Arlington and Sherman, Texas. Bryan asked Wendt if he would be interested in doing some marketing for Hospice Plus, and told Wendt that he would discuss an opportunity for him with Dr. White and Kumar.

About a week later, Hospice Plus hired Wendt on a part time basis as a marketer. Dr. White and Kumar had agreed to pay Wendt a fee of $250 for each patient that he was responsible getting referred to Hospice Plus.

59. Later in 2009, Wendt took Bryan to meet with Khuong Phan, D.O., in Mansfield to discuss Dr. Phan becoming a medical director with Hospice Plus. The three had a couple of lunches at Dr. Phan's office and later Bryan met with Dr. Phan privately and offered him $4,000 a month to become one of Hospice Plus's team doctors, but Dr. Phan declined.

60. Another scheme to get patient referrals from nursing facilities, which was created by Dr. White, involved offering to pay nursing homes in advance for Medicare Part B services. Hospice patients require certain services and supplies, such as room and board and adult diapers. Each month, Medicare pays the hospice provider (such as Hospice Plus) for these supplies and items of service. The hospice provider then reimburses the nursing facility where the patient is housed, which provided these Medicare Part B supplies and services in the first instance. When a patient elects hospice care, (s)he waives the right to Medicare Part B payments. The industry standard is for the hospice provider to pay these monies to the nursing facility after Medicare pays the hospice provider's monthly bill. Those reimbursements are thus, as an industry practice, typically made anywhere from 60 to 90 days after the nursing facility provides the item or service. But Dr. White instructed Hospice Plus marketers to tell the administrators and billing managers of the nursing

facilities that Hospice Plus would, within fourteen days of any patient being referred to Hospice Plus and first coming onto Hospice Plus's service, get the nursing facility an advance check for the Part B supplies and services that Hospice Plus estimated the facility would later be owed (when Hospice Plus billed Medicare), and that, Hospice Plus would adjust the facility's next month's Part B reimbursement for any difference between the estimate and what was actually owed. Dr. White had marketing employees deliver these reimbursement checks to the nursing homes at least once or even twice a month. This inducement worked very well, and brought in more patient referrals, including Medicare and Medicaid patients. Hospice Plus offered to do this for Park Manor Nursing Home, Plaza at Edgemere and Red Oak Nursing Home, among others. This went on from about mid-2007 to 2009.

61. After engaging in these practices for a number of years, Hospice Plus marketers, including Relators, started seeing companies such as Heart to Heart Hospice have their hospice nurses start working nights and weekends at nursing homes as second jobs, so that they could get those nursing homes' patients for their hospice. One of Heart to Heart's nurses, named Kay, worked at Signature Pointe on the Lake, and at Treemont Healthcare and Rehabilitation Center. Bryan was given the task of meeting and recruiting Kay from Heart to Heart so that she would help get new hospice patients referred to Hospice Plus instead. Other hospices were also hosting lunches and engaging in "gifting" practices similar to those of Hospice Plus. Eventually, the

nursing homes would actually call Hospice Plus demanding lunches, gift cards, tickets to ballgames, and other gifts or favors for referrals. These included Diane Wheeler, the Administrator of The Plaza Health Services at Edgemere, Lenwood Nursing Home in DeSoto, Park Manor in DeSoto, and others, who would demand that Hospice Plus provide them a pizza lunch once a week. Jorge Decena provided Mexican food lunches on Mondays for Balch Springs Nursing Home, which was charged on Bryan's Hospice Plus company American Express card. If Hospice Plus did not meet these demands, the facilities would send their patient referrals to other hospice companies. For example, Dawn Kauser, the Administrator at Mesquite Tree Nursing home at the time, called Bryan demanding tickets to the Ranger game that same night. Bryan was at the airport, on his way to a vacation when he got that call. When Bryan told Kauser that he was about to catch a plane, she said "If I don't have these tickets, you don't have any more patients." Bryan made the necessary calls, got her tickets, and had them waiting in her name for pickup at will call.

62. If Bryan had a productive month, with a high number of patient referrals to Hospice Plus, Kumar would let Bryan keep some of the gift cards for himself. On one occasion, Kumar expressed frustration that Sheila Halcrow, at APH, hadn't referred enough patients that month, and asked Bryan to go upstairs and ask her what it would take to get more patients, which Bryan did. Halcrow said she was going on a honeymoon to Mexico, and it would be nice to have some extra cash, which Bryan related

to Kumar. Kumar then handed Bryan $2,000 cash and told Bryan to go give it to her, which Bryan did.

63. The fraudulent conduct continued. Hospice Plus hired marketing nurses, who then primarily worked to get patients from their previous employers. These nurses were at Kumar's disposal to do errands and favors for him, such as going to see a particular patient, or going to get orders signed by the doctors who wrote the referrals. Kumar loaned cars to several of these nurses, including Traci Tigert. Kumar owned these cars, but he allowed them to use these cars for any purpose, be it personal or work. Halcrow told Bryan that Kumar had bought her a sporty Cadillac for all the patient referrals she had gotten him, which included patients, including Medicare and Medicaid patients, for Hospice Plus. These nurses also worked with Remani Kumar ("RKumar"), Kumar's wife, to open new home health and hospice companies.

64. In the fall of 2010, Hospice Plus planned its annual Christmas gifts for its "A," "B," and "C" facilities – which were Hospice Plus's rankings based on the number of patients a source had referred to Hospice Plus. Hospice Plus purchased those gifts, totaling more than $18,000, from Tony Lombardo, a marketing representative from Knockout Specialties in Plano.

65. Over a period of approximately four years, from the time Bryan began his employment with Hospice Plus through the time he began to assist with expanding the business in market areas outside Dallas, Texas, more than 75 percent of the patients referred to Hospice Plus, conservatively, were from sources who received gifts and other items of

monetary value either as inducements or rewards for patient referrals.

66. Late in 2010, it was announced that Hospice Plus was for sale, and that Curo, a North Carolina company was considering buying it. A few months later, in early 2011, employees were called into a meeting, and it was announced that Curo was doing a joint venture with Hospice Plus. The marketing department, including Burkett, Julie Summey, Lawrence Eddington, LeAnn Jackson, Jorge Decena, and Bryan, was informed that Curo was very concerned about Hospice Plus's spending habits, especially regarding gift cards, alcohol, massages, and other giveaways. During this meeting, Dr. White and Kumar told everyone that if Hospice Plus needed to sponsor an event, the employees should come directly to White or Kumar, personally, so they could pay the cost, individually, and it wouldn't show up on the company records. The marketing team was told not to continue giving gift cards, alcohol, parties, happy hours, or other gifts. Dr. White coached Bryan as to what to say in response if questioned about gift card purchases.

67. In early 2011, Burkett and Bryan were called into a meeting with Alice Ann Schwartz, of Curo, and Dr. White regarding Curo's concern about the volume of marketing expenditures by Hospice Plus. Bryan and Burkett were asked what all the gift cards were for, and Bryan said educational purposes, new employees, and supporting other marketers, to which Ms. Schwartz responded, "that works for me."

68. In early to mid-2010, Bryan was given a business development position in Arlington. Bryan

focused on developing business in outlying markets, including Keller, Fort Worth, Weatherford, and Cleburne. While Curo was transitioning into Hospice Plus, all of the marketers were required to take a class on what was appropriate and what was not appropriate in healthcare marketing. Bryan failed the test, as Hospice Plus had never provided any training regarding marketing rules to its employees. Dr. White had Bryan retake the test with Jason Brazina, R.N., sitting beside him to make sure that Bryan got the answers correct.

69. Bryan started working the Cleburne area in early 2011. Bryan was worried because the hospices in Cleburne, particularly Mission Hospice, were using similar fraudulent schemes that Hospice Plus had been previously using in Dallas to get referrals. However, Bryan had not used these methods since Curo came on board. Getting referrals was virtually impossible in Cleburne because, if he got a patient, on information and belief, Mission Hospice's physicians would call that patient and threaten to resign as the patient's primary care physician if the patient did not use Mission Hospice.

70. On March 6, 2012, Richard DalCero, Curo Health Services Vice President for Business Development, sent an email to Bryan, Wendt, Scott Burkett, Jorge Decena, Natalie Spencer, Anthony Flores, and 12 other Hospice Plus employees with a subject of "HCC Fast Start Bonus," a reference to "Health Care Coordinators." In that email, DalCero said:

Texas Team, I spoke with a few of you live line regarding this.

There is an additional March incentive for HCCs (in addition to Delivering Gift incentive). Achieve 130 admits for all of Hospice Plus by March 15 and each HCC will earn an additional $500. Achieve 140 admits by March 15th and the bonus is $600.

As of today in the system we are at 28. 11 admits per day will get us there. I know that is possible.

Good Luck!!

Rich

Richard DalCero
VP Business Development
Curo Health Services
Salt Lake City, Utah
rdalcero@curohs.com

71. This email communicated Curo Health Services' offer of a cash reward of $500 each, or $600 each, to the entire Hospice Plus Marketing team if they obtained 130 or 140 patient referrals, respectively, by the end of March 2012.

72. In May of 2012, Bryan received a phone call from Burkett who told Bryan that Kumar wanted Burkett to move to Tyler to open a new office. Bryan immediately called Kumar and Dr. White to ask if he could open the Tyler office instead of Burkett. They

agreed, and moved Bryan and his family to Whitehouse, Texas, near Tyler, in June of 2012. Nonetheless, since Bryan was not buying referrals, his position was precarious. The first six months in Tyler, there were no employees, no nurses to take care of any referrals, no marketing materials, and no access to Hospice Plus email. Bryan was left with no support, and Dr. White and Kumar apparently had quit talking to Bryan, until October 2012. That October, Krista Goodness became Hospice Plus's area manager for Tyler and hired a nurse named Lana to handle Tyler area patients. Bryan worked with Lana for four weeks, during which time Bryan brought two patient referrals, and also a registered nurse and a licensed vocational nurse, who were well respected in the community. Bryan heard from Bob Barker, Administrator of Hospice Plus, that the company might not open a Tyler office. Bryan complained to Curo, but was told that he was being "hostile." On November 12, 2012, Bryan was asked to resign with six months' severance, which he accepted given the alternative of termination and the reality of six months of lease obligations remaining on his residential lease in Whitehouse.

73. In May of 2013, Kumar and Bryan met in Dallas to discuss the terms of a new job for Bryan with one of Kumar's companies, One Point Home Health (now named One Point Health Services, LLC) ("One Point"). Bryan was told that he was able to come back to work for Kumar because he didn't "spill his guts" about all of their wrongdoings or file a lawsuit against them. He offered Bryan $80,000 per year to work for One Point, which Bryan accepted. A month into this

new job, Bryan realized the fraudulent conduct had not stopped since he had started working the outlying areas in late 2010, as Rebecca Wiltes, the director of marketing, told Bryan she was working on getting a Medicare license for One Point. That was a shock to Bryan because Kumar had Bryan handing out marketing brochures that said One Point was a Medicare provider, and the facility was certified by the Joint Commission on Accreditation of Hospital Organizations ("JCAHO"). Bryan expressed concern at a marketing meeting, blurting out that it was fraud. Kumar was not at that meeting, but Wiltes was, as were Farheen Faisal and an employee named Lonnie. Bryan received a phone call a few days later from Kumar yelling at him for announcing this in a meeting, and for not coming to his office to discuss it with him in private. In mid-July, 2013, Remani Kumar and Brannon Wiltes called Bryan into the office, and said they could no longer afford his salary because he was not bringing in patients, and Bryan was terminated.

74. One Point manages A&S Home Health, Excel Home Health, North Texas Best Home Healthcare, Phoenix Hospice Care, Phoenix Hospice, and Goodwin Hospice. Upon information and belief, Kumar was also obtaining patient referrals for all of these companies, which are owned in full or in part and/or operated by Kumar, in the same manner as described herein for Hospice Plus.

75. On information and belief, in July of 2013, Dr. White asked Sheila Halcrow to transfer patients from Phoenix Home Health to One Point because he was going to transfer Phoenix's Medicare

license to One Point. On information and belief, Halcrow refused, and was then fired. On information and belief, the kickback fraud was continuing in July of 2013. On information and belief, Kumar paid Halcrow with checks drawn on his personal bank account for patient referrals to other home health companies owned by Dr. White and Kumar. On information and belief, Dr. White and Kumar have begun to fraudulently extend patient income streams from Medicare. This is accomplished, when a patient is nearing the end of a plan of care, as stated on a CMS-485 form, by having Halcrow transfer the patient to another one of their own companies, with a new CMS-485, showing yet another plan of care, so that they can keep billing Medicare for that patient. On information and belief, Kumar bought Ms. Halcrow a high priced Cadillac in his name, for all of the patients she had sent him. On information and belief, Beena Kurup, the billing manager for One Point worked weekends during June-July 2013 to fix a big "billing screw up." Kurup asked Halcrow for a computer passcode to get into Phoenix's patient records in order to "fix" nursing entries on the patients' charts, to submit bills to Medicare based on "fixed" patient charts. Virtually all of these home health patients are Medicare or Medicaid patients. Halcrow refused to give Kurup the passcode, but Kurup did get into those patients' charts. On information and belief, Dr. White and Kumar used Halcrow's name as an Administrator of a new home health agency without her permission, and one of Kumar's employed social workers named Stephanie

signed Sheila Obrien's (formerly Halcrow) name without Ms. Halcrow's permission or knowledge.

76. Bryan's paychecks for his work at Hospice Plus were all from a company named "International Tutoring Services."

FACTS – RELATOR FRANKLIN BROCK WENDT

77. Franklin Brock Wendt ("Wendt"), who goes by "Brock", is a Licensed Vocational Nurse ("LVN") and a Registered Nurse ("R.N.") who has worked in intensive care units ("ICU"), emergency rooms ("ER"), operating rooms ("OR"), rehabilitation nursing for joint replacement and post-surgical patients, as a house supervisor at Medical Center Arlington providing oversight for multiple hospital departments, and also has extensive experience with peripherally inserted central catheter, inserted into peripheral vein near heart ("PICC line insertion"), and in home health, and hospice marketing.

78. After Wendt met Bryan in the summer of 2009 on a fishing trip with a mutual friend, Hospice Plus hired Wendt on an "as needed" ("PRN") basis as a marketer, and agreed to pay him $250 for each patient that he was responsible for referring to Hospice Plus. There were several other marketers at the time, including Corrie, Julie Summey, LeAnn Jackson, Scott Burkett, and Natalie Spencer. Some were paid a salary, plus bonuses for referrals. There were also some, like Wendt, working for "bonus" only. This made their respective marketing jobs very competitive. It was very important to these marketers to keep up with their referrals, and how they were

obtained, as other marketers would "steal" them, by taking credit for another marketer's patient referral.

79. Shortly after Wendt began with Hospice Plus, he was advised by Bryan that Dr. White had changed his mind about the terms of Wendt's employment with Hospice Plus, and wanted to put Wendt on a "small salary" plus the $250 bonus per patient. Dr. White wanted to give Wendt more incentive to send referrals in and told Wendt that as long as Wendt was on a little salary it would be *"legal."* So Wendt became a part-time employee of Hospice Plus at $30,000 a year plus $250 bonus for each patient referral he brought in.

80. On about four or five occasions from 2009 to 2012, Wendt got patient referrals to Hospice Plus by offering a power-lift chair, free of charge, to a debilitated patient, such as a stroke patient, in exchange for that patient agreeing to come with Hospice Plus rather than another hospice agency. When the patient agreed, Wendt would call Kumar, who would arrange for the chair to be delivered to the patient. This also induced facilities to refer to Hospice Plus other patients who had the same need. These facilities included Texoma Health Care in Sherman and Sherman Health Care. The power-lift chairs typically cost from several hundred to a thousand dollars. These were all Medicare patients. Hospice Plus also provided power scooters to at least two patients of whom Wendt was aware, free of charge, in exchange for the patient agreeing to use Hospice Plus for hospice care.

81. Also, on an ongoing basis, Wendt would visit nursing homes, assisted living facilities,

hospitals, group homes, and doctors' offices to provide administrators, nurses, doctors, and other staff with meals and "giveaways" from Bath and Bodyworks or other gifts. Wendt would also regularly invite many of these patient referral sources to manicure-pedicure events, which they could attend free of charge. Those manicures and pedicures cost Hospice Plus from $40 to $100 for each person; in addition, Hospice Plus provided all of its guests/referral sources at these events with unlimited food and drinks. Hospice Plus also put on happy hours for its referral sources at Macaroni Grill, On the Border, and many other restaurants and bars. The invitees and attendees to these manicure-pedicure events, and happy hours, included the Case Managers at: Centennial Medical Center in Frisco, Presbyterian Hospital of Plano, Texoma Medical Center, Presbyterian Hospital of Dallas, Baylor University Medical Center in Dallas, the Forum at Park Lane Independent and Assisted Living Facility, Plaza at Edgemere (now just Edgemere), Prestonwood Rehabilitation, and many others. Hospice Plus put on these happy hours every week that Wendt was working for the company. These were all paid for with Hospice Plus or Curo Health Services company credit cards. The purpose of these manicure-pedicure events, and happy hours, was to induce the recipients and the facilities for which they worked to refer patients, including Medicare patients, to Hospice Plus.

82. After joining Hospice Plus in 2009 on a part-time basis, Wendt brought Bryan to meet with Khuong Phan, D.O., in Mansfield to discuss the possibility of Dr. Phan becoming a medical director

with Hospice Plus. A nurse Wendt knew, Kristin Eddy, had told Wendt Dr. Phan was a good doctor to target for potential referrals of hospice patients. Wendt had told Bryan about Dr. Phan, and Bryan told Dr. White, who told Bryan that he and Wendt should meet with Dr. Phan about becoming a medical director. Bryan told Wendt that the medical director they had from that area, Dr. Raymond Westbrook, was not sending enough referrals, and they were looking to replace him. Dr. White had explained to Wendt that if a medical director sent just two to three patients each month, then that medical director would be more than paying for their $3,000 monthly salary from Hospice Plus, even if they performed no medical services. Not all of these "medical directors" were recruited and hired solely to perform chart reviews, interdisciplinary team meetings, or to provide patient care. Many of them were hired primarily as a source of patient referrals. Bryan and Wendt met with Dr. Phan twice over lunch at his office, and Bryan met with him again, but Dr. Phan declined the offers to become a Hospice Plus medical director.

83. In early 2012, Wendt introduced Slade Brown to Kumar. Brown then went to work as a marketer for One Point Home Health (one of Kumar's companies). Brown had been working for Girling Health Care, and had been bringing them about 20 Medicare home health patients each month. Brown had a prior relationship with a group of physicians in Plano that made house calls to homebound patients. Brown suggested that he could introduce Wendt and Kumar to these doctors to solicit hospice patient

referrals. Wendt and Kumar met with Brown and these doctors at the doctors' offices in Plano.

84. After this meeting, Kumar, Brown, and Wendt went to Tupinamba Restaurant in Dallas for lunch. There Kumar offered to hire Brown into One Point Home Health as a marketer at a salary of $90,000 per year, plus bonuses. Brown had with him some intake paperwork on about 20 Medicare home health patients whom he was in the process of bringing into Girling Health Care, his current employer. Kumar offered him $2,000 cash on the spot for those patients. Brown took the cash and gave Kumar paperwork for half of those patients, with the understanding that he would bring Kumar the rest of them when he started at One Point Home Health.

85. After about a month with One Point Home Health, Brown told Wendt that Kumar was going to have him meet with Rich Dalcero, Vice President of Sales for Curo, because Kumar wanted to hire Brown into Hospice Plus, since Brown had gotten so many patients for One Point. Hospice Plus hired Brown, on information and belief, and paid him on a per-patient-referral basis, or on or salary plus per-patient-referral basis. Later, Brown told Wendt that he had been getting some of his patient referrals for Hospice Plus from Dee Ann, a social worker at Presbyterian Hospital of Denton.

86. Brown also told Wendt that he was getting many of his patients for Hospice Plus from Dr. Warner Massey in Irving. Dr. Massey was part of a group of physicians who made house calls. Brown told Wendt that some of the patients for whom Dr. Massey wrote orders to be admitted to hospice had been

previously denied a hospice diagnosis by their own physicians. These were patients in group homes or assisted living facilities whom Brown had gone to see to suggest to them that they become a hospice patient. He would then call those patients' physicians to obtain an order to evaluate the patient for hospice, and if those physicians declined to do so, Brown would have Dr. Massey go to the patient's bedside, evaluate that patient for hospice himself, and write orders for that patient to be admitted to hospice and/or home health. In the case of hospice, Brown would have the patient admitted to Hospice Plus, and for home health, Brown would have them admitted to One Point. On information and belief, One Point Home Health was, at the time, a Medicare-approved provider. On information and belief, all of these patients that Brown was getting for Hospice Plus and One Point Home Health were Medicare or Medicaid patients.

87. In October or November of 2012, Angela Grover, a social worker friend of Wendt's who worked at The Forum at Park Lane, an assisted living and skilled nursing facility, had gotten upset because a Hospice Plus nurse had failed to show up on time to care for a declining patient. Wendt called Kumar to tell him about this, as The Forum was a new account, and a potentially big account. Kumar instructed Wendt to put on a lunch for the facility and to call Juana Beltran, a secretary at Hospice Plus who scheduled its Certified Nurse's Aides ("CNAs") to provide a full time CNA for The Forum. At the time, Hospice Plus had only four patients at The Forum, and so had one of its CNA's there only three days a week. The goal of putting a CNA at a facility like The

Forum full time is to reduce the facility's workload and payroll, as an inducement to get them to refer more patients. Wendt made the arrangements, and provided lunch to the Forum's entire staff, purchasing the lunch with his Curo Health Services company credit card.

88. The next day, Hospice Plus sent a full-time CNA to The Forum, who worked there eight hours a day, Monday through Friday, for several weeks. After a couple of weeks, Kumar and Beltran instructed Wendt to tell The Forum that Hospice Plus had to have a total of eight patients there in order to keep the CNA there full time, and that if they would get Hospice Plus to fourteen patients there, it would provide two full time CNA's. Wendt told Angela Grover this. Although The Forum did continue to refer to Hospice Plus some patients, who were all Medicare patients, it failed to reach eight patients. For this reason, after several weeks, Kumar pulled the full time CNA out of The Forum.

89. In 2012, Anthony Flores, R.N., told Wendt: That he had held several meetings with himself, Kumar, and Dr. Dennis Birenbaum, an oncologist/hematologist who works mainly at Baylor Hospital in Carrollton; that as a result of those meetings, Dr. Birenbaum started living in one of Kumar's houses, Kumar bought Dr. Birenbaum an Audi, and Kumar helped Dr. Birenbaum open up a new cancer center; and that in return, Dr. Birenbaum began referring all of his hospice and home health patients to Hospice Plus and/or One Point Home Health. The majority of these referrals are Medicare or Medicaid patients.

90. In 2010, Wendt persuaded Carla Mercer, R.N., the owner of two group homes, Sanger House and Krum Cottage, to use Hospice Plus as their hospice provider of choice. Hospice Plus had the majority of hospice patients in these group homes from that time forward. These were all Medicare patients.

91. In March of 2013, one of Hospice Plus's CNAs, told Wendt that Traci Houston, R.N., the Director of Operations for Hospice Plus's Lewisville office, had asked her to document in one of Mercer's patient's record visits from this CNA on days this CNA had not visited the patient. This CNA then left Hospice Plus, and went to work for Novus Health, another hospice company. When this CNA left, three of her patients had their care transferred to Novus, as they wanted her to continue as their caregiver. Kumar decided that Hospice Plus had to have this CNA come back to work as its caregiver for Mercer's Sanger House and Krum Cottage facilities, because if she didn't, Hospice Plus could lose all of the patients in those facilities. Kumar instructed Wendt to call this CNA and offer her a $1,000 cash bonus and a $2/hour raise if she would come back to Hospice Plus and bring all her patients with her, all of whom were Medicare patients. This CNA declined. At this time, Kumar was in the process of buying another home health company. So Kumar told Wendt and Anthony Flores, R.N., a Hospice Plus nurse, that he was going to give each of them one-third of this new company, and instructed Wendt to call and tell Carla Mercer, R.N., that he was going to give her the other one-third of the company in exchange for her keeping the patients

housed at her facilities with Hospice Plus, and transferring back to Hospice Plus the patients housed at her facilities who had transferred to Novus. Wendt did this, as instructed.

92. On May 23, 2013 Wendt brought Kumar to a Bone Daddy's restaurant in Arlington to meet with Wendt's friend Jackie Pollard, LVN, about getting more patients for Hospice Plus and One Point Home Health. Pollard works for Enterprise Health Staffing, a nursing staffing agency. In her position as a Care Manager with Enterprise, Pollard is authorized to make patient referrals to home health and hospice agencies. After Pollard explained to Kumar what she does as a Care Manager, Kumar offered her $300 cash for each Medicare patient that she referred to Hospice Plus or One Point Home Health. He also offered her $100 cash for each non-Medicare patient that she referred to either of those entities. As he was telling her this, Kumar pulled out a roll of cash to show her. After Kumar offered Pollard cash for future referrals, Pollard mentioned that she had already sent four patients to Hospice Plus in April and May of 2013. Kumar then handed Pollard $800 cash and thanked her for those referrals. Kumar also told her that he was working on another new hospice company, and that he could therefore potentially pay her more for referrals in the future. Kumar told Pollard to call him before making any referral so that he could instruct her which company to send the patient to. Kumar also told her that, in order to receive her cash payments for referrals, she could call and meet with him, or he would have Wendt deliver the money to her. All of the patients that Pollard had

referred to Hospice Plus in April and May of 2013 were hospice patients with Medicare, and virtually all of any future referrals that Pollard would send would also be Medicare patients, which Kumar knew to be the case.

93. Meetings between Wendt, a potential referral source, and Kumar, where Kumar offered the potential referral source financial incentives including cash for patient referrals, which were virtually all Medicare patients, were held about 20 to 30 times while Wendt worked for Hospice Plus. These potential referral sources included Amy Dorn, R.N., with 1st Choice Home Health in Denton, Randa Smith, R.N. with 1st Choice Home Health in Denton, Chad Meeks, LVN, Anthony Flores, R.N., and many others.

94. Pursuant to his agreement with Hospice Plus, Hospice Plus paid Wendt bonus pay each month that he was responsible for bringing in more than fourteen patients. Up until August of 2011, when Curo bought Hospice Plus, Hospice Plus paid Wendt $250 for each such patient referral. After August of 2011, Hospice Plus paid Wendt $150 for each such patient referral. Because Wendt hit his target of at least fourteen patient referrals every month, Hospice Plus always paid him some bonus pay. Wendt obtained these patient referrals, more than 90 percent of whom were Medicare patients, and about 10 percent of whom were Medicaid patients, in the manner described above, using bribes and rewards.

95. In his work for Hospice Plus, Wendt regularly assisted its billing staff in making sure claims to CMS for payment were correct. For example,

the Director of Operations would have Wendt drop off and pick up signed physicians' orders in order to complete the documentation to support a claim for payment. Sometimes the Director of Operations would tell Wendt that claim information was incorrect or incomplete for a given patient, and would have Wendt get the documentation needed in order to submit the claim.

96. From 2006 to the present, all of Hospice Plus's claims to CMS were submitted electronically. During Wendt's tenure at Hospice Plus, at least 75 percent of the patients, conservatively, referred to it were from sources whom Hospice Plus had offered and/or given gifts or other things of value.

97. All of Wendt's paychecks for his work at Hospice Plus were from a company named "International Tutoring Services," even after Curo bought Hospice Plus.

CMS CLAIMS FILING

98. From 2006 to the present, all of Hospice Plus's claims to CMS were submitted electronically. All of these claims were submitted to CMS by either Hospice Plus, LP, under its own National Provider Identifier ("NPI") number, or under International Tutoring Services, LLC's NPI number. To become approved for electronic claims submissions, Hospice Plus and/or International Tutoring completed, signed and submitted to CMS an Electronic Data Interchange ("EDI") Enrollment Form, which became effective when it was signed by Hospice Plus's and/or International Tutoring's authorized person. The EDI Enrollment form(s) contained a certification that

Hospice Plus and/or International Tutoring would acknowledge that all claims later submitted electronically met all of CMS's requirements. Hospice Plus's monthly electronic batch claims were made using an electronic form CMS-1450, which contains an acknowledgement of the consequences of falsifying or misrepresenting essential information for federal payments, as well as a certification for Medicaid that all the information in the claim is true, and acknowledging the consequences for submitting false claims, statements, documents, or concealing material facts. Virtually all of the periodic submissions for payment to the government by Hospice Plus, whether in its own name or through International Tutoring Services, were false under the False Claims Act, because the requests for payment included patients who had been referred to Hospice Plus in return for the payment of kickbacks, whether bribes or rewards, to the referring organization's management or employees, or the patient.

99. According to the CMS, a hospice is a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals, meets the conditions of participation for hospices, and has a valid Medicare provider agreement. (DHHS Final Rule, Medicare and Medicaid Programs, Conditions of Participation, adopting and amending provisions of 42 CFR § 418 of May 27, 2005, Fed. Reg. Vol. 73, No. 109, June 5, 2008, at 32162). Although some hospices are located as a part of a hospital, nursing home, or home health agency, hospices must separately meet specific Federal requirements and be separately certified and

approved for Medicare participation. CMS requires an entity that wishes to participate in the Medicare program to submit a completed 855A claim form "Medicare Federal Health Care Provider/Supplier Applications that will Bill Medicare Fiscal Intermediaries," or Form CMS-855B "Medicare Federal Health Care Provider/Supplier Applications that will Bill Medicare Carriers" to request payment for specific medical services. 42 CFR § 424.32(b). Form 855-A requires the provider to sign a certification that states in relevant 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.

100. If a provider submits false, inaccurate, or incomplete information on its CMS-855B or CMS-855A claim for Medicare payment, or if a provider submits a claim to CMS when it knew or should have known that it was not entitled to receive Medicare payment, it is considered a false claim, record,

statement and/or certification to the Government and is actionable under the Federal False Claims Act. Any claim for payment that includes a request for payment for items or services resulting from a violation of the Anti-Kickback Statute, 42 USCS § 1320a-7b, constitutes a false or fraudulent claim for purposes of the False Claims Act. 42 USCS § 1320a-7b(g). Intent is not an element of an Anti-Kickback Act violation. 42 USCS § 1320a-7b(h). In addition, in submitting a claim for Medicare reimbursement, the provider certifies that the submitted claim is eligible for Medicare reimbursement and that the provider is in compliance with all Medicare requirements.

101. The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. In order to submit claims to CMS, or to its Fiscal Intermediary ("FI") contractors, a provider, which includes hospices, must complete an Electronic Data Interchange ("EDI") Enrollment Form and submit it to its designated Medicare Contractor. *Medicare Claims Submission Guidelines*, DHHS Medicare Learning Network Fact Sheet, at 10. The EDI Enrollment Form contains the following agreement, which must be signed by an Authorized Individual of the provider:

> The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS's FI's, Carriers, RHHI's, A/B MAC's, or CEDI:

[A156]

The Provider Agrees:

* * *

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, *and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this Agreement may, upon conviction, may be subject to a fine and/or imprisonment under applicable Federal law*.

EDI Enrollment Form, at 2 (emphasis added). The EDI Enrollment Form further contains the following admonishment:

> **NOTE:** . . . This document shall become effective when signed by the provider. *The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the FI, Carrier, RHHI, A/B MAC, or CEDI, or other contractor if designated by CMS*.

EDI Enrollment Form, at 3 (emphasis added). The EDI Enrollment Form further contains the following:

> **ATTESTATION:** Any provider who submits Medicare claims electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the EDI Enrollment.

Id. The EDI Enrollment Form further contains the following signature provision:

> **SIGNATURE:** I certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the provider to abide by the laws, regulations, and the program instructions of Medicare.

Id. When a hospice, such as Hospice Plus, enrolls as a Medicare provider via a Form 855A, it affirmatively binds itself to the provisions of the Anti-Kickback Statute and the False Claims Act. When a provider, such as Hospice Plus, enrolls in electronic data interchange, so that it can submit electronic claims for payment to Medicare, it again affirmatively binds itself to the provisions of the Anti-Kickback Statute

and the False Claims Act for every such electronic submission of a claim for payment.

102. Based on the acts described above, Defendants Suresh G. Kumar, R.N., Bryan K. White, M.D., Hospice Plus, LP, and International Tutoring Services, LLC f/k/a International Tutoring Services, Inc.:

a. knowingly presented, or caused to be presented, a false or fraudulent claim for payment or approval;

b. knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim;

c. knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government; and

d. conspired to

i. knowingly present, or cause to be presented, a false or fraudulent claim for

payment or approval;

ii. knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; and

iii. knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the Government.

ESTIMATED ACTUAL DAMAGES TO THE UNITED STATES.

103. The United States Government, unaware of the falsity of the claims, records, and/or statements made by the Defendants, and in reliance on the accuracy thereof, paid such false or fraudulent claims.

104. Medicare's basic reimbursement rates for hospice patients are based on where the patient is housed. There are four categories of reimbursement, with corresponding rates of reimbursement:

> Hospice care in home, which is currently $153.45 per patient, per day;
>
> Continuous home full rate (24 hrs.), which is currently $895.56 per patient, per day;
>
> Inpatient Respite Care, which is currently $158.72 ($85.92 of which is subject to a geographic wage adjustment), per patient, per day; and
>
> General Inpatient Care, which is currently $682.59 ($436.93 of which is subject to a geographic wage adjustment), per patient, per day.

42 CFR § 424.302. These basic reimbursement rates, which are paid per patient, per day, are increased by care modifiers. So the reimbursements can go up, depending on the patient's status.

105. While Relator Bryan was bringing in patient referrals to Hospice Plus, pursuant to which he actually reviewed each incoming patient's face sheet, Hospice Plus's patient population (called a "census") was approximately 90 percent home-based patients and nursing home-based patients, broken out as approximately 60 percent and 40 percent,

respectively. Overall, Hospice Plus's Medicare census was about 54% home-based patients, 36% nursing home-based patients, and the remaining 10% were hospital inpatient, and inpatient respite care. Home and nursing home patients have the same baseline reimbursement. On information and belief, with modifiers, the average Medicare reimbursement paid to Hospice Plus from 2006 to 2013 was about $200 per patient, per day, 365 days per year.

106. When Bryan started at Hospice Plus in January or February of 2006, its patient census was 132. When Bryan left the Dallas metroplex to market to the outlying territories in 2010, its census was about 900. When Wendt started at Hospice Plus in 2009, its patient census was more than 400, and when he left in July of 2013, it was more than 2,000. Hospice Plus's current census is more than 2500, according to the Texas Department of Aging and Disability Services. About 90 percent of all hospice patients, including Hospice Plus's patients, are Medicare or Medicaid, with about 10 percent of those being Medicaid. Assuming the following census growth: 2007: 130; 2008: 350; 2009: 500; 2010: 700; 2011: 900; 2012: 1100; 2013: 1500, the average patient population was 740 patients per year). An estimated 90 percent of those were Medicare or Medicaid, with 90 percent of those being Medicare. So, on average, there were 600 Medicare and 67 Medicaid patients per year for whom Hospice Plus alone was billing the government. Using the spring of 2005 as a starting point, these figures yield the following calculation of damages to the United States:

600 PATIENTS X $200/DAY X 365 DAYS/YEAR

X 8 YEARS = $350,400,000.00.

107. This does not include the patients that Defendants Kumar and White got using the same kickback techniques for Phoenix Hospice, Phoenix Hospice Care, Goodwin Hospice, and their other hospice and home health entities.

FALSE CLAIMS ACT

108. This action alleges violations of the Federal False Claims Act, 31 U.S.C. §§ 3729-3732, seeking damages and civil penalties on behalf of the United States and Relators as a result of the Defendants' implied and express false statements and claims.

109. The False Claims Act provides that any person who knowingly submits or causes to be submitted to the United States for payment or approval a false or fraudulent claim is liable to the Government for a civil penalty of not less than $5500 and not more than $11,000 for each such claim, plus three (3) times the amount of damages sustained by the Government because of the false claim.

110. The False Claims Act allows any person having knowledge of a false or fraudulent claim against the Government to bring an action in Federal District Court for himself and for the United States Government and to share in any recovery as authorized by 31 U.S.C. § 3730. Relators claim entitlement to a portion of any recovery obtained by

the United States as *qui tam* Relators/Plaintiffs are, on information and belief, the first to file and, in any event both original sources for the allegations in this action.

111. Based on these provisions, Relators on behalf of the United States Government seek through this action to recover damages and civil penalties arising from the Defendants' submission of implied or express false certifications and claims and for payment or approval. *Qui tam* Relators/Plaintiffs believe the United States has suffered significant damages, likely exceeding $350,000,000.00 (USD), as a result of the Defendants' fraudulent conduct.

112. As required under the False Claims Act, *qui tam* Relators have provided the offices of the Attorney General of the United States and the United States Attorney for the Northern District of Texas a Disclosure Statement of material evidence and information related to this complaint. That Disclosure Statement, supported by documentary evidence, supports the claims of wrongdoing alleged herein.

CAUSES OF ACTION
COUNT I
False Claims (31 U.S.C. § 3729)

113. *Qui tam* Relators/Plaintiffs reallege and hereby incorporate by reference each and every allegation contained in preceding paragraphs numbered 1 through 112 of this complaint.

Based on the acts described above, Defendants:

a. knowingly presented, or caused to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval;

b. knowingly made, used, or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

c. conspired to defraud the Government by getting a false or fraudulent claim allowed or paid;

d. knowingly made, used, or caused to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

114. The United States Government unaware of the falsity of these claims, records, and/or statements made by the Defendants and in reliance on the accuracy thereof, paid the Defendants for the fraudulent claim.

COUNT II
VIOLATIONS OF THE TEXAS MEDICAID FRAUD PREVENTION LAW

Tex. Hum. Res. Code § 36.001 et seq.

115. Relators restate and reallege the allegations contained in paragraphs 1 –114 above as if each were stated herein in their entirety and said allegations are incorporated herein by reference.

116. This is a *qui tam* action brought by Relators Kevin Bryant and Brock Wendt and the State of Texas to recover double damages and civil penalties under V.T.C.A. Hum. Res. Code § 36.001 et seq.

117. V.T.C.A. Hum. Res. Code § 36.002 provides that a person commits an unlawful act if the person:

(1) knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;

(2) knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;

. . .

(5) except as authorized under the Medicaid program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program;

(6) knowingly presents or causes to be presented a claim for payment under the Medicaid program for a product provided or a service rendered by a person who:

(A) is not licensed to provide the product or render the service, if a license is required; or

(B) is not licensed in the manner claimed;

(7) knowingly makes or causes to be made a claim under the Medicaid program for:

(A) a service or product that has not been approved or acquiesced in by a treating physician or health care practitioner;

. . .

(9) knowingly enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another person in obtaining an unauthorized payment or benefit from the Medicaid program or a fiscal agent;

(10) is a managed care organization that contracts with the Health and Human Services Commission or other state agency to provide or arrange to provide health care benefits or services to individuals eligible under the Medicaid program and knowingly:

. . .

(C) engages in a fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid program in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid program;

. . .

(12) knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state under the Medicaid program; or

(13) knowingly engages in conduct that constitutes a violation under Section 32.039(b).

Tex. Hum. Res. Code § 36.002 (emphasis added).

Section 32.039. provides:

(a) In this section:

(1) "Claim" means an application for payment of health care services under Title XIX of the federal Social Security Act that is submitted by a person who is under a contract or provider agreement with the department.

(1-a) "Inducement" includes a service, cash in any amount, entertainment, or any item of value.

. . .

(4) A person "should know" or "should have known" information to be false if the person acts in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information, and proof of the person's specific intent to defraud is not required.

(b) A person commits a violation if the person:

(1) presents or causes to be presented to the department a claim that contains a statement or representation the person knows or should know to be false;

(1-a) engages in conduct that violates Section 102.001, Occupations Code;

. . .

(1-d) **offers or pays, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made,**

in whole or in part, under the medical assistance program, provided that this subdivision does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(1-e) **offers or pays, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program;**

(1-f) **provides, offers, or receives an inducement in a manner or for a purpose not otherwise prohibited by this section or Section 102.001, Occupations Code, to or from a person, including a recipient, provider, employee or agent of a provider, third-party vendor, or public servant, for the purpose of influencing or being influenced in a decision regarding:**

(A) **selection of a provider or receipt of a good or service under the medical assistance program;**

(B) **the use of goods or services provided under the medical assistance program**; or

(C) **the inclusion or exclusion of goods or services available under the medical assistance program**; or

. . .

(3) fails to maintain documentation to support a claim for payment in accordance with the requirements specified by department rule or medical assistance program policy or engages in any other conduct that a department rule has defined as a violation of the medical assistance program.

. . .

(x) Subsections (b)(1-b) through (1-f) do not prohibit a person from engaging in:

(1) generally accepted business practices, as determined by department rule, including:

(A) conducting a marketing campaign;

(B) providing token items of minimal value that advertise the person's trade name; and

(C) providing complimentary refreshments at an informational meeting promoting the person's goods or services;

. . .

(3) other conduct specifically authorized by law, including conduct authorized by federal safe harbor regulations (42 C.F.R. Section 1001.952).

Tex. Hum. Res. Code § 32.039.

§ 102.001. Soliciting Patients; Offense

(a) A person commits an offense if the person knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency.

Tex. Occ. Code § 102.001(a).

118. Defendants violated V.T.C.A. Hum. Res. Code § 36.002 and knowingly caused false claims to be made, used and presented to the State of Texas in violation of Federal and State laws, as described herein.

119. The State of Texas, by and through the Texas Medicaid program and other State healthcare programs, and unaware of Defendants' fraudulent and illegal practices, paid the claims submitted by health care providers and third party payers in connection therewith.

120. Compliance with applicable Medicare, Medicaid and the various other Federal and State

laws cited herein was an implied, and upon information and belief, also an express condition of payment of claims submitted to the State of Texas in connection with Defendants' fraudulent and illegal practices.

121. Had the State of Texas known that Defendants were violating the Federal and State laws cited herein, it would not have paid the claims submitted by health care providers and third party payers in connection with Defendants' fraudulent and illegal practices.

122. As a result of Defendants' violations of V.T.C.A. Hum. Res. Code § 36.002, the State of Texas has been damaged to the extent of millions of dollars, exclusive of interest.

123. Relators are private persons with direct and independent knowledge of the allegations of this Complaint, who have brought this action pursuant to V.T.C.A. Hum. Res. Code § 36.101 on behalf of himself and the State of Texas.

PRAYER

124. WHEREFORE Relators Kevin Bryan and Brock Wendt respectfully request that this Court accept pendant jurisdiction of this related State claim as it is predicated upon the same facts as the federal claim, and merely asserts separate damage to the State of Texas in the operation of its Medicaid program.

125. Relators Kevin Bryan and Brock Wendt further request this Court to award the following damages to the following parties and against Defendants:

To the STATE OF TEXAS:

(1) Two times the amount of actual damages which the State of Texas has sustained as a result of each Defendant's fraudulent and illegal practices;

(2) A civil penalty as described in V.T.C.A. Hum. Res. Code § 36.025(a)(3) for each false claim which Defendants caused to be presented to the state of Texas;

(3) Prejudgment interest; and

(4) All costs incurred in bringing this action.

To RELATORS, KEVIN BRYAN AND BROCK WENDT:

(1) A fair and reasonable amount allowed pursuant to V.T.C.A. Hum. Res. Code § 36.110, and/or any other applicable provision of law;

(2) Reimbursement for reasonable expenses which Relators incurred in connection with this action;

(3) An award of reasonable attorneys' fees and costs; and

(4) Such further relief as this Court deems equitable and just.

On behalf of the United States Government, the Relators seek to recover monetary damages equal to three (3) times the damages suffered by the United States Government. In addition, the Relator/Plaintiff seeks to recovery all available civil penalties on behalf of the United States Government in accordance with the False Claims Act.

126. The *qui tam* Relators seek, for their contribution to the government's investigation and recovery, to be awarded a fair and reasonable whistleblower award as provided by 31 U.S.C. § 3730(d) of the False Claims Act;

127. The *qui tam* Relators seeks to be awarded all costs and expenses for this action, including statutory attorneys' fees and expenses, as well as court costs from the Defendants.

128. Pre-judgment interest at the highest rate allowed by law and post-judgment interest as applicable.

WHEREFORE, Relator/Plaintiffs pray that this District Court enter judgment on behalf of the Plaintiffs and against the Defendants, respectively, for the following:

a. Damages in the amount of three (3) times the actual damages suffered by the United States Government as a result of each Defendant's conduct;

b. Civil penalties against the Defendants, respectively, equal to $11,000 for each violation of 31 U.S.C. 3729;

c. *Qui tam* Relators/Plaintiffs be awarded the a fair and reasonable sum to which the Relator is entitled under 31 U.S.C. § 3730(d);

d. *Qui tam* Relators/Plaintiffs be awarded all costs and expenses of this litigation, including statutory attorneys' fees and expenses, as well as costs of court;

e. Pre-judgment and post-judgment, as appropriate, interest at the highest rate allowed by law; and

g. All other relief on behalf of the Relators/Plaintiffs or the United States Government to which they may be justly entitled, under law or in equity, which the District Court deems just and proper.

Request for Jury Trial

Relator respectfully requests a trial by jury as they are accorded under Rule 38 of the Federal Rules of Civil Procedure and the Seventh Amendment of the U. S. Constitution.

Dated: August ___ 2013

UNITED STATES OF AMERICA, ex rel. Kevin Bryan and Franklin Brock Wendt

Respectfully submitted:

BOYD & ASSOCIATES

_____
Samuel L. Boyd
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ATTORNEYS FOR RELATORS/PLAINTIFFS

CERTIFICATE OF SERVICE AND DISCLOSURE

1. On August 12, 2013, Relators served a copy of their Disclosure Statement to US Attorney Scott Hogan for the United States District Court for the Northern District of Texas, by electronic service and overnight mail.

2. On August 12, 2013, Relators served a copy of their Disclosure Statement to United States Attorney Sarah R. Saldana for United States Department of Justice, by electronic service and overnight mail.

3. On August 12, 2013, Relators served a copy of their Disclosure Statement to Dallas Investigative Managers James Hughes and Richard Hill, by electronic service and overnight mail.

4. On August 12, 2013, Relators served a copy of their Disclosure Statement to Texas Attorney General Greg Abbott, by electronic service and overnight mail.

5. On August 12, 2013, Relators served a copy of their Disclosure Statement to Director W. Rick Copeland of the Medicaid Fraud Control Unit in the Texas Office of the Attorney General, by electronic service and overnight mail.

6 On August 22, 2013, Relators served a copy of their proposed Complaint, upon Scott Hogan and Sean R. McKenna for the United States District Court for the Northern District of Texas by electronic service.

7. On August 22, 2013, Relators served a copy of their proposed Complaint, upon United States Attorney Sarah R. Saldana for United States Department of Justice by electronic service.

8. On August 22, 2013, Relators served a copy of their proposed Complaint upon attorney Dallas Investigative Managers James Hughes and Richard Hill by electronic service.

9. On August 22, 2013, Relators served a copy of their proposed Complaint upon Texas Attorney General Greg Abbott, by electronic service.

10. On August 22, 2013, Relators served a copy of their proposed Complaint, as additional disclosure materials, upon Director W. Rick Copeland of the Medicaid Fraud Control Unit in the Texas Office of the Attorney General, by electronic service.

11. On this date, August 23, 2013, a copy of Relator's file-marked Complaint, filed under seal, was served upon the following in accordance with the Federal Rules of Civil Procedure:

Sarah R. Saldana
United States Attorney
Northern District of Texas
1100 Commerce St., Third Floor
Dallas, TX 75242
sarah.saldana@usdoj.gov

J. Scott Hogan
United States Attorney's Office
Deputy Civil Chief
1100 Commerce St., Third Floor
Dallas, TX 75242
214.659.8640
Scott.hogan.usdoj.gov

Gwen Byers, Investigator
US Attorney's Office
1100 Commerce St., Third Floor
Dallas, TX 75242
Gwen.g.byers@usdoj.gov

Greg Abbott
Attorney General of Texas
Office of the Attorney General
PO Box 12548
Austin, TX 78711

W. Rick Copeland, Director
Medicaid/Medicare Fraud Control Unit
Office of the Attorney General
PO Box 12307
Austin, TX 78711

Dallas office for Medicaid Fraud
James Hughes, Investigative Manager
Richard Hill, Investigative Manager
1230 River Bend Drive, Suite 200
Dallas, TX 75247

12. A copy of Relators' Disclosure Statement and file-marked Complaint, filed under seal, was also served, on August 23, 2013, pursuant to FRCP 4(i)(1)(b), via Certified Mail, Return Receipt Requested, upon:

Eric H. Holder
Attorney General of the United States
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530-0001

_____

Samuel Boyd

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

Civil Action No.: 3-12-cv-4457N
Filed November 6, 2012

UNITED STATES OF AMERICA
EX REL. CHRISTOPHER SEAN
CAPSHAW

Relator

vs.

BRYAN K. WHITE, M.D.,
INDIVIDUALLY; BE GENTLE HOME
HEAL TH, INC. d/b/a PHOENIX HOME
HEALTH CARE; SURESH KUMAR,
INDIVIDUALLY; HOSPICE PLUS, L.P.;
SABARI KUMAR, INDIVIDUALLY;
REMANI B. KUMAR, M.D.
INDIVIDUALLY; NORTH TEXAS BEST
HOME HEALTH; A&S HOME HEALTH
CARE; GOODWIN HOME HEALTH
SERVICES, INC.; D. YALE SAGE,
INDIVIDUALLY; KIRK SHORT,
INDIVIDUALLY; SHEILA HALCROW
A.KA. SHEILA WATLEY/SHEILA
TAYLOR, INDIVIDUALLY

Defendants

RELATOR'S COMPLAINT FOR DAMAGES
UNDER THE FALSE CLAIMS ACT

[A187]

31 USC § 3729 ET SEQ.

COMES NOW the United States of America ex rel. Christopher Sean Capshaw Relator/Plaintiff, and, pursuant to 31 U.S.C. § 3729, et seq., and other applicable rules and law, files the instant Complaint against Bryan K. White, M.D., individually; Suresh Kumar, Individually; Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care; North Texas Best Home Health; A&S Home Health Care; Goodwin Home Health Services, Inc.; Hospice Plus, L.P.; Goodwin Hospice, Inc.; D. Yale Sage, individually; Kirk Short, individually, Sheila Halcrow a.k.a. Sheila Watley/Sheila Taylor, individually, for cause of claim would show as follows:

I.

PARTIES

1. Relator, Christopher Sean Capshaw is an adult resident of Dallas County, Texas, residing at 4602 Rockaway, Dallas, Texas, 75214, who brings this action by virtue of being an original source of the information on which the allegations are based, having direct and independent knowledge on which these allegations are based.

2. Relator is an insider to the scheme between the Part A Medicare participant companies (the White/Kumar companies, Defendants) and Part B participants (the American Physician House Calls ("APH"), American Physician House Calls Health Services ("AP **HHS")).**

3. Formally, Relator's position in APH was as Finance Director answering to Senior Vice President of Compliance, Chris McAdam. A graphical

description of Relator's position as within APH is shown in Appendix E, taken from the files of information collected by Relator.

4. Relator has direct and independent knowledge of the allegations herein and is disclosing to the United States substantially all of the evidence and information gathered by Relator upon discovering the scheme among the Defendants and the true relationship between the Defendants and APH/APHHS. Each of these entities and Defendants are more fully described below.

5. Relator is serving upon the Government, pursuant to 31 USC 3730(b)(2) a written disclosure of substantially all material evidence and information the Relator possesses together with this Complaint. This evidence together with the information known by Relator reveal the scheme developed by the Defendants.

6. **Defendant Bryan K. White, M.D.** is a natural person in Dallas, Texas, who may be served with process at 221 West Colorado Blvd., Suite 640, Dallas, Texas 75208. White is a central player in the scheme. He is: (1) part owner of all Part A Medicare participant companies, Defendants, (2) a significant lender to Part B participant APH, and (3) was the Medical Director for APHHS.

7. **Defendant Suresh Kumar** is a natural person domiciled in Dallas, Texas, who may be served with process at 5550 Harvest Hill Road, Suite 125, Dallas, Texas 75230. Kumar is a central player in the scheme. He is: (1) part owner or manager of all Part A Medicare participant companies, Defendants, (2) a significant investor in

Part B Medicare participant APH, and (3) was the manager for all of the White/Kumar owned business (whether personally or through his relatives).

8. **Defendant Be Gentle Home Health, Inc.** (hereinafter "Be Gentle") is a Texas corporation, which may be served with process at Suresh Kumar, Registered Agent, 5550 Harvest Hill Road, Suite 125, Dallas, Texas 75230. Be Gentle is a Part A Medicare participant company owned primarily by White and Kumar (with Defendants Kirk Short and Yale Sage having some ownership interest given as a kickback), and is managed by Kumar.

9. **Defendant Phoenix Home Health Care** is a d/b/a of Be Gentle Home Health, Inc. (hereinafter "Phoenix") and it may be served at its original place of business, 5550 Harvest Hill Road, Suite 125, Dallas, Texas 75230.

10. Defendant North Texas Best Home Healthcare Inc. (hereinafter "North Texas Best") is a domestic for-profit corporation that may be served with process at Sabari Kumar, 2629 Serenity Ct., Carrollton, Texas 75010. North Texas Best is a Part A Medicare participant company owned by White and managed by Kumar.

11. **Defendant A&S Home Health Care** (hereinafter "A&S) is a Texas corporation, which may be served with process at 17826 Davenport Rd., Suite A, Dallas, Texas 75252. A & S is a Part A Medicare participant company owned by White and managed by Kumar.

12. **Goodwin Home Health Services, Inc.** (hereinafter "Goodwin") is a corporation that may be served with process at Mayub Malik, 1909

Kensington Drive, Carrollton, Texas 75007. Goodwin Home Health is a Part A Medicare participant company owned by White and Kumar, and managed by Kumar.

13. **Hospice Plus, L.P.** (hereinafter "Hospice Plus") is a domestic limited partnership (LP) which may be served with process at CT Corporation System, 350 North St. Paul Street, Suite 2900, Dallas, Texas 75201-4234. Hospice Plus is a Part A Medicare participant company owned by White and Kumar, and managed by Kumar.

14. **Goodwin Hospice Inc.** (hereafter "Goodwin Hospice") is a corporation that may be served with process at 3100 McKinnon St. Suite 200, Dallas, Texas 75201. Goodwin Hospice is a Part A Medicare participant company owned by White and Kumar, and managed by Kumar.

15. **Defendant Dan Yale Sage** (hereinafter "Sage") is a natural person domiciled in Dallas, Texas who may be served with process at 5727 W. Hanover Ave., Dallas, Texas 75209-3429. Sage was the primary owner and manager of Part **B** Medicare participant APH, and is also part owner of Part A Medicare participant, Be Gentle Home Health, Inc.

16. **Defendant Kirk Short** (hereinafter "Short") is a natural person domiciled in Dallas, Texas who may be served with process at 6722 Blue Valley Lane, Dallas, Texas 75214- 2716. Short managed Part B Medicare participant APH, and is a part owner of Part A Medicare participant, Be Gentle Home Health, Inc.

17. **Defendant Sheila Halcrow,** a.k.a. Sheila Watley/Sheila Taylor (hereinafter "Halcrow") is a natural person domiciled in Dallas, Texas who may be served with process at 2835 Villa Creek Drive, Apt. 213, Dallas, Texas 75234-7447. Halcrow managed Part B Medicare participant APH, and controlled all APHHS doctors, mandating referrals be directed to one of the Defendant Part A Medicare participant companies.

18. The web of parties is complicated by the corporate identities whose names do not reveal the common interests and ownership and interests of the Defendants White, Kumar, Sage, Short, and Halcrow. The flowchart of the scheme, attached as Appendix I, illustrates the connection.

NON-PARTY CO-CONSPIRATORS

19. **Sage Physician Partners, Inc. d/b/a American Physician Housecalls** ("APH") is a for-profit business formerly owned primarily by Dan Yale Sage (Defendant herein), Kirk Short (Defendant herein) Suresh Kumar (Defendant herein) and a number of other individual shareholders.

20. Relator has tendered in his disclosure statement to the United States the stock and debt holders names and stakes in APH. APH is now bankrupt and out of business.

21. None of the scheme alleged herein was disclosed in the bankruptcy APH.

22. APH was a for profit corporation with a singular purpose, to manage APHHS, whose only

employees were physicians. Defendant Sheila Halcrow coordinated the physician referrals complained of herein by APHHS physicians.

23. Halcrow was employed by APH and coordinated the physician referrals under the APHHS Medical Director, Defendant Bryan White, M.D.

24. **American Physician Housecalls Health** Services, **Inc.** (herein referred to as "APHHS") is a corporation organized as a non-profit that functioned to employ doctors and care providers. These employees of APHHS provided certifications, re-certifications and orders necessary to effectuate the referrals of Part A eligible patients to populate the White/Kumar owned Defendant Part A Medicare participant companies in violation of Stark law and the AntiKickback statute.

25. The type of patient referred by APHHS personnel to the White/Kumar Part A companies were patients that did not already have an existing relationship with another similar Part A Medicare provider.

26. In addition to the scheme as outlined by Appendix I, the APHHS physicians submitted false claims related to Care Plan Oversights (CPO} for patients that were referred by APHHS to the White/Kumar Part A companies. The CPO funds were used, in addition to the kickback loans and investment from White and Kumar, to sustain the business of APH and APHHS, so that these failing Part B companies could continue to be a source of illegal referrals to the White/Kumar Part A Defendant companies.

27. To be clear, APH and APHHS were not profitable and the business model they could have legitimately operated under was not sustainable. However, in order to keep the referral pipeline flowing, White and Kumar invested millions of dollars with no hope for any monetary return. A description of the debt instruments from APH's own files is attached here as Appendix F. Though titled "expired" debt instruments, the terms reveal that 13 of the 14 instruments were "extended indefinitely," which is evidence the loans were never intended to be paid in the ordinary course of business by APH.

28. In essence, the profitable Part A Medicare providers threw good-money-after-bad to keep the fledgling Part B Medicare participant APH/APHHS provider afloat in order to continue the illegal referrals scheme.

29. The party Defendants together with the non-parties described here acted in a conspiracy to violate the False Claims Act through express and implied false certification that Stark law and the Anti-Kickback statute were being complied with when in fact they were being violated habitually, and in the ordinary course of business under the scheme.

II.
TABLE OF RELATOR'S APPENDIX

A. Medicare Enrollment Application (Form 8551) containing Certification Statement – *See* p. 25.

B. Spreadsheet tracking 1. 75 years of referrals to Non-Hospice Providers. The scheme

lasted approximately 6 years in total. (None of the Hospice referrals are included in this document).

C. Superbill excerpts, includes specific patients referred in violation of the Anti-Kickback Statute and Stark law and shows actual payments by Medicare for the services in violation of the False Claims Act. The full text Superbill is over 4000 pages.

D. Hospice Plus Monthly Billing Statement showing payments by Medicare of over $29.3 million during 3.25 years of the 6 year scheme. Approximately $14.6 million of the payments in that period were paid through false claims generated by the scheme described below. The balance of the 6 year scheme includes 5 additional Medicare Part A facilities.

E. Organization Chart for APH showing Relator's connection to the entities involved.

F. Debt Chart identifying some of the debt instruments used to keep APHHS and APH operating during the scheme and demonstrating the financial relationship between the Medicare Part A Defendants and the Medicare Part B entities.

G. APH Family of Companies from the files of APH.

H. Citymark Lease.

I. Flowchart of the Scheme.

II.
NATURE OF THE CASE

30. This case involves a conspiracy to commit violations of the Federal Anti-Kickback statute and Stark law, which resulted in violations of the False Claims Act by Defendants. This action is brought by Relator pursuant to the *qui tam* provision of 31 U.S.C. 3729 *et seq.,* the False Claims Act.

31. Defendants, directly and through conspiracy, made material false statements to Medicare in order to receive payment on Medicare claims. The material false statements were (1) false express certifications made as a condition of *payment* that all claims and underlying transactions complied with the Federal Anti-Kickback statute, Stark law, and other such law; and, (2) implied false certification when *billing* Medicare that all claims and underlying transactions complied with the Federal Anti-kickback statute, Stark law, and other such law.

32. These false certifications were made through a web of Part A and Part B Medicare participants involved in a scheme of referrals and kickbacks. The scheme is illustrated by the flowchart attached as Appendix I.

33. In essence, Defendants Bryan White and Suresh Kumar, together with Defendants Yale Sage, Kirk Short, and Sheila Halcrow, knowingly set up a system of kickbacks and illegal referrals. In this scheme a financially unviable Part B Medicare participant company primarily owned by Sage, and

managed by Sage, Short, and Halcrow (specifically, American Physician House Calls ("APH") and its non-profit arm, American Physician House Calls Health Services ("APHHS")) were used as tools to significantly increase referrals and, thereby Part A Medicare payments, to the White/Kumar owned Part A Medicare participant companies (specifically, Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care, North Texas Best Home Health, A&S Home Health Care, Goodwin Home Health Services, Inc., Hospice Plus, L.P., Goodwin Hospice, which are all Defendants in this case).

34. The illegal kickbacks to Sage, Short, and Halcrow from White and Kumar in the scheme include: (1) equity interest for Sage and Short in at least one White/Kumar owned company (Be Gentle d/b/a Phoenix), (2) loans from White to APH (primarily owned by Sage) which were never intended to be repaid, and in fact were never repaid, (3) and leased spaced for APH for which rent was not paid on a monthly basis. 35. The self-interested illegal referrals include (1) a steady stream of original referrals and re-certification referrals to the White/Kumar owned Part A companies from the Sage owned Part B companies (APH/APHHS) managed by Sage, Short, and Halcrow, and (2) referrals back to the Sage owned Part B companies (APH/APHHS) from the White/Kumar owned Part A companies for re-certification.

36. The illegal purpose, which the evidence shows that White, Kumar, Sage, Short, and Halcrow all had the requite knowledge, was to maintain the cycle of self-interested referrals to the White/Kumar

owned Part A Medicare participant companies in order to substantially bill and receive payment from Medicare.

37. As a result of this scheme, the White/Kumar owned Part A companies were able to bill Medicare an astronomical amount of money through claims that were falsely certified. Specifically, the White/Kumar Part A companies received Medicare payments in excess of $100,000,000.00 from 2006 to 2012, based on the personal knowledge of Relator and an analysis of internal documents provided in Appendix B, D, by Relator, the finance Director of APH.

38. Under the False Claims Act the consequential civil penalties and damages for this scheme are substantial. Each individual false claim (of which there are tens of thousands) creates liability in civil penalties of between $5,500.00 and $11,500.00 per false claim (when adjusted for inflation), plus 3 times the amount of damages the Government sustained, which again, is well in excess of $100,000,000.00.

39. This action is filed by Relator Christopher Sean Capshaw on behalf of the United States of America. Relator has personal knowledge of the scheme including documentation detailing the specific scheme of illegal referrals and the amounts paid by Medicare as a result of this scheme. Through the attached appendices and disclosure statement, Relator is providing over 30 gigabytes of detailed information and proof in support of these claims. This information provides the identity, subject,

places, dates, and amount of money involved in the corpus of the scheme.

40. Since the collapse of APH and APHHS, the individual Defendants have resurrected the scheme for the benefit of the Medicare Part A Defendants. Sheila Halcrow fills the same role in the new company as she did in APH.

III.
JURISDICTION

41. Relator brings this action in the name of the United States of America. The federal district court has original jurisdiction in this proceeding pursuant to Section 31 U.S.C. Title 3729 and 3730, in this civil action arising under the Federal laws of the United States. Relator is not a present or former member of the government including Congress, the Executive branch or the armed forces. No Defendant is a member of the government. No claim herein is the subject of any other federal criminal, civil or administrative hearing. No claim herein has been otherwise publicly disclosed. The Relator himself, a true innocent insider, is the original source of all information provided here and information provided in his disclosure statement to the United States. The requisite disclosure statement is being provided to the United States. All conditions precedent have been met. This complaint is filed under seal Pursuant to 31 U.S.C. 3730(b)(2)

IV.
VENUE

42. The venue is proper in this District by virtue of Title 28 Section 1391(b) in that all of the Defendants maintain an office and principal place of business and are subject to personal jurisdiction in the District as a result of conducting substantial business in the District.

V.
LAW

43. Under Federal law, a conspiracy to commit knowingly false certification of compliance (with the Anti-Kickback and Stark law) when seeking payment and/or billing a Federal Government Program (such as Medicare)--as a matter of law--is a conspiracy to commit legally false claims under the False Claims Act, when the certification is a prerequisite for payment.

44. Therefore, as a matter of law, express certifications which are a condition of *payment* from Medicare that are false, as well all implied false certifications made when *billing* Medicare create liability under the False Claims Act.

Materiality of the False Certifications

45. Furthermore, as a matter of law, when a false certification of compliance (with the Anti-Kickback and Stark law) is a "condition of payment," the false certification is "material" within the meaning of the False Claims Act. Federal Courts have recognized that if Medicare knew the

certification of compliance was false, it would refuse to pay.

The False Claims Act

The False Claims Act (FCA) provides, in pertinent part that:

> (a)Liability for certain acts.--In general [] (1) Any person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false for fraudulent claim; (C) conspires to commit a violation ... ; (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government,
>
> ***
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, plus 3 times the amount of damages which the Government sustains because of the act of that person ....

> (b) For purposes of this section--(1) the terms "knowing" and "knowingly"--(A) mean that a person, with respect to information (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information, and (B) require no proof of the specific intent to defraud.

31 U.S.C. § 3729.

46. In this case, the false certifications made to Medicare were that the Anti-Kickback Statue and Stark Law were complied with when in fact they were not.

The Anti-Kickback Statute

47. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), arose out of congressional concern that payoffs to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the program from these difficult-to detect harms, Congress enacted a *per se* prohibition against the payment of kickbacks in any form, regardless of whether the particular kickback gave rise to overutilization or poor quality of care. 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 of1972, 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. I 00-93.

48. The Anti-Kickback Statute prohibits any person or entity from making or accepting payment to induce or reward any person for referring, recommending or arranging for federally-funded medical services, including services provided under the Medicare and Medicaid programs with both civil and criminal penalties.

Under 42 U.S.C.A. § 1320a-7a Civil Monetary Penalties:

> (a) Improperly filed claims
>
> Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5) of this section) that—
>
> (8) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; ...

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each item or service ... [or]$50,000 for each such act, in cases under paragraph (8) ... .In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim

Under 42 U.S.C.A. § 1320a-7b Criminal Penalties for Acts Involving Federal Health Care Programs

(b) Illegal remuneration

(1) whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring 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) in return for purchasing, leasing, ordering, or arranging for or recommending 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.

(2) 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).

49. Violation of the statute can also 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).

Stark Law

50. Enacted as amendments to the Social Security Act, 42 U.S.C. § 1395nn (commonly known as the "Stark Statute") prohibits a hospital (or other entity providing healthcare items or services) from submitting Medicare claims for payment based on patient referrals from physicians having a "financial relationship" (as defined in the statute) with the healthcare provider. The regulations implementing 42 U.S.C. § 1395nn expressly require that any entity collecting payment for a healthcare service "performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353.

51. The Stark Statute establishes the clear rule that the United States will not pay for items or services prescribed by physicians who have improper financial relationships with other providers. The statute was designed specifically to reduce the loss suffered by the Medicare program due to such increased questionable utilization of services.

52. Congress enacted the Stark Statute in three parts, commonly known as Stark I, Stark II and most recently Stark III (Stark III is actually just a new phase of Stark II). Enacted in 1989, Stark I applied to referrals of Medicare patients for clinical laboratory services made on or after January 1, 1992, by physicians with a prohibited financial relationship with the clinical lab provider. *See* Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, § 6204.

53. In 1993, Congress extended the Stark Statute (Stark II) to referrals for ten additional designated health services. *See* Omnibus Reconciliation Act of 1993, P.L. 103-66, §13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152.

54. As of January 1, 1995, Stark II applied to patient referrals by physicians with a prohibited financial relationship for the "designated health services" which included inpatient and outpatient hospital services. *See* 42 U.S.C. § 1395nn(h)(6).

In pertinent part, the Stark Statute provides:

(a) Prohibition of certain referrals

(1) In general

Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship

with an entity specified in paragraph (2), then –

> (A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and
>
> (B) the entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payer, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

42 U.S.C. § 1395nn.17.

55. The Stark Statute broadly defines prohibited financial relationships to include any "compensation" paid directly or indirectly to a referring physician. The statute's exceptions then identify specific transactions that will not trigger its referral and billing prohibitions. Those exceptions do not apply in this case.

56. Violation of the statute may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including (a) a civil money penalty of$15,000 for each service included in

a claim for which the entity knew or should have known that payment should not be made under Section 1395nn(g); and (b) an assessment of three times the amount claimed for a service rendered pursuant to a referral the entity knew or should have known was prohibited. *See* 42 U.S.C. §§ 1395nn(g), 1320a-7a(a).

The Medicare and Medicaid Programs

57. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. *See* 42 U.S.C. §§ 426, 426A.

58. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4.

59. Part B of the Medicare Program authorizes payment for medically necessary doctor's services, outpatient care, and most other services that Part A does not cover such as home health care services. See 42 U.S.C. §§ 1395c-1395i-4.

60. HHS is responsible for the administration and superv1s10n of the Medicare program. The Centers for Medicare and Medicaid Services (CMS) is an agency of HHS and is directly responsible for the administration of the Medicare program.

61. Under the Medicare program, CMS makes payments retrospectively (after the services

are rendered) to healthcare providers for inpatient and outpatient services. Medicare enters into provider agreements with the healthcare providers in order to establish the providers' eligibility to participate in the Medicare program. However, Medicare does not prospectively contract with hospitals to provide particular services for particular patients. Any benefits derived from those services are derived solely by the patients and not by Medicare or the United States.

62. As detailed below, Defendants submitted or caused to be submitted claims both for specific services provided to individual beneficiaries as a result of referrals in violation of the Stark law and Anti-Kickback Legislation whereupon the Defendants' bills to Medicare incurred in treating these Medicare beneficiaries were paid by Medicare.

VI.
FACTUAL PREDICATE AND BACKGROUND
The Co-Conspirators' Scheme (Who, What, When, Where, How, and Scienter).

Paragraphs 1-62 are incorporated herein as if fully set forth.

Co-Conspirators (Who):

63. In this case, Suresh Kumar, Bryan K. White, D. Yale Sage, Kirk Short and Sheila Halcrow are the principals in the fraudulent scheme alleged in this Complaint.

64. The Part A Medicare participant companies, specifically, Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care, North Texas Best Home Health, A&S Home Health Care, Goodwin Home Health Services, Inc., Hospice Plus, L.P., Goodwin Hospice, which are all Defendants, were all involved in the scheme.

65. The Part B Medicare participants companies, specifically, American Physician House Calls ("APH") and its non-profit arm, American Physician House Calls Health Services ("AP HHS") were involve in the scheme, but are not defendants in this case only because they are now bankrupt entities.

66. The ownership and management of the Part A and Part B companies reveal the following:

Bryan K. White

Bryan K. White owned in whole or in part the following Part A Medicare participant companies: Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care, North Texas Best Home Health, A&S Home Health Care, Goodwin Home Health Services, Inc., Hospice Plus, L.P., Goodwin Hospice. Bryan White also directed the physicians employed by Part B Medicare Participant APHHS in his position as Director of Medicine of APHHS.

Suresh Kumar

Suresh Kumar owned in whole or in part the following Part A Medicare participant companies: Be

Gentle Home Health, Inc. d/b/a Phoenix Home Health Care, Goodwin HomeHealth Services, Inc., Hospice Plus, L.P. Suresh Kumar also was a substantial investor in Part B Medicare Participant APH. Kumar also managed (personally or through his family relations), Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care, North Texas Best Home Health, A&S Home Health Care, Goodwin Home Health Services, Inc., Hospice Plus, L.P., Goodwin Hospice.

Dan Yale Sage

Dan Yale Sage owned, in part, the following Part A Medicare participant company, Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care. Sage also was the primary owner of Part B Medicare Participant company, American Physician House Calls (APH). Sage was also a primary manager of APH, and therefore APHHS, which had a sole management agreement to manage APH.

Kirk Short

Kirk Short owned, in part, the following Part A Medicare participant company, Be Gentle Home Health, Inc. d/b/a Phoenix Home Health Care. Short also was a stakeholder of Part B Medicare Participant company, American Physician House Calls (APH). Short was also a primary manager of APH, and therefore APHHS, which had a sole management agreement to manage APH.

Sheila Halcrow

Sheila Halcrow also was a stakeholder of Part B Medicare Participant company, American Physician House Calls (APH). Halcrow was also a primary manager of APH, and therefore APHHS, which had a sole management agreement to manage APH.

The Scheme (What & How):

67. This scheme, in essence, was a conspiracy to commit violations of the Federal Anti-Kickback statute and Stark law, which resulted in violations of the False Claims Act by Defendants.

68. Defendants, directly and through conspiracy, made material false statements to Medicare in order to receive payment on Medicare claims. The material false statements were express certifications, which were made as a *condition of payment,* made by the doctors in their Medicare Enrollment Application and ongoing reapplication. The express certification, specifically states:

> "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 supplier's compliance with

all applicable condition of participation in Medicare."

69. In addition, Defendants also made an implied false certifications when *billing* Medicare that all claims and underlying transactions complied with the Federal Anti-kickback statute, Stark law, and other such laws.

70. In order to guarantee a steady stream of referrals to the White/Kumar Part A Medicare participant companies, illegal kickbacks were made to Sage, Short, and Halcrow from White and Kumar (in violation of the Anti-Kickback statute). Specifically, Kickbacks include (1) equity interest for Sage and Short in at least one White/Kumar owned company (Be Gentle d/b/a Phoenix), (2) loans from White to APH (primarily owned by Sage) that were never intended to be repaid, which is evidenced by the Debt Instrument Chart, attached as Appendix F, and (3) leased spaced for APH for which monthly rent was never paid, which is evidenced by The City Mark Lease attached as Appendix H.

71. The self-interested illegal referrals made to and from Defendants include (1) a steady stream of original referrals and re-certification referrals to the White/Kumar owned Part A companies from the Sage owned Part B companies (APH/APHHS) managed by Sage, Short, and Halcrow, which is evidenced by the Referral Spreadsheet attached as Appendix B; and (2) referrals sent back to the Sage owned Part B companies (APH/APHHS) from the White/Kumar owned Part A companies for re-certification, which is

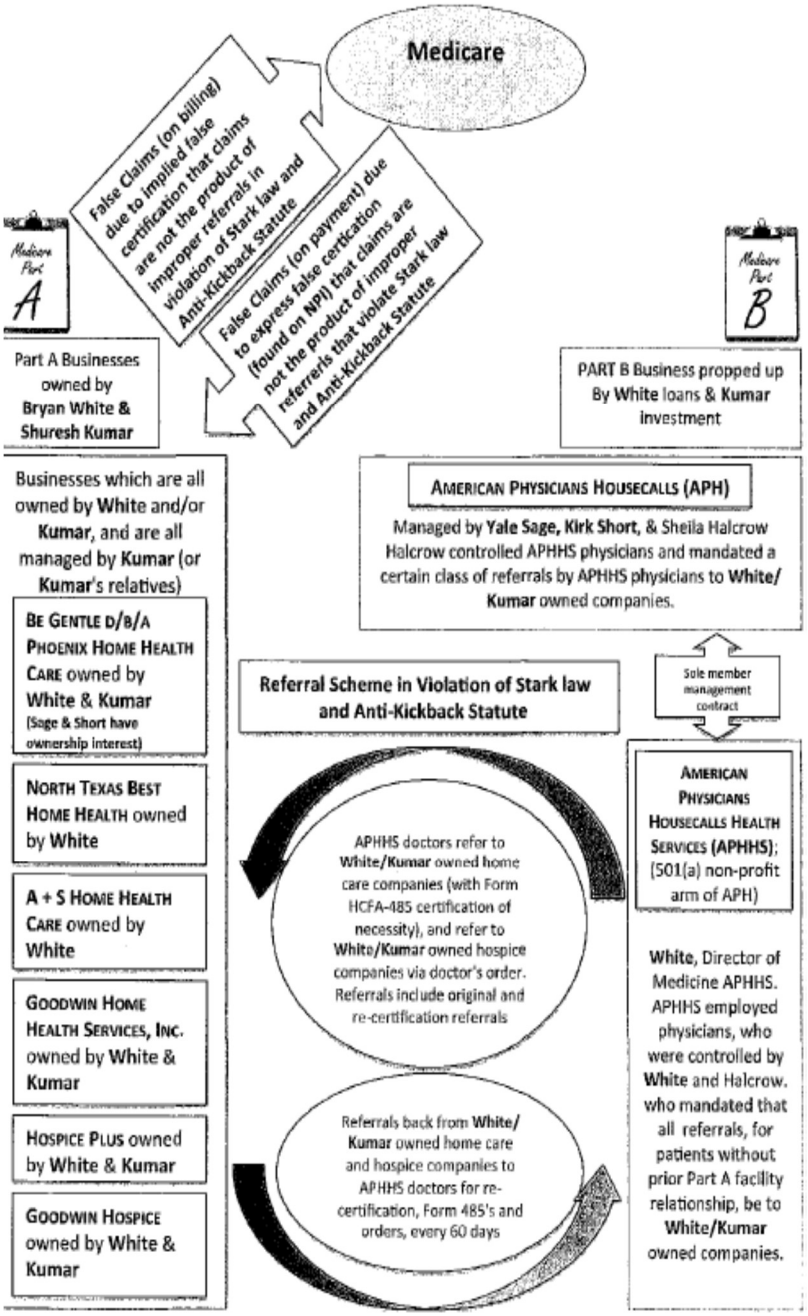
evidenced by The SuperBill document showing billing to Medicare, excerpts of which are attached as Appendix C.

72. The illegal purpose was to maintain the cycle of self-interested referrals to the White/Kumar owned Part A Medicare participant companies in order to substantially bill and receive payment from Medicare.

73. As a result of this scheme, the White/Kumar owned Part A companies were able to bill Medicare an astronomical amount of money through claims that were falsely certified. Relator's analysis, as the Director of Finance for APH, is that the combined Medicare payments put the amount received as a direct result of the false certification upwards of$ I 00,000,000.00. This analysis is further evidenced by The Summary of The Hospice Plus Monthly Billing Statements which is attached as Appendix D, as well as the personal knowledge of Relator.

74. The Flowchart below, which is also attached as Appendix I, has been inserted to clarify how the scheme worked. But for this scheme, the government would not have paid the billings by the Defendants.

[A215]


Medicare
False Claims (on billing) due to implied false certification that claims are not the product of improper referrals in violation of Stark law and Anti-Kickback Statute
False Claims (on payment) due to express false certication (found on NPI) that claims are not the product of improper referrels that violate Stark law and Anti-Kickback Statute
Medicare Part A
Medicare Part B
Part A Businesses owned by Bryan White & Shuresh Kumar
PART B Business propped up By White loans & Kumar investment
Businesses which are all owned by White and/or Kumar, and are all managed by Kumar (or Kumar's relatives)
BE GENTLE D/B/A PHOENIX HOME HEALTH CARE owned by White & Kumar (Sage & Short have ownership interest)
NORTH TEXAS BEST HOME HEALTH owned by White
A + S HOME HEALTH CARE owned by White
GOODWIN HOME HEALTH SERVICES, INC. owned by White & Kumar
HOSPICE PLUS owned by White & Kumar
GOODWIN HOSPICE owned by White & Kumar
AMERICAN PHYSICIANS HOUSECALLS (APH)
Managed by Yale Sage, Kirk Short, & Sheila Halcrow Halcrow controlled APHHS physicians and mandated a certain class of referrals by APHHS physicians to White/ Kumar owned companies.
Sole member management contract
Referral Scheme in Violation of Stark law and Anti-Kickback Statute
APHHS doctors refer to White/Kumar owned home care companies (with Form HCFA-485 certification of necessity), and refer to White/Kumar owned hospice companies via doctor's order. Referrals include original and re-certification referrals
Referrals back from White/ Kumar owned home care and hospice companies to APHHS doctors for re-certification, Form 485's and orders, every 60 days
AMERICAN PHYSICIANS HOUSECALLS HEALTH SERVICES (APHHS); (501(a) non-profit arm of APH)
White, Director of Medicine APHHS. APHHS employed physicians, who were controlled by White and Halcrow. who mandated that all referrals, for patients without prior Part A facility relationship, be to White/Kumar owned companies.

75. Importantly, Sheila Halcrow was employed by APR but handled the administrative duties related to patient record keeping and referrals for APHHS as well. Bryan White, as the Medical Director for APHHS, controlled the APHHS physicians through daily directions given by Sheila Halcrow.

76. When a patient did not have a prior existing relationship with a Part A Medicare participant company, Sheila instructed the APHHS physicians to refer the patient to the appropriate White/Kumar owned Part A companies in a controlled manner so as not to arouse the suspicion any curious government employees or outsiders. The initial certification of necessity for services by the APHHS physicians (made via an HCFA form 485 for the home care companies, and Orders for the hospice companies) were made habitually, by mandate, so that the White/Kumar Part A companies could continue to make claims to Medicare and receive payment.

77. For patients in need of Hospice services, only a doctor's or Medical Director's order is necessary (as opposed to the HCFA-485 form) for the referral to a Medicare Part A facility. In these instances, patients cared for by physicians were referred to Hospice Plus and Goodwin Hospice, which are also White/ Kumar owned companies.

78. When the Medicare Part A patients needed recertification of necessity for services provided by the Part A Defendants companies, the patient was referred back to the physician for recertification. The recertification was signed by the

actual physician directed by Halcrow who often had consent from some physicians to sign their names, in some instances.

79. Furthermore, through this cycle, the Part A Defendant companies were able to continue to bill Medicare for this class of patients again and again.

80. All *payments* made by Medicare in connection with these referrals from each of the Part A Medicare Defendant entities are express violations of the Certification Statement by each Defendant in each of their Medicare Enrollment Applications that state in pertinent part:

> "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 supplier's compliance with all applicable condition of participation in Medicare."

This is evidenced by the Medical Enrollment Application attached as Appendix A. *See* p.25.

81. All *billing* to Medicare in connection with these referrals are implied violations of the Certification Statement by each Defendant (including billing by or through the Defendant

entities) in each of their Medicare Enrollment Applications that state in pertinent part:

> "I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in Section 4A of this application."

See id at 25.

82. Hospice Plus provides an example to measure the amount of damages involved in this False Claims scheme. In only a 3.25 year period, at least 50 percent of Hospice Plus patients came from referrals by APPHS employees. For that period alone, Hospice Plus (which is only one Part A provider Defendant) was paid over $29,300,000.00 from Medicare. This is evidenced The Summary of The Hospice Plus Monthly Billing Statements which is attached as Appendix D. Based on the analysis and the personal knowledge of the Relator, Hospice Plus was one of the smaller entities involved in this scheme.

83. During the time where the scheme was in operation, APR and APHHS were not profitable and were steadily losing money. However, the Part A White/Kumar owned companies (like Hospice Plus) were profiting significantly from the referrals by APHHS employees.

84. In order to sustain the stream of referrals and re-certifications by APHHS employees, White "propped up" APR and APHHS through a series of debt instruments and loans. By the time APR failed, White personally provided approximately

$1,900,000 in loans to fund the APR/ APHHS operation. There is no evidence that any of the loans were repaid or were ever intended to be repaid. One of the promissory notes through which White funneled money to APR was a backdated note executed just prior to the Bankruptcy filings of these entities. In addition to this back-dated note, APR documents reveal a schedule of the debt instruments; the terms of those instruments were extended "indefinitely". This is evidenced by The Debt Instrument Chart attached as Appendix F.

Dates of the Overall Scheme and Individual Referral Transactions (When)

85. There are two levels of "when" the scheme occurred. In the most broad sense, the scheme began in on or about 2006 until on or about May of 2012. All referrals by APHHS physicians to all Medicare Part A Defendants, and all billing associated with each patient referred represents violations of the False Claims Act (and violations of the Anti-Kickback Statute and Stark law).

86. On a more individualized level, meaning per patient, the referrals occurred in accordance with the referral transaction, which can be seen by way of example, in Appendix B.

Location of the Scheme (Where)

87. In the most broad sense, the scheme transpired in the Northern District of Texas. More

specifically, scheme unfolded at location of the Defendants offices and the offices of APH and APHHS, which are as follows:

3100 McKinnon, Suite 400, Dallas, Texas, in addition to each Medicare Part A Defendants' address, described above and incorporated herein, under the heading "Parties."

Evidence of Scienter ("Knowingly")

88. Bryan K. White, Suresh Kumar, Dan Yale Sage, Kirk Short and Sheila Halcrow all played a role in causing false claims to be presented to Medicare. Specifically, they caused all the physicians who worked for APHHS throughout the duration of the scheme, who are listed in the extreme right column of the spreadsheet attached as Appendix B and incorporated herein (as well as any other similarly situated APHHS physician not listed), to make certifications that were false. Moreover, Bryan K. White, Suresh Kumar, Dan Yale Sage, Kirk Short and Sheila Halcrow knowingly caused these false certification to be made in furtherance of the scheme. The included evidence specifically shows that White, Kumar, Sage, Short, and Halcrow had actual knowledge, or acted with deliberate ignorance, of the false certifications being made to Medicare (and the underlying violations of the Anti-Kickback statute and Stark law) in order to effectuate the scheme and obtain payment to the Part A Medicare Defendants.

VII.
COUNTS
Count 1--False Claims Act, 31 U.S.C. § 3729(a)(l) Presenting Claims to Medicare and Medicaid for Services Rendered as a Result of Kickbacks

89. Relator incorporates by reference paragraphs 1-89 of this complaint as if fully set forth.

90. Defendants knowingly presented, or caused to be presented, false and fraudulent claims for payment or approval to the United States, including claims for payments and/or reimbursement for services rendered to patients unlawfully referred to by physicians and others to whom defendants provided kickbacks and/or illegal remuneration and/or with whom defendants entered into prohibited financial relationships in violation of the Anti-Kickback Statute and the Stark Statute.

91. By virtue of the false or fraudulent claims defendants caused to be made, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,500 for each violation. Each bill for each patient paid by Medicare that followed the referrals is an individual violation.

Count II--False Claims Act, 31 *V.S.C.* § 3729(a)(2)
Use of False Statements

92. Relator incorporates by reference paragraphs **1-91** of this complaint as if fully set forth.

93. Defendants knowingly made, used, and caused to be made or used, false records or statements.

94. By virtue of the false or fraudulent claims defendants knowingly caused to be made, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $11,500 for each violation. Each bill for each patient paid by Medicare that followed the referrals is an individual violation.

Count III--False Claims Act, 31 *U.S.C* § 3729(a)(3)
Conspiracy to Submit False Claims

95. Relator incorporates by reference paragraphs 1-94 of this complaint as if fully set forth.

96. Defendants entered into agreements with certain physicians and conspired to defraud the United States by causing the submission of false or fraudulent claims for payment and/or reimbursement from the United States for monies to which they were not entitled, in violation of 31 U.S.C.§3729(a)(3).

97. As part of the schemes and agreements to obtain payment and/or reimbursement from the United States in violation of federal laws, defendants conspired to provide kickbacks and illegal remuneration to each other, to physicians, and others, and to engage in prohibited financial relationships with physicians and others in violation of the Stark Law and Anti- Kickback statute--i.e., the false certifications and representations made and caused to be made by defendants when submitting the false claims for payments and the false certifications made and caused to be made by defendants in submitting the cost reports as well as false entries in medical records--to get false or fraudulent claims paid and approved by the United States.

98. By virtue of the false or fraudulent claims made by the defendants, the United States suffered damages and therefore is entitled to multiple damages under the False Claims Act, to be determined at trial, plus a civil penalty of $5,500 to $ 11 ,500 for each violation. Each bill for each patient paid by Medicare that followed the referrals is an individual violation.

VII.
PRAYER FOR RELIEF

WHEREFORE, Plaintiff/Relator demands judgment against the Defendants, requesting relief as follows:

1. Find for the Plaintiff and award treble damages or any other applicable provision of law, including any alternate remedy provisions for each false or fraudulent charge, or overcharge, submitted for payment to the United States government;

2. Awarding civil penalties against the Defendants each jointly and severally in an amount between Five Thousand, Five Hundred Dollars ($5,500.00) and Eleven Thousand Dollars ($11,500.00) for each violation of 31 U.S.C. §3729, et seq.; of 2 U.S.C.§1320a-7b(b), and other Anti-Kickback Statutes; of 45 C.F.R. 46, et seq.; of the Settlement Agreement with the Office of lnspector General Department of Health and Human Services; or such other maximum amount allowed by law.

3. Award all actual damages.

4. Award costs and reasonable attorneys' fees.

5. Award other such relief as may be just.

Respectfully submitted,

TED B. LYON & ASSOCIATES, P.C.

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